

**THE DOD HEALTH CARE PROVIDER'S PERSONAL  
LIABILITY FOR ALLEGED MALPRACTICE**

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1. Introduction.

a. One of the many concepts and principles of English law that was adopted as a part of the American common law was that of sovereign immunity. The principle of sovereign immunity is essentially that the Governmental entity of the United States cannot be sued for its negligent acts without its consent. The Government as an entity seldom, if ever, is guilty of tortuous misconduct. Actions against the Governmental entity originate and have their legal basis in the actions of Governmental employees and agents that were representing the Government acting within the scope of their employment. One United States statute which creates a limited exception to the doctrine of sovereign immunity (a waiver of the doctrine if you will) is the Federal Tort Claims Act (FTCA).<sup>2</sup> The statute provides for the payment for death, personal injury, or damage to or loss of property (real or personal) when the injury or damage is caused by negligent or wrongful acts or omissions of military personnel or civilian employees of the Government while acting within the scope of their employment. Payment is made under such circumstances in which the United States, if a private person, would be liable to the claimant in accordance with the law of the place where the act or omission occurred.<sup>3</sup> The Federal Tort Claims Act is an opportunity for redress by individuals feeling they have been wrongfully injured by employees or agents of the Government. With the exception of Section 2679,<sup>4</sup> the Act did not limit the aggrieved individual from pursuing his remedies against the tort-feasor individually. For many years this was not much of a practical problem. The United States Government had unlimited resources with which to satisfy administrative claims and judgments under the Federal Tort Claims Act, and Governmental employees for the most part were totally incapable of satisfying substantial judgments. Also, the Supreme Court decision of Barr v. Matteo<sup>5</sup> in 1959 held that Government officials, acting within

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<sup>2</sup>28 U.S.C. §§ 2671-2680.

<sup>3</sup>Paragraph 4-3a, AR 27-20, Legal Services - Claims.

<sup>4</sup>This section, commonly known as the Government Driver's Act, protected the operators of Government vehicles acting within the scope of their employment from personal liability.

the scope of their employment, were immune from personal tort liability. However, later, in Henderson v. Bluenick<sup>6</sup> the Court held that there was not absolute immunity for such personnel.

b. With the Government having the ultimate deep pocket, and Government employees for the most part being unable to pay large judgments, why then would an aggrieved party be interested in suing the individual employee? There can be several reasons, not the least of which is that the Federal Tort Claims Act does not authorize the award of punitive damages,<sup>7</sup> and does not authorize jury trials.<sup>8</sup> Punitive damages can greatly increase the amount of any judgment, and persuasive attorneys with gruesome facts tend to be far more successful before a jury. Other factors may be a lengthier statute of limitations in the state jurisdiction, or that the alleged injury occurred overseas. The Federal Tort Claims Act is not extraterritorial in its application.<sup>9</sup>

c. At about the same time as the Bluenick decision, and starting in the late 1960s, the number of malpractice claims filed against physicians and the size of the verdicts began to increase at an unprecedented rate. "By 1974, physicians in several states began to experience severe problems in obtaining malpractice insurance. Even with the substantial premium increases a number of insurers left the market entirely and some health care providers were simply unable to secure liability insurance at any price. These factors led to a situation that many have labeled a 'crisis' in malpractice insurance."<sup>10</sup> With the realization that military physicians were generally paid less than their civilian counterparts and were unable to pay for malpractice insurance, the legislature recognized the necessity of providing Governmental physicians additional protection. The result was the 1976 enactment of the Medical Malpractice Immunity Act, also known as the Gonzalez Act.<sup>11</sup> The principal

<sup>5</sup>Barr v. Matteo, 360 U.S. 564, rehearing denied, 361 U.S. 855 (1959).

<sup>6</sup>511 F. 2d 399 (D.C. Cir. 1974).

<sup>7</sup>28 U.S.C. § 2674.

<sup>8</sup>Yedwab v. U.S., D.C.N.J. 1980, 489 F. Supp 717.

<sup>9</sup>28 U.S.C. 2680(k).

<sup>10</sup>Report of the Task Force on Medical Liability and Malpractice, Department of Health and Human Services, 1987, page 4.

<sup>11</sup>10 U.S.C. § 1089 (1982).

Legislative sponsor of this Act was Representative Henry B. Gonzalez (Dem., Texas). The Gonzalez Act provides that an action under the Federal Tort Claims Act was the exclusive remedy for individuals seeking damages for alleged medical malpractice. In effect, patients or their survivors who seek compensation must seek it from the Government, while the health care providers are immune from individual liability for care given while acting within the scope of their duties or employment.

d. For all its good intent, the Gonzalez Act, and in particular subsection (f)<sup>12</sup> and the reference to acting within the scope of such person's duties if such person is assigned to a foreign country or detailed for service with other than the Federal department, were to be the source of other problems and concerns. Those problems for the most part concern themselves with alleged malpractice occurring overseas, the military personnel receiving training at civilian medical institutions under so-called gratuitous agreements,<sup>13</sup> and personal services contract providers.<sup>14</sup>

## 2. Alleged Malpractice Overseas.

a. As previously stated, the Federal Tort Claims Act does not apply to malpractice actions that occur in overseas military installations.<sup>15</sup> It would initially appear that this should not create a problem as there is a "sister" statute creating an administrative remedy for individuals feeling that they have been the victims of malpractice in an overseas area. This is the Military Claims Act.<sup>16</sup> This Act provides for liability of the United States Government under the same circumstances as the

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<sup>12</sup>Id, Section (f) The head of the agency concerned may, to the extent that the head of the agency concerned considers appropriate, hold harmless or provide liability insurance for any person described in subsection (a) for damages for personal injury, including death, caused by such person's negligent or wrongful act or omission in the performance of medical, dental, or related health care functions (including clinical studies and investigations) while acting within the scope of such person's duties if such person is assigned to a foreign country or detailed for service with other than a Federal department, agency, or instrumentality or if the circumstances are such as are likely to preclude the remedies of third persons against the United States described in section 1346(b) of Title 28, for such damage or injury.

<sup>13</sup>10 U.S.C. § 4301, Section 1, Chapter 4, AR 351-3.

<sup>14</sup>10 U.S.C. § 1091.

<sup>15</sup>28 U.S.C. § 2680(k) (1902).

<sup>16</sup>10 U.S.C. § 2733.

Federal Tort Claims Act. However, there is one dramatic difference. That difference is that it is strictly an administrative claims settlement procedure with no judicial remedy being available.<sup>17</sup> The settlement of such claims, and the appellate procedure, is within the Army claims system and to the Secretary of the Army.<sup>18</sup> The problem arises when the administrative settlement of the claim is less than the claimant believes he is entitled to, or even worse, if the claim is denied based upon the statute of limitations or that there was no negligence involved. For some time the law was considerably unsettled. In Jackson v. Kelly,<sup>19</sup> the Court held that military physicians could be sued in their individual capacity but that they were financially protected through indemnity or insurance as provided by the Government in the Gonzalez Act.<sup>20</sup> However, in a later case, Powers v. Schultz,<sup>21</sup> the Court held that it was the intent of Congress to immunize military physicians in foreign, as well as in domestic courts.<sup>22</sup>

b. In order to fully understand the consternation and confusion caused the possibility that a physician who was in the employee of the United States Government and acting within the scope of his employment might be facing personal liability in a medical malpractice suit, one needn't look very far. While it is assumed that the indemnity provisions of 10 U.S.C. 1089(f) would protect the military physician from personal liability, there were many unanswered questions as to exactly how this would work. For example, where the individual's representation by counsel would come from, and who was to pay for it. Also, the protection against punitive damages and trial by jury would probably not be available if trial were held in state court.

c. Malpractice allegedly occurring within the United States at a military facility which might result in a suit against the physician individually in state court has a set procedure that is quite comforting to the military physician. Once the suit is filed in state court, and a certificate of scope of employment

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<sup>17</sup>Lundeen v. Department of Labor and Industries, 1970, 469 P.2d 886, 78 Wash 2d 66.

<sup>18</sup>Chapter 3, AR 27-20, Claims.

<sup>19</sup>557 F.2d 735 (10th Cir. 1977).

<sup>20</sup>The Army Lawyer, Are Military Physicians Assigned Overseas Immune from Malpractice Suit?, March 1988. See also, Pelphry v. United States, 674 F.2d 243 (4th Cir. 1982) and Heller v. United States, 776 F.2d (3rd Cir. 1985).

<sup>21</sup>821 F.2d 292 (1987).

<sup>22</sup>See Supra note 8 at 46.

is filed with the United States Attorney, the United States Attorney makes an appearance in state court and requests removal of the Federal matter from state court to Federal court. This was previously done under one of several removal authorities.<sup>23</sup> Once in Federal District Court, the United States is entered as the appropriate party defendant under the Federal Tort Claims Act, and the individual action against the physician would be dismissed. It could then be anticipated that this would be an "honest" forum with no jury trial and no punitive damages.

d. Conversely, if Section (f) of the Gonzalez Act, the insurance and indemnity provisions, really meant that trial could proceed in state court, a number of problems remained. One question would be whether or not the United States Attorney would provide representation for the Federal employee. Even if representation were provided, having a young, inexperienced Assistant U.S. Attorney, unfamiliar with jury trials in tort cases and state civil procedure did not seem to be the best solution. The U.S. Attorney could be seen as an outsider by the state court and the jury, not leaving the physician with a level playing field. The alternative was for the physician to up-front money for a good defense attorney who had established his reputation in the appropriate state court. The alternatives did not instill great confidence in the system for the military physician.

e. As this controversy raged, Congress, facing other successful suits against other Federal employees acting within the scope of their employment, enacted the so-called Westfall<sup>24</sup> legislation, now known as the Federal Employee's Liability Reform and Tort Compensation Act of 1988 (FELRTCA).<sup>25</sup> This legislation appeared to be a comprehensive statute. It provided for the exclusiveness of remedies against the United States Government for injury or loss arising from the negligent wrongful act or omission of any employee of the Government while acting within the scope of his office or employment. It also incorporated procedures of certification to the Attorney General that the employee was acting within the scope of his office, deeming such

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<sup>23</sup>See 28 U.S.C. § 1346 (U.S. as a Defendant), 28 U.S.C. § 2679 (Tort Claims Procedures), 28 U.S.C. § 1441 (General Removal Statute), 28 U.S.C. § 1442a (Member of the Armed Forces Sued).

<sup>24</sup>Westfall v. Irwin, 484 U.S. 292, 1988.

<sup>25</sup>28 U.S.C. § 2679 (1988).

action to be an action against the United States, substituting the United States for party defendant, removal from state court to district court, and the resultant dismissal of the individual action against the employee.

f. Even with this statute it was not until the decision in United States v. Marcus S. Smith, et al.,<sup>26</sup> that the issue was decided. This case arose out of obstetrical care provided by an Army physician in an overseas military hospital. The plaintiff sued the Army physician in his individual capacity in Federal court. The United States was substituted as proper party defendant for the Army physician,<sup>27</sup> and the District Court dismissed the action as barred by the Foreign Country Exception to the Federal Tort Claims Act.<sup>28</sup> The 9th Circuit reversed, holding that neither the Gonzalez Act nor FELRTCA required substitution of the Government or otherwise immunized the Army physician. The basis of the Court of Appeals ruling was that while FELRTCA confers absolute immunity on Government employees where the FTCA provides a remedy, it does not apply where an FTCA exception bars recovery. The FTCA could not provide a remedy in this instance because it is not extraterritorial in its application. The Supreme Court reversed, rejecting the 9th Circuit's narrow interpretation of FELRTCA. The Court held that Government employees, such as the Army physician, were entitled to absolute immunity when acting within the scope of their Federal employment even when an FTCA exception precludes a plaintiff's recovery from the United States. The Court also recognized the continuing vitality of the Gonzalez Act, and Section (f), which provides additional protection to foreign based medical personnel by indemnifying them from possible suit in foreign courts.

g. The Smith case would appear to lay to rest all of the divergent opinions and questions concerning the protection from personal liability of military physicians serving overseas, for acts within the scope of their official duties.

### 3. Training in Civilian Institutions.

a. It is recognized that within military medicine it is desirable and necessary to have our employee physicians, usually military, receive both short-term and long-term training at civilian medical facilities. This includes both rotations on a short-term basis to round out general medical training, and residencies at civilian institutions where expertise and

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<sup>26</sup>499 U.S. 160, 113 L.Ed.2d 134, 111 S.Ct. 1180.

<sup>27</sup>Para (d)(1), 28 U.S.C. § 2679 (1988).

<sup>28</sup>28 U.S.C. § 2680(k).

specialty training are available. At this point it is well to remember the other limitation in the Gonzalez Act, Section (f). These medical training agreements, referred to as gratuitous agreements, are entered into under statutory authority.<sup>29</sup> Under this law the Secretary of the Army can detail soldiers as "students, observers, or investigators at such...hospitals, and other places, as are best suited to enable them to acquire knowledge or experience...." This law is implemented by Army Regulation.<sup>30</sup> Army policy also provides that the contracting procedures in the Army Federal Acquisition Regulations Supplement (AFARS) will be used in these agreements.<sup>31</sup>

b. There is also a danger that physicians participating in civilian residencies might be sued in their individual capacities in Federal or state court for alleged negligence occurring during such participation. The same issues concerning representation, removal to Federal court, substituting the United States Government as party defendant, and dismissing the individual suit against the physician, all apply to gratuitous agreements as to overseas malpractice occurrences. These issues were at least partially laid to rest in a letter<sup>32</sup> to the service chiefs of tort and claims staff. Mr. Jeffrey Axelrad, the Director of the Torts Branch, Civil Division, indicated that as a matter of policy a consensus had been reached. That consensus was that as the medical residents are employees of the military component, such residents would be subject to the provisions of 28 U.S.C. Section 2679, FELRTCA. The Department of Justice, upon receipt of appropriate certifications, would remove cases to Federal District Court, substitute the United States as a party defendant, and dismiss the suit against the individual physician. Although the question was not addressed in United States v. Smith, supra, it is difficult to imagine a result contrary to that decision in the case of military physicians being trained in civilian institutions. However, the 25 July 1991 Memorandum to the Secretary of the Army on the Quarterly Report of Significant cases summarizes a case in the D.C. District Court where the

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<sup>29</sup>10 U.S.C. § 4301.

<sup>30</sup>Section 1, Chapter 4, AR 351-3.

<sup>31</sup>Supra, Paragraph 4-7a.

<sup>32</sup>December 29, 1989 letter to COL Hornbrook, USAF; COL Aileo, USARNG; and Mr. Hannas, U.S. Navy, re: Military Doctors and Civilian Hospitals, from Jeffrey Axelrad, Director, Torts Branch, Civil Division, U.S. Department of Justice.

judge is apparently unaware of Smith.<sup>33</sup> The courts will continue to try to find ways to create a remedy in spite of Smith.

c. There are caveats to the Department of Justice position and the applicability of United States v. Smith. One such caveat is that the Justice Department will require that the military components not accept one-sided training agreements. The Government must ensure that when agreements to rotate residents between private facilities and Government facilities are agreed upon, the United States does not assume liability for residents to a greater extent than private facilities accept residents who are military officers. The Army Medical Department had established a precedent of providing in the agreements that the military resident was an employee of the United States Government and that the United States accepted liability for any alleged malpractice. This was true even though civilian training institutions, having the benefit of the labor of such residents, included all nonmilitary residents under their general risk management insurance plan. The Department of Justice directive makes it clear that every attempt should be made to give the United States Government the same treatment as other residents. This good faith effort is necessary to continue the cooperative stance of Department of Justice. The U.S. Army Health Services Command had, as a result of urging from the Department of Justice, published guidance directing that gratuitous agreements attempt to secure the agreement of the civilian institution that military residents would be considered servants of the training institution.<sup>34</sup>

d. A further caveat footnoted in Mr. Axelrad's letter is that since scope of employment determinations will be predicated upon action pursuant to orders. Scope of employment certifications will not necessarily issue in instances where a resident is engaged in activity during permissive TDY. This also raises the issue of so-called "handshake agreements." A commander or other supervisor within an Army medical treatment

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<sup>33</sup>Ward v. United States, (W.D. Wash.). An Army resident physician while performing a rotating residency at a civilian hospital pursuant to military orders participated in plaintiff's surgery. Plaintiff sued the military physician in state court. The U.S. Attorney certified that the physician was acting within the scope of his federal employment and removed the case to federal court. Pursuant to FELRTCA, the Court granted our motion to substitute the United States for the physician. Later, however, when we moved to dismiss the case for a failure to file an administrative claim, the Court held that the physician was the borrowed servant of the civilian hospital and

facility who authorizes a subordinate to engage in civilian training without complying strictly with the provisions of AR 351-3, and ensures that the individual is on official orders, places them in danger of being outside the scope of their employment and personally liable.

#### 4. Personal Service Contract Providers.

a. The Army, and in fact DOD, supplements its employee health care provider resources, both military and civilian, with contracted-for providers. Although it would constitute an entirely separate article to give this subject the appropriate treatment, it is perhaps at least advisable to provide a brief history of contracting for medical personnel in DOD.

b. The Department of Defense is for the most part supposed to obtain services to execute their mission through uniformed personnel and civil servants. The stability of the workforce, the rights of civil servants, and numerous other factors made it preferable to obtain services that way. Consequently, the general rule was that contracting for services was limited to certain unique situations.

c. There are two basic types of services contracts, personal services and nonpersonal services. Nonpersonal services are those services provided without direct hands-on day-to-day supervision of the performance of those services by Government personnel. Those services usually result an end product, a "deliverable." The authority to contract for nonpersonal services is longstanding.<sup>35</sup> Conversely, the personal services contract means a contract that by its express terms or in its execution makes the contractor personnel appear, in effect, to be Government employees.<sup>36</sup> Authority to do personal services contracts is not longstanding.

d. Personal services contracts were frowned upon because they were an attack on the Civil Service System. Also, within the medical community there was great concern with the effect of having a personal services health care provider commingled with active duty physicians and civil servants. At the crux of this concern was compensation. Consequently, the initial 1983 version of the authority to contract for personal services limited the amount of compensation that could be paid to these health care providers to that of a full colonel O-6 with over 26 years of

that he was not entitled to immunity under FELRTCA. The Court then remanded to state court. A request for reconsideration has been filed.

<sup>34</sup>3 Feb 1988, Memorandum for Commanders, HSC Activities, Subject: Gratuitous Agreements.

service.<sup>37</sup> Because of this compensation limitation the personal services contracting authority was used sparingly. An attempt to alleviate the problem occurred in 1990 with an amendment to the statute to add pay and allowances to the compensation equation.<sup>38</sup> The addition of pay and allowances did not greatly increase the use of personal services contracts.

e. Finally in 1993 the statute was amended to increase the amount of compensation to that specified in Section 103 of Title 3 of the United States Code.<sup>39</sup> This sets the pay of the President, which is currently \$200,000 per year. The ability to pay contract providers \$200,000 per year opened the way for a much greater use of personal services contracts in the medical arena.

f. The utilization of personal services providers allows the easy supplementation of the uniformed and civil service medical staff because it allows the contractors to, for the most part, appear indistinguishable from employees. The "plugging in" of individuals into TDAs of health care facilities where we provide the supervision and oversight is more practical and it cuts out the cost of administration. Also, if personal services contractors are "like" Government employees for the purposes of coverage under the Federal Tort Claims Act<sup>40</sup> and the Gonzalez Act,<sup>41</sup> then that is an additional saving because there is no need for malpractice insurance.

g. However, the Department of Justice, Torts Branch of Civil Division, took the position that contractors are contractors. They would refuse to provide representation, personal services contractors or not, and would interpose the independent contractor defense if the Government were named in either a claim or in a follow-on lawsuit. The Department of Defense disagreed with this position, and in DOD Instruction 6025.5, Personal Services Contracting, paragraph D8, flatly stated that there was an employer-employee relationship created by a personal services contract, that claims alleging negligence by personal services

<sup>35</sup>10 U.S.C. § 2304 and 21 U.S.C. § 253.

<sup>36</sup>FAR Part 37.101.

<sup>37</sup>10 U.S.C. § 1091, 1983.

<sup>38</sup>Id., 1990.

<sup>39</sup>Id., 1993.

<sup>40</sup>28 U.S.C. §§ 2671-2680.

<sup>41</sup>10 U.S.C. § 1089.

health care providers should be processed by the Department of Defense and that no medical malpractice insurance was necessary.

h. For several years the argument raged and it was uncertain whether a personal services contract provider, who became a respondent in a medical malpractice claim or lawsuit, would be entitled to representation by the United States Attorney and immunity under the Gonzalez Act.<sup>42</sup>

i. There was finally an end to this saga when, in the 1998 Appropriation's Act, Congress amended Section 1089 of Title 10 by adding that 1089 indemnity provisions specifically covered personnel serving under a personal services contract entered into under the authority of Section 1091 of Title 10.

j. So the impasse is finally broken and the statute now makes it clear that a personal services contract provider who is lawfully performing a contract under the authority of 10 U.S.C. 1091 shall be indemnified the same as employees.

## 5. Conclusion.

The enactment of FELRTCA and the case of United States v. Smith would appear to have resolved for the moment the problems of overseas malpractice and gratuitous agreements. The amendment to the Gonzalez Act solves the personal services contractor problem. It would be naive to believe that perhaps there will be no further assaults or imaginative legal theories being raised in an attempt to subject military physicians to the threat of personal liability. There is also a fundamental danger that the military physician, now feeling confident of his immunity, will fail to promptly advise the local Staff Judge Advocate that he or she is involved in malpractice litigation. This is particularly true in gratuitous agreements where the training institution is sued for malpractice and is seeking a deep pocket contributor to any decision adverse to its financial interest. Also, denials or perceived inadequate settlements for overseas malpractice under the Military Claims Act and the lack of a judicial remedy in that statute will continue to evoke the sympathy of the courts. Attorneys involved in providing legal support to the Army medical community must be alert to these problems and aware of the current status of the law.

<sup>42</sup>Id.

