

# **ETHICAL AND LEGAL IMPLICATIONS OF MANAGED CARE**

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## ABSTRACT

This article addresses several ethical, regulatory and legal issues in managed care with attention to recent court cases that focus on physicians' responsibility, fiduciary duty and the impact that these legal decisions have on physicians practicing in a managed care environment. Discussion of the impact of changes in the control of decision making processes for physicians, the use of managed care protocols, restriction of resources and gatekeeping systems are addressed as are the specific duties and obligations of physicians to their patients.

In spite of the fact that President Clinton's Healthcare Reform proposals were defeated, a vast change in health care is sweeping our country in the form of Managed Care (Managed Cost). The new system has been touted by many in the insurance industry as an innovation that has improved American medicine by lowering health care costs and enhancing its quality by "managing" health care providers. Supporters argue that "managed systems" provide a "managed product" that is (1) better regulated; (2) less expensive than fee for service medicine; and (3) more socially responsible, providing care for the poor and disadvantaged.

Recent articles have raised questions as to whether these assumptions are true.(1-15) Critics of the system argue that managed care is reducing the introduction of new technology, interfering with the physician-patient relationship, worsening outcomes, restricting clinical research, reducing funding for physician training and adversely effecting community based hospitals. Others raise concern about monopolistic trade practices, ruthless business techniques and the subversion of medical ethics.(1,2,7,12,16-26)

As managed care continues to grow, the relationships among providers, hospitals, physicians and other healthcare professionals are undergoing change and, in many cases, strain. Emanuel and Dobler(21) cogently argue that managed care is producing a major change in the physician-patient relationship which has traditionally been based on what they term the six Cs. I.E.: (1) The patient's ability to choose their physician; (2) provider competence; (3) physician-patient communication; (4) compassion; (5) continuity of care and most importantly (6) that there be no conflict of interest on the part of the health care provider. They warn that when managed care restricts patients' choices of physicians; controls their access to care, limits the treatments their physicians can prescribe; limits their doctors' ability to refer them to specialists, and erodes the patients' trust in their doctors by creating a persistent, corrosive conflict of interest; it will ultimately destroy the doctor-patient relationship. Finally, they argue that many of the currently employed salary schemes which reward physicians and hospitals for not providing needed medical services produce a serious, inescapable and pernicious conflict of interest.(21)

Many in our profession feel that the juggernaut of manager care is a fait accompli and that modifying change if it occurs, will be too little, too late. The underlying fear of large

corporate medicine is summarized by the aphorism, "When money talks, truth is silent." How will health care providers, community hospitals and academic medical centers fare in the new "dance of vertical integration?"(25) As noted in a recent JAMA editorial, no method of health care reimbursement is devoid of financial self-interest.(22) It can be argued that fee-for-service encourages doing more rather than less for patients while capitation encourages the reverse. While physicians are faced with pressure to be cautious in the allocation of resources, they must strive to make decisions that do not adversely affect the health of their patients.

In any balanced discussion of this topic, one needs to keep in mind that if appropriate ethical standards are employed, managed care programs can work with reasonable success. They can provide systems that encourage effective and long-standing relationships between patients and their primary care providers; they can commit to provide quality medical care to their patients; and they can ethically assume a population-based approach that incorporates public health concerns as well as individual medical strategies. They can encourage-outcome management studies and apply the most current standards to both diagnosis and treatment while rejecting unproven and inefficient treatment methods. The best models of these "optimal" plans are found in the older staff-model HMOs which were established between 1940 and 1970, when cost containment represented an unexpected benefit rather than the primary purpose of the organization.(22) In these instances, the bottom line was not the first item on the company's mission statement and, therefore, did not intrude on the medical decisions made for an individual patient. The best of these programs encouraged academic pursuits, collegial interactions, and team-building. They placed a premium on physician-patient relationships as well as the relationships that existed between these systems' primary care physicians and the specialists they consulted.

Conversely, in the worst case scenarios which, incidentally, occur more commonly among the newest generation of managed care organizations(22), care delivery is regulated by "managers" who have had no previous experience in providing health care. Their corporate mission is to provide care at the lowest possible price. Corporate goals relate more to cornering a market and locking out the competition than to providing high quality health care. In these systems, clinical leadership is often inadequate or absent and the goals that drive the plan are optimization of profit, not optimization of patient care. These plans control costs through the exclusion of sicker patients, rationing by inconvenience, creating a burden on physicians by forcing compliance with the micromanagement of the clinical environment, which is generally "physician-hostile" and "administrator-friendly". These systems polarize doctors and nurses, and deny beneficial but expensive care through (1) micromanagement, (2) imposition of complex bureaucracy, (3) threats of physician job loss, and (4) perverse financial incentives for providers. They discourage teamwork among providers and often attempt to fractionalize various sub-groups, setting primary care physicians and specialists against each other in their quest to ratchet down costs to their lowest possible level.(26-28)

In an attempt to clarify physicians' responsibilities in dealing with managed care, the American Medical Association issued a report in June, 1990 entitled "Financial Incentives to Limit Care; Financial Implications for HMOs and IPAs".(29) The AMA made clear that patient welfare must remain the first consideration of all physicians working in health maintenance organizations and IPAs and that physicians in such systems must disclose to their patients all relevant financial inducements and contractual constrictions that affect the delivery of their health care to patients. Failure to disclose has become an important element in litigation, as was evidenced in the recent 89 million dollar verdict obtained by the family of Nadine Fox against Health Net, a California HMO.(30)

In a recent report, the AMA(31) states, "It is therefore essential that the profession and society now act to ensure that managed care techniques are implemented in a way that protects patients and the integrity of the patient-physician relationship." The report emphasizes that physicians must first be committed to the welfare of their patients and avoid the conflicts of interest produced by practicing in a managed care environment. It urges physicians to preserve their fundamental duty as advocates of their patients and in so doing, to reduce the risk of rationing and inappropriate financial incentives.

The Council notes that while efforts to contain costs are critical and that many of the approaches used by managed care companies can have an impact on constraining health costs, that **managed care can compromise the quality and integrity of the patient-physician relationship and reduce the quality of care received by patients.** "In particular, by creating conflicting loyalties for the physician, some of the techniques of managed care can undermine the physician's fundamental obligation to serve as patient advocate. Moreover, in their zeal to control utilization, managed care plans may withhold appropriate diagnostic procedures or treatment modalities from patients."(32)

The Hippocratic Oath emphasizes the primacy of trust in the relationship between patient and physician. It obligates the physician to keep his/her patient's information confidential, to avoid mischief and sexual misconduct, and to give no harmful or lethal agents. Over time, patients have come to expect that their physicians might even jeopardize their own health to care for the ill.(33) In short, the physician becomes the advocate for his/her patient, using his knowledge and the patient's trust for the patient's good. Managed care forces physicians to balance the interests of their individual patients with the interests of other patients in the system (rationing of care and constraining cost) and may place the physician in a position where the needs of his patients are in conflict with his own financial interests. His very livelihood may be at risk since many managed care plans drop physicians who incur higher treatment costs than their colleagues, even though they take care of sicker patients. This fear of retribution for providing appropriate but more expensive care can become a powerful force in distorting physicians' clinical judgment. The "ethics of minimums," (i.e., doing as little as possible) as a corporate culture is at variance with the physician's training and basic integrity.

Many managed care plan executives insist on hiring only recently graduated physicians who are more willing to accept the new corporate managed care culture and who rapidly become dependent upon it. But the "culture of minimums" often conflicts with striving for excellence. An optimal health delivery system must (1) be patient responsive, (2) provide adequate and compassionate care, (3) encourage physician excellence, (4) be accessible, (5) reduce bureaucracy to a minimum, (6) provide humane treatment based on scientific merit and (7) be accountable to the patient. Failure to meet these goals has prompted an increasing number of law-suits which may in fact limit the seemingly capricious decisions that so many fear. Many of these suits spring from the cost containment strategies employed by managed care corporations which include (1) controlling the use of medical services wherever possible, (2) limiting treatment, (3) reducing follow up visits, (4) limiting diagnostic studies, (5) controlling formularies, (6) eliminating the use of costly medications and treatments wherever possible, (7) reducing visits to specialists, (8) reducing or eliminating laboratory procedures, (9) reducing or eliminating expensive measures to preserve life, (10) providing care using the least expensive "professionals", (11) making patients work through gatekeepers, (12) placing healthcare providers at financial risk, (13) rewarding providers for limiting their services through salary increases, bonuses, paybacks, etc, (14) dropping sick patients from panels at the time of contract renewal, (15) forcing providers to follow rigidly defined protocols, (16) limiting physician judgement, (17) using utilization review techniques in an arbitrary manner which may define appropriate treatment as "medically unnecessary,"(18) requiring cumbersome pre-certification, (19) mandating the use of a rigid treatment hierarchy before more expensive care can be offered, (20) insisting on the use of mail-order pharmacies, and (21) limiting the services of ancillary care providers such as nurses, physical therapists, special nursing assistants, sitters, etc.

Because of injuries and conflicts arising from these cost containment strategies, litigation in the area of managed care has increased considerably during the last several years. Emerging liabilities in managed care litigation stem from issues of (1) patient care management; (2) contracting and (3) joint collective provider activities. Law-suits in the area of patient care management derive from the increased intervention of third and fourth parties into the treatment process. Limitation of a patient's access to medical care by pre-treatment disallowal has become the most fertile area for successful litigation followed by protocol mandated discharges which provide complaints of negligence, malpractice, patient abandonment, neglect, inappropriate provision of care, and premature patient transfer and discharge. Other areas of litigation center around disputes of patient/provider financial obligations under the terms of the patient's contract, and refusal of the managed care company to provide treatment authorization as medically necessary pursuant to specific elements in the patient's contract. New areas of litigation include breaches of confidentiality, lack of protection of the medical record, and misuse of medical information to deny future insurance. Recently the courts have held that corporations can not elude

liability for the behavior of their external utilization reviewers when disallowals are medically inappropriate.(34)

Claims of insurer and reviewer fraud, evidenced by systematic inappropriate application of review criteria or the use of invalid medical criteria instead of accepted community standards to deny care, as well as suits stemming from the faulty qualifications of reviewers who disallow care have also been successfully litigated. Finally, the courts have held that both insurers and reviewers may be liable for a bad outcome and have extended responsibility to employers for the inappropriate application of cost-containment provisions.(34-36)

Increased corporate liability has been inferred from several recent cases concerning issues that include negligent implementation of utilization review, premature patient discharge, financial risk profiles that change the traditional duties of providers to patients, failure to refer in a timely manner, elimination of post-termination continuation of care responsibilities when illness persists, inappropriate sharing of medical information, and poor quality control of employed physician's practices.(34-43)

An important area of recent litigation has to do with patient management processes imposed by managed care companies. These break down into suits that involve restriction of patient access, usually prompted by some complaint concerning the utilization review process such as refusal of requests for prior authorization, disallowal of a continued stay request, or refusal of an appeal for payment. Increasingly, suits are being directed at providers who fail to meet their responsibilities under the terms of a contract.

The legal accountability of HMOs and managed care organizations is in large measure determined by their organizational structure. Staff model HMOs have the greatest responsibility for the behavior of their physicians. IPAs and group model HMOs that have treatment protocols and corporate medical directors also assume responsibility for the physician care they provide. Managed care organizations working through PPO contracts incur less of a medical-legal risk for their providers' behavior.(38)

Recently the courts have ruled in the Salley and Wilson cases(34,37) that utilization review companies which act as intermediaries between insurance companies and the patient's physician to constrain utilization by disallowing appropriate care as medically unnecessary, are bound by the standard of reasonable community practice. The protocols that these companies develop must be (1) realistic, (2) available to providers, (3) based upon a reasonable interpretation of the medical literature, (4) applied consistently and (5) provide mechanisms and procedures for both appeal and review. Using the scientific data as the benchmark, the court in Wickline has defined, and subsequent courts have reaffirmed the concept that prospective disallowal of treatment has more important medical-legal implications than post-treatment disallowal of costs, and that managed care organizations cannot prospectively disallow care without a firm scientific basis.(36)

Let us review some of the more important decisions that define the physician's role and duty in this complicated arena. We are indebted to Chittenden(38) for his excellent review of the legal basis by which managed care companies can be sued and the reader is referred to that source document for a more indepth analysis of the issues we are about to consider.(Table 1) As we review these specific cases for guidance as to how physicians should practice vis a vis managed care, it is important that the reader keep in mind that many of these cases apply only in the jurisdiction in which they occur; yet as a group they provide a trend for understanding national judicial thought in this complicated area. They are often cited in ongoing litigation and consequently affect future court decisions.

### **ELEMENTS NECESSARY TO DEMONSTRATE CONTROL OF PHYSICIAN BEHAVIOR**

The 1957 case of Bing v Thunig(39) provides one of the important conceptual cornerstones for current managed care litigation. In Bing, the court ruled that a hospital could be held liable for the contractual relationship that it had with a physician, even if that physician was not a full-time employee of the hospital. In defining the hospital-physician relationship, the court ruled that the same factors that determine any other principle-agent relationship could be employed to define the physician-employer relationship and that if the employing entity exercised control over the physician, that it would incur responsibility for the physician's behavior, i.e. his/her treatment decisions and actions.

The 1981 Georgia case of Stewart v Midani(40) defined what these crucial elements of employment were. In this important case, the court ruled that the factors to be used in determining whether an institution affected a physician's judgement or behavior depended upon the specific elements of the relationship that existed between the physician and the employing institution, specifically whether the institution had (1) the right to directly oversee the physician's work, (2) a contract with the physician to perform a specific service or task, (3) the authority to control the time during which a physician worked, (4) the right to inspect a physician's work product, (5) contracted to provide facilities or supplies to the physician, (6) a right to terminate the physician's contract, (7) the ability to determine the degree of skill necessary for the physician's employment and (8) control of the method by which the physician was paid. The court felt that if a preponderance of these elements were present, that there was a master-servant relationship between the physician and the institution and under such terms that the hospital or corporation would be at least partially accountable for the results of the physician's work.

Applying Midani(40) subsequent courts have ruled that staff model HMOs which employed physicians on a salaried basis and who directly control the physician's work product are liable for the doctor's behavior because they fulfill all the terms of the "master-servant" relationship. Other cases have expanded Midani to apply to IPA model HMOs

and in some cases even PPOs(41,42) where financial arrangements or protocols define practice.

The 1987 Indiana case of Sloan v. Metropolitan Health Council(42) further defined the relationship between managed care providers and physicians. Metropolitan Health Council employed physicians using a written employment contract in which the physician agreed to "provide treatment to HMO members." In exchange for their medical services the physicians received an annual salary and fringe benefits. During the malpractice suit, metropolitan Health Council argued it should not be sued since the malpractice was caused by the physician who was responsible for his decisions. The court ruled that the Metropolitan Health Council was responsible for the behavior of its physicians since its contract had several elements of a master-servant relationship; specifically it forbade private practice, and employed a medical director who "established medical policy" and whose job description defined him as "ensuring that medical services were properly provided to member-patients."

The court noted that the HMO had a series of treatment guidelines that it expected its employed physicians to follow and as such, it was able to control how its employed physicians ordered tests and treatment options.

The 1989 District of Columbia case of Schleier v. Kaiser Foundation Health Plan(42) extended the liability of HMOs to IPAs and potentially to PPO contracts. In Schleier v. Kaiser Foundation Health Plan, the staff model HMO was held vicariously liable for an independent consultant's malpractice even though the contract that the physician had with the HMO emphasized the lack of an employer-employee relationship. The court reasoned that because the HMO had (1) cost control mechanisms common to both IPA model HMOs and PPOs such as diagnosis and treatment protocols, which provided step by step instructions that described how the care of a patient with a given symptomatology should be managed, and because the HMO (2) employed concurrent and prospective utilization review, and because the HMO had (3) preset fee maximums that realistically constrained the treating physicians' options, that there was a level of control suggestive of more than an independent contractor relationship. The court in Schleier evoked the legal philosophy of ostensible/apparent agency which states that when an independent contractor performs services for another party that are accepted in the reasonable belief that the services are being rendered by the employer or his servants, that the employer is liable for any physical harm that is caused by the negligence of the contractor who supplies those services to the same extent as though the employer were supplying them himself or by his servants.

In addressing the boundaries of the physician-patient relationship in the context of a physician's contractual relationship with a managed care organization, the court suggested the following tests to define if the patient relates to the managed care organization or the physician:

1. Does the patient look to the institution rather than the individual physician for care?
2. Does the managed care organization "hold out" the physician as its employee?
3. Does the patient have a choice of physician?
4. Is there a direct contractual relationship between the physician and the patient?

Since the physician in Schleier met those tests, it was the view of the court that the organization incurred liability for his behavior even though the physician was deemed an independent contractor by the HMO. The court referred to the original federal statutes that encouraged the development of health maintenance organizations and their definition. "A health care maintenance organization is an entity that provides basic and supplemental health services to its members."(41)

Most courts currently employ the following tests to define if a physician has a master-servant relationship with an HMO:

1. Can the patient choose any physician in the community or only an HMO or managed care defined physician, or some other doctor under "penalty?"
2. Does the managed care organization define itself as a provider of medical care?
3. Does the managed care organization obligate physicians in its employ to follow a particular set of rules?
4. Does the managed care organization maintain a quality assurance program that reviews the physician's work product?
5. Does the patient pay the managed care organization or the physician directly?
6. Does the managed care organization provide 24-hour coverage or are after hours emergency services the responsibility of the individual physician?

These principles were tested in the 1988 Pennsylvania case of Boyd v. Albert Einstein Medical Center(43) Mrs. Boyd was a patient of the Albert Einstein Medical Center's HMO. She discovered a lump in her breast during self examination and sought consultation from her physician. A mammogram revealed a suspicious area and she was referred to a surgeon for biopsy. During the biopsy her chest wall was inadvertently punctured and she developed a significant hemothorax. She was hospitalized but subsequently told that further hospitalization was not necessary and that she could recover at home. After discharge her condition deteriorated. Because her family sought further diagnosis and treatment from the HMO, she was seen and evaluated by her primary care physician who diagnosed Tietz's Syndrome. The family requested that she be rehospitalized but the HMO felt this was not necessary. Mrs. Boyd was advised to rest at home; her condition continued to deteriorate; her husband called the HMO and reported

that she was doing poorly. This call was received by an HMO physician on call who suggested that she rest. She died.

The family filed a law-suit but the court awarded a summary judgment to the HMO. The family appealed the decision and it was overturned. The Appellate Court felt that the HMO was responsible for the care that was provided to Mrs. Boyd since the record showed that (1) Mrs. Boyd looked to the HMO for care and that the HMO held itself out as offering care through its employee, her physician. The court noted that the HMO's master contract with its clients agreed to "provide health care services and benefits to members in order to protect and promote their health." The court deemed this to be a specific promise to the patient. It also noted that the plaintiff's contractual relationship was with the HMO, not with any individual physician and that because of the nature of the plan in which she enrolled, that Mrs. Boyd had a limited choice of physicians. In fact, she was obligated to "use the physicians to whom she was referred." The court also noted that because of its policies constraining costs and the quality of care, Mrs. Boyd's hospital stay was prematurely terminated. The court believed that if she had remained in the hospital that it would have been reasonable to assume that some other form of care would have been rendered as she deteriorated and that she might not have died.(43)

### **NON-DELEGATABLE DUTY AND NEGLIGENT SELECTION**

The concepts of non-delegatable duty and negligent selection are also important. In the 1987 Alaska case of Jackson v Power(44) the court ruled that a hospital was responsible for the quality of care that its physicians rendered to patients in the emergency room. In this case, the hospital employed a physician and placed that physician in public service. The court ruled that the hospital had an obligation to ensure that a reasonable standard of care was met. The court reasoned that the quality of medical care provided to the public was too important to be compromised by lowering standards or delegating authority to some other agency.(37)

By extension, the courts have also found that there is a direct liability incurred by managed care organizations for the negligent selection or retention of health care providers who place the public at risk. In these situations the courts have ruled that managed care organizations face direct liability for organizational or corporate negligence. The classic case in this area is Darling v. Charleston Community Hospital(45) in which it was ruled that a hospital was negligent for permitting a general practitioner to perform orthopedic surgery. The court ruled that the hospital had a duty to apply reasonable standards to the practice of its physicians, since it was responsible for the privileging of physicians on its staff.

The 1989 Missouri case of Harrell v. Total Health Care(34) defined the responsibility of a managed care organization for its cost-control implementation policies, particularly when such cost control mechanisms affected physician's decision-making process and lead to negligence. Mrs. Harrell presented to Total Health Care with a urinary

problem and was seen by an HMO gatekeeper who referred her to an approved specialist. Surgery was performed and the patient was injured. Total Health Care argued that if malpractice occurred, it was the problem of the physician, not of the managed care organization. The court disagreed. In its review of the facts, it found that Total Health Care's fee structure limited the physician provider to certain procedures by protocol. These procedures were based on cost control measures promulgated by the HMO which affected the doctor's judgment. The court also noted that the HMO gatekeeper was responsible for referring Mrs. Harrell, and in fact, that the HMO's rules made it clear that he was the only person who could refer her for care. The court also noted that all specialists had to work within the HMO's medical guidelines. The court ruled that because its physicians had to accept the HMO's protocols, medical supervision, and fee structure, and because the specialist to whom Mrs. Harrell was referred had been the object of several malpractice suits, (four of which had been concluded in favor of patients), that Total Health Care was culpable. In its decision, the court reasoned that the HMO collected a premium for medical care expenses and limited the subscriber's choice to specific physicians who participated in its plan. In so doing, it had placed the patient at an unreasonable risk of harm if the physicians included in the HMO plan were unqualified or incompetent; or, if based on its price control structure, it forced physicians to choose less than acceptable procedures that had a higher risk of adverse outcome than more costly procedures.

The court in Harrell opined, "The HMO, in making the plaintiff's choice of physician for her, is required to use due care in making that decision. The duty to exercise care in selecting and maintaining the integrity of its physician panels is non-delegatable to third parties." It further ruled that "if managed care organizations offered themselves as more than health care financiers, they incur a specific duty to supervise the quality of the medical care that their physicians provide to patients and that they are responsible for negligent supervision if they impose treatment guidelines and/or supervision that is below 'acceptable community standards'." Conversely, managed care organizations are not responsible for negligent supervision in PPO models where there are no treatment guidelines or protocols and where their relationship with their physicians is simply based upon a discounted fee structure.

Another approach to law-suits against managed care organizations is to sue under alternative theories of liability, particularly negligence and breach of contract. These cases require a lower standard of proof and are easier to litigate. Awards often include punitive damages which may be high, consequently, this approach is becoming a popular way to sue managed care companies.(30)

Breach of contract suits are most frequently employed since the contracts that exist between a managed care organization and its subscribers define the duties of the respective parties. The courts have consistently ruled that a breach of contract exists if a managed care organization fails to provide the quality of health care promised. The landmark case in this area is the 1987 Ohio case of Williams v HealthAmerica.(46) Mrs.

Williams saw her physician gatekeeper with a series of physical complaints but was not immediately referred to a specialist. She felt that her delayed referral resulted in a belated diagnosis and subsequent injury. She filed suit against HealthAmerica under the theory that they had failed to deliver the quality health benefits that she had been promised in her managed care contract and that they had deprived her of her right to be referred to an appropriate specialist. The court upheld the breach of contract suit against the physician but recharacterized the action against the managed care organization as a tort claim for breach of duty to handle the patient's claim in "good faith."

The previously cited case of *Boyd v. Albert Einstein Medical Center*(44) also had a significant breach of warranty component. The court, in reviewing the marketing brochures for Einstein Medical Center, felt that they contained promises to provide high quality health care. The court felt that the standard of care delivered to Mrs. Boyd was below that promised in Einstein's brochures. It therefore ruled that the standard of care was not met and that the promises were sufficient to impose a ruling for breach of warranty on the HMO.

Other successful approaches for suit against managed care organizations include litigating under the state consumer fraud statutes, particularly if the plaintiff can show that the HMO has a systematic pattern of denying care. The courts have ruled that a breach of fiduciary duty or fraud exists when plaintiff's have been able to show that managed care organizations **routinely** deny appropriate care and/or **routinely** deny appeals for care or when such organizations have denied care based on standards of "medical necessity" that are not related to accepted community standards for care. Increasingly courts are holding managed care companies to the standard of "community practice" for care rendered and are not permitting them to arbitrarily determine that appropriate medical treatments or procedures are "not medically necessary."

Other practices that have come under scrutiny as representing breach of contract or fraud include the routine disallowal of the last one to three days of hospitalization on retrospective review, use of systems designed to intimidate or harass physicians, cumbersome bureaucracies that make provision of appropriate care difficult or impossible, bureaucratic mechanisms designed to discourage treatment with appropriate drugs and refusal of appropriate referral as promised in the patient's contract. Courts have ruled that complicated provider compensation methods and/or the provision of financial incentives to physicians or intermediaries which encourage them to disallow (1) appropriate hospitalization, (2) medically necessary tests and/or procedures, (3) appropriate length of hospital stay and (4) appropriate consultation with specialists, may represent a tortious interference with the patient's contract.(30)

Finally, managed care organizations have increasingly come under criticism for eliminating physicians from their medical panels who treat patients using community standards while retaining other physicians whose practice is based on utilization of cost containment guidelines.

Negligent implementation of cost control mechanisms has become another important area for litigation. Courts have ruled that when cost control mechanisms are designed which adversely affect a physician's medical judgment and result in injury, that they can be seen as a proximate factor in that injury and that the plaintiff can claim economic and emotional damage from the HMO.(35,36,43) The courts have also ruled that the improper influence of reviewers who systematically disallow appropriate care may represent a breach of fiduciary duty, a breach of contract, or outright fraud.(46) The Wickline decision(35) represents the sentinel case in this regard.

## **THE WICKLINE DECISION**

When Wickline was first heard, the judge noted that this was "the first attempt to tie a health care payor into the medical malpractice causation chain" and that it "therefore deals with issues of profound importance to the healthcare community and to the general public."(40) The judge noted that the cost containment program at issue centered on prospective utilization review where mandatory preauthorization for care was required before a patient could receive treatment. The court noted that "a mistaken conclusion about medical necessity following retrospective review will result in a wrongful withholding of payment. An erroneous decision in a prospective review process, on the other hand, in practical consequences, results in the withholding of necessary care, potentially leading to a patient's permanent disability or death." In reviewing the facts of Wickline, the court reasoned that when managed care companies deny access to care, they bear a higher burden of responsibility than when they disallow payment after care has been provided.

A short review of the facts of Wickline may be of assistance in helping clinicians understand the impact of this case. In 1976, Lois Wickline, a married woman in her mid-40s sought consultation for intermittent claudication. Outpatient treatment was unsuccessful and she was admitted to hospital in October, 1976. A consulting peripheral vascular surgeon diagnosed Leriche's syndrome. Although immediate surgery was recommended, the patient had to be discharged home to await approval for the surgery under the California Medi-Cal statute. Appropriate paperwork was submitted and a request for hospitalization was made. On January 6, 1977, Mrs. Wickline was readmitted and underwent a teflon grafting procedure the following day. Her post-operative course was stormy; the graft clotted and Mrs. Wickline required a second procedure. Following this, she continued to experience severe leg pain, arterial, arterial spasms and hallucinations. On January 12, she underwent a lumbar sympathectomy to reduce arterial pain and spasms.

Mrs. Wickline was not doing well on January 16, the date scheduled for her discharge. Her physicians called Medi-Cal to advise them that it was medically necessary for her to remain in the hospital. Her attending physician requested eight additional hospital days. Her attending surgeon reported that all three physicians involved in her care felt that she required this extra time because she was medically unstable and was at risk

for infection and the development of further blood clots which could lead to impaired circulation and possibly an amputation. Court testimony revealed that Medi-Cal was told that her physician felt that they could save both her legs if she were to receive continued hospital treatment.

More paperwork was submitted to justify Mrs. Wickline's additional hospital stay. The hospital provided Medi-Cal with the patient's complete medical diagnosis, history, clinical status and a detailed treatment plan. After all the paperwork was done, the on-site Medi-Cal nurse, who was authorized to approve the request without any further review, refused it, stating "Nothing in Wickline's case would have warranted eight additional days." She called the Medi-Cal consultant as was required for her to disallow the request. The consultant, a general surgeon, supported the rejection of eight days and authorized "an additional four days based on the nurse's feelings about the case." At the trial, this consultant testified that he had never seen the history, physical or treatment plan that had been submitted until it was forwarded for his disallowal signature. The forms required that a reason for the patient's extended stay denial be provided by the reviewing physician; this section of the form was blank. This Medi-Cal consultant testified he couldn't remember why he disallowed the request or why he gave four days. Neither he nor the nurse remembered the case. When later reviewing forms, he testified that he gave four days because there was no note of Mrs. Wickline's temperature, diet or bowel function in the information provided by the hospital. In addition, he disallowed because she could ambulate with help and was beginning whirlpool treatment. At trial, other surgeons testified that these elements were irrelevant to her circulatory condition and the consultant-surgeon had not concerned himself with the signs and symptoms that a reasonable physician would have typically considered in such a case. The disallowing consultant did not seek the opinion of a peripheral vascular surgeon who was available to him for consultation. At the end of Mrs. Wickline's four day extension, her attending physician wrote a discharge order. When asked at trial why he, as her attending physician, had not asked for an additional extension, he testified that there had been no change in her condition since her initial disallowal. One of her attendings testified that he felt that the Medi-Cal consultant was more concerned about the state's interest than the patient's welfare. He also felt that the Medi-Cal reviewer had the "power" to order him to discharge her. All of Mrs. Wickline's physicians testified that they were within community standards in discharging her.

At the time of discharge, Mrs. Wickline was unhappy and protested the decision. She asked to remain in the hospital, stating that she did not feel that her husband could care for her at home. Her request was denied and she was discharged despite her protests that she was not in a position to take care of herself. Following discharge she developed pain in her leg. Her leg became "whitish, cold, worse, turned gray" and three days after discharge, her husband called her physician and was advised that she should take more pain medication. The leg became "blue" and the pain "excruciating" to the point that "no pain medication helped whatsoever." On January 30th, eight days after discharge, Mrs. Wickline was readmitted to the hospital in severe pain with an open wound in the right

groin, a secondary infection in the right femoral incision, a mottled right foot, and a cold right leg. Because of an infection in her toe, she could not be immediately re-operated. She was started on a medical regimen which proved to be unsuccessful, and on February 8th, a right below-the-knee amputation was performed. Because the wound failed to heal, she underwent a right above the knee amputation nine days later.

At the trial, her surgeon testified "to a reasonable medical certainty", if Mrs. Wickline had remained in the hospital for the eight additional days as first requested, she would not have suffered the loss of her leg. Her attending physician also testified that the Medi-Cal physicians' rejection did not conform to prevailing medical standards. He felt that the Medi-Cal physician should not have been permitted to make decisions about her care without (1) first seeing the patient, (2) reviewing the patient's chart, or (3) discussing the patient's condition with her treating physicians.

The state argued that it was not negligent as a matter of law and because the patient's attending physician had discharged her and had testified that his discharge met prevailing community standards. The state argued discretionary immunity and absolute immunity.

In its judgment of the case, the court cited *Rowland v. Christian*,<sup>(38)</sup> "Everyone is responsible not only for the results of his willful acts but also for an injury occasioned to another by his want of ordinary care or skill in the management of his property or person, except insofar as the latter has, willfully or by want of ordinary care, brought the injury upon himself." All persons are required to use ordinary care to prevent others being injured as a result of their conduct."

The court ruled that the state was not liable because the physician attending Mrs. Wickline had caused her discharge. This was the pivotal fact in the case. The court opined, however, that "What is at issue here is the effect of cost-containment programs upon the professional judgment of physicians to prescribe hospital treatment for patients requiring the same. While we recognize realistically that cost consciousness has become a permanent feature of the health care system, it is essential that cost limitation programs not be permitted to corrupt medical judgment."<sup>(35)</sup> In *Wickline*, the court ruled that if a patient needs treatment and is harmed when care that should have been provided is withheld, they can recover from all responsible for the deprivation of care, including where appropriate, health care payors. The *Wickline* court ruled that third party payors of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms, such as when appeals made on the patient's behalf for medical or hospital care are arbitrarily ignored, unnecessarily disregarded, or overridden. Finally, it ruled that the physician's duty to the patient is not mitigated by the patient's insurance and that physicians who comply with treatment limitations imposed by managed care organizations without protest, when

such limitations are at variance with their own medical judgement, cannot avoid the ultimate responsibility for any injury that occurs.

The Wickline decision was revisited, upheld, and clarified in the Wilson Case. The 1990 California case of Wilson vs Blue Cross of California(36) reaffirmed Wickline and clarified the court's interpretation of its principles. In this case, a managed intermediary, Western Medical, disallowed a requested stay in a psychiatric hospital for Mr. Wilson whose attending physician felt that it was necessary to treat his depression. A three to four week stay was requested but further hospitalization was disallowed after a 10 day hospital stay. Twenty days following discharge, Mr. Wilson committed suicide and his estate filed suit. Blue Cross/Blue Shield obtained a summary judgment dismissing the suit because the patient's physician had discharged him. They also argued that aggressive utilization management was necessary to constrain rising health care costs. The Appellate court reversed the decision stating that Wickline did not apply to this private case because it was not a public-policy determined case and that the issues of the Wickline case were not valid in a for profit system where an insurance policy had been issued which defined provider responsibilities. The Wilson court ruled that no clear public policy immunized the utilization review contractor from liability for the patient's suicide after he was discharged from the hospital due to the contractor's alleged decision that hospitalization was unnecessary. Mr. Wilson's estate sued using the theory of tortious breach of an insurance contract since Mr. Wilson's policy with Blue Cross/Blue Shield stated that he was entitled to 30 days hospitalization during any 12 month period if his attending physician determined that hospitalization was necessary, as was clearly the case.

In Wilson, Western Medical, the managed care intermediary argued that when a treating physician decides to discharge a patient because an insurance company refuses to pay benefits, that the sole liability rests with the physician. The Wilson court rejected this argument stating that the sole reason for discharge, based on the evidence adduced in connection with the summary judgment motion, was that the decedent had no insurance or money to pay for any further inpatient benefits. Mr. Wilson's treating physician testified that he believed that had Mr. Wilson completed his planned hospitalization, there was a reasonable probability that he would not have killed himself. Western Medical declared that the physician was liable because he had failed to appeal its decision. The court, however, noted that the physician's failure to follow an informal policy allowing for reconsideration did not warrant granting summary judgment.

Wilson thus became an important case because it (1) defined the limits within which managed intermediaries can disallow care recommended by a patient's treating physician, and (2) clearly defined the liability of physicians working for third party intermediaries who may cause or contribute to an adverse outcome.

Salley(33) carried corporate liability one step further. In this 1992 Federal case, the court ruled that a managed care company could not disregard part of a physician's

recommendations and act on only those elements which were likely to reduce their cost. In *Salley*, the 5th U.S. Circuit Court of Appeals in New Orleans found DuPont liable for the hospital expenses incurred in treating a 15 year old girl after multiple outpatient treatment failures. The court found that Dupont was liable even though it had contracted the management of individual cases to a third party managed care organization, Preferred Healthcare.

Danielle Salley, the 15 year old daughter of a DuPont retiree had been hospitalized with suicidal tendencies. During her third hospitalization, her psychiatrist told the intermediary that although her hospital behavior had improved, he was fearful that her condition would deteriorate unless she was discharged to a structured environment. The intermediary then cut off her benefits. Her physician refused to discharge her until a suitable therapeutic environment outside the hospital was obtained. The 5th U.S. Circuit held DuPont liable for her hospital bills from October through January, and noted under its contract with Preferred Health, that "the employer reserves final authority to authorize or deny any payment for services to beneficiaries of a plan." The court ruled that (1) DuPont abused its discretion when it terminated Danielle's benefits and (2) DuPont was liable for the action or inaction of its third party intermediary; (3) it concluded that Preferred Health did not heed the warnings of Danielle's psychiatrist and that hospital records showed that her inpatient hospitalization was medically necessary until a suitable disposition was found. The court noted that her hospitalization was disallowed without a Preferred psychiatrist examining the patient. In its ruling, the court said that since Preferred health had relied on the treating physician's description that she was no longer suicidal or out of control, that they improperly ignored his other advice that to release her to a non-structured environment could cause a relapse.

The case of *Sarchett v Blue Shield of California*(47) established the principle that an insurance company does have a right to challenge a treating physician's determination of medical necessity. The court ruled that retrospective review was an implied right of an insurance relationship but concluded that "doubts and uncertainties in an insurance policy would be construed in favor of coverage for the insured."

The need for physicians to be cautious in their contractual relations with managed care organizations was highlighted by the Michigan case of *Carol v. Blue Cross and Blue Shield*.(48) In this case several psychiatrists contracted to participate in a model mental health program developed by General Motors and the United Auto Workers. After 14 months they filed suit complaining that the provisions of the plan affected their medical judgment and asked for revisions in the contract. The court ruled against the physicians, reasoning that they had voluntarily agreed to the requirements and criteria that they now objected to. The court felt that they were obligated to abide by the terms of the contract that they signed, and warned that neither cost-containment nor cost reimbursement provisions mitigated the physician's "ethical and legal obligations to provide appropriate treatment to the patient."

Marshall and Muszynski(49), attorneys working in this area, caution that providers must carefully evaluate and negotiate any contracts that they enter into with payors imposing managed care techniques that interfere with the treatment process. They recommend that providers seek favorable "out clauses" to allow them to quickly exit an unfavorable contract and counsel that any decision to discharge a patient or modify that patient's treatment should be based solely on the patient's clinical condition.

The 1988 case of Hughes v. Blue Cross of Northern California(50) demonstrated the court's determination to ensure that providers of managed care services not be permitted to retreat from their obligations to patients, vis a vis the application of overly restrictive, arbitrary or inappropriate criteria, requirements, processes or the like.(38,p2) In this case, Blue Cross which acted as a utilization review organization, retroactively denied a hospitalization and part of another hospitalization for an acutely ill patient. At trial, it became clear that Blue Cross had inadequate information to evaluate the claim. The reviewing physician applied a standard of care which was different from community standards and the treating physician was never told the reason that Blue Cross disallowed the patient's hospitalization. The suit was resolved through the award of \$150,000 in compensatory damages and \$700,000 in punitive damages because Blue Cross was found to have violated the insured's right to good faith and fair dealing. This case suggests that physicians might benefit from working cooperatively with patients in helping them seek the rights and benefits that are assured them in their contracts.

### **ETHICAL AND BEHAVIORAL CAVEATS FOR PHYSICIANS DEALING WITH MANAGED CARE**

The foregoing cases suggest that physicians are ultimately responsible for their behavior with patients. As community standards remain the yardstick by which care will be measured, clinicians are well advised, where there is disagreement, to seek consultation with peers, specifically requesting for their opinion about what treatment is needed and whether the recommended treatment meets community standards. Physicians cannot follow protocols which they feel could potentially injure their patients without risk to their licenses.

How should a physician act then, in dealing with managed care organizations?  
Here are some practical suggestions:

1. First and foremost, as your patient's physician do the right thing and do no harm.
2. Keep your patient's rights and interests foremost.
3. Treat your patient as you would want your family treated.
4. Remember that you are the clinically responsible party. you will be held accountable for your decisions. If there is a conflict between your patient's interest and that of a third party intermediary committed to reducing costs, (for example, about tests, referrals, hospital days, etc.), be sure that the course you choose is medically appropriate and defensible. There is nothing wrong with protecting your patient's

rights in the most prudent and cost-efficient manner. The danger lies in distortions of judgment that are caused by financial considerations. Where possible, attempt to work amicably and effecting the managed care companies and if their constraints are reasonable, comply with them. If on the other hand, you feel that they are not reasonable, you should represent your patient's interests.

5. If a conflict should occur between you and a managed care organization or its intermediary such that your patient may be put at risk, appeal those decisions vigorously and repetitively. Discuss your dilemma with your patient explaining the pros and cons of each viewpoint and eliciting feedback from him/her. If your patient rejects your advice in favor of the managed care company, ask the managed care organization to provide another physician to care for the patient. Document these facts carefully and send appropriate confirmatory letters to both the patient and the managed care organization. Ask the patient to sign an "Against Medical Advice" form that clearly states your recommendations for continued or other treatment and the possible consequences of failure to obtain the treatment that you recommend. Document the managed care company's role in affecting your patient's decision.

If, on the other hand, your patient elects to follow your advice and the managed care organization disallows treatment, continue to treat the patient. Carefully document the insurance company's refusal, provide continuing care, and carefully define the clinical facts that are the basis of your recommendation. Contact the managed care company and attempt to reason with another reviewer. Request reconsideration. Try to clarify any areas of disagreement. If no resolution is possible, Federal Express the patient's chart to the insurance company and request that a reconsideration be made in a timely fashion (i.e. 2-3 working days). If the managed care organization fails to reverse its decision, request in writing clarification as to the basis of the disallowal and by whom the disallowal was made.

Provide this information to your patient. Obtain a consultation from a respected peer concerning the need for and appropriateness of the treatment you recommended, and specifically ask that peer to comment about whether your treatment decision (1) meets community standards, (2) is necessary to render appropriate care to the patient, and (3) is appropriate to the patient's current level of functioning. Ask the consultant to also specifically define the risks of not providing the treatment you have recommended. Provide the consultant's opinions to the managed care organization and request another reconsideration. If a disallowal again ensues, carefully note the clinical information that was provided to the insurance company or their reviewers, your reasons for requesting the appeal, the number of appeals requested, the reviewer's name and the time and date that you were notified of the company's determination of the appeal. Include a copy of your statement to the insurance company informing them of the risk the patient may experience if treatment is withheld or disallowed. With the patient's permission, provide that information to the patient's attorney and to your hospital administration if appropriate.

Maintain complete files on all appealed cases. If you see a pattern of arbitrary and capricious disallowal, collect these cases and with the patient's permission, forward them

to the insurance commissioner of your state. A copy of that letter should be sent to the insurance company's senior management, the senior administrator of any managed care intermediaries and the patient's attorney, all only after obtaining the patient's permission in writing.

Have all contracts issued by managed care organizations carefully reviewed by your attorney before signing as the courts have ruled that physicians are responsible for the consequences of their agreements.

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## TABLE 1

### THEORIES OF LIABILITY

#### 1. Vicarious Liability

Respondent superior (actual agency)

Ostensible/apparent agency

Nondelegable duty

#### 2. Direct Liability

Negligent selection or retention

Negligent supervision/control

Other alternative theories

Breach of contract

Breach of warranty

Fraud

Breach of fiduciary duty

Negligent implementation of cost-control mechanisms