Legal Liability Under Managed Care

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Market forces are driving the delivery of health care into managed care. New alignments among health care providers, payers, utilization reviewers and hospitals create new legal liability. Better-informed patients, concurrent credentialing by hospitals and payers, and new incentives to reduce hospital and physician-related costs have resulted in new federal legislation and agencies that reshape health care delivery and legal liability.

Introduction

Managed care is coming to Hawaii. Indeed, it is in place to a great extent in many areas of this country. The politicos in Washington may differ noisily as to how delivery of health care should be retooled, but the inexorable forces of the marketplace are moving the delivery of health care into managed care. Some insurers and physician groups are purchasing hospitals. Some hospitals are dispensing with *independent medical staffs* and are employing physicians directly. Like it or not, we must anticipate what managed care will bring. Part of what managed care will bring are new alignments among insurers, hospitals, and physicians, and with those realignments both major and subtle changes in legal liability within a managed care system will be seen.

A review of the forces driving us toward managed care yields insight into what those legal liability changes probably will be. Using a medical analogy, if we evaluate what the disease within the system is, we can anticipate the attempted cure and the side effects of the cure.

Economic Forces Driving Toward Managed Care

In 1994 the United States acknowledged its participation in a global economy. NAFTA and GATT thrust us anew into the global marketplace. Current discussions and negotiations with Pacific Rim countries will undoubtedly yield even more formal agreements between the United States and its Pacific Rim trading partners. Increased participation in the global economy means, among other things, that anything spent on goods and services that cannot be exported and sold abroad will make us less competitive in the international marketplace. Unquestionably, exploitation of medical technology and know-how is, and should be, a significant component of our trade overseas, but expenditures for health care within our country are a resource not favorably affecting the balance of trade. Unnecessary expenditures within a wasteful health care delivery system renders us less competitive in the global marketplace.

Health Care Finance and Review demonstrates vividly the increasing percentage of gross national product consumed by U.S. national health expenditures (Fig 1). Under the current system, a full 32% of gross national product will be consumed by health expenditures by 2030. A jump from 5.3% of GNP in 1960 to 32% in 2030 would destroy any attempt for this country to compete internationally.

In 1990, health care expenditures in the United States were almost twice that of our primary Pacific economic competitor, Japan, and almost four times that of China (Fig 2, 3). The remarkable statistic of 1.9% for Singapore is probably the result, in large part, of a system called Medisave. In Singapore, whatever portion of an annual health care expenditure allotment an individual does not spend is deposited into a pension plan for that individual. This system of incentives to save money can be argued to support a system under managed care into which incentives can be built. Such incentives will undoubtedly yield interesting twists in the area of health care practitioner legal liability.

A given then is the percentage of gross national product spent in this country on health care as one of the significant factors that reduces our global economic competitiveness.

The *disease* is a costly health care system. A look at the most expensive components of the system points out what the attempted *cure* will include (Fig 4). Of particular interest is the fact that hospital care constitutes 38 cents of each health care dollar spent in 1990. Physician services are the next largest single cause of health care expenditures. Therefore, it is not unreasonable to project that a managed care system will ultimately be in place that will 1) be incentivized to reduce total health care expenditures; 2) target, in particular, the cost of hospital care; and 3) will be designed to reduce the cost of physician services.

Fig 1.—U.S. National Health Expenditures 1980 to 2030

YEAR	GROSS DOMESTIC PRODUCT (Billions)	NATIONAL HEALTH EXPENDITURES (Billions)	PERCENT OF GDP
1980	$2,708	$250.1	9.2
1990	$5,514	$666.2	12.1
1991	$5,674	$736.5	13.0
1992	$5,909	$819.9	13.9
1993	$6,259	$903.3	14.4
1995	$7,069	$1,101.9	15.6
2000	$9,637	$1,739.8	18.1
2010	$17,238	$3,787.8	22.0
2020	$29,594	$7,839.4	26.5
2030	$49,936	$15,969.6	32.0

NOTE: 1992-2030 Projected.
SOURCE: Health Care Financing Review, Fall 1992, Vol. 14, No. 1.

Fig 2.—National Health Expenditures as a Percent of GDP, Selected OECD Countries, 1970 to 1990

Country	PERCENT OF GDP					
	1970	1975	1980	1985	1989	1990
Canada	7.1	7.2	7.4	8.5	8.8	9.3
France	5.8	7.0	7.6	8.5	8.7	8.8
Germany	5.9	8.2	8.4	8.7	8.2	8.1
Italy	5.2	6.1	6.9	7.0	7.6	7.7
Japan	4.4	5.5	6.4	6.5	6.6	6.5
United Kingdom	4.5	5.5	5.8	6.0	6.1	6.2
United States	7.4	8.4	9.2	10.5	11.5	12.1

SOURCE: Schieber and Poullier (1991); Scheiber, Poullier, and Greenwald (1992).

Fig 3.—National Health Expenditures as Percentage of GDP 1990, Selected Asian Countries

COUNTRY	% of GDP
India	6.0
China	3.5
Indonesia	3.7
Japan	6.5
Pakistan	3.4
Philippines	2.0
Thailand	5.0
South Korea	6.6
Sri Lanka	3.7
Hong Kong	5.7
Singapore	1.9
Malaysia	3.0
Papua New Guinea	4.4

SOURCE: World Bank.

What is Managed Care?

Managed care within the context of the delivery of health care services is a carefully planned system within which the following are important components:

1. An agreement by a hospital or related organization to provide certain health care services;
2. Those certain health care services are subject to a system designed to assure proper utilization and quality of care;
3. In exchange for a payment by a third-party payer.

This management of care may be imposed solely by the payer, by hospitals, or medical service organizations in concert with payers, physicians, and hospitals. There are almost countless potential configurations of interrelationships among components of managed care systems. There is no indication which configuration of the many possibilities will be implemented eventually in Hawaii. Currently physicians, medical center and clinic CEOs, and attorneys are attending many seminars and programs being offered with a view toward deciding on and implementing managed care systems in Hawaii.

With the foregoing components of managed care in mind and reflecting on the economic forces driving us toward managed care, it can be predicted with probability that managed care in Hawaii will utilize a variety of devices to eliminate or minimize to every extent possible the economic uncertainties of the present health care delivery system. Under the present system, a third-party payer, such as HMSA, will reimburse a fixed percentage of approved services. Although reimbursement is for approved services only and at a fixed percentage, there is enormous financial uncertainty within the current system. The current system is tantamount to a system of property insurance in which an insurer agrees to reimburse a homeowner 80% of whatever the replacement cost may be of a home destroyed by fire. To be sure, a replacement home under those circumstances will be considerably grander and more expensive than if the home were replaced under a system in which the insurer imposed a fixed limitation on the cost of a replacement home.

A concept of *capitation* will incorporate into managed care the fixed limitation on the amount available for health care for each patient/participant in the program. As an example, if the system allocates for each patient/member of a particular managed care program a total of $5,000 a year for total health care costs, including hospitalization, physician charges, drugs, etc, the managed care system will make money if less than $5,000 per patient is spent. Money will be lost if more than $5,000 is spent per year per member for health care expenditures. A similar system is already in place in Hawaii and throughout the Mainland in the form of health maintenance organizations (HMOs).

Major and Subtle Changes of Legal Liability of Managed Care

A look at the economic forces driving us toward managed care, and the realignment of hospitals, physicians, and insurers within a system of capitation, suggest what the legal liability issues will be in a managed care system.

Independent medical staff will lose its meaning in a system in which physicians own a hospital or in which a hospital employs physicians. Hospital administration will not have available to it the defense that it exercises no control over a physician's independent practice of medicine within its physical facilities. The hospital will have total vicarious liability for the acts and omissions of the physicians whom it employs. Therefore, a hospital-employed physician will no longer have the incentive to point the finger of liability at hospital employees and, conversely, the hospital will not have the incentive to point the finger of liability at the physician, who is no longer a member of an independent medical staff. Indeed, the same attorney may represent both the hospital and the physician when both are sued by a patient. Under the present system, a patient may sue a hospital and also name as a defendant nurses employed by the hospital. Just as there is usually no conflict of interest for one attorney to represent both the hospital and the nurses in that

Fig 4.—The Nation's Health Dollar: 1990

PAYMENT SOURCE (Cents)	
Private Health Insurance	33
Medicare	17
Medicaid	11
Other Government	14
Other Private	5
Direct Patient Payments	20
EXPENDITURE (Cents)	
Hospital Care	38
Physician Services	19
Nursing Home	8
Other Personal Health Care	23
Other Spending	12

NOTES: Other private includes industrial, non-patient revenue, private construction. Other personal care includes dental, drug, other goods and services. Other spending includes, administrative, research and construction.

SOURCE: Health Care Financing Administration

setting, there would be no conflict of interest for the same attorney to represent a hospital and a physician who is employed by that hospital. Therefore, terms such as "independent contractor," "ostensible agency" and "independent medical staff" may no longer be relevant in the medical malpractice setting.

The reversal of incentive to treat a patient creates other legal liability issues. There will be incentives for hospitals to maintain the lowest possible census to reduce hospital expenditures within a system of capitation. Similarly, there will be incentives for physicians to see patients as infrequently as the standard of care will allow. Consequently, Medicare fraud and abuse concerns may focus on a provider's failure to deliver sufficient services rather than a delivery of unnecessary services in exchange for payment.

Managed care contracting among groups of physicians, hospitals, and insurers can and will raise antitrust issues as providers and payers enter into exclusive arrangements. Therefore, it is imperative that exclusive arrangements among health care providers, hospitals, and insurers be drafted carefully to avoid antitrust issues.

Various payment mechanisms can raise issues of fee-splitting which, again, should be addressed carefully in the formulation of managed care agreements.

The provision of certain health care services, subject to a system designed to assure proper utilization and quality of care, can and probably will raise legal issues with respect to a payer's utilization review decision, which may limit access to care. Cases on the Mainland have already been the subject of considerable publicity in which bone marrow transplants, for example, have been denied reimbursement by third-party payers. Accordingly, patients will sue payers and providers independently and in parallel claims for provider's alleged negligent care and payer's imposing unreasonable limitations on the delivery of care because of this utilization review decision. This will create even greater polarity between payers and providers resulting in finger-pointing between payers and providers if a patient alleges failure to provide sufficient services.

Concurrent credentialing by hospitals and payers or their affiliated utilization review organization will cause a retooling of peer review confidentiality and protection. Traditionally, hospitals are concerned with the competence of a physician. Under the present system a hospital's credentials committee will rarely concern itself with a physician's utilization track record. Again, what with an attempt to reduce hospital census and reduce the frequency of physician visits under a capitation system, credentialing will be based on both the physician's competence *and* utilization track record. A hospital may conclude that a physician is competent, while the payer component of the managed care system may wish to exclude the entry of a physician into the system because of a track record of over-utilization.

The credentialing process will, therefore, incorporate into it a much greater emphasis on a physician's morbidity and mortality track record. Not only will morbidity and mortality statistics become an integral part of credentialing decisions, but such statistics will become available to patients in formulating an informed decision in selecting physicians.

Because hospitals and payers will each conduct their own credentialing process, peer review protection will either have to be broadened to include credentialing by payers or may be reduced or eliminated altogether as morbidity and mortality statistics are considered important information to be made available to patients in making health care decisions.

Agency for Health Care Policy and Research Section 6103 of OBRA 1989

The major functions of the Agency for Health Care Policy and Research section 6103 of OBRA 1989 creates a new Title IX of the Public Health Service Act:[1]

1. To conduct and support research, demonstration projects, evaluations, training, guideline development and the dissemination of information on health care services and systems for the delivery of such services including activities with respect to: a) the effectiveness, efficiency and quality of health care services and procedures; b) the outcomes of health care services and procedures; c) clinical practice, including primary care and practice-oriented research; d) health care technologies, facilities, and equipment; e) health care costs, productivity and market forces; f) health promotion and disease prevention; g) health statistics and epidemiology; and h) medical liability. This legislation also will assess health technology and establish an advisory council for health care policy, research, and evaluation.

What will probably be the most controversial and discussed component of this new legislation is the establishment of the Office of the Forum for Health Quality and Effectiveness. This office will arrange for the development, periodic review and updating of clinically relevant guidelines that may be used by physicians, educators and health care practitioners to assist in determining how diseases, disorders and other health conditions most effectively and appropriately can be prevented, diagnosed, treated and managed clinically.

Further, the Office of the Forum for Quality and Effectiveness will develop, review periodically, and update standards of quality, performance measures and medical review criteria through which health care providers and other appropriate

entities may assess and review the provision of health care and assure the quality of such care. Such guidelines, standards, performance measures and review criteria are to be based on the "best available research and professional judgment" and are to be presented in formats appropriate for use by physicians, health care practitioners, providers, medical educators, and medical review organizations, and in formats appropriate *for use by consumers of health care*. This will include treatment-specific or condition-specific practice guidelines for clinical treatments and conditions, and forms appropriate for use in clinical practice, educational programs, and in reviewing quality and appropriateness of the medical care.

Priorities in establishing such practice guidelines, standards, performance measures and review criteria will be prioritized based on needs of Medicare, particularly high-cost or controversial items and items with substantial variation nationally. Among those areas of clinical practice selected for application of the guidelines, standards, performance measures, and review criteria are:

- Post-operative pain management
- Urinary incontinence in adults
- Prediction and prevention of bedsores
- Benign prostatic hypoplasia
- Low-back pain problems
- Depression treated by primary care physicians in an out-patient setting
- Evaluation and management of early HIV infection
- Management of cancer-related pain
- Treatment of pressure ulcers in adults
- Quality determinants of mammography
- Otitis media with effusion in children
- Heart failure: evaluation and care of patients with left ventricular systolic dysfunction
- Post-stroke rehabilitation
- Screening for Alzheimer's disease and related dementia
- Cardiac rehabilitation
- Diagnosis and management of unstable angina
- Smoking prevention and cessation
- Diagnosis and treatment of anxiety and panic disorder in a primary care setting

Definitions within this new legislation are as follows:

- Practice guidelines: Systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.
- Medical review criteria: Systematically developed statements that can be used to assess the appropriateness of specific health care decisions, services and outcomes.
- Standards of quality: Authoritative statements of 1) minimum levels of acceptable performance or results, 2) excellent levels of performance or results, or 3) the range of acceptance performance or results.
- Performance measures: Methods or instruments to estimate or monitor the extent to which the actions of a health care practitioner or provider conform to practice guidelines, medical review criteria, or standards of quality.

"Cookbook" Medicine from a Legal Liability Viewpoint

There are seemingly insurmountable obstacles in developing practice guidelines in some areas, such as treating back pain. Once the obstacles are overcome and practice guidelines are developed and put in place, the question arises as to whether deviation from the guidelines can be used by a patient in a lawsuit against a physician. Physicians argue that the establishment of practice guidelines that cannot possibly apply in every instance to every patient will now provide patients and their attorneys with even more ammunition in medical malpractice lawsuits.

Once practice guidelines are enacted, won't this give patients and their attorneys new ammunition to use in lawsuits against physicians? Maine and other states have confronted this potential problem by decreeing by statute that only the defendant physician may refer to practice guidelines in his or her defense. In other words, practice guidelines cannot be raised initially by the patient's attorney to prove a deviation from the guideline and, thus, care and treatment below the standard of care. Initially, only the physician's attorney can utilize as evidence a practice guideline to show conformance with the guideline as a defense for a medical malpractice lawsuit. Therefore, in Maine and the other states, a practice guideline in a medical malpractice lawsuit is not a spear, it is a shield.

Whatever the legal liability implications may be of practice guidelines or practice parameters, the demonstration project in Maine appears to have some profound impact on the practice of medicine. A *Wall Street Journal*[2] article said that 80% of practicing physicians in Maine are participating in the demonstration project, it is reported that prior to the imposition of practice parameters, 95% of all victims of falls and car accidents were ordered to have $170 neck x-rays at the emergency room of Maine Medical Center. Following the imposition of the practice parameters, that percentage was reduced to 50%. It is also reported that anesthesiologists are now doing fewer blood tests

Fig 5.—Sample Protocol in Maine Medical Liability Demonstration Project Excerpts

MEDICAL LIABILITY DEMONSTRATION PROJECT
OBSTETRICS AND GYNECOLOGY PRACTICE PARAMETERS

CONTENTS:

I.	Procedure:	Cesarean Delivery for Failure to Progress
II.	Procedure:	Assessment of Fetal Maturity prior to repeat Cesarean delivery or elective induction of labor
III.	Procedure:	Hysterectomy, abdominal (68.4) or vaginal (68.5)
IV.	Procedure:	Hysterectomy, abdominal (68.4) or vaginal (68.5)
V.	Procedure:	Tocolysis
VI.	Condition:	Presumed Ectopic Pregnancy in a clinically stable patient
VII.	Condition:	Singleton Breech Presentation
VIII.	Condition:	Perinatal Herpes Simplex Virus Infections
IX.	Condition:	Intrapartum Fetal Distress
X.	Topic:	Antepartum Management of Prolonged Pregnancy

IV. PROCEDURE: HYSTERECTOMY, ABDOMINAL (68.4) OR VAGINAL (68.5)

A. Indication: Abnormal uterine bleeding in women of reproductive age (626 all, except 626.0, 626.1, 626.3, 626.7)*

Confirmation of indication:

1. History of all of the following:
   a. Excessive uterine bleeding or irregular uterine bleeding defined as bleeding for more than 8 days during more than a single cycle and profuse bleeding requiring additional protection;**
   b. No history of a bleeding diathesis or use of medication that may cause bleeding;
   c. Negative effect on patient's quality of life.
2. Failure to find on physical examination, uterine or cervical pathology that would cause abnormal bleeding.
3. Laboratory data:
   a. No finding of endometrial neoplasia;
   b. No malignancy found in cytological studies of cervix.
4. No finding of endometrial polyps by D&C, hysteroscopy, or hysterogram.

B. Actions Prior to Procedure:

1. Determine that attempted hormone treatment (estrogen-progestogen) was not successful or contraindicated or refused.
2. Hemoglobin or hematocrit documented.
3. Document and attempt to correct anemia if present.
4. Offer autologous blood donation if appropriate.
5. Document patient education and informed consent.

C. Contraindication:

1. Desire to maintain fertility.

Reference: Quality Assurance in Obstetrics & Gynecology, 1989 ed.

* Other diagnoses that should also be evaluated according to these criteria include menorrhagia (626.2, 627.01, hypermenorrhea (626.2).

** For example, large clots, gushes, irritations on activity.

[Me Rev Stat Ann X 24, Section 2971 (West Supp 1991)]

and chest x-rays before surgery. Radiologists are saying that the guidelines are one reason why they no longer require as many patients to stay overnight in the hospital after certain blood vessel x-rays.

One thing is certain: When practice parameters/guidelines are in place and a consumer version of the practice parameters is published for use by patients, the often-heard allegation of "lack of informed consent" will be heard less and less. Some health care practitioners may view the prospect of a dialog between practitioner and patient, each with his or her version of the relevant practice guideline in hand, as yet another burden for the health care profession to carry. Patients who are armed with their own practice guidelines when they come to the physician's office will certainly have more questions and will initiate more discussion regarding the proposed treatment. This may consume more time and affect the bottom line because fewer patients will be seen. However, when a physician charts reference to the practice guideline and the fact that the patient was referred to the consumer version of the practice guideline, and there was full discussion about the practice guideline, it will be extremely difficult for that patient to claim later that he or she lacked informed consent before the care/treatment/procedure began. Therefore, the patient who is armed with knowledge may be viewed as an irritant, but ultimately, that patient will have less to complain about if a recognized risk of the procedure is encountered post-operatively.

When practice parameters are discussed in the Hawaii Legislature, it is proposed that the treatment/procedure guidelines be included along with alternatives, the risks, so there can be no question about a patient's having participated in a discussion about these issues and the material covered in guidelines, such as those proposed in Maine. If practice parameters include a thorough discussion of the recognized alternatives and risks of a procedure, a physician who follows the guidelines and who furnishes to a patient the consumer version of the practice guidelines should never lose a case on the issue of lack of informed consent. This is particularly important because a recent Hawaii Appellate case says, in effect, that a patient who signs an informed consent form on which all of the pertinent information appears with respect to providing informed consent is not conclusive evidence that informed consent was obtained from the patient before a procedure.[3]

Legal Liability Fallout Under Managed Care

Maintenance of morbidity and mortality statistics with respect to practitioners such as surgeons will mean more stringent controls on the delivery of health care and, therefore, clearer guidelines for evaluating which physicians should and should not be licensed, have staff privileges, and how their care can be evaluated. Therefore, there will be a new balance struck between a physician's right to a license, to staff privileges, and cost-effective reasons for precluding or removing a license and staff privileges. We will see more administrative altercations between licensing authorities and physicians, and credentialing bodies in hospitals and physicians.

We will see more lawsuits against hospitals for negligent credentialing. Because there will be greater emphasis on affording privileges within much more stringent control parameters, patients' attorneys will look increasingly to the information available or what should have been available to an institution before a practitioner was granted staff privileges.

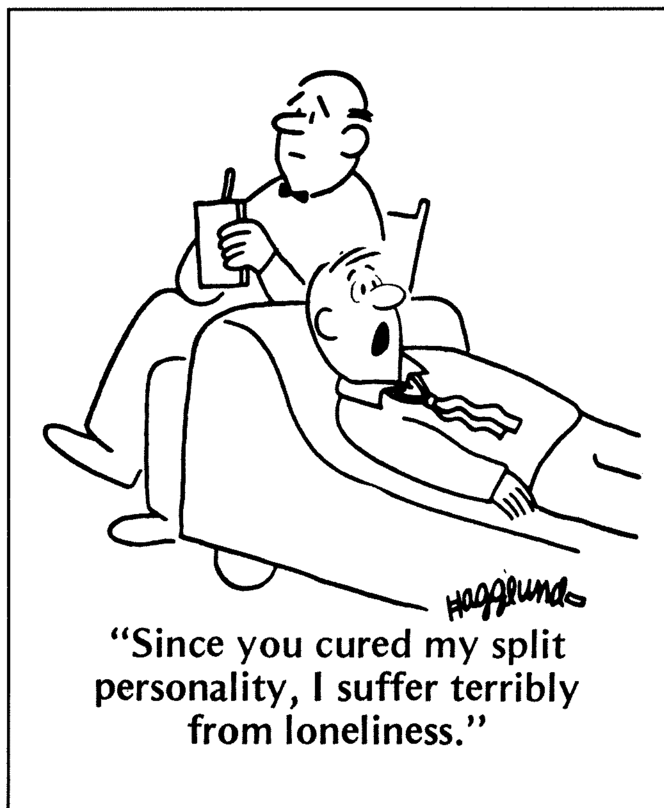
Market forces will move us toward capitation and reduction of hospital and physician-related costs. Therefore, we will see an expanded role of nurses and the creation of new areas of nursing liability. As an example, if patients are discharged earlier from hospitals to reduce post-operative hospital care costs, it will probably be nurses and not physicians who will go to the home of a patient for post-operative evaluation. This will require a higher level of decision-making among nurses and will require a heightened level of communication between nurses and physicians.

Of all the things that feel uncomfortable and are disliked most is *change*. In discussions with groups of physicians regarding what managed care will mean in terms of the law and liability, it is extremely obvious that physicians are anxious, fearful and angry about the prospect of the changes managed care will bring.

Whether it's lawyers who represent patients and cases against physicians, lawyers who handle the corporate and business aspects of a changeover into managed care, or lawyers who represent physicians in a medical malpractice lawsuit, physicians are now of the mind that all lawyers are the enemy and managed care is what lawyers are creating. This is not true. Economic forces are driving the health care delivery system into managed care. Although non-lawyers do not like to view lawyers as victims, the economic forces behind managed care are in fact victimizing attorneys as much as physicians. The economic forces are bigger than the medical and legal professions. Whether we are physicians or attorneys, managed care is coming and both professions are well advised to adapt as much as they can, rather than fighting the process along the way.

References

1. Title IX of the Public Health Service Act, Agency for Health Care Policy and Research, Section 6103 of OBRA 1989.
2. Felsenthal, F. Cookbook care: Maine limits liability for doctors who meet treatment guidelines. *Wall Street J.* May 3, 1993, A1, A9.
3. *Keomaka v. Zakaib.* 8 Haw App 518.



"Since you cured my split personality, I suffer terribly from loneliness."