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COST CONTAINMENT AND THE PHYSICIAN’S FIDUCIARY DUTY TO THE PATIENT

Thomas H. Boyd*

In whatever kind of organizational setting physicians practice these days, they must above all be more vigilant than ever to ensure that patients’ interests are protected. If patients ever lose their trust in the commitment of the medical profession, they and their physicians will be deprived of an element vital to good care, and the quality of medical services will decline. Physicians have an obligation to preserve their patients’ trust. It is an obligation quite different from, and often incompatible with, the relations between sellers and buyers in a commercial market. That is why what is good, i.e., profitable, for the new health care businesses may not be so good for ethical physicians or for the patients they are sworn to serve.

INTRODUCTION

During the 1970’s and early 1980’s, both public and private sector health insurance programs were structured in such a way as to encourage extravagance and waste.2 Payments were made on the basis of services actually rendered.3 Thus, there was great incentive for wasteful duplication and overutilization of services and facilities.4 This retrospective cost reimbursement system5 has of course permitted health care providers to receive higher profits. It has also bestowed upon physicians the ability to shield themselves from liability through the practice of “defensive medicine.”6


6. The term “defensive medicine” refers to a practice in which physicians utilize exhaustive diagnostic and treatment methods of minimum value to ensure the best quality of health care while at the same time erecting an undefeatable defense against liability. Shavell, Theoretical
Facing a crisis in the area of health care costs, however, Congress enacted a prospective payment system in 1986. As a consequence, payments made under Medicare are now based on predetermined rates which correspond with one of 470 diagnosis related groups. The prospective payment system generates incentive to reduce costs so as to keep them at or below the given rate. This, in turn, has led to a reduction in services provided to the

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7. Carlucci, supra note 2, at 15; Entin, supra note 4, at 676; Macaulay, supra note 6, at 91; Miller, supra note 2, at 2. “In 1977, health care expenditures were $170 billion and represented 9 percent of the gross national product. At the beginning of 1987, health care expenditures had risen to $458 billion, or 10.9 percent of the gross national product.” Greenberg, Introduction, Special Issue on Competition in the Health Care Sector: Ten Years Later, 13 J. Health Pol’y, Pol’y & L. 223, 223 (1988). See generally Wing, American Health Policy in the 1980’s, 36 Case W. Res. L. Rev. 608 (1986). One commentator aptly stated the problem as follows:

Both as individuals and as makers of public policy, our individual and collective wants clearly exceed our resources. This is particularly true in medicine, where medical technology has outpaced the ability of the public to pay. In medicine the infinite needs of the public have collided with our society’s finite resources. Commentators have aptly observed that the divergence between what is good for the patient and what is efficient for society is crucial to current concerns over health care spending. No set of expenditures can rise faster than the Gross National Product forever. The U.S. cannot maintain its present rate of growth in health care spending while simultaneously investing to restore productivity, growth, and international competitiveness.


9. Carlucci, supra note 2, at 15. As Carlucci explains,

Diagnosis Related Groups [D.R.G.] is a reimbursement system developed by researchers at the Yale University School of Organization and Management in the early 1970’s. The system is premised on the identification of various patient diagnoses. There are a total of eighty-three major diagnoses categories where illnesses are grouped together as they relate to pathology or clinical management of the illness. To deal with a wide variation in the cost of treating illness within the major categories, the D.R.G. is further broken down by a variety of factors such as age, secondary diagnosis and surgical procedures. . . . The entire system is premised on the concept that a patient who is classified into a given D.R.G. should cost the same as all other patients within that D.R.G. as the care requirements will be the same.

Id.

patient. Private health care insurance programs have followed the government's lead in adopting prospective payment as the primary compensation scheme.

Our society is in the process of making a total commitment to provide adequate and affordable health care to all of our citizens. The method by which such an objective can be achieved is through the cost containment strategies which have evolved in the prospective payment period. Consequently, the proliferation of Health Maintenance Organizations ("HMO's"), Preferred Provider Organizations ("PPO's") and similar forms of third-party payor programs, which emphasize cost containment through managed

11. Cline & Rosten, supra note 3, at 122.
12. Entin, supra note 4, at 680-82. Indeed, the federal government has actively encouraged the private sector to develop payment plans that use a similar prospective payment approach. Schuck, Malpractice Liability and the Rationing of Care, 59 Tex. L. Rev. 1421, 1421-23 (1981).

The President's Commission concluded that the correct standard for judging the fairness of health care distribution is one that ensures everyone equitable access to care, defined as access to "an adequate level of health care." The commission concluded that equitable access to care requires that people not face "excessive burdens" in obtaining care—such as out-of-pocket expenses, travel and waiting time, and the like. Adequate care is "enough care to achieve sufficient welfare, opportunity, information, and evidence of interpersonal concern to facilitate a reasonably full and satisfying life."

Capron, Containing Health Care Costs: Ethical and Legal Implications of Changes in the Methods of Paying Physicians, 36 Case W. Res. L. Rev. 708, 743-44 (1986) (citing President's Comm'n for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Securing Access to Health Care 20-22 (1983)). See also Harris, Gatekeepers and Cost-Containers in HMO's, 318 New Eng. J. Med. 1698, 1698 (1988) ("Government, business, and our own patients are telling us to change the delivery of medical care to include all our citizens.").
14. See generally Wing, supra note 7.
15. An HMO can be defined as:

a single entity providing comprehensive health care services for a prepaid fee. An HMO, as both a health insurer and a health care provider, contracts with enrolled subscribers to provide a range of health services. Generally, an HMO will provide, at a minimum, physician, laboratory, x-ray, inpatient and outpatient hospital services, and emergency care. Supplemental services, such as dental care, are often included in the plan.

Note, Health Maintenance Organizations and the McCarran-Ferguson Act, 7 Am. J.L. & Med. 437, 437 (1982). An HMO may own the facility, provide most of the services, and employ the care providers or it could contract with Individual Practice Associations or Networks where providers collectively contract with HMOs to provide services to subscribers at the physicians' own offices. Id.

16. "The private sector increasingly uses preferred provider networks ("PPO's") to direct beneficiaries to selected providers. Plan administrators enroll providers that offer high quality care at favorable prices. Provider performance is assessed through utilization review, and poor performers are excluded from the network." Roper, supra note 10, at 178.
health care,\textsuperscript{17} has been encouraged.\textsuperscript{18} The rationale is that the greater the involvement of the private sector, the lighter the burden which must be borne by the government.\textsuperscript{19}

This revolutionary shift from retrospective cost reimbursement to a prospective payment system has resulted in a serious conflict of interest for physicians.\textsuperscript{20} On the one hand, a doctor has the responsibility of providing adequate care to his or her patients.\textsuperscript{21} On the other hand, a physician is subject to tremendous pressure to minimize the expense of that care.\textsuperscript{22} The difficulty of this situation is intensified by the fact that the standard of care by which physicians are evaluated is based on practices and case law developed during the period of retrospective reimbursement and defensive medicine.\textsuperscript{23}

Many commentators view the change from retrospective reimbursement to a prospective payment system as a repudiation of society's objective to provide adequate care to all subscribers.\textsuperscript{24} As a result, they have forwarded an array of radical proposals that would fundamentally alter the state of the law and the standard of professionalism in medicine.\textsuperscript{25} The purpose of this article is to evaluate these various proposals in light of society's expressed objectives and the state of modern case law. Part I reviews the legal status of the physician-patient relationship.\textsuperscript{26} Part II examines provisions in agree-


\textsuperscript{18} Capron, supra note 13, at 712.


\textsuperscript{21} Note, \textit{Rethinking Medical Malpractice Law in Light of Medicare Cost-Cutting}, 98 Harv. L. Rev. 1004, 1013-15 (1985). For example, staff privileges may be directly or indirectly tied to the level of utilization. See also Knapp v. Palos Community Hosp., 125 Ill. App. 3d 244, 257, 465 N.E.2d 554, 564-65 (1st Dist. 1984) (physician's staff privileges revoked for overutilization).

\textsuperscript{22} Note, supra note 22, at 1008-13.


\textsuperscript{24} See infra notes 97-138 and accompanying text.

\textsuperscript{25} See infra notes 31-71 and accompanying text.
ments made in the private sector between third-party payors and physicians which may affect the physician-patient relationship. Part III evaluates a number of the proposals which assume that the objective of providing health care for all Americans necessitates the sacrifice of quality care, and in light of this assumption have been offered as ways to help physicians cope with this dilemma. Finally, Part IV proposes an additional and preferable solution based on the doctrine of fiduciary duty which currently applies to physicians.

I. THE PHYSICIAN’S STANDARD OF CARE

No authority may seriously dispute that physicians owe a fiduciary duty to their patients. Essentially, this means that a physician must place the

28. See infra notes 72-96 and accompanying text.
29. See infra note 97-138 and accompanying text.
30. See infra notes 139-67 and accompanying text.
31. See generally Restatement (Second) of Trusts § 2 comment b (1959); H. Henn & J. Alexander, Laws of Corporations § 235 (3d ed. 1983). The Honorable Benjamin Cardozo wrote the classic description of fiduciary duty:

Many forms of conduct permissible in a workaday world for those acting at arm’s length, are forbidden to those bound by fiduciary ties. A trustee is held to something stricter than the morals of the market place. Not honesty alone, but the punctilio of an honor the most sensitive, is then the standard of behavior. As to this there has developed a tradition that is unbending and inveterate. Uncompromising rigidity has been the attitude of courts of equity when petitioned to undermine the rule of undivided loyalty by the “disintegrating erosion” of particular exceptions. . . . Only thus has the level of conduct for fiduciaries been kept at a level higher than that trodden by the crowd.

32. 10 Williston on Contracts § 1286A, at 947 & n.3 (3d ed. 1967 & Supp. 1988). The Supreme Court of North Carolina has fairly described this duty:

The relationship of patient and physician is generally considered a fiduciary one, imposing upon the physician the duty of good faith and fair dealing. This special relationship envisions an expectation by both parties that the patient will rely upon the judgment and expertise of the doctor. Furthermore, this relation is predicated on the fundamental proposition that the physician possesses special knowledge or skill in diagnosing and treating diseases and injuries, which the patient lacks, and that the patient has sought and obtained the services of the physician because of such special knowledge and skill.

interests and well-being of the patient above his or her own interest. This is not to say that physicians must provide their services gratis. Rather, they are entitled to reasonable compensation for services rendered. Once a


34. Physician compensation has long been held to be a matter of basic contract law. Where the physician has made an express contract to provide the patient with care at a certain fee, the right to compensation is limited to the amount stated in the agreement. See, e.g., Shields Constr. Co. v. Cowan, 270 Ky. 173, 178-79, 109 S.W.2d 585, 588 (1937) (mutual promises by physician and injured worker's employer create contract). In the absence of an express agreement, the law will imply a right to compensation in the amount of the reasonable value of the services rendered and the expenses incurred in providing those services. See Citron v. Fields, 30 Cal. App. 2d 51, 57, 85 P.2d 534, 537-38 (1938) (court may question physician and look at patient's ability to pay to set fee); In re McKeelhan's Estate, 358 Pa. 548, 552-53, 57 A.2d 907, 909 (1948) (value of services may be set by court). It must be kept in mind, however, that a physician always has the right to refuse to enter into any physician-patient relationship. See Findlay v. Board of Supervisors of Mohave, 72 Ariz. 58, 65, 230 P.2d 526, 531 (1951) (hospital may exclude physicians from their staff); Rice v. Rinaldo, 67 Ohio L. Abs. 183, 185, 119 N.E.2d 657, 659 (1951) (physician's office is not a place of public accommodation for those prohibited from racial discrimination).
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physician assumes the care of a patient, however, any conflict between the physician's and the patient's interests must be resolved in favor of the patient.\textsuperscript{35}

Generally, a physician's fiduciary duty is considered to attach at the time the physician undertakes to treat the patient.\textsuperscript{36} From that point, through the duration of the treatment of and consultation with the patient, the physician is bound to fully disclose his or her findings to the patient,\textsuperscript{37} to ensure the confidentiality of the relationship,\textsuperscript{38} and, most significantly, to provide a level of care that meets accepted standards in the profession.\textsuperscript{39}

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\textsuperscript{35} A. JONSEN, M. SIEGLER & W. WINSLADE, CLINICAL ETHICS §§ 4.2.4, 4.4.3 (2d ed. 1986).
\textsuperscript{36} In the Hippocratic tradition, the actions of medical practitioners are supposed to promote the interests of patients above all others, including the physicians.” Capron, supra note 13, at 710. See also R. VEATCH, A THEORY OF MEDICAL ETHICS 22 (1981) (the Hippocratic Oath encompasses a fundamental moral principle—do good or at least do no harm to your patient). Indeed, “physicians are ethically bound to place the medical needs of their patients above their own financial interests.” Relman, Dealing With Conflicts of Interest, 313 NEW ENG. J. MED. 749, 750 (1985).
\textsuperscript{37} R. MILLER, PROBLEMS IN HOSPITAL LAW 227-29 (4th ed. 1983). The creation of the relationship must be an intentional act on the part of the physician. For example, the mere presence of a physician who is monitoring the conduct of another physician so as to evaluate the latter physician's qualifications has not entered into a fiduciary relationship with the patient and does not have the duty to intervene if he or she witnesses malpractice. Clarke v. Hoek, 174 Cal. App. 3d 208, 215-16, 219 Cal. Rptr. 845, 850-51 (1985).
\textsuperscript{38} See Lambert v. Park, 597 F.2d 236, 239 & n.7 (10th Cir. 1979) (ensuring informed consent is in the nature of “fiduciary duty” of physician); Nardone v. Reynolds, 538 F.2d 1131, 1136 (5th Cir. 1976) (physicians’ duty to disclose stems from fiduciary duty); Ostojic v. Brueckmann, 405 F.2d 302, 304 (7th Cir. 1968) (existence of physician's fiduciary duty requires full disclosure); Margaret S. v. Edwards, 488 F. Supp. 181, 207 (E.D. La. 1980) (fiduciary duty entails full disclosure and informed consent). The fiduciary duty may create a presumption of fraud where there has been nondisclosure. See Smith v. Cook County Hosp., 164 Ill. App. 3d 857, 865, 518 N.E.2d 336, 341 (1st Dist. 1987) (Illinois courts have not applied a fiduciary relationship exception to the requirement that a fraud action be brought within a reasonable time after discovery); Walters v. Rinker, 520 N.E.2d 468, 470-74 (Ind. Ct. App. 1988) (physician did not actually deceive patient because he did not know he misdiagnosed the patient).
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At one time, the standard of care to which a physician was held varied from one locality to another due to the significant discrepancy of resources and equipment, and the general availability of competent physicians. The standard for evaluating care has since evolved toward a singular national or profession-wide standard. Rather than making allowances for inequities of location, the medical profession and the courts expect physicians to make decisions that are in the best interests of the patient, including making referrals to more competent specialists who have the advantage of better equipped facilities. Today, barring an emergency situation, a physician

care and skill as well as to inform patient and obtain informed consent); McCarroll v. Reed, 679 P.2d 851, 854 (Okla. Ct. App. 1983) (physician had duty to use skill, care and diligence to prevent drug addiction of patients).


42. See supra notes 32-35 and accompanying text. See generally Callahan, Competency in Medical Care, 63 Neb. L. Rev. 663 (1984) (physician must be more than technically competent, he or she must also be sensitive to the moral aspects of health care); Furrow, Malpractice Revisited: Of Medical Errors, Social Transformation, and Tort Standards, 63 Neb. L. Rev. 810 (1984) (malpractice litigation provides an incentive for physicians to act in their client's best interests); Janulis & Hornstein, Damned If You Do, Damned If You Don't: Hospitals' Liability for Physicians' Malpractice, 64 Neb. L. Rev. 689 (1985) (hospital liability is expanding because law presumes that the average person is not medically sophisticated and as such, places their trust in the physician and hospital); Shapiro, Medical Malpractice: History, Diagnosis and Prognosis, 22 St. Louis U.L.J. 469 (1978) (physician is held to standard of care which is defined by the medical profession, regardless of locality).

43. Taylor v. Wilmington Med. Center, Inc., 577 F. Supp. 309, 317 (D. Del. 1983) (physician has duty to refer patient to specialist if other neurosurgeons in similar situations would do so); Dewes v. Indian Health Serv., 504 F. Supp. 203, 208 (D.D.C. 1980) (physician has duty to consult specialist if he lacks requisite skill for patient's condition); Lewis v. Soriano, 374 So. 2d 829, 831 (Miss. 1979) (general practitioner should have referred patient to orthopedic surgeon for complicated fracture). See generally Stevens, Malpractice Liability of a Referring Physician, 32 Med. Trial Tech. Q. 121 (1986) ("The general rule is that a physician who calls in or recommends another physician or surgeon is not liable for the other's malpractice, at least where there was no agency or concert of action, or no negligence in the selection of the other physician or surgeon." (citing Stoval v. Harms, 214 Kan. 835, 840, 522 P.2d 353, 357 (1974))).

44. Finley, Goodwin & Fisher, Tort Reform and Medical Malpractice: Iowa's Past, Present, and Future, 36 Drake L. Rev. 669, 674 (1987). See generally Note, Good Samaritans and Liability for Medical Malpractice, 64 Colum. L. Rev. 1301 (1964) (good Samaritan statutes were created to shield physicians from liability in emergency situations where their expertise may be in some other area); Note, Good Samaritan Legislation: An Analysis and a Proposal, 38 Temp. L. Q. 418 (1965) (many of these statutes require "good faith" and "no compensation" prerequisites).
has a duty to refrain from providing health care except where he or she is able to provide that care at an acceptable level.\textsuperscript{45}

In addition to the duty owed by a physician during treatment, there also are decisions made by the physician prior to the commencement of treatment which can be retroactively subjected to the strict scrutiny of the fiduciary standard. Such decisions may include securing the assistance of a competent support staff,\textsuperscript{46} designing and maintaining an adequate recordkeeping system,\textsuperscript{47} participating in available continuing education programs to ensure an understanding of the state of the art diagnostic and treatment methods,\textsuperscript{48} attaining privileges with high quality health care facilities,\textsuperscript{49} and making provisions which ensure the financial ability to meet any potential liability which may arise from the practice.\textsuperscript{50} All of these decisions involve the common concern that physicians must strive to minimize any potential interference with their ability to treat patients once the physician-patient relationship has been established. There are certain situations where a physician may take into account the patient's economic interests in making treatment decisions.\textsuperscript{51} However, taking a patient's economic interest into account will constitute a breach of the physician's fiduciary duty if he or she has unreasonably permitted a third party to compromise the physician-patient relationship.\textsuperscript{52}

\begin{footnotes}
\item[47] This responsibility is closely tied to the physician's duty to keep patient records confidential and the duty to provide proper care in light of the information that has been gathered on the individual patient's condition. See supra notes 37-38 and accompanying notes.
\item[48] In addition, the duty to keep abreast of new developments in medicine is crucial in view of the evolution of the national standard of care. See supra notes 40-43 and accompanying text.
\item[49] See Furrow, supra note 24, at 1030.
\item[51] "A doctor is not ethically required to pay for hospitalization or drugs that a patient cannot afford, nor to be insensitive to a patient's desire to avoid crushing debts far beyond his or her ability to pay." Rosenblatt, supra note 19, at 926 n.43. See also Furrow, supra note 20, at 205.
\item[52] See Swayze v. McNeil Labs, Inc., 807 F.2d 464, 471 (5th Cir. 1987) (physicians have a duty to protect patients against undue exercise of third-party discretion in treatment of patients). See also Hammonds v. Aetna Cas. & Sur. Co., 237 F. Supp. 96, 99-100 (physician has duty to treat patient—should not allow insurance company to interfere), reh'g, 243 F. Supp. 793, 799 (N.D. Ohio 1963) (physicians have duty to provide patients with undivided loyalty and protection against third-party interference with physician-patient relationship).
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A recent and much celebrated case, *Wickline v. State*, dramatized the difficult circumstances that physicians now face as they try to reconcile the conflict between adequate care and cost containment. In *Wickline*, a patient brought an action against Medi-Cal, California's medical assistance program. The patient had been hospitalized for arteriosclerosis and consequential circulatory complications in her right leg. Her treating physician believed that she should remain in the hospital for continued treatment and monitoring of her condition. Consultants who reviewed the case on behalf of Medi-Cal, however, determined that she should be discharged. Soon after the patient left the hospital, she experienced problems arising from a blood clot in her right leg. The seriousness of her condition eventually required the amputation of that leg.

In the ensuing lawsuit against Medi-Cal, the patient successfully alleged that the amputation was the result of premature discharge from the hospital. She had not named the treating physician as a defendant, so the jury verdict was solely against Medi-Cal. This verdict, however, was reversed on appeal. In making its ruling, the California Court of Appeals stated:

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 as, for example, when appeals made on a patient's behalf for medical or hospital care are arbitrarily ignored or unreasonably disregarded or overridden. However, the physician who complies without protest with the limitations imposed by a third party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for the patient's care. He cannot point to the health care payor as the liability scapegoat when the consequences of his own determinative medical decisions go sour.

In other words, the pressures and constraints of a prospective evaluation of medical care costs will not be taken into account when assessing a physician's liability. The treating physician retains "ultimate responsibility" for the care of the patient.

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53. 183 Cal. App. 3d 1175, 228 Cal. Rptr. 661 (1986).
55. *Wickline*, 183 Cal. App. 3d at 1633, 228 Cal. Rptr. at 662.
56. *Id.* at 1634, 228 Cal. Rptr. at 663-64.
57. *Id.* at 1636, 228 Cal. Rptr. at 664.
58. *Id.* at 1638, 228 Cal. Rptr. at 665.
59. *Id.* at 1640, 228 Cal. Rptr. at 667.
60. *Id.* at 1641, 228 Cal. Rptr. at 668.
61. *Id.* at 1633, 228 Cal. Rptr. at 662.
62. *Id.*
63. *Id.*
64. *Id.* at 1647, 228 Cal. Rptr. at 672.
65. *Id.* at 1645, 228 Cal. Rptr. at 670-71 (emphasis added).
66. The California Court of Appeals stated that it: appreciates what is at issue here is the effect of cost containment programs upon the professional judgment of physicians to prescribe hospital treatment for patients.
Courts have similarly refused to accept compliance with a payor’s guidelines as a satisfactory substitute for the physician’s legal standard of care. Moreover, jurors, sitting on medical malpractice cases, will be unsympathetic towards physicians who have discharged a patient prematurely, or who have misdiagnosed a patient’s condition due to a concern for keeping costs down. These circumstances will instead be viewed as the result of irresponsible conduct by a physician who subordinates the practice of responsible medicine to the objective of maximizing profits. Furthermore, as Wickline reflects, there is a reluctance to hold third-party payors liable for fear of discouraging private sector involvement in the area of low cost health care. In essence, the great pressures placed on physicians to minimize costs will not serve as an adequate excuse to avoid liability for inadequate or improper medical care.

II. PROBLEMS ARISING FROM CONTRACTUAL ARRANGEMENTS

As Wickline demonstrates, physicians must carefully examine the terms and conditions of the agreements which they enter into with health insurers. The language of these contracts may severely narrow the physician’s discretion in the care of a patient. For example, the constructive result of such contracts may be to allow nonattending physicians and health plan or hospital administrators to make, or at least greatly influence, treatment decisions while leaving the attending physician completely exposed to liability for those 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.

Id. at 1647, 228 Cal. Rptr. at 672.


68. Note, supra note 22, at 1010.

69. Entin, supra note 4, at 678.

70. Macaulay, supra note 6, at 108; Pellegrino, supra note 21, at 42-44.

71. Schuck, supra note 12, at 1426-27.

72. There are various types of these agreements and there is some debate as to which best serves the market. See Rosenblatt, Health Care, Markets, and Democratic Values, 34 VAND. L. REV. 1067, 1073-88 (1981) (impact on competition from these agreements can be classified into three models: individual, entrepreneurial and organizational). See also Marmor, Boyer & Greenberg, Medical Care and Procompetitive Reform, 34 VAND. L. REV. 1003 (1981) (proposes fourth model: procompetitive approach).
Physicians who fail to remain vigilant during contract negotiations, and who permit the terms of these agreements to interfere with their ability to provide the proper quality of care, are in breach of their fiduciary duty to their patients.

A. Hold Harmless Provisions

The "hold harmless" provisions contained in many contracts between health insurers and physicians provide that the attending physician should be wholly responsible for the quality of the health care that subscribers are to receive. If the care provided is substandard, this provision requires the physician to hold harmless, indemnify, and defend the insurer. The language of these provisions shifts all contractual liability to the physician, regardless of the effect any constraints or pressures imposed by the third-party payor may have on the delivery of care. A "hold harmless" provision may have a positive influence in that it provides physicians with significant incentive to maintain quality care. At the same time, however, it excuses, if not encourages, third-party interference with the physician-patient relationship by guaranteeing indemnity of such third-parties. Consequently, it places the patient's welfare in danger and, in turn, results in a breach of the physician's fiduciary duty.

73. Comment, Wickline v. State: The Emerging Liability of Third Party Health Care Payors, 24 SAN DIEGO L. REV. 1023, 1025 (1987). See also Capron, supra note 13, at 752-53 ("By shifting the incentives and creating the disincentive that results from having one's own finances at risk, the new method of physician reimbursement turns physicians into gatekeepers for the health care system."); Rosenblatt, supra note 19, at 961 (physician's views on how to promote patient care varies with their differences in reimbursement).

74. See infra notes 75-96 and accompanying text.

75. R. ROBINSON, REVISED PHYSICIAN'S CONTRACTING HANDBOOK 3 (rev. ed. 1985) [hereinafter CMA CONTRACTING HANDBOOK]. An indemnification clause may take the following form:

The physician shall be responsible for the quality of care rendered to the participants, and agrees to hold harmless, indemnify, and defend the Health Insurance Organization, its employees, officers, and directors from any and all liability, including reasonable attorney's fees, interests, and costs, arising out of or related to health care provided by the physician under this contract.

Rodgers, Boyd, Boyd & Wilson, The HMO Contract and Quality of Care, 78 IOWA MED. 466, 467 (1988) [hereinafter Rodgers]. This type of hold harmless provision would not have been a serious concern ten or perhaps even five years ago. At that time, physicians enjoyed virtually complete autonomy in making diagnosis and treatment decisions. See supra notes 2-6 and accompanying text. Subsequent contractual arrangements have imposed prior authorization restrictions, utilization limitations, and cost containment regulations. These constraints affect the decisionmaking process and, consequently, the quality of care. See Rodgers, supra, at 467. See also Comment, Contractual Theories of Recovery in the HMO Provider-Subscriber Relationship: Prospective Litigation for Breach of Contract, 36 BUFFALO L. REV. 119, 123 (1987) (the contractual relationship between HMO and subscriber has a spillover effect on the physician patient relationship). While decisionmaking is shared, the hold harmless provision provides the treating physician with complete responsibility for these decisions. CMA CONTRACTING HANDBOOK, supra, at 3-4.
Authorization requirements and utilization regulations are perhaps the greatest source of problems created by contracts between health insurers and physicians. The purpose of these provisions is to discourage overutilization so as to maximize the potential profit under a capitation system. However, these requirements and regulations may very well contain conditions that are inconsistent with the accepted standard of care, thus creating a potential incompatibility with good medical practice.

It is essential to keep in mind that the retrospective reimbursement programs led to the development of a lavish standard of care. Despite the fact that reimbursement schemes have changed, the standard of care does not necessarily reflect this change. As a result, a patient who does not recover against their health insurer may have a colorable claim against the attending physician because that physician prematurely discharged the patient, failed to order exhaustive testing, or did not prescribe the state of the art treatment. If the physician has contracted away his or her ability to practice at

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76. As the following example demonstrates, these provisions are intended to contain costs: The physician agrees that all non-emergency hospital admissions of participants must be authorized in advance by the Health Insurance Organization. The Health Insurance Organization shall establish an appropriate length of stay necessary to treat the condition(s) for which the participant is hospitalized. The initial length of stay assigned the plan will comply with length of stay criteria and Quality Assurance Standards adopted by the Utilization Review Committee. Rodgers, supra note 75, at 674. See also Spivey, The Relation Between Hospital Management and Medical Staff Under a Prospective-Payment System, 310 NEW ENG. J. MED. 984, 984 (1984).

77. Furrow, supra note 20, at 190.

Capitation systems such as HMO's put physicians at risk by conscious design. The capitation principle means that payment is determined in advance for each subscriber to the HMO, and the HMO will lose money if its costs per patient exceed the amount they have collected. Physician gatekeepers attempt to discourage overutilization in the HMO; the norms of practice of physicians in HMO's tend toward lower levels of utilization generally.

Id.


79. See supra notes 2-6 and accompanying text.

80. Entin, supra note 4, at 679-80.


82. See, e.g., Golanka v. Gatewood, 199 Neb. 216, 225-26, 257 N.W.2d 403, 408-09 (1977) (physician failed to carefully diagnose tumor before removing it and causing nerve damage); Wilkinson v. Vesey, 295 A.2d 676, 682 (R.I. 1972) (claim for misdiagnosis requires finding that diagnosis was wrong and physician was negligent); Gates v. Jensen, 92 Wash. 2d 246, 253, 595 P.2d 919, 924 (1979) (physician liable for failure to test borderline patient for glaucoma).
the accepted standard of care, it is possible that he or she has breached the fiduciary duty owed to his or her patients.

C. Liability for Peer Review

As part of their contractual obligations, physicians may be required to participate in peer review. The purpose of peer review in this situation is to contain costs by evaluating the medical necessity of the treatment provided by the attending physician. This is yet another way in which physicians may be held liable for rendering inadequate care. Peer review can be characterized as an interference with the physician-patient relationship in that a collective judgment may be substituted for that of the treating physician. Concurrently, since the treating physician permits this interference to take place, it may well constitute a breach of his or her fiduciary duty.

There are several issues surrounding the status of peer review. First, there is some question as to whether physicians who conduct peer review enjoy statutory immunity. Most peer review statutes were enacted before pro-

83. Moreover, that physician might also have breached his or her obligation to the state as a licensed practitioner. See Emory Univ. v. Porubiansky, 248 Ga. 391, 394, 282 S.E.2d 903, 905 (1982) ("We find that it is against the public policy of this state to allow one who procures a license to practice [medicine] to relieve himself by contract of the duty to exercise reasonable care."). It is also very possible that the physician has become exposed to liability without the protection of professional liability insurance. CMA CONTRACTING HANDBOOK, supra note 75, at 5-6. It is inconceivable that malpractice carriers would be bound to insure physicians who have deliberately contracted away their ability to properly practice medicine. "[P]hysicians should give professional liability insurers copies of the proposed contracts. The insurer can offer useful analysis of the terms of the agreement. This will also inform the physician on the ways in which the contracts may relate and influence their coverage. Advice from the insurer can be invaluable in negotiating these contracts." Rodgers, supra note 75, at 468.

84. R. MILLER, supra note 36, at 128-30.
85. Carlucci, supra note 2, at 16.
87. Capron, supra note 13, at 756-58.
88. This is understandable since peer review originally dealt with review of hospital privileges. See generally Goldberg, The Peer Review Privilege: A Law in Search of a Valid Policy, 10 AM. J.L. & MED. 151 (1985); Note, The Legal Liability of Medical Peer Review Participants for Revocation of Hospital Staff Privileges, 28 DRAKE L. REV. 692 (1979); Note, The Missouri Rule: Peer Review is Discoverable in Medical Malpractice Cases, 50 Mo. L. REV. 459 (1985); Comment, The Medical Review Committee Privilege: A Jurisdictional Survey, 67 N.C.L. REV. 179 (1988); Comment, Anatomy of the Conflict Between Hospital Medical Staff Peer Review Confidentiality and Medical Malpractice Plaintiff Recovery: A Case For Legislative Amendment, 24 SANTA CLARA L. REV. 661 (1984). However, the federal government's recent enactment of the Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101, 11111-11152 (Supp. IV 1988), is intended "to foster an environment in which health care professionals will be encouraged to engage in good faith evaluation of their peers by limiting participants' potential
spective payment and concurrent review came into existence. Second, there may also be some doubt as to whether physicians' professional liability insurance would cover peer review activities. Finally, peer review activities are potentially subject to violations of the antitrust laws. In spite of these issues, however, many physicians' contracts still require peer review which, as stated above, could lead to a breach of a physician's fiduciary duty.

D. Unilateral Modification

The terms of some contracts between health insurers and physicians may provide the third-party payor with the power to unilaterally modify authorization policies, utilization limitations, and economic sanctions for noncompliance with the terms of the contract. These provisions create what can


90. CMA CONTRACTING HANDBOOK, supra note 75, at 8.
92. A provision which permits unilateral modification may take the following form: “[t]he Physician shall adhere to the terms and provisions of the Provider Manual published and amended periodically by the Health Insurance Organization.” Rodgers, supra note 75, at 468.
be characterized as an "implicit contract" whereby "it is the plan's policy of determining what it will approve as 'necessary' that triggers full benefits rather than the stipulations of a contract." In its extreme form, a unilateral modification clause constitutes egregious overreaching and may be unenforceable. However, if such a clause is enforced, then the physician, by signing the agreement, has essentially permitted potentially unreasonable third-party interference with his or her relationship with the patient. Once again, this could represent a breach of the physician's fiduciary duty.

E. Economic Sanctions

Health insurance organizations may insert a threat of economic sanctions in a physician's contract in order to compel him or her to comply with its terms. Through this type of provision, a physician may be liable for the patient's medical expenses if he or she believes that a patient must remain hospitalized for a period beyond that prescribed by the health insurance plan. A physician may also face sanctions for unauthorized admissions and referrals.

Economic sanction provisions are arguably a legitimate attempt to discourage waste and unnecessary utilization. However, economic sanctions may also have the effect of discouraging the practice of medicine at the appropriate level of care. Furthermore, a judge or jury in a medical malpractice case, hearing evidence of such contractual terms, may seriously doubt the appropriateness of a physician's conduct where a patient was discharged prematurely, or was misdiagnosed due to less than exhaustive testing. Similarly, a physician who accepts a contract containing certain economic sanction provisions may be viewed as having greater concern for cost containment than for providing adequate health care. Moreover, the physician may be found to have breached his or her fiduciary duty by placing concern for his or her own well-being over that of the patient.

In light of the effect of the provisions discussed above, it is imperative that physicians carefully examine the contracts they enter into with health care insurers. A physician's failure to carefully examine such contracts, or to identify the significance of any of the above contractual terms may result in the breach of his or her fiduciary duty to the patient.

94. For example, contractual provisions relating to prior authorization and utilization regulations may state: "The physician will be liable for the expenses of any non-emergency hospitalization not approved in advance by the plan or the expense of any unauthorized period of hospitalization that extends beyond the length of stay assigned by the plan." Rodgers, supra note 75, at 467.
95. Schramm, State Hospital Cost Containment: An Analysis of Legislative Initiatives, 19 Ind. L. Rev. 919, 945 (1986).
96. See supra notes 68-69 and accompanying text.
Several commentators have assumed that physicians are the necessary and proper decisionmakers to determine both the appropriate distribution of our society’s finite health care resources and the corresponding standard of health care. This assumption is implicitly founded on two dubious premises. First, that our society and its medical profession have decided that they will settle for substandard care. Second, that physicians are both ethically and legally permitted to provide substandard care even in circumstances where adequate care is available. Despite this questionable foundation, several commentators have nonetheless advanced various proposals aimed at altering the existing law based on these assumptions. A review of these proposals, however, will demonstrate their inadvisability.

A. Contracting for the Standard of Care

The first proposal is to hold physicians who provide care through an HMO liable under a standard of care based on contract rather than tort. With the proliferation of HMO’s, it has been said that the medical services provided in this nation, which at one time were treatment oriented, have been transformed so as to emphasize the prevention of illness. Essentially, an HMO has a contractual responsibility to provide or to assure the delivery of health care services to its subscribers, and failure to perform this obligation constitutes a breach of contract. This situation has led some to argue that “if these breaches occur in the context of the performance of the physician-patient relationship, then it may follow that traditional causes of action, such as malpractice, could sound in contract instead of a negligence action in tort.” Indeed, many health care subscribers have agreed, at least in principle, to accept the type of care expressly or implicitly outlined in the terms of the health care insurance contract.

97. See infra notes 98-138 and accompanying text.
98. Comment, supra note 75, at 119.
99. Id.
100. Id.
101. Id. The author readily admits that this contention has been raised previously. See Ficarra, Medical Negligence Based on Bad Faith, Breach of Contract, or Mental Anguish, in Legal Medicine 187 (C. Wecht ed. 1980); Stern, supra note 32, at 911. See also Howard, Medical Malpractice Liability and Cost Containment: Law and Economics in Conflict, 43 Food Drug Cosm. L.J. 309, 332-34 (1988).
On the other hand, proponents of this point of view admit that "the actual services rendered by physicians to their patients in an HMO are no different than those in the independent practice." Furthermore, this position presumes that the contracts which provide the basis for this cause of action are the products of arms-length dealings between a health care provider and a particular subscriber. The ultimate proposal based on these presumptions is the application of a special standard of care to both HMO's and the physicians that provide health care as a part of the HMO agreements. As one commentator has explained:

In the typical case of negligent medical malpractice, the standard by which a physician's conduct is judged is that of '[t]he reasonably prudent physician or surgeon, acting under the same circumstances.' Analogously, the contractual standard may be expressed as the performance or delivery of any terms and conditions for which the parties have contracted.

There are several problems involved in accepting the view that physicians providing care under an HMO should be held to a contractual standard of care. First and foremost, this proposal clearly violates the well established public policy against permitting anyone licensed to practice medicine by the state to contract away his or her duty to exercise reasonable care. Second, health care delivery made on such terms may very well destroy profession-
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Physicians hold a position of trust and receive deference from their patients. Practicing at the accepted professional standard, and with the best interests of the patient as the primary concern, is a logically separate concern from a physician's agreement to abide by the terms of a health care contract and the more limited obligation to provide only those services required therein. Third, and related to the decline of professionalism, the general quality of health care available to Americans as a whole would in all probability decline as the result of implementation of this proposal.

There is a significant margin in the varied bargaining power of individuals who are in need of health care. Permitting physicians to contract away their duty to exercise the proper standard of care would surely lead to substandard health care for those without means to obtain better care. Additionally,

107. Capron, supra note 13, at 733-34. See also Schuck, supra note 12, at 1422 (rationing medical care challenges the very foundation of medical professionalism); Stone, Law's Influence on Medicine and Medical Ethics, 312 New Eng. J. Med. 309, 310 (1985) (an ethical void is created when "medical practice is viewed through the prism of cost-benefit analysis.").


109. This general principle has been reflected in the fact that exculpatory clauses have long been viewed as adverse to public policy and therefore unenforceable. See Tunkl v. Regents of the Univ. of Cal., 60 Cal. 2d 92, 102, 383 P.2d 441, 447, 32 Cal. Rptr. 33, 39 (1963) (patient has an inferior bargaining position to hospital, thus exculpatory clause is void); Porubiansky v. Emory Univ., 156 Ga. App. 602, 605, 275 S.E.2d 163, 165-66 (1980) (dental school's exculpatory clause void), aff'd, 248 Ga. 391, 392-93, 282 S.E.2d 903, 905 (1982); Olsen v. Molzen, 558 S.W.2d 429, 432 (Tenn. 1977) (exculpatory clause to perform abortion void). In Tunkl, the California Supreme Court stated:

In insisting that the patient accept the provision of the waiver in the contract, the hospital certainly exercises a decisive advantage in bargaining. The would-be patient is in no position to reject the proffered agreement, to bargain with the hospital, or in lieu of agreement to find another hospital. The admission room of a hospital contains no bargaining table where, as in a private business transaction, the parties can debate the terms of their contract. As a result, we cannot but conclude that the instant agreement manifested the characteristics of the so-called adhesion contract. Finally, [the patient] completely placed himself in the control of the hospital; he subjected himself to the risk of carelessness. Id. at 102, 383 P.2d at 447, 32 Cal. Rptr. at 39.

110. Capron, supra note 13, at 751.

Even though the feasibility of the private contract approach to reconciling legal and economic incentives becomes stronger as the fee-for-service system is replaced by prepaid health packages which could stipulate liability coverage as part of their contract, unfortunately no one can doubt that the poor often lack the requisite freedom of choice necessary to assure the courts that the resultant contract is one negotiated by two parties with equal bargaining power. In fact, the ability of the poor to choose their own health care plan or provider is often quite limited.

contracting for a variable standard of care could lead to gross overutilization and the waste of our health care resources. Those with means would most likely receive more care than their conditions require and, as the consequence of limited resources, those without means would receive insufficient health care to adequately meet their needs. It has even been suggested that, because there is always a potential for physician and third-party payor discrimination against certain types of patients "on the basis of age or other characteristics, as doctors employ a calculus that aims to conserve social resources where treatment is likely to be 'wasted'... [such a modification could] reinforce existing biases in medical decisionmaking, particularly negative biases toward the old, or members of stigmatized minorities such as homosexuals." Finally, even those persons able to afford quality health care may not be capable of contracting for that care because they do not have the medical expertise which would enable them to know what constitutes quality health care.

B. Economic Constraints Defense

Another proposal suggests "a direct economic defense which would most plausibly take the form of a rebuttable presumption." Under this approach, it would be presumed that physicians owe all patients the same duty to provide quality care regardless of the patient's financial resources. This proposal, however, would "offer economically pressed physicians some opportunity to rebut this presumption where their diminution of care arose by necessity and not by negligence." Rebuttal of this presumption would involve demonstrating the nature and severity of the physician's fiscal constraints and showing that alternatives to the substandard care were

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111. Furrow, supra note 24, at 990. "Capitation programs, packaging of services, and prepaid arrangements such as HMO's have a built-in disincentive to accept the sickest and the poorest patients, the very ones who have the hardest time obtaining health care." Capron, supra note 13, at 752.
112. Furrow, supra note 20, at 203.
113. Bovbjerg, supra note 32, at 1392; Morreim, supra note 32, at 1754.
114. Morreim, supra note 32, at 1757. See also Furrow, supra note 24, at 1024 (citing P. Danzon, Medical Malpractice: Theory, Evidence, and Public Policy 223 (1985)).
115. Morreim, supra note 32, at 1757. Professor Morreim notes that "[s]uch a presumption is important, for it is appropriate that the law urge physicians to seek the highest possible quality of care, and not to defer too easily to apparent constraints. A major purpose of tort law is, after all, the deterrence of needlessly injurious conduct." Id.
116. Id.
117. The author of this proposal suggests that the following could be used to demonstrate the nature and severity of the physician's fiscal constraints:

information about the hospital's overall economic situation, its uncompensated care burden, the needs of the plaintiff-patient compared with other patients' needs at the time, the policies developed within the hospital and elsewhere to cope with fiscal limits, and perhaps even the pressures that have been personally applied to the physician-defendant.

Id.
"not readily available." The physician would do this by introducing
evidence relating to the specific decisions made in a particular patient's case
or even by offering general guidelines that he or she consistently follows in
all cases when making similar treatment decisions. While admitting that
this is a novel approach, the author of this proposal maintains that it captures
the fundamental tort concepts of fairness and reasonableness in realistically
dealing with the allocation of our finite health care resources.

This approach has a number of drawbacks. The most disturbing short-
coming is that this approach would permit the resurrection of the locality
doctrine. A physician who is unable to render adequate care due to the
constraints of a particular health care facility, the state of its equipment, or
the level of his or her expertise would be less compelled to make a referral
to a provider that can provide the accepted standard of care. It was
precisely this situation which modern medical malpractice case law has tried
to move away from in dispensing with the locality rule. Moreover, the
objectives of tort law actually militate against such a defense in that it fails
to provide victims adequate compensation and quality assurance.

Furthermore, it is difficult to comprehend a uniform standard for the
determination of when alternatives to substandard care are "not readily
available" that would be acceptable to physicians, hospital administrators,

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118. Id. at 1758. Professor Morreim admits that this element is "hazardous." On the one
hand, the physicians cannot be expected to make an exhaustive search for alternative sources
of care. On the other hand, the physician's actions in seeking alternatives must be something
more than a pro forma search. Id.

119. Id.

120. Id. As Professor Morreim has explained:
Medical malpractice litigation generally falls within the broad area of tort law that
requires a finding of fault for the ascription of liability. This requirement, in turn,
is essentially founded upon the moral notion of fairness. On one hand, we believe
it is unfair for an innocent victim to bear the costs of someone else's intentionally
or carelessly harmful conduct. Conversely, we also believe that we should not
ordinarily require someone to pay for unfortunate occurrences when he is not at
fault. Id. (footnotes omitted).

121. See supra notes 40-43 and accompanying text. Interestingly, Morreim does not seem
concerned with the outmoded qualities of the locality rule which she argues also embody the
themes of reasonableness and fairness. Id. at 1759.

122. See Comment, supra note 110, at 466-67.

123. Id. at 467. At least one commentator has argued that,
reliance on customary medical practices to set the standard of care under mal-
practice law is justified for two reasons. First, medical decisions are typically beyond
the competency of laymen. Judges and juries are usually unable to assess risk
appropriateness. Second, the aggregate of professional medical judgment best sets
the socially appropriate level of risk. The concept of medical professionalism, which
makes the customary practice standard appropriate, is devoted to the patient's best
interests. Thus, malpractice law emphasizes quality of care. Cost containment
objectives emphasize reduced quantity of care which may result in reducing the
quality of care.

Id. at 467-68.
third-party payors, and our courts. Such an approach is at odds with the current state of the law which maintains that anyone who undertakes to provide health care assumes the absolute duty to provide adequate health care. If such care cannot be provided, then the physician must not undertake to provide any care whatsoever. "Medical passivity in the face of corporate and other cost containment pressures is neither desirable nor necessary." In other words, the physician's fiduciary duty requires him or her to aggressively advocate the patient's interests rather than merely accepting treatment limitations and undertaking to provide substandard health care.

C. Shared Tort Liability

Some commentators propose that "the malpractice liability associated with cost-cutting initiatives should be allocated between hospitals and physicians so as best to alleviate conflicts, maintain the quality of care, and reduce costs." To achieve this objective, a rebuttable presumption of joint hospital-physician liability could be applied "whenever failure to order tests or procedures or to hospitalize a patient for an appropriate length of time results in a breach of professional standards and in a medical injury." A hospital could rebut this presumption by demonstrating that, despite the applicability of the protocol or the cost-cutting measure in question, the patient's injury was actually caused by the physician's negligence. Proponents of this approach argue that it "would allow a jury to find that a physician's cost-cutting behavior was reasonable without having to deny compensation to the victim, . . . [and] enable malpractice law to recognize cost considerations while satisfying the egalitarian and humanitarian values served by a uniform standard of care."

While this proposal is not without its advantages, the basic flaw involved in shared physician-hospital liability, and shared physician-payor liability for

124. See supra notes 31-39 and accompanying text.
125. Furrow, supra note 24, at 1025.
126. Note, supra note 22, at 1019-20. See also Furrow, supra note 24, at 1031-32 (placing focus on the institution improves the "detection of errors and medical misadventure").
127. Note, supra note 22, at 1020. "Because this proposal is meant to affect liability only when cost-cutting is involved, the existence of a utilization protocol or other cost-cutting initiative applicable to the injured patient would be a prerequisite to invoking the presumption."
128. Id.
129. Howard has listed a number of advantages, as well as several disadvantages, to this proposal which have been pointed out by a number of commentators:

First, a hospital's push to reduce services indiscriminately would be tempered by their expanded liability. Second, if physicians faced a lesser malpractice risk, incentives to practice defensive medicine would decrease. Third, shared liability would provide new incentives for physicians and hospitals alike to identify cost containment guidelines which are both medically and economically sound. On the other hand, shared physician-hospital liability can generate increased court costs
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that matter, is that it permits physicians to shirk their fiduciary duty to the patient as the primary decisionmakers on health care matters. A physician's conduct must be in accordance with the reasonable standard of medical care. A physician must not permit anything to interfere with his or her ability to conform to this standard. Joint liability not only permits interference with these duties, it also allows the physician to escape total responsibility for injuries which may have been avoided had he or she not allowed a third-party to interfere with the physician-patient relationship.

D. Modification of the Standard of Care

The Medicare and Medicaid Patient and Program Protection Act of 1987 provides for the exclusion of HMO's and other competitive medical plans which have “failed substantially to provide medically necessary items and services” to Medicare and Medicaid beneficiaries “if the failure has adversely affected [or has a substantial likelihood of adversely affecting]” such beneficiaries. In discussing this provision, the Senate Finance Committee Report stated “that the practice standards used to determine that items or services were medically necessary would be based on generally accepted HMO practice standards.” This statement “arguably suggests a recognition and acceptance of a distinction between the standards of acceptable care in the fee-for-service setting and in managed health care plans such as HMOs.”

from litigating the rebuttable presumption issue. Additionally, the apportionment of liability between physicians and hospitals is a causation issue which can also increase litigation costs. Lastly, sharing liability with an insolvent hospital may not be of much assistance for physicians practicing at public facilities whose financial solvency is precarious.

Howard, supra note 101, at 330-31 (footnotes omitted).

130. Id. at 331-32. While such shared liability has been suggested for private payors, governmental immunity will generally preclude such a theory in the public sector. See Comment, Provider Liability Under Public Law 98-21: The Medicare Prospective Payment System in Light of Wickline v. State, 34 BUFFALO L. REV. 1011, 1032-34 (1985) (Wickline v. State, 183 Cal. App. 3d 1175, 228 Cal. Rptr. 61 (1986), is an aberration in government immunity law); Comment, supra note 73, at 1028-1035 (there are various approaches in defining the discretionary/ministerial dichotomy for governmental tort immunity).


132. 42 U.S.C.S. § 1320a-7(b) (c) & (d) (Supp. 1988).


134. Basanta, Quality Health Care and Physician Regulation—Recent Developments, 77 ILL. B.J. 214, 220 (1988). Modification of the standard of care has been discussed elsewhere: Tort law would operate as a multifaceted mirror, reflecting different standards in different delivery settings. No cases can be found in the appellate records to analyze judicial reactions to HMOs, which may suggest that injured plaintiffs are avoiding suits for other reasons. The theoretical judicial question, however, is the proper weight to give to customary practice: conclusive weight versus only some evidence? Given the uncertainty at present as to the quality of care provided in terms of the balance between patient risk and money saved, courts are likely, if they adopt a separate HMO standard, to treat it only as some evidence rather than conclusive.

This is probably a desirable perspective until further evidence is available.

Furrow, supra note 24, at 1018.
An easy solution to the problem arising from this nation's finite health care resources would involve lowering the standard of care applicable to physicians practicing in managed health care or cost containment systems. Without question, however, such a modification of the standard of care would mean a fundamental change of legal objectives. For example, "'[the primary mechanism for incorporating cost considerations into the malpractice standard would be to redefine the concept of fault: if cost-cutting initiatives are to be encouraged, some cost-cutting behavior that was previously considered 'negligent' might now be deemed 'socially desirable.'" Such a modification would also signal a radical overhaul of our social agenda which at present includes the objective of quality health care to all members of our society. As for the future, it seems inconceivable that either the physicians of this nation or our society at large will readily choose to accept the delivery of substandard care. Such a radical reform would certainly be inconsistent with our objective to eventually provide quality health care to all inhabitants of this nation. Moreover, it would be in direct conflict with the physician's fiduciary duty to ensure that his or her patients' receive adequate and proper care.

IV. PHYSICIANS AND THEIR FIDUCIARY DUTY TO THEIR PATIENTS

Emphasis on the physician's fiduciary duty to his or her patients is the most appropriate focus for reforms relating to the cost containment goals now associated with medicine. The fiduciary duty has commonly been applied to circumstances involving commercial transactions. Consequently, in the health care setting, it would perhaps at first glance seem appropriate to confine application of this concept to the third-party payor and the ad-

135. Note, supra note 22, at 1017. "Some see [modification of the standard of care] as appropriate in the evolving health care system to permit different standards of care to develop for care provided in different practice settings. Others, however, see this development as a threat to society's basic commitment to provide equally high quality of care for all." Basanta, supra note 134, at 220. Even those who acknowledge the inevitability of two-class medicine insist on the maintenance of certain minimal standards of care and the limiting of market access to only those practitioners who are genuinely qualified. Pauly, supra note 93, at 231.

136. "Physicians are unlikely to press for such a change because their training inculcates an ethical obligation to do everything possible to help the patient and because peer approval depends heavily on practicing the 'best medicine.'" Note, supra note 22, at 1018 (footnotes omitted).

137. Courts "have been reluctant to second-guess the profession's standards, and on the rare occasions that they have done so, it has been to impose a higher standard." Id. See also Comment, supra note 75, at 21-23 (distinction between "statistical lives" and "identifiable lives").


ministrators of a given health care facility. However, the courts have also traditionally applied the fiduciary doctrine to physicians in evaluating their conduct in the physician-patient relationship. As the expert and the professional in that relationship, doctors must accept the responsibility of protecting its sanctity. Countless examples in the case law, most recently in Wickline, demonstrate that regardless of the conduct of the administrators of the insurance program or the hospital policymakers, a physician's actions will be independently scrutinized to determine whether he or she did anything, either by act or omission, to jeopardize the quality of the patient's care.

Physicians are generally not held to a breach of warranty standard unless there has been a clear expression by the physician to the patient guaranteeing a specific result. The warranty standard is not usually applied to physicians because their responsibility is simply to provide the most appropriate care in light of the patient's condition. However, there may be grounds for breach of warranty actions where physicians undertake to provide care under circumstances in which they themselves have restricted their ability to provide appropriate care. The warranty, of course, does not have to be expressly stated in contract. The law will instead find that a warranty is an implicit component of the physician-patient relationship.


141. See supra notes 31-52 and accompanying text.


143. Prosser, supra note 40, at 186-87. See Ward v. United States, 838 F.2d 182, 186 (6th Cir. 1988) (physician is only liable for negligence); Bagherzadeh v. Roeser, 825 F.2d 1000, 1003-04 (6th Cir. 1987) (jury can be instructed that a physician is not a warrantor of cure or diagnosis).

144. A. Holder, Medical Malpractice Law 1-7 (2d ed. 1978); S. Pegalis & H. Wachsmann, supra note 41, at § 2:3.

145. Capron, supra note 13, at 733-39. The relationship between physician and patient has been described as a covenant or a contract:

"The structure of the contract has tended to increase not only the physician's technical authority, but also his 'moral' influence." The physician's authority is clearly undermined when he fails to honor this contract, either by violating an explicit ethical rule or by departing from the implicit purpose of the relationship (as by providing inadequate treatment because of cost constraints or providing excessive treatment to increase income). Breach of this contract violates the patient's trust.

Id. at 737 (footnotes omitted) (citing J. Frank, Persuasion And Healing (rev. ed. 1973)).
a term from contract law, conveys the basic duty of the physician-fiduciary. Understanding that the fiduciary duty shall be applied to evaluate a physician’s conduct both during contract negotiations with the third-party payor, as well as the policymaking process with the administrators of the health care facility, will provide greater incentive for the preservation of the standard of care.

Physicians may reasonably protest that they were trained in medicine rather than finance and business administration, and that they should not be viewed as fiduciaries in the negotiation of insurance contracts and the formulation of hospital policy. For the most part, this position is entirely reasonable. Indeed, bureaucrats and administrators are most qualified to oversee facility maintenance and fiscal management. The proposal of this article, however, does not require physicians to have such expertise. Moreover, the fiduciary duty, which applies despite the fact that a physician may have a contractual relationship with the third-party payor, must be applied to ensure the preservation of an adequate quality of health care. Physicians are the sole source for determining whether this standard can be met. Thus, the basic thrust of this article’s proposal involves a plea to physicians to do as their fiduciary duty requires, that is, to force the issue of whether appropriate care shall be provided under the total health care system. Physicians must assume a role as “codeveloper[s] of the new medical care provision mechanisms.” In the evaluation of whether a physician has adhered to his or her fiduciary duty, the proper inquiry should be whether a reasonable physician would agree that the terms of his or her contract with a health care provider are not inconsistent with providing health care at the acceptable standard of care.

It is helpful to compare the relationship between the physician and the third-party payor in the health insurance context with the attorney and the third-party payor in the liability insurance contract. In many of the latter circumstances, the insurer has a duty to defend the insured. The attorney

146. Furrow, supra note 24, at 1006-07. Prosser, supra note 40, at 189. This is axiomatic considering the fact that only physicians are qualified to testify on the issue of whether “reasonable care” has been provided in a given instance. F. Harper, F. James & O. Gray, supra note 40, at 555-59. “The law generally permits the medical profession to establish its own standards of care.” Toth v. Community Hosp., 22 N.Y.2d 255, 261-62, 239 N.E.2d 368, 372, 292 N.Y.S.2d 440, 446-47 (1968). “There is no one more qualified than the physician to determine whether the authorization scheme proposed in the agreement is compatible with the standards of responsible medical practice. The physician must negotiate an adequate system for review of treatment or refuse to enter into the agreement.” Rodgers, supra note 75, at 468.

147. Furrow, supra note 20, at 216.


who is hired to perform that function has a fiduciary duty to faithfully represent the insured and, in the event that his client’s interests conflict with those of the insurer, he or she must resolve those conflicts in the insured’s favor. Moreover, an attorney’s obligation to the client always supercedes his or her own interests, and nothing can be permitted to interfere with that fiduciary duty. Similarly, physicians who agree to permit third-party interference with their ability to properly treat their patients, even when that interference is by the payor of the health care, have breached the fiduciary duty owed to their patients.

Professor Barry Furrow has persuasively argued that in the age of prospective payment systems, and the utilization review which has accompanied these systems, physicians play a crucial role as “patient-advocates.” Furrow correctly interprets Wickline, not to mention the physician’s ethical obligations, as requiring attending physicians to vigorously advocate a patient’s cause through all levels of utilization review so as to ensure adequate care. This interpretation must be applied in evaluating physician conduct in the negotiation of contracts with the third-party payors and in their interaction with hospital authorities in the creation of policy that relates to the coordination of payment under health insurance programs in relation to actual utilization costs. The activities of all of these parties affect the type of care that the patient will ultimately receive: Very simply, physicians have the affirmative responsibility by virtue of their fiduciary duty to ensure that neither hospital policy nor health insurance agreements will inhibit their ability to provide the proper quality of care for all patients. Where physicians are unable to succeed in this charge, they are precluded from undertaking to provide any care whatsoever.

There are a number of general considerations that should guide physicians in the negotiation of contracts with third-party payors. First, a physician’s practice income should always be limited to fees and salaries actually earned


151. MODEL RULES OF PROFESSIONAL CONDUCT Rule 1.7(b), 5.4(c) (1984); MODEL CODE OF PROFESSIONAL RESPONSIBILITY EC 5-21 & -22, DR 5-107(B) (1980). See also A. Jonsen, M. Siegler & W. Winslade, supra note 35, at § 4.4.4(b).

152. Furrow, supra note 20, at 215-17. Professor Furrow also states, however, that physicians may satisfy their fiduciary duty through full disclosure to their patients. Furrow, supra note 24, at 1024-32. This is necessarily inconsistent with the physician’s fiduciary duty which always compels negotiation of an agreement that permits care consistent with accepted standards.


154. See supra notes 72-96 and accompanying text.

155. Furrow, supra note 20, at 221-22. See also Howard, supra note 101, at 330-31; Spivey, supra note 76, at 985-86; Note, supra note 22, at 1019-22.

156. Relman, supra note 20, at 1150-51.

157. See supra notes 36-52 and accompanying text.
from patient services which were personally provided or supervised. A fundamental element of a physician’s fiduciary duty requires that he or she remain always vigilant in assuring that the patient receives quality health care. The receipt of fees for care which has not been closely monitored, as required by legal and ethical standards, is the receipt of fees for improperly provided health care.

Second, physicians must avoid any third-party arrangement that rewards them for choosing a particular facility or service for their patients or which rewards them for withholding services from their patients. These sorts of arrangements, which constitute a clear conflict between the patient’s interest in attaining proper health care and the physician’s interest in receiving the best possible compensation, are obviously prohibited by the fiduciary duty.

Third, “physicians practicing in investor-owned hospitals, health maintenance organizations, or any other kind of for-profit corporate setting should be either self-employed or a part of a self-managed and self-regulated medical group that contracts with the company.” Indeed, the new breed of third-party agreements attempt to control physicians as if they were employees or agents in the implementation of managed care. These same contracts, however, label physicians as independent contractors with regard to liability for the care that is provided. Such an arrangement is clearly unfair and repugnant to both sound medical practice and ideals of professionalism.

Finally, “in negotiating a contract physicians should retain the right to terminate the relationship at any time in the future without cause. The right to terminate without cause allows a physician to escape a program which causes unanticipated problems.” This may be a very difficult condition to successfully negotiate. Physicians should nevertheless attempt to secure

158. Relman, supra note 20, at 1151.
160. See also Relman, supra note 20, at 1151; Rodgers, supra note 75, at 467-68.
161. See supra notes 30-32 and accompanying text.
162. “To protect their professional independence, practitioners should avoid direct individual employment by a for-profit corporation, because as employees they would be expected to give primary allegiance to corporate goals rather than patients’ needs.” Relman, supra note 20, at 1150-51.
163. See supra note 73 and accompanying text.
164. Cf. Jones v. City of Chicago, 787 F.2d 200, 206-07 (7th Cir. 1986) (physician’s employer cannot expect physician to practice in manner inconsistent with oath and ethical obligations regardless of prevailing community medical standard).
165. Rodgers, supra note 75, at 468.
166. Obviously, third-party payors would view this type of provision as a vehicle to play insurers against each other for the purpose of attaining the highest possible compensation. This concern may be solved by accepting a good faith condition and a legitimate manner of documenting contract flaws.
this type of provision as a safety valve for dealing with unanticipated
constraints on the physician's ability to provide proper health care.167

There is no one else who participates in the general structure of our health
care delivery systems who is as qualified as the attending physicians to judge
whether the system's procedures are compatible with accepted standards of
responsible medical practice. Moreover, there is no one else who is legally
and ethically bound as a fiduciary in the same fashion as the attending
physicians. It is, therefore, imperative that physicians negotiate these health
care contracts and hospital utilization procedures aggressively and sensibly
so as to ensure that proper health care is always provided to their patients.

CONCLUSION

It is unfair for society to ask physicians to make the hard decisions relating
to the balancing of our finite health care resources and the quality of care
that all patients shall receive. Moreover, it is unethical and constitutes
malpractice for physicians to accept such a role because it is a breach of
their fiduciary duty to their patients. The physicians' fiduciary duty demands
aggressive negotiation of health care contracts and hospital utilization pro-
cedures by physicians.

Physicians must advocate cost containment systems and procedures that
do not compromise their ability to provide proper health care. The California
Court of Appeals, in Wickline v. State, was correct in concluding that
attending physicians should be held liable when they allow health care
decisions to be made by someone other than themselves. Despite the fact
that our society has made a commitment to providing health care to all
Americans, it has not yet determined that this goal shall be achieved through
the sacrifice of quality care. It is doubtful that our society or our medical
profession will ever accept such a compromise. Therefore, physicians who
permit an erosion of the quality of health care do so at their own peril.

167. This includes both those conditions expressly contained within the four corners of the
contract, see supra notes 71-89, 92-94 and accompanying text, and those which may be
unilaterally added by the third-party payor in the future. See supra notes 90-91 and accom-
ppanying text.