Helling v. Carey Revisited: Physician Liability in the Age of Managed Care

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In 1974, the Supreme Court of Washington decided *Helling v. Carey*,[1] perhaps the "most infamous of all medical malpractice cases."[2] In *Helling*, the court ignored expert testimony at trial as to medical custom and held two ophthalmologists liable as a matter of law for failing to administer a routine pressure test (tonometry test) to detect glaucoma.[3] The *Helling* court did its own analysis of the purported custom of not routinely testing for glaucoma in persons less than forty and found it lacking. Instead, it determined it was cost effective to use the test routinely in these age groups.[4]

Helling is a notorious decision because it rejects the traditional professional standard of care.[5] Most courts in medical malpractice cases focus on whether the physician treated the patient in accordance with the prevailing medical custom.[6] The physician who complies with custom is not deemed negligent even though the custom itself could be deemed inadequate to protect the patient.[7] Typically, in

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1. 183 Wash. 2d 514, 519 P.2d 981.
2. WILLIAM J. CURRAN ET AL., HEALTH CARE LAW AND ETHICS 374 (5th ed. 1998).
3. *Helling*, 183 Wash. 2d at 519, 519 P.2d at 983.
4. *Id.*
5. *See id.*
6. DAN B. DOBBS, THE LAW OF TORTS 633 (2000).
7. *Id.*

malpractice cases, unlike other tort cases, the trier of fact is not asked to weigh the risks and utilities of the physician's conduct.[8] Instead, the *Helling* court focused on the cost effectiveness of the treatment that the treating physician withheld.[9] Although there are a few other cases explicitly rejecting the customary standard,[10] *Helling* has not been followed by courts in other states insofar as it imposes liability as a matter of law on physicians for withholding medical treatment based on an appellate court's cost benefit analysis.[11] Even in Washington State its influence has waned.[12]

The opinion of the court in *Helling*, authored by Justice Hunter, articulated the applicable standard of care as that of a "reasonable, prudent physician."[13] In a recent article, Professor Peters argues that there is currently a trend in the courts toward adoption of the reasonable, prudent physician standard.[14] In fact, as Professor Dobbs notes: "[C]ourts seem increasingly to blend the language of reasonable person with the language of professional standards in an uncertain mixture with uncertain effects."[15] Moreover, it does not appear, that this trend toward the adoption of a reasonable, prudent physician standard has resulted in a change in the way that most malpractice cases are tried.[16] Although courts may articulate the standard in terms of the reasonable, prudent physician, they still generally require the plaintiff

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8. *Id.*

9. *See Helling*, 183 Wash. 2d at 519, 519 P.2d at 983.

10. *See, e.g.*, Gates v. Jensen, 92 Wash. 2d 246, 595 P.2d 919 (1979); Nowatske v. Osterloh, 543 N.W.2d 265 (Wis. 1996), *abrogated on other grounds*, Nommensen v. Am. Cont'l Ins. Co., 629 N.W.2d 301 (Wis. 2001).

11. *See, e.g.*, Truman v. Thomas, 155 Cal. Rptr. 752, 755 (Cal. Ct. App. 1979), *opinion vacated on other grounds*, 611 P.2d 902 (Cal. 1980).

12. See, e.g., Harris v. Groth, 99 Wash. 2d 438, 451, 663 P.2d 113, 120 (1983), wherein the court stated:

> Our holding today may be summarized as follows. The standard of care against which a health care provider's conduct is to be measured is that of a reasonably prudent practitioner possessing the degree of skill, care, and learning possessed by other members of the same profession in the state of Washington. The degree of care actually practiced by members of the profession is only some evidence of what is reasonably prudent—it is not dispositive. Absent exceptional circumstances such as were present in *Helling*, expert testimony will be necessary to show whether or not a particular practice is reasonably prudent.

13. *See Helling*, 83 Wash. 2d at 519, 519 P.2d. at 983.

14. Philip G. Peters, *The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium*, 57 WASH. & LEE L. REV. 163 (2000).

15. DOBBS, *supra* note 6, at 633.

16. *Compare* Peter D. Jacobson & Matthew L. Kanna, *Cost-Effectiveness Analysis in the Courts: Recent Trends and Future Prospects*, 26 J. HEALTH POL., POL'Y & L. 191, 300 n.6 (2000) ("Even if Peters is correct, it is not clear how the emerging reasonable physician standard differs conceptually from professional custom and whether case outcomes are actually different in jurisdictions switching to the new approach.").

to present expert testimony as to the prevailing professional standard and the defendant's breach of that standard.[17]

The outcome in *Helling* has been widely criticized. In an influential article, Professors Fortess and Kapp pointed out the shortcomings of the *Helling* court's cost/benefit analysis in light of the high rate of false positives on the tonometry test.[18] Certainly, one lesson that we may glean from *Helling* is that it is not wise for a court to perform its own cost/benefit analysis without the aid of expert testimony.

On the other hand, an empirical study by Professor Wiley of the impact of the *Helling* decision also casts doubt on the veracity of the expert testimony in that case as to the prevailing custom and suggests that courts should be somewhat skeptical of customary standards.[19] In his study, Professor Wiley determined that "Washington ophthalmologists did test patients less than forty with some regularity even before *Helling*."[20] In light of Wiley's study, the *Helling* court was justified in disregarding the custom evidence in the case and focusing on the cost-effectiveness of the treatment that was withheld even if its cost effectiveness analysis was faulty. Indeed, with some modification the court's approach in *Helling* with its focus on cost effectiveness could point the way to a more realistic approach in malpractice cases particularly in light of the changing role of the physician in the managed care era.

As a result of threats of greater exposure to lawsuits, as well as market pressures, health plans are dropping treatment preauthorization requirements and forcing treating physicians to focus on the cost effectiveness of medical treatments. There is widespread dissatisfaction with the intrusion of managed care bureaucrats into the

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17. *See, e.g.*, Hood v. Phillips, 554 S.W.2d 160 (Tex. 1977) wherein the court adopted the reasonable, prudent physician standard and then further stated:

> The burden of proof is on the patient-plaintiff to establish that the physician-defendant has undertaken a mode or form of treatment which a reasonable and prudent member of the medical profession would not have undertaken under the same or similar circumstances. The circumstances to be considered include, but are not limited to, the expertise of and means available to the physician-defendant, the health of the patient, and the state of medical knowledge. Unless the mode or form of treatment is a matter of common knowledge or is within the experience of the layman, expert testimony will be required to meet this burden of proof.

Id. at 165–66; *see also* Harris v. Groth, 99 Wash. 2d 438, 439, 663 P.2d 113, 114 (1983) (stating that expert testimony usually will be necessary under reasonable, prudent physician standard).

18. Eric E. Fortess & Marshall B. Kapp, *Medical Uncertainty, Diagnostic Testing, and Legal Liability*, 13 LAW, MED. & HEALTH CARE 213 (1985) (criticizing court's cost-benefit analysis in light of high rate of false positives on test).

19. Jerry Wiley, *The Impact of Judicial Decisions on Professional Conduct: An Empirical Study*, 55 S. CAL. L. REV. 345, 383 (1982).

20. *Id.*

physician/patient relationship.[21] This has resulted in calls for Congress to remove the bar posed by the Employee Retirement Income Security Act of 1974 (ERISA) and authorize lawsuits under state tort law against health plans for denials of benefits.[22] At this writing, the bar to these suits has not been removed.

As a reaction to the prospect of greater liability exposure for denials of benefits and market forces, however, health plans have already been reducing their reliance on required pre-authorizations of treatments and shifting responsibility for cost containment to their physicians. In the fall of 1999, United Health Care, one of the largest managed care plans in the United States, announced that it would no longer require physicians to obtain pretreatment authorizations.[23] Thereafter, a number of other plans announced similar changes in policy. U.S. Healthcare, a subsidiary of Aetna, hired a new C.E.O., who vowed to reduce the number of procedures requiring precertification.[24] As a result, several of the nation's largest health insurers no longer require prior authorizations for diagnostic tests or treatments, hospital admissions, or referrals by gatekeeper physicians to specialists.

Health plans have touted their elimination of pre-authorization requirements as a cost saving measure and an appropriate response to changes in consumer attitudes. In announcing its decision, United Health Care noted that it was approving virtually all requests anyway so dropping the requirement would actually save money.[25] This change in policy may have been in part an attempt to revitalize managed care stocks that had become depressed as a result of investor concerns about the backlash against managed care.[26] It was also an attempt to reduce exposure to lawsuits in the future based on denial of benefits by health plans.[27]

Under ERISA, patients cannot sue their health plans for denials of benefits under state tort law.[28] Courts now seem to distinguish be-

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21. *See, e.g.*, Clark C. Havighurst, *The Backlash Against Managed Health Care: Hard Politics Made Bad Policy*, 34 IND. L. REV. 395 (2001).

22. *See, e.g.*, Corrine P. Parver & Kimberly Allison Martinez, *Holding Decision Makers Liable: Assessing Liability Under a Managed Care Health System*, 51 ADMIN. L. REV. 199 (1999).

23. Milt Freudenheim, *Big H.M.O. to Give Decisions on Care Back to Doctors*, N.Y. TIMES, Nov. 9, 1999, at A1.

24. Barbara Martinez, *Aetna Tries to Improve Bedside Manner in Bid to Help Bottom Line*, WALL ST. J., Feb. 23, 2001, at A9.

25. Freudenheim, *supra* note 23.

26. *Id.*

27. *Id.*

28. *See, e.g.*, Dukes v. U.S. Healthcare, Inc., 57 F.3d 350, 360 (3d Cir. 1995), Corcoran v. United HealthCare, Inc., 965 F.2d 1321 (5th Cir. 1992); *see also* Joshua M. Spielberg, *Overcoming ERISA*, TRIAL, May 2000, at 54 (discussing *Dukes* and *Corcoran*).

tween "eligibility decisions" and "treatment decisions."[29] Claims based on the former are preempted while the latter are not. If a claim is completely preempted, then it may be removed to federal court and the plaintiff is consigned to the limited remedies available under ERISA.[30] When a claim against a health plan is preempted by ERISA, a plan beneficiary may not recover compensatory and punitive damages for personal injuries in an action against the plan.[31]

ERISA does not preempt claims against a health plan alleging negligent adoption and implementation of utilization policies or negligent selection, supervision, and retention of a physician.[32] On the other hand, a claim against a health plan alleging that it negligently delayed in providing the patient with a referral outside its physician network is completely preempted.[33] The impact of ERISA preemption on claims against physicians is not clearly defined at this time. With the shift of responsibility for cost containment to physicians, it is likely that physicians will frequently be making "mixed eligibility and treatment decisions."[34] In some instances, physicians may successfully argue that ERISA preempts claims against a physician who makes primarily eligibility decisions.[35]

Congress has reacted to the public's concerns about managed care by attempting to remove the ERISA bar to state tort lawsuits.[36] This legislative action has been fueled by the outcry of consumer groups who have expressed outrage over denials of benefits by anonymous managed care plan bureaucrats. Physicians have also complained about health plan red tape and infringements on their ability to provide appropriate care to their patients.[37] Naturally, these developments have encouraged health plans to shift responsibility for

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29. Pryzbowski v. U.S. Healthcare, Inc., 245 F.3d 266, 273 (3d Cir. 2001) (quoting Pegram v. Herdrich, 530 U.S. 211, 228 (2000)).

30. *Dukes*, 57 F.3d at 354.

31. Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 144 (1985).

32. In re U.S. Healthcare, Inc., 193 F.3d 151, 162–63 (3d Cir. 1999).

33. *Pryzbowski*, 245 F.3d at 273.

34. *Pegram*, 530 U.S. at 229 (holding that mixed eligibility and treatment decisions by plan physicians are not fiduciary acts under ERISA).

35. *Pryzbowski*, 245 F.3d at 279 (holding that claim against physician alleging negligent delay in providing further treatment may be preempted under ERISA). *But cf.* Nealy v. U.S. Healthcare HMO, 711 N.E.2d 621, 622 (N.Y. 1999) (holding a claim against physician for delay in submitting referral form is not preempted by ERISA).

36. *See, e.g.*, Bipartisan Patient Protection Act, H.R. 2563, 107th Cong. § 402 (2001) (removing ERISA bar against state tort law suits for denial of benefits but imposing $1.5 million limit on noneconomic damages and making them available only where managed care plan has failed to comply with the independent medical reviewer's decision that the benefit should be paid).

37. *See, e.g.*, Linda Peeno, *Managed Care and the Corporate Practice of Medicine*, TRIAL, Feb. 2000, at 18.

denials of care to the treating physicians. Professor Clark Havighurst notes that "cost control is often achieved through sub rosa, or secret, rationing by clinicians whose choices are influenced by financial incentives to economize."[38]

Where it is the physician rather than a plan administrator that decides not to use a particular diagnostic test or treatment, the plan may be able to point to the physician as the responsible decision maker. Moreover, dropping prior authorization requirements and instead employing financial incentives like capitation to encourage health plan physicians to economize deflects criticism from the plan to the physician. This could in turn reduce public scrutiny of the role of health plan bureaucrats in implementing cost containment policies. In fact, it seems that health plans have already revamped themselves in response to proposed legislative reforms.[39]

The failure of a health plan to provide treatment recommended by a patient's physician obviously places in high relief the role of the plan bureaucrats. On the other hand, leaving such rationing decisions to treating physicians is a much more subtle and less visible form of rationing that may be less likely to result in a lawsuit. The proposal to remove the ERISA bar to claims against plans for denial of benefits does not seem to contemplate a system whereby the treating physicians rather than the plan administrators take responsibility for implementing cost containment goals. Instead, the proposed legislation focuses on denial of benefits by plan bureaucrats.[40] In the current environment, however, treating physicians are taking primary responsibility for selecting cost effective care. Therefore, it is appropriate to modify the liability regime to take into account the physician's role in cost containment. In this article, I propose that the traditional custom-based standard applicable in medical malpractice cases be replaced with a reasonable, prudent physician standard that will more adequately take into account the role of the physician in rationing care.

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38. Clark C. Havighurst, *Vicarious Liability: Relocating Responsibility for the Quality of Care*, 26 AM. J. L. & MED. 7, 12 (2000).

39. In an interview, Charles Inlander, President of the People's Medical Society, notes:

> Q. Will the legislation on patients' rights really make a difference for consumers?
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> A. I don't think consumers are going to see a major difference. The issue has been lingering so long that most health plans have pretty much made all of the changes that any version of the patient's bill of rights will have in it. The major plans have dropped requiring prior permission to go to the emergency room and for a woman to see an obstetrician or gynecologist. Most plans have third-party, outside review for disputes over care decisions. The new law would mean uniformity for the managed care companies, but most people are not going to see much of an effect.

Milt Freudenheim, *Patients Rights: What Is at Stake?*, N.Y. TIMES, Aug. 19, 2001, at BU11.

40. *See, e.g.*, H.R. Res. 219, 107th Cong. § 402 (2001).

By now it is abundantly clear that managed care has changed the traditional physician/patient relationship. The traditional relationship was "dyadic" and the physician's role was to serve the patient by providing all medically necessary care.[41] The relationship is now modified by the presence of third parties (*i.e.*, health plans and employers) and their role in ensuring that physicians provide care in an economically efficient manner.[42] This role is perfectly legitimate in light of the vast array of costly technological devices and pharmaceuticals now available to the physician. Moreover, this role is also justified by the underlying contract entered into between the patient and the health plan insofar as that contract calls for the provision of cost effective care and utilization of various cost containment devices.

As Professor Baruch A. Brody has noted, physicians function in two roles vis-à-vis their patients: (1) the "professional" role, and (2) the "honest businessman" role.[43] As a "professional," the physician serves primarily in a fiduciary role. In this role, physicians are expected to act in their patient's best interests. "The model of physician as professional calls for physicians to place patient interests first and their own economic interests second . . . ."[44]

On the other hand, under the "honest businessman" model, the physician/patient relationship is essentially a business relationship in which the physician acts in his or her own economic self interest. But this does not mean that the physician is free of any external ethical re-

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41. E. HAAVI MORREIM, BALANCING ACT: THE NEW MEDICAL ETHICS OF MEDICINE'S ECONOMICS 2 (1995). Professor Morreim notes:

> If the physician-patient was once a simple dyad, this was only because the times, and medicine itself, were simpler. In the vastly more complex present and future, the physician's obligations to the patient can no longer be a single-minded, unequivocal commitment, but rather must reflect a balancing. Patient's interests must be weighed against the legitimate competing claims of other patients, of payers, of society as a whole, and sometimes even of the physician himself. Although there still is a physician-patient relationship, it is now set within a broader health care nexus. In this latter context, the rights and interests of economic agents, society, and other parties are both routine and proper, not exceptional or *per se* morally distasteful.

Id.

42. *Id.*

43. Baruch A. Brody, *The Physician as Professional and the Physician as Honest Businessman*, 119 ARCHIVES OF OTOLARYNGOLOGY 495, 495 (1993).

44. *Id.*; *see also* Martin Gunderson, *Eliminating Conflicts of Interest in Managed Care Organizations Through Disclosure and Consent*, 25 J. L. MED. & ETHICS 192, 195 (1997).

> [P]atient consent determines the scope of the underlying duty of the physician to exercise professional judgment and thereby influences what counts as good practice. Because the exercise of professional judgment is now included within its scope of cost containment, a conflict of interest no longer exists between the incentives placed on a physician to minimize costs and the duty to exercise professional judgment in patient care.

Id.

straints. On the contrary, in the "honest businessman role," the physician is expected "to pursue his or her economic interests by providing necessary quality services in an honest fashion."[45] Moreover, in this latter role, it is appropriate for physicians to provide their patient with cost-effective care in accordance with the cost containment goals of the patient's health plan. In the "professional" role, the physicians are responsible for serving the interests of their patient by providing care that meets the needs of their patient. In the "honest businessman" role, however, the physician is primarily concerned with the economics of medicine. While there may be some tension between these two roles, it is also possible to reconcile them. And it is not per se immoral or unethical for a physician to balance the patient's needs and desires against the costs of proposed treatments.[46]

Under the traditional customary malpractice standard that developed in the days of fee for service medicine, the plaintiff in a malpractice action must present expert testimony that the physician failed to comply with the prevailing professional custom.[47] In theory, the physician who complies with the prevailing custom is absolved of liability. In affixing liability, reliance on the customary standard focuses the attention of the fact finder on the failure of the individual physician to abide by the prevailing standard of care in a particular medical community, whether it is local or national. While some commentators have criticized the continued use of the traditional customary standard in medical malpractice cases,[48] others have defended its use.[49] Nonetheless, regardless of the utility of the traditional customary standard in relation to the evaluation of the physician's performance in the "professional" role, it cannot adequately measure the physician's performance in the "honest businessman" role.

My focus in this article is on physician liability rather than on the liability of health plans for denials of benefits. It may be that it would be preferable, as suggested by Professor Havighurst, to hold health plans exclusively liable for the negligence of plan physicians.[50] None-

45. Brody, *supra* note 43, at 495.

46. MORREIM, *supra* note 41, at 2.

47. PAUL C. WEILER, MEDICAL MALPRACTICE ON TRIAL 18 (1991).

48. *See, e.g.*, James A. Henderson & John A. Siliciano, *Universal Health Care and the Continued Reliance on Custom in Determining Medical Malpractice*, 79 CORNELL L. REV. 1382 (1994); Theodore A. Silver, *One Hundred Years of Harmful Error: The Historical Jurisprudence of Medical Malpractice*, 1992 WIS. L. REV. 1193 (1992).

49. *See, e.g.*, Michelle M. Mello, *Of Swords and Shields: The Role of Clinical Practice Guidelines in Medical Malpractice Litigation*, 149 U. PA. L. REV. 645, 709 (2001).

50. Clark C. Havighurst, *Making Health Plans Accountable for the Quality of Care*, 31 GA. L. REV. 587, 588 (1997); *see also* William M. Sage et al., *Enterprise Liability for Medical Malpractice and Health Care Quality Improvement*, 20 AM. J.L. & MED. 1, 27 (1994) (arguing for

theless, this reform is not likely to be widely adopted in the immediate future. And even if it were adopted, it would still be necessary to determine that the physician acted negligently in order to hold the plan vicariously liable.

Under the reasonable prudent physician standard that I propose, custom evidence would no longer be determinative in medical malpractice cases, but evidence as to prevailing practices would continue to be admissible as evidence on the question of whether the physician acted as a reasonable, prudent physician. While it would not be imperative that the plaintiff present such evidence in all cases, most plaintiffs and defendants would nevertheless still present such evidence in many cases. In cases involving a refusal to provide a particular diagnostic procedure or treatment, however, the focus would be on whether or not the physician properly assessed the cost effectiveness of the alternative procedures or treatments rather than on prevailing practices.

This proposal is particularly appropriate in light of recent changes in the managed care market whereby physicians are increasingly held responsible for delivering care in accordance with the cost containment goals of the patient's health plan. Physicians are now expected to take into account cost effectiveness in determining whether to employ a particular treatment or diagnostic procedure. In these cases, prevailing practice evidence could divert attention from the more appropriate inquiry into whether the physician has properly performed in her "honest businessman" role. Under my proposed reasonable prudent physician standard, the focus in malpractice cases arising out of the failure of the physician to use a particular diagnostic technique or treatment would be on the influence of financial incentives and cost effectiveness analysis rather than on custom. I argue that my proposed reasonable prudent patient standard is better than the customary standard insofar as it takes into account the legitimate role of the physician in providing cost effective care and holds the physician accountable in that role.

Part I of this article focuses on the heightened tension between tort and contract in managed health care. Part II of this article examines managed care cost containment techniques and their possible impact on physician decision making. Part III focuses on the widely acknowledged shortcomings of the customary standard. Part IV

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enterprise liability at the health plan level); *but cf.* Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381, 415, 434 (1994) (arguing that it would be more appropriate to place sole responsibility for physician malpractice on hospitals rather than on health plans; also arguing in favor of a no fault system).

provides an outline of the doctrinal regime for my proposed reasonable, prudent physician standard.

I. THE TENSION BETWEEN TORT AND CONTRACT

As many commentators have noted, medical malpractice cases are on the boundary between tort and contract.[51] Since medical malpractice cases involve parties who are not strangers and have been involved in a preexisting consensual undertaking, they are in some ways more closely related to contract than to tort. Accordingly, contract enthusiasts such as Professors Epstein[52] and Havighurst[53] have advocated greater reliance on contract as opposed to tort in providing compensation for iatrogenic injuries. In this regard, Professor Robinson argues: "The affirmative case for contract is simple and powerful. In terms of utilitarian efficiency, contractual arrangements allow parties to achieve the most efficient combination of efforts to manage risk in accordance with their respective comparative advantages and their respective risk preferences."[54]

Legal categories of criminal law, tort law, and contract law are located on a spectrum ranging from relatively high to relatively low levels of state control. In our legal culture, where an extensive social welfare system is coupled with a market economy, the placement of cases into these legal categories reflects societal attitudes toward the importance of certain activities or exchanges.[55] Some injury inflicting activities deemed particularly significant in terms of their social, economic and political consequences or particularly noxious in moral terms may subject participants to state regulation under the criminal law. This carries with it the threat of punitive sanctions for violation of state-sanctioned norms. Although generally iatrogenic injuries have not been dealt with under the criminal law, Professor Humbach has proposed that managed care officials should be subject to criminal prosecution in cases where the denial of a benefit they are legally obligated

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51. *See, e.g.*, Richard A. Epstein, *Medical Malpractice: The Case for Contract*, 1 AM. B. FOUND. RES. J. 87, 93 (1976).

52. RICHARD A. EPSTEIN, MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE 412–16 (1997).

53. Clark A. Havighurst, *Prospective Self-Denial: Can Consumers Contract Today to Accept Health Care Rationing Tomorrow*, 140 U. PA. L. REV. 1755, 1806 (1992).

54. Glen O. Robinson, *Rethinking the Allocation of Medical Malpractice Risks Between Patients and Providers*, LAW & CONTEMP. PROBS., Spring 1986, at 172, 183.

55. *See generally* Guido Calabresi, *Torts—The Law of the Mixed Society*, 56 TEX. L. REV. 519, 521 (1978) ("Tort law and more particularly the rule of liability is . . . the paradigmatic law of the mixed society. The purely 'liberal,' *laissez-faire* polity prefers contracts, the truly collective state the criminal sanction; tort law lies in between.")

to provide to some patient results in injury to the patient.[56] Nonetheless, criminal prosecutions of physicians for malpractice are rare. The traditional reluctance to criminalize the infliction of iatrogenic injury is not surprising in light of the typically benign motive of the physician responsible for inflicting the injury.

Other injury inflicting activities deemed less significant in their effects or less egregious in their moral impact may be dealt with under tort law where sanctions are imposed for violation of state defined norms. Activities deemed even less significant in their social, economic, political, and moral consequences may be treated as private matters subject to contractually defined standards set by the parties to the exchange. Traditionally, our courts have been unwilling to allow contract law to displace tort law in cases involving iatrogenic injury. Tort law imposes certain obligations notwithstanding agreements reached by the parties.

In a perfectly functioning market, tort remedies would arguably be unnecessary to ensure the provision of health care at an acceptable level of quality and quantity. In theory, deterrence and compensation goals could be served by reliance on the market. Patients who were dissatisfied with the quality of care provided by a particular health plan could merely shift to a plan that would provide a more acceptable level of quality. Eventually, poor quality health plans would find themselves without patients and would either improve quality or be driven from the market. And appropriate levels of compensation for iatrogenic injuries and liability standards could be bargained for as part of the contracting process between the patient and the health plan. In a perfectly functioning market, it might not be necessary to resort to the uncertain remedies available under tort law.

Arguably, health plans and physicians should be able to contract out of tort liability for iatrogenic injury resulting from the withholding of care where the physician is merely implementing the cost containment features of the patient's health plan. Courts have been hostile to preclaim waivers of the right to sue by a patient.[57] But perhaps a stronger argument could be made for allowing a more narrowly tailored waiver of the right to sue in tort where the physician is acting to conserve resources in accordance with the plan's cost containment goals.

In theory, such an option could be attractive to employers if it would reduce the cost of coverage. Certainly, employers may be con-

56. John A. Humbach, *Criminal Prosecution for HMO Treatment Denial*, 11 HEALTH MATRIX 147 (2001).

57. *See, e.g.*, Tunkl v. Regents of Univ. of Cal., 383 P.2d 441 (Cal. 1963).

cerned about the quality of care provided to their employees under their health plan because employee dissatisfaction with the plan could result in the loss of valuable employees. But most employees may not be particularly concerned *ex ante* about such a waiver provision even if they were aware of it at the time that they enrolled in the health plan. If this is the case, then inclusion of such a clause may not work to the disadvantage of the employer in attracting employees. Post injury, however, such clauses could over time breed employee dissatisfaction.

Although commentators such as Professor Havighurst[58] have proposed limiting liability by contractual provisions, health plans have not rushed to include these provisions in their master contracts. This is not surprising, since health plans have a strong incentive to tout the quality of their product when marketing it to employers. A no-liability or sharply restricted liability feature could undermine claims of quality insofar as it gave employees the impression that the plan was of inferior quality. Employers also have a strong incentive to tout the quality of their health plans to their employees and would not derive any benefit from providing a plan perceived to be of poor quality to their employees. Provision of an employer-sponsored health care plan is not mandatory in most of the United States.[59] Most employers offer health plans in an effort to attract and retain qualified employees. If an employer offers a health plan that is perceived as poor quality, this may run off better employees.

Consumer advocates argue that allowing health care providers to contractually modify the standard of care in malpractice cases could result in a liability regime that does not adequately take the interests of patients into account.[60] Professor Atiyah notes: "[T]he reality is that the rules which will govern the physician/patient relationship will not be tailored to the individual patient's needs at all. They will be fixed by third parties, just as much as the tort rules."[61]

Typically, health plan subscribers do not have the opportunity to bargain directly with their plan over the terms and conditions of their coverage. In most instances, patients receive coverage through their place of employment. Judicial enforcement of contractual limitations on tort claims against health plans and physicians would be more de-

58. Havighurst, *supra* note 53.

59. *But see* HAW. REV. STAT. ANN. § 393-2 (1999) (mandating provision of employer sponsored health insurance).

60. *See, e.g.*, P.S. Atiyah, *Medical Malpractice and the Contract/Tort Boundary*, LAW & CONTEMP. PROBS., Spring 1986, at 287; Sylvia A. Law, *A Consumer Perspective on Medical Malpractice*, 49 LAW & CONTEMP. PROBS 305, 316–17 (1986).

61. Atiyah, *supra* note 60, at 296.

fensible if employees had a greater choice of health plans. But many employers offer only one health plan to their employees.[62]

Even if there are alternative health plans available, changing plans may not be an attractive solution. Changing plans may result in changing physicians and the other available plans may have undesirable features.[63] In light of these factors, tort law should not be displaced in favor of contract as the governing regime for compensating negligently inflicted iatrogenic injuries regardless of whether the injury results from the physician's failure in either the "professional" or "honest businessman" role. Instead, I propose modifications to the tort regime that would adequately take into account physicians' dual roles.

Tort law has traditionally provided remedies for iatrogenic injuries due to negligent medical care under a custom-based standard of care. Using the custom-based standard has been justified by reference to an implicit contract between the physician and the patient to provide care in accordance with the prevailing customs of the medical profession.[64] Under this view, the custom-based standard imposes tort liability based on the understandings of the parties to the underlying contract for the provision of medical care.

Prior to the advent of managed care, the implicit contract between the physician and the patient usually did not include cost containment provisions. Under managed care, however, the explicit contract between the patient or the patient's employer and the health plan typically obligates the plan to provide medically necessary care, but also provides for cost containment features. In this context, a deliberate refusal by a physician to provide a particular treatment to a patient because of its cost may be viewed as an appropriate attempt to implement the cost containment guidelines of the plan.

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62. Marc A. Rodwin, *Consumer Voice and Representation in Managed Healthcare*, 34 J. HEALTH L. 223, 229 (2001). Professor Rodwin notes:

> First, participation in MCOs is often *not voluntary*. For many privately insured individuals, being a managed care subscriber is not a matter of choice. Most employers do not give employees a choice of more than one health plan. In 1999, 35% of covered employees were offered only one health plan and only half of employees were offered three or more plans. In 1998, 54% of Medicaid recipients were enrolled in health plans. And once an individual is enrolled in an MCO, his choice is more restricted than otherwise.

Id. (citations omitted).

63. MARC A. RODWIN, PROMOTING ACCOUNTABLE MANAGED CARE: THE POTENTIAL ROLE FOR CONSUMER VOICE 10–11 (2000) (School of Public and Environmental Affairs, Bloomington, Indiana; Center for Law and Health, Indiana University School of Law-Indianapolis).

64. RICHARD A. POSNER, ECONOMIC ANALYSIS OF LAW 185 (5th ed. 1998).

At the time that the patient purchased coverage, he or more likely the patient's employer found that these cost containment features were a desirable feature of the health plan. When health insurance is provided by the place of employment, the employer is in effect operating as the employee's agent in searching and contracting for insurance. Thus, it is inefficient to allow a malpractice lawsuit to nullify the contract when the cost containment techniques actually have some impact. The patient should not be able to use a lawsuit in tort to rewrite the contract after an injury occurs as a result of the appropriate use of cost containment techniques. Allowing tort to replace contract in this way may undermine cost containment and increase the cost of health care to the patient. It may also be seen as an unwarranted attempt by courts to interfere with market forces.

The advent of managed care has resulted in the modification of the traditional relationship between physician and patient. Under the older fee-for-service system, the physician was expected to provide treatment to the patient in accordance with the prevailing standards of the profession without regard to cost considerations. Even after the advent of health insurance in the 1930s, insurers did not generally impose significant cost restraints on physicians. Typically, health insurers reimbursed physicians in accordance on a fee-for-service basis and health insurers rarely interfered with the medical judgment of the physician as to the appropriate mode of treatment.[65]

Under managed care, however, contractual arrangements between the physician, the plan, and the patient impose significant cost restraints. The patient, or the patient's employer, purchases coverage for medically necessary health care services from the health plan, but this coverage also includes cost containment features. The patient benefits from these cost containment features because of the relatively lower cost of coverage as compared to traditional health insurance that provides coverage on a fee-for-service basis. The physician may also enter into an agreement with the health plan to provide services to its subscribers in accordance with its cost containment features.

Typically, the physician and patient do not enter into an explicit contract at the point of delivery of care setting out the terms and conditions governing the treatment relationship. Moreover, they usually do not specify the doctrinal regime that will govern any actions brought by the patient for injuries arising from treatment. In the current environment, when the patient seeks care, the patient expects the physician to provide medically necessary care that is fully covered by

65. Stephen R. Latham, *Regulation of Managed Care Incentive Payments to Physicians*, 22 AM. J.L. & MED. 399, 400 (1996).

the health plan with the exception of the usual copayments and deductibles. Most patients do not want to pay out-of-pocket for care that is beyond the coverage provided by their health plan. And most patients (or their employers) would not want to pay significantly higher premiums in the future because of the failure of the health plans to implement cost containment guidelines. Accordingly, an implicit term of the contract between the patient and physician is that the physician will provide cost-effective care in accordance the cost containment goals of the patient's health plan.[66]

The physician's role in rationing care should be viewed as legitimate in the current environment. The remaining question is whether the physician's failure to act appropriately in the rationing role should be redressable in tort or solely in contract. Professor Morreim has noted a distinction between defects of expertise and defects of resources that parallels the distinction between contract and tort.[67] According to Morreim, expertise defects are attributable to deficiencies in "knowledge, skill or effort" by health care providers.[68] On the other hand, "resource defects" are due to economic constraints.[69]

The purpose of Morreim's classification scheme is to determine the applicable doctrinal regime in particular cases. She proposes that a tort regime should apply to defects of expertise and a contract to defects of resources.[70] She further acknowledges, however, that, in a given case, both resource and expertise defects may be intertwined and difficult to separate.[71] Accordingly, delineation of the respective spheres of tort and contract requires intensive factual investigation.[72] Indeed, delineating and separating the physician roles in a particular case in order to apply differing doctrinal regimes would be a daunting task for judges and jurors. As noted by the United States Supreme Court in *Pegram v. Herdrich*, physicians working with a health plan

66. Joan H. Krause, *Reconceptualizing Informed Consent in an Era of Cost Containment*, 85 IOWA L. REV. 261, 351 (1999). Professor Gunderson states: "Patients who voluntarily and knowingly join a managed care plan that provides incentives to physicians to contain costs are in effect consenting to professional judgment that takes into account costs as well as health needs." *Id.* (quoting Gunderson, *supra* note 44, at 195). "In this way, patient consent determines the scope of the underlying duty of the physician to exercise professional judgment and thereby influences what counts as good medical practice." Gunderson, *supra* note 44, at 195.

67. E. Haavi E. Morreim, *Medicine Meets Resource Limits: Restructuring The Legal Standard of Care*, 59 U. PITT. L. REV. 1, 35 (1997).

68. *Id.* at 36.

69. *Id.* at 40.

70. *Id.* at 41.

71. *Id.* at 63–64.

72. *Id.* at 81–82.

may frequently be called upon to make "mixed eligibility and treatment decisions" that implicate both expertise and resource issues.[73]

There is a relative dearth of physician malpractice cases explicitly focusing on resource limitations as a defensible basis for withholding care.[74] There are, however, undoubtedly, many cases where courts or juries have *sub silentio* taken into account resource limitations. For example, *Schrempf v. State*,[75] a 1985 New York opinion, provides an example of a case where the court implicitly takes into account resource limitations in rejecting a tort claim against a physician. The patient in *Schrempf* was an outpatient from a state psychiatric facility. The claimant's husband was an employee of an organization providing vocational rehabilitation to the patient. The patient killed claimant's husband. The claimant argued that the psychiatrist was negligent in allowing the patient to remain as an outpatient after she discovered he was no longer taking his medication.

In *Schrempf*, the New York Court of Claims concluded that the psychiatrist was negligent in initially admitting the patient to outpatient care and should have done "something more" at the time she discovered the patient was no longer taking her medication.[76] On appeal, the New York Court of Appeals reversed the lower court, characterizing the physician's exercise of discretion "as an exercise of professional judgment for which the State cannot be held responsible."[77] It then dismissed the plaintiff's claim, holding that, as a matter of law, the state could not be held liable for the psychiatrist's decisions. The Court of Appeals concluded that the psychiatrist had performed an appropriate risk/benefit analysis in making the determination to allow the patient to remain as an outpatient rather than attempting to hospitalize him on an involuntary basis.[78] The court did not focus on the customary standard, and recognized that the treatment decision had to be based upon the facts of the individual case.

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73. Pegram v. Herdrich, 530 U.S. 211, 228–29.

74. *But cf.* Hall v. Hilbun, 466 So. 2d 856, 879 (Miss. 1985) (discussing resource limitations as a factor to consider in establishing the professional standard of care where the malpractice occurs in a rural area with limited availability of health care personnel, facilities, and equipment), *superseded by statute as stated in* Narkeeta Timber Co., Inc. v. Jenkins, 777 So. 2d 39, (Miss. 2000) (statute abolishes joint and several liability over fifty percent of the judgment and leaves untouched joint and several liability up to fifty percent of the judgment).

75. Schrempf v. State, 487 N.E.2d 883 (N.Y. 1985); *see also* RALPH REISNER ET AL., LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS 142–47 (1999) (discussing *Schrempf*).

76. *Schrempf*, 487 N.E.2d at 886.

77. *Id.* at 889.

78. *Id.*

Although cost factors were not explicitly articulated in the opinion, these factors could have been a significant factor in the psychiatrist's decision to continue with treatment on an outpatient basis. The costs of inpatient care are obviously much greater, and the state has to be concerned about its use of the limited resources available for treatment of the mentally ill. Arguably, in *Schrempf*, the claim was rejected because of resource constraints. *Schrempf* suggests that courts in malpractice action may *sub silentio* recognize the legitimate role of resource constraints as a defense to liability.

It may not be necessary to displace a tort regime with a contract regime in order to recognize the physician's legitimate role in implementing cost containment. The traditional tort doctrine of assumption of risk could come into play in this context. On occasion, courts have recognized express assumption of the risk as a defense to malpractice liability in cases involving experimental treatment.[79] On the other hand, courts have not generally upheld releases from liability for negligently provided medical treatment.[80]

It is likely that an express agreement by the patient to assume the risks of adverse outcomes resulting from the provision of cost-effective care would be upheld by courts if there was no negligence on the part of the health care provider in the selection or provision of treatment. In these instances, there has been no breach of duty on the part of the health care provider. The express assumption of risk, however, is more problematic where there is provider negligence in the provision or selection of care.

Traditionally, courts have not allowed patients to assume this risk. From the standpoint of deterrence, it does not make much sense to allow a patient to assume the risk of unskillfully provided care. This merely has the effect of undermining incentives for physicians to maintain the level of their skills. On the other hand, patients should arguably be able to assume the risk of negligently selected treatment in order to serve the goal of cost containment. This may provide some financial benefit to the patient in the long run insofar as it encourages physicians to be more aggressive in their pursuit of cost containment goals. But negligently selected treatment is unlikely to provide long-term benefits to either the health plan or the patient if it results in an injury to the patient that could have been avoided by the selection of a more appropriate alternative.

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79. *See, e.g.*, Schneider v. Revici, 817 F.2d 987, 989 (2d Cir. 1987) (recognizing availability of defense of express assumption of the risk in a medical malpractice action against a physician using non-traditional means for the treatment of breast cancer).

80. *See, e.g.*, Tunkl v. Regents of Univ. of Cal., 383 P.2d 441 (Cal. 1963).

By purchasing a health insurance plan with cost containment features, the patient impliedly assumes the risk of adverse outcomes resulting from the nonnegligent selection of cost-effective treatment. This proposition accords with conventional tort law because it does not involve any breach of duty by the physician. It is, however, more difficult to argue that the patient also assumes the risk of negligently selected treatment unless the patient is fully informed of the risks and benefits of the care selected and various alternatives. But even if the patient is given that information, the patient should not be expected to be able to do a sufficient analysis of cost effectiveness in order to determine whether the physician has selected the appropriate treatment. By signing up for the health plan, the patient has agreed to accept the cost containment goals of the plan as properly implemented, but not to assume the risk of negligent selection of treatment by the physician. The patient is relying on the physician's expertise in selecting cost-effective treatment and diagnostic tools.

Continued reliance on the tort system is necessary to provide incentives for physicians to exercise reasonable care in the selection of treatment. Allowing physicians to avoid liability for negligent selection of treatment under a contract regime would pose a risk of under deterrence. Tort law should be used to enforce the patient's legitimate expectation that the physician will properly select cost-effective treatment in accordance with the cost containment goals of the plan. On the other hand, however, physicians should be held responsible in tort for the negligent selection of treatment or diagnostic tools.

II. THE POTENTIAL IMPACT OF COST CONTAINMENT TECHNIQUES ON PHYSICIAN DECISIONS

Although some commentators have voiced concern that the abandonment of pre-authorization by health plans could lead to an increase in costs for consumers,[81] this overlooks other available cost saving techniques. Health plans utilize an assortment of financial, clinical, and managerial techniques to deliver health care in a cost-effective manner. There is great variation among health plans, but the most frequently used cost containment techniques are the following: (1) selective contracting with providers; (2) aligning incentives so that providers will take cost effectiveness into account in making treatment decisions; (3) use of gatekeepers to control access to specialists and hospitals; (4) use of prospective, concurrent, and retrospective review; (5) use of practice guidelines or clinical protocols; (6) physician profil-

81. Myriam Marquez, *Change in Way HMO Does Business is a Wise Political Move*, ORLANDO SENTINEL, Nov. 12, 1999, at A16.

ing comparing plan physicians with peers around the country; and (7) deselection of providers who do not practice cost-effective medicine.[82]

One of the most potent cost containment techniques is aligning incentives so as to encourage cost containment. Financial incentives include bonuses, withholds, and capitation.[83] Health plans may offer bonuses to physicians for practicing cost-effective medicine.[84] A plan may also withhold a portion of a capitation payment to a physician and place it in a risk pool to be used to pay for referrals to specialists or hospitalization. At the end of the fiscal year, the physician may receive a portion of the funds left in the risk pool.[85] One particularly potent form of financial incentive is the global capitation of physicians, which effectively shifts the financial risk of over-utilization from the health plan to the physicians.[86] Under global capitation, it is the physicians rather than the health plan administrators that decide what care to provide.

In addition, using clinical practice guidelines is becoming more widespread.[87] Health plans, professional groups, and governmental agencies develop guidelines.[88] Typically, guidelines developed by health plans are motivated by cost control concerns.[89] Guidelines may be used as a tool in physician profiling in order to determine whether or not a physician is practicing in a cost-effective manner.[90] If not, then the physician's mode of practicing medicine can be brought into question. Obviously, the threat of deselection can be a very potent influence if the plan has a large share of the relevant market.

Using preauthorization requirements and gatekeeper referrals to specialists is on the wane. When preauthorization requests are required, nonphysicians may question the judgment of the treating physician. Admittedly, ultimate review of the authorization may involve review by a physician, but even here the physician doing the review may not have the same specialty credentials as the treating physician

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82. *See, e.g.*, Thomas Bodenheimer, *The American Health Care System: Physicians and the Changing Medical Marketplace*, 340 NEW ENG. J. MED. 584 (1999); Marc A. Rodwin, *Conflicts in Managed Care*, 332 NEW ENG. J. MED. 604 (1995).

83. Paul A. Sugarman & Valerie A. Yarashus, *Admissibility of Managed Care Financial Incentives in Medical Malpractice Cases*, 34 TORT& INS. L.J. 735, 739 (1999).

84. *Id.*

85. *Id.*

86. *Id.*; *see also* Krause, *supra* note 66, at 284.

87. Robert Kuttner, *Must Good HMOs Go Bad? Second of Two Parts: The Search for Checks and Balances*, 338 NEW ENG. J. MED. 1635 (1998).

88. Mello, *supra* note 49, at 650.

89. *Id.* at 651.

90. *Id.*; Jerome P. Kassire, *The Use and Abuse of Practice Profiles*, 330 NEW ENG. J. MED. 634 (1994) (expressing concern about uses of physician profiles).

and will not be as familiar with the patient.[91] And of course, this additional level of bureaucracy is expensive.

III. THE SHORTCOMINGS OF THE CUSTOMARY STANDARD

A. The Unique Role of Custom in Malpractice Cases

In its exclusive reliance on custom, professional malpractice law is unique: it is the only area of tort law where custom is not merely relevant—it is binding on the courts. The emphasis on the customary standard is based on deference to professional judgment. This in turn is based on the notion that professionals are not typical economic actors. Those who are called to a profession are deemed to have embraced an ethic of selfless devotion to the interests of their clients or patients. In this view, a professional is by definition one who should be above the temptations of financial self-interest.

This exclusive reliance on custom has also been viewed as appropriate because of the patient's expectation that the physician will treat him or her in accordance with the prevailing professional standards.[92] Reliance on medical custom allows the medical profession to set its own standards. This deference has been justified by the specialized knowledge possessed by the medical profession and the inaccessibility of that knowledge to lay persons.[93] Historically, this exclusive reliance on custom has been viewed as beneficial to the medical profession, but with the advent of managed care, it could actually prove to be detrimental to physicians.

There has been considerable debate as to whether courts will adequately take into account and defer to newer cost sensitive modes of practice.[94] Certainly, at a more practical level, there is no guarantee that the expert testimony presented by plaintiffs as to the standard of care will take into account the legitimate role of cost containment on the decision of the treating physician to provide or withhold a particular treatment. Indeed, there are still some commentators who argue that physicians are required to provide optimal care to all their patients without regard to the coverage provided by the patient's health care plan.[95] Moreover, in this context, the defendant may antagonize

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91. Thomas Bodenheimer & Lawrence Casalino, *Executives with White Coats—The Work and World View of Managed-Care Medical Directors—First of Two Parts*, 341 NEW ENG. J. MED. 1945 (1999) (discussing role of physicians and managed care plan medical directors).

92. POSNER, *supra* note 64, at 185.

93. WEILER, *supra* note 47, at 20.

94. *See, e.g.*, Jacobson & Kanna, *supra* note 16, at 291–326.

95. *See, e.g.*, William M. Sage, *Physicians as Advocates*, 35 HOUS. L. REV. 1529, 1534 (1999).

the jury by bringing up cost as a justification for her failure to employ what is arguably customary care.

Even within the body of traditional malpractice law, there are certain pockets where some courts recognize that it is inappropriate to premise liability on a physician's failure to conform to a unitary custom. The honest error of judgment and respectable minority doctrines may both be viewed as attempts to modify the traditional reliance on a unitary custom in order to deal with the problems of uncertainty in the practice of medicine. For many conditions there are numerous treatment options available. These doctrines provide physicians with immunity when making a good faith choice among various treatment options.

Under the honest error of judgment (or professional judgment) doctrine, courts defer to the decision of the physician to pursue a particular mode of treatment. This doctrine recognizes the need to provide the physician with a zone of immunity when his or her judgment in evaluating the available treatment options is challenged by an injured patient.[96] The respectable minority doctrine (or two schools thought doctrine) recognizes patterns of variation in prevailing customs and protects a physician who complies with a customary standard followed by a minority of physicians.[97] Both doctrines are used primarily in cases where the physician has made a correct diagnosis, but the patient is complaining that the treatment modality was negligently selected.

In recent years, some courts have rejected the honest error of judgment doctrine.[98] Other courts have, however, held that the giving of such an instruction may be appropriate where necessary to protect a physician's exercise of discretionary authority in the selection of available treatments.[99] The honest error of judgment doctrine attempts to provide additional leeway for a physician who selects a particular course of treatment.

The respectable minority or two schools of thought doctrine operates somewhat differently from the honest error of judgment doctrine. The respectable minority doctrine is used where the treatment modality chosen by the treating physician is not in conformity with the customary standard employed by a majority of the medical profession, but does conform to the customary practices of a respectable minority of the profession. This approach provides the physician with

96. *See, e.g.*, Kinning v. Nelson, 281 N.W.2d 849 (Minn. 1979).

97. *See, e.g.*, Chumbler v. McClure, 505 F.2d 489 (6th Cir. 1974).

98. *See, e.g.*, Oullette by Ouellette v. Subak, 391 N.W.2d 810 (Minn. 1986).

99. *See, e.g.*, Yates v. Univ. of W. Va. Bd. of Trs., 549 S.E.2d 681, 690 (W. Va. 2001) (upholding use of instruction in appropriate cases but not in case at bar).

immunity from liability for choosing a particular course of treatment in accord with this minority custom.[100] It provides a physician with some leeway in exercising his or her decision-making authority.

The respectable minority doctrine also recognizes that in some instances there is no unitary custom. As Professor Morreim has noted, however, the respectable minority standard can no longer account for the diversity of approaches to treatment in the current health care environment. She states: "Medicine is no longer characterized by a mainstream practice surrounded by a limited number of alternatives."[101] Both the honest error of judgment and respectable minority rule should be contrasted with occasional decisions requiring a physician to use his or her "best judgment" in treating a patient.[102] In these cases, courts have held a physician accountable despite his or her provision of treatment in accordance with a prevailing practice.

B. The Myth of the Existence of a Unitary Custom

Insofar as it presupposes the existence of a unitary standard, the reliance on custom as determinative is inappropriate in the current health care environment. This is particularly true when it comes to decisions to withhold a particular diagnostic tool or treatment because of costs. The customary standard simply fails to take the complexity and diversity of the contemporary health care system into account. Exclusive reliance on custom may have been more appropriate in the older fee-for-service system, where the physician was an autonomous decision maker who was not required to take cost into account when treating insured patients, but it is not defensible in the current environment.

Several commentators have noted the dissonance between the notion of a unitary custom and the actual functioning of the current health care system. For example, in a 1994 article Professors Henderson and Siliciano stated: "[M]odern medicine displays few of the features that tend to generate reliable customs in other contexts."[103] And in a 1997 article, Professor Morreim notes: "Prevailing practice has been replaced by near chaos; what is customary depends upon who is asked."[104]

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100. *See, e.g.*, Jones v. Chidester, 610 A.2d 964, 969 (Pa. 1992) (custom must be followed by a "considerable number of [respected] physicians" to afford defendant a complete defense).

101. Morreim, *supra* note 67, at 23.

102. *See, e.g.*, Burton v. Brooklyn Doctors Hosp., 452 N.Y.S.2d 875 (N.Y. 1982); Toth v. Cmty. Hosp. at Glen Cove, 239 N.E.2d 368 (N.Y. 1968), *discussed in* BARRY FURROW ET AL., LIABILITY AND QUALITY ISSUES IN HEALTH CARE 144 (4th ed. 2001).

103. Henderson & Siliciano, *supra* note 48, at 1394.

104. Morreim, *supra* note 67, at 18.

A physician's decision as to the appropriate course of therapy in a particular case may be influenced by several factors including: (1) the characteristics of the patient (height, weight, age, and sex); (2) the patient's medical history; (3) the patient's preferences; (4) the coverage provided by the patient's health plan (including limitations imposed by a health plan's drug formulary); (5) the physician's training and area of specialization; (6) the array of diagnostic tools and therapeutic responses available with respect to the medical condition in question; and (7) the cost containment techniques employed by the patient's managed care plan.[105] It is illusory to speak of a medical custom in light of all these variable factors. In fact, the expert testimony on medical custom in this regard may simply be the witness's personal standard of care as influenced by who is paying him or her to testify.

First, there are the characteristics of the patient. There is tremendous individual variation among patients. Patients presenting with the same symptoms may require different diagnostic or therapeutic responses due to other factors such as age, height, weight, and sex. The likelihood of the patient suffering from a particular disease or condition is often related to these other factors. Various treatment modalities may be more or less appropriate based on the interplay among these factors. The patient's medical history is also a relevant factor. The selection of the appropriate diagnostic tool or treatment may depend upon the physician's prior knowledge of the patient and this in turn is linked to the duration of the physician's treatment relationship with the patient, the availability of medical records, and the patient's ability to communicate with the physician.

In theory, under the doctrine of informed consent, patients are supposed to have greater involvement in decisions concerning treatment and diagnostic choices. Indeed, a physician who utterly fails to involve the patient in decision-making may risk tort liability under the doctrine of informed consent. The widespread judicial recognition of informed consent coincides with an upsurge in consumer activism. Certainly, younger physicians are more sensitized to the role of informed consent than earlier generations and more inclined to involve patients in treatment decisions.

On the other hand, as Peter Schuck has noted, there is often a "gap" in this area between the law "in books and the law "in ac-

105. *Cf.*, Henderson & Siliciano, *supra* note 48, at 1390–95 (discussing some of these factors). There also appears to be substantial regional variation in the patterns of surgical care across the United States. *See Practice Variations and the Quality of Surgical Care for Common Conditions*, *in* THE DARTMOUTH ATLAS OF HEALTH CARE: THE QUALITY OF MEDICAL CARE IN THE UNITED STATES, 140–74 (1999), *available at* http://www.dartmouthatlas.org/99US/toc5.php.

tion."[106] For many routine procedures, the doctrine of informed consent has had little impact. But in cases involving serious conditions and more invasive procedures, the impact of the doctrine of informed consent may have had a more significant impact. For example, when a physician administers a treatment that could cause sterility to a woman, the patient's interest in bearing a child is of utmost importance. Certainly, in many cases involving serious ailments, preferences of the patient or of the patient's family should play an important role in the selection of a treatment or diagnostic procedure.

The treating physician's area of specialization may also have a significant impact on the treatment selected. Surgeons are more likely to choose surgical interventions while nonsurgical specialists may prefer other forms of treatment. For example, cardiac patients who experience blockages of blood vessels leading to the heart may either undergo bypass surgery if treated by a heart surgeon or angioplasty if treated by cardiologist. And a patient with sinus problems may be treated with antihistamines, decongestants, and antibiotics for sinusitis by an allergist while an otolaryngologist may recommend surgical intervention.

There are significant differences in insurance coverage that may affect the physician's decision. Some patients may have no insurance while others may have very generous coverage. A health plan may cover surgery, but not prescriptions. Co-pays may vary according to the type of treatment employed. Naturally, if the patient is going to have to pay substantially more out of pocket for certain treatments, this should have an impact on the choices made. An ideal physician-agent would take the patient's cost preferences into account. For example, an insurer may discharge an uninsured patient one day sooner to save the patient the $1000 per day cost of an additional hospital stay, while allowing an insured patient, or an uninsured patient with higher income, an additional day. While an egalitarian approach to health care access posits that there should not be differential treatment based on insurance coverage, it is inevitable that insurance coverage will influence treatment choices.

In the current health care environment, physicians must take into account the cost containment features of the patient's health plans. Physicians can no longer make autonomous choices as to diagnostic tools and treatment modalities. The physician may have to gain prior authorization for the use of some diagnostic tools and treatment modalities. Even if there is no prior authorization requirement, the practice patterns of the physician will inevitably be reviewed on a retro-

106. Peter Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899, 903 (1994).

spective basis. There are also financial incentives in place designed to decrease physicians' use of expensive diagnostic tools and treatment modalities. Physicians have to heed the policies of the patient's health plan in making treatment choices or risk termination from the plan.

Due to ongoing technological developments there is also an array of available diagnostic tools and treatment modalities with variations in costs and potential benefits. As the complexity of medical care increases and technological development accelerates, the tools available for the diagnosis and treatment of particular diseases and conditions continue to multiply. The marginal cost of the more expensive tools may exceed their marginal benefits in particular cases. In these cases, the physician, under the influence of financial incentives, may decide to withhold the treatment as an inefficient use of resources and in these instances custom has little to do with this determination.

IV. THE REASONABLE PRUDENT PHYSICIAN STANDARD: OUTLINE OF A PROPOSED DOCTRINAL REGIME

Under the traditional malpractice standard, the physician has a duty to treat the patient in accordance with the prevailing standards of the profession. Changes in the health care environment require a reformulation of this standard. Under my proposal, a physician contracting to treat subscribers to a health plan would have a duty to treat patients with the care of a reasonable, prudent physician acting under the same or similar circumstances, in good faith, and in the best interests of the patient. This language is borrowed in part from the standards of conduct for corporate officers set out in the Model Business Corporation Act.[107] The analogy is appropriate because a physician in the era of managed care acts as an "honest businessman" as well as a "professional."

Moreover, as in the case of physicians: "[C]orporate managers make numerous decisions that involve the balancing of risks and benefits. . . . Although some decisions turn out to be unwise or the result of a mistake in judgment, it is not reasonable to reexamine an unsuccessful decision with the benefit of hindsight."[108] In the health care context, the physician is making purchasing decisions on behalf of the patient and the risk/benefit analysis is performed pursuant to the contractual relationships among the physician, the health plan, and the patient.

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107. 2 MODEL BUS. CORP. ACT ANN. § 8.42(a) (3d ed. Supp. 1998–1999); *see also id.* § 8.31(2) (concerning standards of liability for directors).

108. *Id.* at 8-192 (official comment to § 8.31).

My proposed standard is also modeled on the standard set out in the American Medical Association's (AMA) proposal for the adoption of an administrative procedure for the resolution of malpractice claims.[109] My proposal, however, goes somewhat beyond the AMA proposal in more specifically recognizing the legitimate role of the physician in effectuating cost containment goals. Under my proposed doctrinal standard, the physician would be required to treat the patient in accordance with the cost containment goals of the patient's health plan.

My proposed standard will also impact certain features of the law of informed consent. As to obligations of disclosure, where a more costly alternative treatment or diagnostic technique has been withheld, the physician would be obligated to provide this information to the patient when it would be material to the patient. Similarly, the physician would be obligated to provide the patient with information of the applicable financial incentives that may have influenced the physician to provide the less costly alternative only when that information would be material to the patient. Breach of these disclosure obligations, however, should only be actionable in tort where provision of information on the more costly alternative would have lead to an improved outcome for the patient.

A. With the Care of a Reasonable, Prudent Physician

The reasonable, prudent physician standard is consistent with the approach that courts take in most negligence cases other than professional malpractice. The reasonable, prudent physician standard is intended in part to embody the regime of the common law of negligence. The applicable standard here is Learned Hand's risk formula.[110] It is also intended to adopt the *T.J. Hooper* rule insofar as it recognizes that custom evidence is relevant but not binding.[111] This was the approach taken by the *Helling* court in determining whether the plaintiff should have been given a tonometry test.[112] It rejects the traditional approach in malpractice cases insofar as the common law treats a physician's failure to comply with prevailing unitary custom as determinative on the liability issue.

The focus of inquiry under the reasonable, prudent physician standard varies with the nature of the case. In some cases, the focus

109. *See* Carter G. Phillips & Paul E. Kalb, *Replacing the Tort System for Medical Malpractice*, 3 STAN. L. & POL'Y REV. 210 (1993); Kirk B. Johnson et al., *A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims*, 42 VAND. L. REV. 1365 (1989).

110. United States v. Carroll Towing, 159 F.2d 169 (2d Cir. 1947).

111. T.J. Hooper, 60 F.2d 737 (2d Cir. 1932).

112. *See* Helling v. Carey, 183 Wash. 2d 514, 518–19, 519 P.2d 981, 983 (1974).

should be on whether the treatment selected was carried out in accordance with the level of skill generally prevailing in the profession. For example, where it is alleged that a surgeon improperly performed a surgical procedure or failed to properly diagnose a particular condition, the primary concern is with the level of the physician's skills.

There has been some confusion in the cases as to whether the traditional standard of care refers to the minimal level of skill or average level of skill exercised by physicians.[113] Under the reasonable, prudent physician standard, it is more appropriate to focus on the skill level of the average practitioner. In the managed care context, managed care plans, either explicitly or implicitly, vouch for the quality of their physicians. Typically, there is a selection process for plan physicians and usually some sort of continuing oversight of physicians by the health plan. Moreover, in some health plans, the patient must select a gatekeeping physician from a list provided by the health plan. Access to a specialist may require referral from the gatekeeper, and the list of accessible specialists may be limited to those preselected by the health plan.

Under these circumstances, it seems plausible that the patient's expectation is that she will receive care in accordance with the average level prevailing in the profession rather than at a minimal level. Insofar as the proposed standard focuses on the average level of skill rather than the minimal level of skill, my proposed standard bears some resemblance to the implied warranty of merchantability in the law of products liability as it applies to both manufacturers and retailers.[114] Under the implied warranty of merchantability, the seller is required to provide goods of average quality. This analogy is appropriate because of the greater standardization of the practice of medicine within health plans and the greater oversight of physician practices by health plans.

Where a treatment or diagnostic procedure is withheld because of cost, the focus should be on the risk/utility calculation. More particularly, the evidence in the case should focus on the appropriateness of a physician's analysis of cost effectiveness and the influence of financial incentives. These two are necessarily intertwined. When the patient alleges an improper withholding of treatment, the inquiry focuses on the appropriateness of the physician's analysis of cost effec-

113. *See, e.g.*, Holt v. Levine, 29 Conn. L. Rptr. 20 (Conn. Super. Ct. 2001).

114. *Cf.* William S. Brewbaker III, *Medical Malpractice and Managed Care Organizations: The Implied Warranty of Quality*, 60 LAW & CONTEMP. PROBS. 117 (1997) (proposing that courts impose an implied warranty of quality on health plans).

tiveness, and one factor in this inquiry is whether the physician was unduly influenced by financial incentives.

While a physician could be held liable for negligently performing this cost effectiveness analysis, we should recognize that in making a decision as to the appropriate course of treatment or diagnostic procedure for the patient in question, physicians are entitled to take costs into account. Although these decisions may occasionally be erroneous, they should not be reexamined with the benefit of hindsight. The focus of inquiry should be on the reasonableness of the decision at the time that it was made with the information available to the physician. This approach more accurately reflects the actual decision making process of the physician in a managed care environment and the expectations of the contracting parties.

In cases where the patient alleges that the physician improperly withheld treatment, the trier of fact should compare the cost effectiveness of the treatment provided with the treatment withheld. Certainly, we should expect a reasonable, prudent physician to make treatment decisions based on cost effectiveness and outcomes research when such data is available.[115] Professor Marc Rodwin has noted that traditionally, the practice of medicine was primarily based on a physician's "medical training, individual experience, and local custom."[116] More recently, however, there has been a shift toward "evidence-based medicine" where "clinical choices" are supposed to be:

> [B]ased on data from journal articles in medicine, epidemiology, and economics[,] which rely on such analytical techniques as random clinical control trials, multiple regression analysis, and cost-effectiveness analysis. These methods don't require a medical education and place nonphysicians trained in social science, science, or public policy analysis on par with physicians.[117]

Certainly, evidence-based medicine should be the key proof in an action alleging that a physician negligently selected a particular treatment or diagnostic tool. In a recent article, Professor Peter Jacobson and Matthew Kanna persuasively argue that cost effectiveness analysis

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115. *See generally* Jacobson & Kanna, *supra* note 16, at 293–301. Cost effectiveness analyses may or may not be used in outcomes research. Thus, cost effectiveness is a particular methodology that is frequently used in outcomes studies, but outcomes research may rely on other methodologies. Conversation with Stephen Mennemeyer, Ph.D., University of Alabama School of Public Health (August 28, 2001).

116. Marc A. Rodwin, *The Politics of Evidence-Based Medicine*, 26 J. HEALTH POL., POL'Y & L. 439, 440 (2001).

117. *Id.* at 440–41.

should be incorporated into the standard of care.[118] They further suggest that it should be "treated as one piece of evidence to be considered by the jury rather than being used to determine the standard of care."[119] In discussing the value of "evidence-based medicine," Professor Rodwin opines that the available evidence may frequently not be determinative on the question of the appropriate choice of treatment in a particular case.[120]

In another recent article, Professor Arnold Rosoff notes: "[O]utcomes research is increasingly making it possible to know and know more precisely and certainly what is, and what is not, effective therapy."[121] And Dr. F. Ronald Feinstein, a practicing physician, has noted: "Bringing and evidence-based outcomes-study approach to clinical decision-making will go a long way toward reducing unwanted variation and lead to savings in both individual and natural resources."[122]

At the time of the actual delivery of care, the costs to the patient may be minimal, amounting to the payment of a copayment or deductible. Accordingly, with respect to cost effectiveness, the costs should be calculated from the health plan's perspective. Moreover, in light of the ongoing contractual relationship, the plan (and the physi-

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118. Jacobson & Kanna, *supra* note 16, at 292. The authors describe cost effectiveness analysis as follows: "In assessing the alternatives, CEA (cost effectiveness analysis) uses a ratio where the denominator is the gain in health (such as adverse reactions avoided) and the numerator is the incremental cost of obtaining the benefits. The denominator may be expressed in years of lives saved or undesirable outcomes averted." *Id.* at 293. They further note that cost effectiveness analysis is sometimes distinguished from cost benefit analysis because in the former the effectiveness of resource use is expressed in nonmonetary terms, while in the latter it is expressed in terms of dollars. *Id.* They also refer to cost utility analysis where the benefit is expressed in terms of quality adjusted life years. *Id.* Finally, they note that "some economists treat CBA [cost benefit analysis] and CUA [cost utility analysis] as a variant of CEA." *Id.* at 293 n.3. In this article, I use the term in the latter sense to encompass cost benefit analysis, cost utility analysis and cost effectiveness analysis.

119. *Id.* at 293.

120. Rodwin, supra *note* 116, at 442. He further notes:

> Sometimes[,] evidence may be preliminary rather than well established, or the therapies may be so new that their long-term effects are not known. Assessments of the effectiveness of a therapy may vary across studies depending on the population studied, the questions asked, or the methodology employed. Even when an area is carefully scrutinized, there is frequently significant uncertainty and ambiguity about what approach will work best. The pros and cons of different therapies may also vary depending on the patient's other medical conditions. There may be trade-offs between effectiveness and safety, or between effectiveness in treating the medical condition and quality of life.

Id. at 442–43.

121. Arnold J. Rosoff, *Evidence-Based Medicine and the Law*, 26 J. HEALTH POL., POL'Y & L. 327, 328 (2001).

122. F. Ronald Feinstein, *Access to Health Care: It's Not Rocket Science—It's Tougher*, 22 J. LEG. MED. 235, 237 (2001).

cian) should be expected to take a longer view. Thus, in a particular case, it may be that use of a relatively more expensive approach today could head off problems downstream and actually save money in the long run. Generally, the cost effectiveness of the treatment is calculated by determining the costs of the treatment to the health plan and comparing those costs to the potential outcome for the patient in terms of "gain in health" both immediately and in the longer term[123]

Clinical practice guidelines may also have some bearing on the appropriateness of the physician's decision to withhold treatment. In effect, the physician may allege that the group that has formulated the clinical practice guideline has already done an appropriate cost benefit analysis. There has been some controversy under the professional standard as to the role of clinical practice guidelines in malpractice cases. In some cases, a plaintiff may rely on a clinical practice guideline to establish liability on the part of a physician. In other cases, the physician may attempt to justify the withholding of a particular treatment or diagnostic procedure by pointing to a practice guideline or clinical protocol. Most of the controversy has focused on whether clinical practice guidelines may be used to establish the customary standard either standing alone or in support of expert testimony.

In a recent article, Professor Michelle Mello has argued against increased reliance on clinical practice guidelines to establish the standard of care in malpractice cases.[124] She reasons that under the customary standard, it is not appropriate to place too much emphasis on clinical practice guidelines because "[clinical practice guidelines] do not appear to represent custom in most instances."[125] Mello further argues that, while it may be appropriate for courts to admit clinical practice guidelines into evidence for the consideration of the jury in order to establish custom, the guidelines should not displace expert testimony on the prevailing standard of care.[126] On the other hand, Professor Mark Hall has argued that, while compliance with a guideline could provide a conclusive defense to a malpractice action, violation of a guideline should not be treated as conclusive evidence of malprac-

123. Jacobson & Kanna, *supra* note 16, at 293. The authors further state: "In assessing alternative, CEA uses a ratio where the denominator is the gain in health (such as adverse reactions avoided) and the numerator is the incremental cost of obtaining the benefits. The denominator may be expressed in years of lives saved or undesirable outcomes averted." *Id.*

124. Mello, *supra* note 49.

125. *Id.* at 709.

126. *Id.* at 710 (arguing that clinical practice guidelines should not replace expert testimony as to the customary standard of care, but should be used to support expert opinion as to the prevailing custom). *Contra* Richard E. Leahy, *Rational Health Policy and the Legal Standard of Care: A Call for Judicial Deference to Medical Practice Guidelines*, 77 CAL. L. REV. 1483 (1989) (arguing that juries should not be permitted to disregard or overrule clinical practice guidelines).

tice.[127] He argues that differential treatment is appropriate in light of the two schools of thought (or respectable minority) doctrine.[128]

The use of clinical practice guidelines is not particularly problematic under the reasonable, prudent physician standard. The physician's compliance or noncompliance with a clinical practice guideline should be treated as relevant, but not conclusive evidence on the question of whether the defendant acted as a reasonable, prudent physician. This approach is actually consistent with the current approach taken by most courts under the customary standard. As noted by Professor Mello, "the prevailing practice is to admit [clinical practice guidelines] in connection with expert testimony, but not to give them determinative weight."[129] Certainly, if clinical practice guidelines are relevant to the jury's assessment of whether the defendant acted in accordance with the prevailing professional standard, they will also be relevant to the question of whether the physician acted in a reasonable and prudent manner under the circumstances.

Where the physician has complied with a guideline or protocol in denying access to a particular treatment or diagnostic technique, the physician is in effect arguing that the group that developed the guideline performed the relevant cost effectiveness analysis in an appropriate manner. Compliance with a guideline certainly supports an inference that the physician performed the cost effectiveness analysis in a reasonable and prudent manner in the case at bar, but should not be conclusive on the question. And likewise the plaintiff should be able to use the physician's noncompliance with a guideline to establish that the physician's cost effectiveness analysis was unreasonable.

The strength of inference in cases of both compliance and noncompliance with a clinical practice guideline depends on a number of other factors including the nature of the issuing organization and the fit between the guideline and the particular case. If the guideline is issued by a reputable medical specialty organization, this is certainly persuasive evidence that the complying physician acted as a reasonable prudent physician. In this regard, Professor Mello notes that these guidelines are particularly authoritative because "unlike insurers, physicians' financial incentives have traditionally been aligned with providing top quality care to their patients."[130] On the other hand, if the guideline is issued by a health plan, it may be entitled to less deference because such guidelines "are heavily influenced by cost-control con-

127. Mark A. Hall, *The Defensive Effect of Medical Practice Policies in Malpractice Litigation*, 54 LAW & CONTEMP. PROBS. 119, 131 (1991).

128. *Id.*

129. Mello, *supra* note 49, at 665 (citing Hall, *supra* note 129, at 131 & n.53).

130. Mello, *supra* note 49, at 650.

cerns."[131] Such considerations should also come into play under the reasonable prudent physician standard.

Under the customary standard, there is apparently still some uncertainty as to whether evidence of financial incentives is admissible to prove breach of the standard of care.[132] The central question in these cases is whether evidence of financial incentives is relevant to the issue of breach of the standard of care.[133] In a 1999 article, Paul Sugarman and Valerie Yarashus, partners in a Boston law firm, argue that such evidence should be "admissible . . . because it provides an explanation for the defendant's treatment decisions and sheds critical light on whether the patient received the benefit of the defendant's best medical judgment unencumbered by competing financial considerations . . . ."[134]

On the other hand, in *Shea v. Esensten* (*Shea III*), the Minnesota Court of Appeals held that the trial court judge properly excluded evidence that managed care financial incentives discouraged referrals to specialists.[135] In *Shea*, The plaintiff's husband died of a heart attack after being treated by defendants, Drs. Esensten and Arenson, for chest and abdominal pain.[136] The doctors had referred the decedent to a gastroenterologist, but not a cardiologist.[137] There was a dispute in the evidence as to whether the decedent had ever asked to be referred to a cardiologist.[138]

The plaintiff sought to offer evidence regarding the structure of financial incentives under her husband's health plan in order to show why he had not been referred to a cardiologist.[139] The appellate court concluded that the exclusion of this evidence was in the discretion of the trial court judge where there was no showing of relevance to the plaintiff's claim for malpractice.[140] On the question of relevance, the appellate court stated: "The elements of malpractice do not require the plaintiff to show a physician's reasons or motivations for departing from acceptable standards. Instead, it is the proof that the physician *in fact* departed from the standard of care that is critical."[141] The court

131. *Id.*
132. Sugarman & Yarashus, *supra* note 83, at 748.
133. *Id.* at 754.
134. *Id.* at 760.
135. 622 N.W.2d 130, 132 (Minn. Ct. App. 2001) [hereinafter *Shea III*].
136. *Id.*
137. *Id.* at 133.
138. *Id.*
139. *Id.*
140. *Id.* at 146.
141. *Id.* at 135.

also observed that under the Minnesota licensing statute,[142] a physician has no duty to disclose the existence of a capitation contract to a patient.

Although the admissibility of evidence of financial incentives may be problematic under the traditional customary standard, it seems obvious that evidence as to financial incentives and their effect on physician decision making is relevant to the inquiry as to whether the defendant acted as a reasonable, prudent physician in failing to provide a more expensive diagnostic technique or treatment. While the custom standard is narrowly focused on prevailing practices, the reasonable, prudent physician standard is more contextual. Proof of the existence of a financial motive may not in itself establish liability, but it certainly has some bearing on the question of liability. Accordingly, evidence of financial incentives should ordinarily be admissible to establish that the defendant negligently failed to select a more costly alternative treatment or diagnostic technique.

B. Acting Under the Same or Similar Circumstances

The AMA proposal advocates a change in substantive law by suggesting that the customary standard should be replaced by the standard of a reasonable, prudent, and competent physician working under similar circumstances.[143] The factors to be considered under the AMA proposal include the level of the physician's expertise, the state of medical knowledge, the availability of health care facilities, and "whether the nature or severities of the patient's medical problems limit the options available for treatment."[144] This listing of factors, however, is not sufficiently comprehensive.

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142. *Id.* The statute provides the following:

(1) The following conduct is prohibited and is grounds for disciplinary action:

. . . .

(p) Fee splitting, including without limitation:

. . . .

(4) dispensing for profit any drug or device, unless the physician has disclosed the physician's own profit interest. The physician must make the disclosures required in this clause in advance and in writing to the patient and must include in the disclosure a statement that the patient is free to choose a different health care provider. This clause does not apply to the distribution of revenues from a partnership, group practice, nonprofit corporation, or professional corporation to its partners, shareholders, members, or employees if the revenues consist only of fees for services performed by the physician or under a physician's direct supervision, or to the division or distribution of prepaid or capitated health care premiums, or fee-for-service withhold amounts paid under contracts established under other state law.

MINN. STAT. § 147.091(1)(p)(4) (2001).

143. Phillips & Kalb, *supra* note 109, at 212–13.

144. Id. at 213.

The acting under the same or similar circumstances language of my proposed standard is intended to recognize that the conduct of the physician of the physician is to be judged in light of the specific factual context including such factors as: (1) the characteristics of the individual patient; (2) the complexity of the case; (3) the urgency of the situation; (4) the information about the patient's condition that was available to the physician at the time of the treatment; (5) the background and training of the physician (*i.e.*, more is to be expected of a board-certified specialist); (6) the resources available in the local treatment community; and (7) the terms of the patient's health plan.

Of particular importance among these contextual factors are the terms of the patient's health plan. Physicians in their rationing role also constantly make decisions requiring the balancing of costs and benefits. Under my proposed standard, the physician duty in tort is modified by the physician's obligation to provide treatment that is in accordance with the cost containment goals of the patient's health plan. The physician's balancing of costs and benefits in making treatment decisions is also consistent with an economic model of managed care that views the patient as delegating to the physician the task of taking clinical and cost considerations into account as the patient would if she had sufficient information. Accordingly, in holding physicians accountable in tort, the triers of fact should consider the effect on physicians of legitimate cost containment mechanisms of the patient's health plan. Juries should be appropriately instructed in this regard.

Reference to the plan's cost containment provisions in this context is also appropriate here because of the initial contract to provide health care coverage. When purchasing coverage from a health plan, the patient becomes part of a risk pool consisting of all health plan members. The contract contemplates that the plan will utilize a variety of cost containment techniques to provide cost-effective treatment to the patient. This benefits the patient over the long run because it will contain the costs of coverage. It also has the additional benefit of protecting the patient from unnecessary treatment that was more likely to occur under the older cost-based reimbursement model of health care financing. When the physician contracts to treat patients insured by a particular health plan, the physician should look to the interests of all the patients covered by that plan.[145]

145. In this regard, Professors Hall and Berenson state:

> We propose that the devotion to each *individual* patient's best medical interests be replaced with an ethic that calls for devotion to the best medical interests of the *group* for which the physician is responsible. Physicians working in organizations with restrained resources should attempt to maximize overall health outcomes for all patients

C. *In Good Faith and the Best Interests of the Patient*

The good faith and best interests requirements are intended to require the physician to act in accordance with the fiduciary nature of the physician/patient relationship. But the physician's fiduciary role vis-à-vis the patient is necessarily limited by the physician's obligations to the patient's health plan.[146] Certainly, the obligation of good faith is violated by a physician who acts or fails to act solely because of his or her own financial interests. And the best interests requirement complements the good faith requirement insofar as it requires the physician to put the interests of the patient ahead of his or her own financial interests.

These obligations, however, should be viewed in light of the physician's obligation to provide cost-effective care in accordance with the cost containment policies of the patient's health plan. The good faith and best interests do not require the physician to provide care to the patient regardless of its cost. After all, the purpose of the financial incentive arrangements employed by a health plan is to force physicians to take costs into account.

Under the general principles of agency law, "an agent is subject to a duty to his principal to act solely for the benefit of the principal in all matters connected with his agency."[147] On the other hand, "one employed as an agent violates no duty to the principal by acting for his own benefit if he makes a full disclosure of the facts to an acquiescent principal and takes no unfair advantage of him."[148] The physician who responds in an appropriate manner to financial incentives does not have a conflict of interest in the same sense as a purchasing agent who receives an undisclosed kickback from the seller of goods purchased on behalf of the principal.

In the managed care context, the cost containment features are deliberately designed to force the physician to take costs into account

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> treated in that setting rather than to maximize care for their personal patients. . . . The shift from individual health to group health is consistent with managed care's focus on the health of the population it serves and with the basis on which HMOs and providers increasingly are being judged for quality of care. The group focus is also consistent with the very essence of insurance, which is based on subscribers' pooling their medical and economic interests with others.

Mark A. Hall & Robert A. Berenson, *The Ethics of Managed Care: A Dose of Realism*, 28 CUMB. L. REV. 287, 306–07 (1998) (footnotes omitted).

146. Marc A. Rodwin, *Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System*, 21 AM. J.L. & MED. 241, 255 (1995) (noting that "the law may hold doctors to fiduciary standards yet also expect physicians to take adequate account of the interests of many patients or even parties other than patients").

147. RESTATEMENT (SECOND) OF AGENCY § 387 (1958).

148. *Id.* at § 390 cmt. a.

and appropriately designed financial incentives may be an effective means of achieving that desired response. Presumably, the patient (or the patient's employer) has purchased the coverage under the plan at least in part because of its desirable cost containment features. As long as the plan's financial incentives for its physician are disclosed to the patient by the plan at the outset, there should be no breach of the duty of loyalty merely by taking into account the cost effectiveness of available treatments.

Some aspects of my proposed good faith and best interests component are borrowed from the business judgment rule in corporate law. In a 1994 article, Professors Arkes and Schipani discussed the analogy between the situation of corporate directors and physicians in a decision-making role.[149] But they stop short of proposing that the medical liability doctrinal regime be reconfigured along the lines of the business judgment rule.[150] Their analogy, however, has become even more appropriate in light of the dual role of physicians the current environment as both "professional" and "honest businessman."

In corporate law, there is a presumption that directors and officers have acted in good faith and the best interests of the corporation in making a business decision.[151] Consistent with the business judgment rule, physicians are entitled to a rebuttable presumption that they have acted in good faith and in the best interests of their patient. This presumption could, however, be overcome by evidence that the financial incentives are simply too strong an influence on physician behavior.

Naturally, to establish a breach of duty the patient should also have to establish that the physician failed to provide care that a reasonable, prudent physician acting under similar circumstances would provide due to the overweening influence of the financial incentives. As Professors Hall and Berenson note: "If doctors start seeing dollar signs on their patient's heads, the incentives are too strong."[152] Under my proposal, in order to recover damages, the patient would have to establish some actual harm as a result of the influence of the financial incentives. Ordinarily, this harm would consist of the loss of a chance

149. Hal R. Arkes & Cindy A. Schipani, *Medical Malpractice v. the Business Judgment Rule: Differences in Hindsight Bias*, 73 OR. L. REV. 587 (1994).

150. *Id.* at 629.

151. MODEL BUSINESS CORP. ACT ANNOT., *supra* note 107, at 8-197 (official comment to § 8.31).

152. Hall & Berenson, *supra* note 145, at 305.

of an improved condition because of the denial of access to a particular treatment or diagnostic procedure.[153]

The fiduciary nature of the physician/patient relationship is necessarily limited by the contractual undertakings among the physician, the patient and the health plan. The fiduciary obligation does not impose an absolute duty that requires the physician to ignore financial incentives. The appropriate balance between the physician's fiduciary obligation to the patient and the physician's obligation to conserve resources by appropriately responding to financial incentives will necessarily be worked out on a case-by-case basis. In this regard, Professors Hall and Berenson propose a series of ethical guidelines that could be useful to courts in determining whether the physician has acted in good faith and in the patient's best interests:

> Financial incentives should influence physicians in their professional, not their personal or business, lives. That is, financial incentives should cause doctors to think about what is necessary for their patient's health care and what is advisable for their own professional reputations, not what will increase their own income. . . .
>
> Physicians should not enter into incentive arrangements they would be embarrassed to describe accurately to their patients . . . .
>
> Physicians should be wary of incentive arrangements that are not in common use elsewhere in the market. . . .[154]

Lack of candor concerning the influence of financial incentives is also indicative of bad faith and failure to act in the patient's best interests. An important component of the good faith and best interests requirement is the obligation of the physician to make appropriate disclosures to the patient. As Professors Hall and Berenson note: "Fidelity to patients also requires a strong measure of candor, especially when physicians function under a financial conflict of interest and these conflicts are not obvious or in common knowledge, as in the case today with capitation and physician ownership interests."[155]

The most important issues regarding the scope of disclosure obligations of physicians are: (1) whether the treating physician should be required to inform the patient of alternative treatments or diagnostic procedures that are being withheld for financial reasons; and (2)

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153. *Cf.* Herskovits v. Group Health Coop. of Puget Sound, 99 Wash. 2d 609, 619, 664 P.2d 474, 479 (1983) (recognizing the loss of chance doctrine).

154. Hall & Berenson, *supra* note 145, at 304–05.

155. *Id.* at 312.

whether the treating physician should disclose the plan's financial incentives to the patient where those incentives are designed to influence the physician's treatment decisions. Some commentators argue for an expansive version of the informed consent doctrine that would impose disclosure obligations on the treating physician both as to financial incentives and withheld treatments,[156] while others argue that blanket imposition of these more expansive duties is inappropriate.[157] These debates parallel earlier conflicts between informed consent idealists and realists.[158]

Under my proposal, physicians would be held responsible for failure to disclose more costly alternative treatments or diagnostic treatments where this information would be material to a reasonable patient. Some courts already recognize the obligation of a physician to inform the patient of alternative treatments[159] Under my proposal, a physician should be required to disclose a more costly treatment or diagnostic alternatives where this information would be material to a patient; that is, where the selection of the less costly alternative could have a significant impact on the patient's health or where the physician knows or reasonably should know that the rationing decision will be especially important to the particular patient.

The latter requirement contemplates a more subjective standard. In other, more routine circumstances, a physician should not be obligated to disclose the existence of withheld diagnostic techniques or treatment alternatives. As noted by Professor Hall, if the requirement of disclosure is imposed across the board, it could greatly increase the amount of time that physicians spend with their patients and ultimately increase the costs of health care and undermine the physician/patient relationship.[160] The difficulty is in drawing the line between those cases where the information concerning alternative treatments is material to the patient and those where it is not. Unfortunately, this will have to be worked out on a case-by-case basis.

There has also been an ongoing debate among commentators as to whether disclosure by the physician of financial incentives should be required under the doctrine of informed consent. Professor Hall has evinced some skepticism as to the propriety of imposing this obligation on physicians and is concerned about the effect of such disclo-

156. *See, e.g.*, Krause, *supra* note 66.

157. *See, e.g.*, Mark A. Hall, *A Theory of Economic Informed Consent*, 31 GA. L. REV. 511 (1997).

158. Schuck, *supra* note 106, at 902.

159. *See, e.g.*, Archer v. Galbraith, 18 Wash. App. 369, 567 P.2d 1155 (1978).

160. Hall, *supra* note 157, at 545–46.

sures on the trust aspect of the physician/patient relationship.[161] On the other hand, Professor Johnston favors the imposition on the treating physician of this disclosure obligation.[162]

At this point, there is limited support in case law for imposing an obligation on physicians to disclose financial incentives. In *Moore v. Regents of the University of California*,[163] the California Supreme Court expanded the informed consent disclosure obligation to impose a duty on the physician to disclose financial conflicts of interests arising from the use of the patient's cells by researchers to develop a highly profitable cell line.[164] But *Moore* may have limited precedential value because of its unusual facts. In *Moore*, the plaintiff alleged that he had specifically and repeatedly inquired as to the commercial value of his blood and bodily substances and that defendant Golde actively concealed the commercial possibilities.[165] In *Moore*, the financial incentives in question did not arise from the contract between the plan and the physician, and they were not developed for the potentially beneficial purpose of encouraging physicians to withhold marginally beneficial treatment. Thus, it does not appear that *Moore* supports the notion that a physician has a general obligation to disclose financial incentives to the patient.

In *Neade v. Portes*,[166] the Illinois Supreme Court refused to recognize a distinct cause of action against a physician for the failure to disclose financial incentives.[167] But in *Shea I*, the Eighth Circuit imposed a duty on a health plan under ERISA to disclose financial incentives.[168] Subsequently, in *Shea II*, the Eighth Circuit held that ERISA did not preempt a state law claim against physicians for negligent misrepresentation.[169] After reviewing Minnesota case law, the court concluded: "Minnesota law indicates that the breach of a doctor's state-imposed ethical duty to disclose financial incentives is a medical malpractice claim, requiring a showing of actual harm to state a cause of action."[170] Accordingly, it remanded the case to the district court with

161. *Id.* at 526.

162. Kim Johnston, *Patient Advocates or Patient Adversaries? Using Fiduciary Law To Compel Disclosure of Managed Care Financial Incentives*, 35 SAN DIEGO L. REV. 951, 957 (1998).

163. 793 P.2d 479 (Cal. 1990).

164. *Id.* at 485.

165. *Id.* at 485–86.

166. 739 N.E.2d 496 (Ill. 2000)

167. *Id.* at 498.

168. Shea v. Esenten, 107 F.3d 625, 626 (8th Cir. 1997) [hereinafter *Shea I*].

169. Shea v. Esenten, 208 F.3d 712, 719 (8th Cir. 2000) [hereinafter *Shea II*].

170. *Id.* at 717 (relying on D.A.B. v. Brown, 570 N.W.2d 168, 171 (Minn. Ct. App. 1997)).

directions to remand the misrepresentation claim to the state court.[171] Subsequently, in the trial in state court, the jury returned a verdict for the physicians and this verdict was affirmed on appeal.[172]

In *Pegram v. Herdrich*,[173] the United States Supreme Court rejected a full frontal assault mounted under ERISA attacking the use of financial incentives to influence physician behavior. The court held "that mixed eligibility and treatment decisions by health plan physicians are not fiduciary decisions under ERISA."[174] It is not clear what effect the *Pegram* decision will have on the attempt to impose obligations to disclose financial incentives. In imposing the disclosure obligation under ERISA, *Shea I*[175] relied in part on the questionable nature of the financial incentives. These types of arrangements have now, however, arguably been upheld as consistent with public policy. On the other hand, in footnote eight of its opinion in *Pegram*, the court somewhat obliquely states:

> Although we are not presented with the issue here, it could be argued that Carle [the health plan working through its physician-owners] is a fiduciary insofar as it has discretionary authority to administer the health plan, and so it is obligated to disclose characteristics of the health plan and of those who provide services to the health plan, if that information affects beneficiaries material interests.[176]

In conclusion, under my proposed standard, the physician is not required to provide information to the patient on the health plan's financial incentive structure at the time of enrollment. The physician satisfies her obligation to the patient by disclosing alternative diagnostic techniques or treatments in cases at the time of treatment where this information would be material to the patient. Along with the disclosure of these alternatives, however, the physician should also be required to share with the patient the cost considerations that influenced the physician's decision.

If the financial incentive arrangements influenced the physician's decision, then that information ought to be provided to the patient. It is not necessary to go into a detailed disclosure of financial incentive arrangement at the time of delivery of care, but the physician should at least alert the patient to the fact that financial incentives did play a role

171. *Id.* at 721.
172. *Shea III*, 622 N.W.2d at 132.
173. 530 U.S. 211 (2000).
174. *Id.* at 237.
175. *Shea I*, 107 F.3d at 628.
176. *Pegram*, 530 U.S. at 228 n.8.

in the selection of treatment. As Mark Hall has noted, it seems unduly burdensome on the physician to keep track of the financial incentive arrangement of each patient's plan and frequently unnecessary to discuss such matters with each patient on an individual basis.[177]

Moreover, imposing such an obligation may have the potential to significantly undermine the physician/patient relationship if it is done on a constant and repetitive basis.[178] On the other hand, where the selection of a particular treatment or diagnostic tool may have serious consequences to the patient, and where financial incentives played a role in the physician's selection of a less expensive alternative, it is appropriate that the physician share that information with the patient. Indeed, some patients may find this candor refreshing, and gain increased respect for the physician.

Nonetheless, a patient should not be permitted to recover damages for the physician's breach of the disclosure obligation unless the patient establishes a causal link between the physician's failure to disclose and some actual harm. In a typical informed consent case, the patient is required to establish two types of causation. First, the patient must establish that the patient actually suffered some adverse event as the result of the administration of the treatment. Secondly, in the usual case, the patient must establish that an appropriate disclosure would have resulted in the patient refusing the proffered treatment that resulted in the adverse event. The vast majority of jurisdictions have adopted an objective test of causation that focuses on whether or not a reasonable prudent patient would have pursued a different course if properly informed and thereby avoided injury.[179]

Establishing this counterfactual scenario becomes more difficult where the patient is basing her claim on: (1) the failure of the physician to inform the patient of a more costly alternative treatment; or (2) the failure of the physician to disclose the financial incentives that influenced the physician's selection of a less costly diagnostic or treatment alternative. In these cases, the plaintiff must show that the proper disclosure would have resulted in avoiding the injury. The injury could be (1) a failure to diagnose a condition that would have been diagnosed with use of an alternative diagnostic tool; (2) an adverse side effect of the treatment or diagnostic technique selected that would not have occurred if an alternative had been utilized; or (3) fail-

177. Hall, *supra* note 157, at 548–49.

178. *Id.*

179. Fain v. Smith, 479 So. 2d 1150, 1154 (Ala. 1985); Backlund v. Univ. of Wash., 137 Wash. 2d 651, 665 n.4, 975 P.2d 950, 957 n.4 (1999).

ure to achieve a cure or an improved condition that would have been achieved if an alternative treatment had been selected.

Where the patient alleges that the physician failed to inform the patient of a more costly alternative treatment, then the patient must show that the disclosure would have resulted in the patient successfully seeking the more expensive alternative and that the alternative could have avoided the injury incurred by the patient. This would require the patient to establish that she either would have paid out of pocket for the more expensive alternative or successfully sought some recourse under the terms of the plan.

As to the failure to disclose financial alternatives, the patient must establish that the disclosure of this information would have increased her suspicion of the physician's motive, and thereby led her to seek care at her own expense outside the parameters of the plan. Alternatively, she would have to show that she would have successfully pursued some other recourse under the plan. In these cases, it may be very difficult to persuade a jury that disclosure by the physician would have led the patient to pursue successfully these alternative paths.

Notwithstanding the current majority rule, the patient should be held to a subjective standard in these cases rather than an objective standard of causation.[180] Under both standards, the primary evidence is the patient's statement as to what he or she would have done if properly informed. The primary difference between the two standards is the jury instructions given under each. Under the objective standard, the jury is instructed to judge the plaintiff's claims against a reasonable person standard. Instead, the jury should be allowed to focus on what the particular patient would have done rather than the hypothetical reasonable patient. This is more in keeping with the stated goal of the doctrine of informed consent: the enhancement of patient autonomy.

Another component of the best interests requirement is the obligation to act as the patient's agent in dealing with the patient's health plan. Under some state court decisions,[181] it has been recognized that a physician may be required to act as an advocate for his or her patient in obtaining authorization for treatment. In addition, it has been recognized that a physician may have an obligation to process in a timely manner the necessary paperwork required for referral of a patient to a specialist.[182] Under the best interests component of the reasonable

180. *See, e.g.*, Scott v. Bradford, 606 P.2d 554 (Ok. 1980).

181. *See, e.g.*, Wickline v. State of Cal., 239 Cal. Rptr. 810 (Cal. Ct. App. 1986). *But cf.* Pryzbowski v. U.S. Healthcare, Inc., 245 F.3d 266, 281–82 (3d Cir. 2001) (holding that under New Jersey law physician to act as advocate for a patient to an HMO).

182. *See, e.g.*, Nealy v. U.S. Healthcare HMO, 711 N.E.2d 621, 625 (N.Y. 1999).

prudent physician standard, the physician should have a duty to act as the patient's agent in providing appropriate advocacy for the patient. The physician should also be obligated to act as the patient's agent in order to provide the necessary information and paper work to the health plan's administrators in a timely fashion.

CONCLUSION

Under my proposed standard, a physician has a duty to treat patients with the care of a reasonable, prudent physician acting under similar circumstances in good faith and the best interests of the patient. This tort duty is, however, modified by the obligation of the physician to treat the patient in accordance with the legitimate cost containment provisions of the patient's health plan. Adoption of this standard would require courts to take into account the contractual arrangements among the patient, the physician and the health plan.

My proposal also borrows from the laws governing the conduct of corporate officers and agents. It includes a rebuttable presumption that the physician has acted in good faith and best interests in selecting treatments or diagnostic procedures. This presumption may be rebutted by evidence showing that the financial incentive arrangements agreed to by the physician place too much pressure on the physician to place his or her financial interests ahead of the patient. Naturally, in order to recover in tort the breach of this fiduciary obligation, the patient must still show actual harm. This actual harm would consist of a worsened condition because of the denial of access to more beneficial treatment because of the improper influence of financial incentives. The good faith and best interests component of my proposed standard also impose significant requirements on the physician to be candid with the patient concerning the influence of financial incentives.

My proposal builds in part on the foundation laid by the Supreme Court of Washington in *Helling*. In that case, the court disregarded testimony as to the prevailing custom and held two physicians liable for their failure to provide a patient with a diagnostic test. Although the *Helling* court's cost/benefit analysis may be flawed and has been widely criticized, its focus on the cost-effectiveness of withheld treatment provides a better approach than the traditional rule in the era of managed care.

Health plans have been dropping pre-authorization requirements in response to liability concerns and placing responsibility on physicians to take into account the cost of the care that they provide. The traditional physician/patient relationship has been altered by the pres-

ence of a third party, the health plan, and its concern that physicians provide care in an economically efficient manner. The role of the health plan in providing financial incentives for the provision of cost effective care is perfectly legitimate in light of the contractual arrangements between the patient and the plan. In the current health care environment, physicians act in dual roles as both a "professional" and "honest businessman."[183] In the latter role, the physician is in effect acting as a rationing agent. Physicians are now expected to take costs into account when selecting treatments and diagnostic tests for their patients. Therefore, it is appropriate to modify the liability regime to take into account the physician's role in cost containment.

Under the liability regime that I propose, custom evidence would no longer be determinative in malpractice cases. The notion of a unitary custom that can serve as the benchmark for delivery of professional services is no longer tenable. Moreover, in determining whether a physician acted reasonably in denying access to a particular treatment or diagnostic technique, the courts should look to such evidence as cost-effectiveness and outcome studies and clinical practice guidelines in determining whether the physician breached his or her legal duty to the patient, but none of these standing alone should be conclusive on the issue of liability.

While the notion of custom as a unitary standard is untenable in the managed care environment, evidence as to prevailing practices may still be helpful in resolving some malpractice cases. Certainly, physicians whose skills do not come up to the level of the average practitioner should be subject to liability. Where the patient is injured because of the physician's lack of skill, inadvertence or use of an improper technique, testimony should focus primarily on the techniques taught in medical schools and utilized in the profession. Because of the necessity of customizing techniques for individual patients, it may still be impossible to identify a unitary custom. Accordingly, even in these cases, prevailing practice evidence should be treated as relevant but not binding.

Although the courts have been slouching toward a reasonable, prudent physician standard, they have not sketched out the parameters of a new doctrinal regime to supplant the traditional customary standard approach. Of course, common law courts do not normally promulgate comprehensive regimes, preferring rather to develop doctrine on an ad hoc, case-by-case basis. My proposal provides an outline of a new doctrinal regime. While it is admittedly incomplete and tentative, it may at least provide an impetus for courts to question the

183. Brody, *supra* note 43.

role of customary standards in malpractice litigation. Particularly in cases involving the withholding or denial of treatment, it is my hope that the courts will recognize that physicians should be held accountable for negligently rationing health care. On the other hand, this accountability must be tempered by the recognition that the physician's rationing role is necessary for the common good.