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ON PHYSICIAN DECISION MAKING AND MANAGED CARE -- Introduction

Maxwell J. Mehlman

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SYMPOSIUM

PHYSICIAN DECISION MAKING AND MANAGED CARE

INTRODUCTION

THIS ISSUE OF *HEALTH MATRIX* contains seven articles that were presented as part of a workshop on June 8-9, 1995, on physician decision-making in managed care settings. The workshop was sponsored by the American Medical Association, the P.I.E. Mutual Insurance Company, and the Ohio State Medical Association. Drafts of these papers were presented at the workshop and were refined for publication following the discussion. Discussants included John Blum, Randall Bovbjerg, Harry Brown, Ruth Anna Carlson, Carl Gillombardo, Dan Klais, David Kern, Frank Lettieri, Rosemary Macedonio, Thomas Murray, Rand Rosenblatt, Mark Rust, Simonetti Samuels, Dinah Siever, Andrew Smith, Stephanie Switzer, Norman Tazlitz, Charles Weller, Sidney Wolfe, and Walter Zelman.

In preparing their remarks, each of the authors was asked to respond to a specific aspect of the following thesis statement:

Market forces are rapidly transforming the traditional roles of physicians and patients. Historically, patients and physicians had control over the medical care that was provided to patients. The physician recommended the course of treatment that the physician believed was in the best interests of the patient, and the patient decided whether to accept the recommendation.

Tort law buttressed this relationship by requiring the physician to meet minimum standards of knowledge and skill, and by requiring that the patient give informed consent prior to receiving medical care. The law generally did not take into account a societal need to expend resources wisely in determining whether the physician met the standard of care. The traditional health insurance indemnity plan accommodated these roles by paying for any care recommended by a physician and received by the patient, provided it was within the scope of coverage of the plan.

Due to a need to control costs, payors have begun to insist that physicians comply with payor-endorsed controls, protocols, and standards before they will pay for medical care received by one of their beneficiaries. A new element has been introduced into the decision-making process — whether the course of treatment recommended by the physician is the most cost-effective medical option available.

These changes have thrown the law into confusion. On the one hand, the law seems willing to accept the control lost by the patient as a choice made as a matter of contract with the payor. On the other hand, the law continues to insist that the physician continue to meet the traditional, patient-centered standard of care. Some courts have resisted efforts by patients and physicians to shift tort responsibility for medical decision-making to the health plans. Other courts have not. The physician has been asked to find the appropriate balance between cost control and the needs of the patient. Yet antitrust and other laws have facilitated the ability of health plans to obtain economic leverage over physicians, making it difficult for physicians to challenge the controls exerted by health plans over medical decision-making.

These issues have not raised serious patient care problems to date because traditional medical practice built in large margins of safety for the care of patients, and also facilitated a substantial amount of waste. As a result, it has been possible to reduce costs by reducing the size of the margins of safety and by eliminating waste.

What will happen when the ability of physicians to reduce costs in this fashion reaches its limit? Will they have the leverage necessary to resist pressures to achieve further savings by degrading the quality of patient outcomes? What legal controls should be put in place that will enable physicians to draw the line?

As the Director of the Law-Medicine Center, I want to thank all of those whose efforts and generosity made this workshop possible.

Maxwell J. Mehlman*

* Arthur E. Petersilge Professor of Law and Director, The Law-Medicine Center.