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Irreconcilable Differences: Why the Doctor-Patient Relationship is Disintegrating at the Hands of Health Maintenance Organizations and Wall Street

Mark O. Hiepler*

Brian C. Dunn**

Less than a year before his death from pancreatic cancer, Cardinal Joseph Bernardin, the Archbishop of Chicago, addressed the American Medical Association (AMA) House of Delegates at the AMA's Annual Meeting in December 1995.¹ His topic? Given his condition, one may have expected the Cardinal to touch on a practical aspect of medicine, perhaps a call for more research and development funding. No, a man who undoubtedly had access to the best medical care available was concerned for the care that the rest of the country was to receive in the future. Instead, Cardinal Bernardin touched on what he termed the "moral crisis" facing medicine today, particularly with respect to doctors.²

Cardinal Bernardin articulated what all of us know, but few will talk about: the doctor-patient relationship is, at its heart, a moral covenant between physician and patient.³ More importantly, however, he identified what most have only begun to recognize: the onset of managed

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1. See *Reflections on 'Moral Crisis' Gripping Medical Profession*, AM. MED. NEWS, Feb. 5, 1996, at 31 [hereinafter *Reflections*]. In actuality this is an excerpted transcript of the Cardinal's remarks before the assembled AMA House of Delegates. See *id.*

2. See *id.*

3. See *id.*

care in America has steadily and increasingly attacked the moral center of the doctor-patient relationship, in effect precipitating a "divorce" between doctor and patient.⁴ By interfering with and constraining this relationship between patients and doctors, health maintenance organizations (HMOs)⁵ have made the two no longer accountable to each other, all the while standing back and claiming that they have nothing to do with medical decisions. If managed care chooses to impose the many restrictions and constraints on the relationship between doctor and patient that it currently does, then any and all overseers and administrators causing the interference should be held to the same standard as doctors. Cardinal Bernardin was completely correct in his call for a return to the application of a high moral and ethical standard for doctors, but that standard needs to be required of *all* participants in the health care delivery system.

Part I of this Article briefly explores the evolution of the various aspects of the doctor-patient relationship.⁶ Part II examines the various pressures that are being exerted against it by the managed care industry.⁷ Part III provides the key to the reconciliation and restoration of the relationship.⁸ Finally, in Part IV a brief conclusion is offered.⁹

I. FROM HIPPOCRATES TO BERNARDIN: THE EVOLUTION AND IDEAL OF THE DOCTOR-PATIENT RELATIONSHIP

The doctor-patient relationship of the modern era is inextricably intertwined with the Hippocratic Oath. The importance of the Hippocratic Oath, believed to have been written by the celebrated Greek physician, Hippocrates, around 400 B.C.,¹⁰ lies in its elevation of medicine as an esteemed profession and its creation of an ideal to which all physicians, past and present, should strive. More than two thousand years ago, Hippocrates recognized that doctors hold a special place in any society, one that comes with certain responsibilities. The idea of

4. *See id.*

5. Throughout this Article, HMOs will be used as representatives for all managed care organizations (MCOs). In our experience, we have found that this nomenclature is not merely for convenience, but because HMOs are the largest and most populated of the MCOs, and are also the entities that draw the most complaints from consumers.

6. *See infra* notes 10-29 and accompanying text.

7. *See infra* notes 30-58 and accompanying text.

8. *See infra* notes 59-70 and accompanying text.

9. *See infra* notes 71-73 and accompanying text.

10. *See A.D. 1995 Restatement of the Oath of Hippocrates (Circa 400 B.C.)* (visited Nov. 4, 1997) <<http://ccmemac4.bsd.uchicago.edu/CCMEPolicies/MedCodes/Hippo#hippo law>>.

"do no harm"¹¹ is one of the most oft-quoted statements in history. Through the years, the Hippocratic Oath has been adapted and rewritten to conform to the customs and mores of each age, but its precepts have remained virtually unchanged.

The modern doctor-patient relationship, however, consists of much more than the idea that physicians are to do no harm. In California, the relationship between doctor and patient has been held sacred and has been protected since at least 1872.¹² Like the priest-penitent¹³ and attorney-client relationships,¹⁴ the relationship between doctor and patient carries with it a special privilege.¹⁵ This privilege is in place to encourage informed exchanges between doctor and patient with the hopes of healing.

Today, however, the doctor-patient relationship is largely defined by legal principles. Our nation's courts have determined the following: (1) a doctor owes a fiduciary duty to the patient,¹⁶ a duty to place the interests and well-being of the patient above the interests of the doctor or a third party,¹⁷ and (2) the doctor owes a duty to the patient to main-

11. *See id.* The original text of the Hippocratic Oath reads, in relevant part, "I will follow that system of regimen which, according to my ability and judgement [sic], I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous." *Id.*

12. *See* CAL. EVID. CODE § 994 (Deering 1997 & Supp. 1998) (codifying the privileged relationship between physicians and their patients).

13. *See id.* §§ 1033-1034 (codifying the privileged relationship between clergy-persons and their parishioners).

14. *See id.* § 954 (codifying the privileged relationship between attorneys and their clients).

15. *See id.* § 994.

16. For a more comprehensive discussion of the fiduciary duty and its evolution in the managed care setting, see Thomas H. Boyd, *Cost Containment and the Physician's Fiduciary Duty to the Patient*, 39 DEPAUL L. REV. 131 (1989); 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 (1995).

17. The North Carolina Supreme Court gave a more complete description of the fiduciary nature of the doctor-patient relationship in *Black v. Littlejohn*, 325 S.E.2d 469, 482 (N.C. 1985). The court stated the following: "The relationship of patient and physician is generally considered a fiduciary one, imposing upon the physician the duty of good faith and fair dealing." *Id.* (citing 61 AM. JUR. 2D *Physicians Surgeons, and Other Health Healers* § 166 (1981)). "This special relationship envisions an expectation by both parties that the patient will rely upon the judgment and expertise of the doctor." *Id.* (citing *Witherell v. Weimer*, 421 N.E.2d 869 (Ill. 1981)). "Furthermore, this relation is predicated on the fundamental proposition that the physician

tain the standard of care to which doctors are held, the breach of which would give rise to malpractice liability. Various governing bodies have compiled codes of ethics that impose minimum standards by which doctors are to conduct the practice of medicine; if they fail to adhere to such standards, doctors run the risk of losing their license to practice medicine.¹⁸ Lost among this increased emphasis on legal and ethical standards is the very moral aspect of the doctor-patient relationship.

As Cardinal Bernardin described it, the doctor-patient relationship is first and foremost a moral one for four reasons: (1) the patient's reliance on the doctor's competence, morality, and compassion; (2) the holistic, caretaker-like character of the medical decisions made by doctors; (3) society's investment of faith in medicine; and (4) the personal commitment and advocacy that patients expect from their doctors.¹⁹

One might expect a moral discussion from a person like Cardinal Bernardin, but other doctors, scholars, and health care observers have recognized the moral nature of the relationship as well.²⁰ In an article published in the *Journal of the American Medical Association*, a doctor and a lawyer pooled their collective talent and knowledge in an attempt to describe the ideal doctor-patient relationship.²¹ Their conclusion bears a remarkable resemblance to that reached by Cardinal Bernardin. They described the ideal doctor-patient relationship in terms

possesses 'special knowledge and skill in diagnosing and treating diseases and injuries, which the patient lacks, and that the patient has sought and obtained the services of the physician because of such special knowledge and skill.'" *Id.* (quoting 61 AM. JUR. 2D *Physicians Surgeons, and Other Health Healers* § 167 (1981)).

18. An example is the International Code of Medical Ethics, which was adopted in 1949. See 1 WORLD MED. ASS'N BULL. at 111 (1949). The governing code of physicians in the United States is the AMA Code of Medical Ethics. See AMA CODE OF MED. ETHICS, reprinted in CODES OF RESPONSIBILITY 263 (Rena A. Gorlin ed., 3d ed. 1994).

19. See *Reflections*, *supra* note 1, at 32.

20. See *infra* notes 21-28 and accompanying text.

21. See Ezekiel J. Emanuel & Nancy Neveloff Dubler, *Preserving the Physician-Patient Relationship in the Era of Managed Care*, 273 JAMA 323 (1995).

of six Cs:²² choice,²³ competence,²⁴ communication,²⁵ compassion,²⁶ continuity,²⁷ and no conflict of interest.²⁸

This ideal is slowly disappearing due to the ever-changing face of medicine. The advent of HMOs in the last two decades, with their increased emphasis on cost-cutting and rationing of medical care, has forced a change in the way we look at medicine, specifically the doctor-patient relationship. Can it survive as a commodity traded on the stock market? The early returns are not promising as more and more doctors flee the states where HMOs are most prominent.²⁹

22. *See id.* at 324-25; *see also* Gail Povar & Jonathan Moreno, *Hippocrates and the Health Maintenance Organization, A Discussion of Ethical Issues*, 109 ANNALS INTERNAL MED. 419 (1988). In their discussion, Povar and Moreno broke their analysis of the doctor-patient relationship into three duties. *See id.* at 420-22.

23. *See Emanuel & Dubler, supra* note 21, at 324. Among the choices discussed are those relating to the "practice type and setting," the "primary care physician," "specialist or special facility," and "treatment alternatives." *Id.* Emanuel and Dubler speak of choice as an essential "component of self-determination, a central ideal of American culture." *Id.*

24. *See id.* Emanuel and Dubler stressed that physicians must have competence in "current" knowledge, "technical skills," "clinical judgment," and in the "understanding of their own limitations and a willingness to consult specialists . . ." *Id.*

25. *See id.* at 324-25. Communication entails the ability to "listen to and understand the patient" as well as to communicate to the patient that the doctor is listening and understanding, and the ability to explain to patients "the nature of their disease" and the treatment options in clear language, including giving advice and counseling. *See id.*

26. *See id.* Compassion includes both empathy and assisting patients in changing their perspectives on the situation. *See id.*

27. *See id.* The ideal doctor-patient relationship involves a long-term commitment that allows the doctor and patient to feel comfortable with each other and develop a rapport that can greatly assist the treatment and healing process. *See id.*

28. *See id.* The patient expects that the doctor will act as a fiduciary, that the patient's interests will "take precedence over the physician's own personal interests, especially financial interests," or "the interests of a third party." *See id.* at 325. In other words, patients need to be able to trust their doctors. For a deeper discussion of the role of trust in the doctor-patient relationship, see David Mechanic & Mark Schlesinger, *The Impact of Managed Care on Patients' Trust in Medical Care and Their Physicians*, 275 JAMA 1693 (1996); *see also* David Mechanic, *Managed Care as a Target of Distrust*, 277 JAMA 1810 (1997) (criticizing the economic motivations of managed care groups).

29. *See* Cara S. Trager, *Doctors Become Candidates for Transplants: Economic Demands Forcing Many to Relocate or Switch Their Careers*, CRAIN'S N.Y. BUS., Nov. 8, 1996, at 28, available in LEXIS, News Library, Busdtl File (discussing the recent trend, although consisting primarily of anecdotal evidence, of doctors leaving states,

II. PATIENTS VERSUS PROFITS: THE ECONOMIC EXPERIMENTATION ON HUMANS³⁰ BY HMOs THAT IS CAUSING THE BREAK-UP OF THE DOCTOR-PATIENT RELATIONSHIP

Managed care is a generic term used to describe the various health care delivery systems created in response to the traditional fee for service (FFS) indemnity insurance system. The two most common managed care organizations³¹ are HMOs³² and preferred provider organizations (PPOs).³³ In exchange for a monthly premium, and possibly some sort of small copayment at the point of service, HMOs purport to provide a variety of health care services to their members,³⁴ but often restrict the provider, the amount, or the type of service, as well as the

such as California, where HMOs are highly saturated); *The HMO Wars: The Patchwork System of Regulating Health Maintenance Organizations Is Getting New Scrutiny Amid the Ever-Growing Drumbeat of Complaints About HMOs*, CAL. J., Aug. 1, 1997, at 12, available in LEXIS, News Library, Cjmr1 File (same).

30. See *infra* note 39. This phrase came up somewhere in the many conversations with Dr. Dennis Robbins, whose book is mentioned in note 39. Though we cannot remember who originated the phrase, Dr. Robbins at least deserves the bulk of the credit for its elaboration in his books and numerous speeches.

31. Although HMOs and PPOs are by far the most common, new hybrids and variations are being created all the time. The newest entries into the market are the Provider-Sponsored Organizations (PSOs), which attempt to do away with the HMO/PPO infrastructure by having individual doctors and/or medical groups take over the administrative functions. While it is too soon to really analyze the point of service (POS) effect on managed care, it is unlikely that PSOs will improve the doctor-patient relationship in any significant way. In fact, with doctors having increased administrative roles, they will have less time per patient than ever before.

32. HMOs purport to provide basic health care services to their members in exchange for the prepayment of a monthly premium. There are two basic HMO models. Staff or Group Model HMOs contract directly with physician medical groups and may employ the physicians directly at HMO hospitals. Network Model HMOs or Individual Practice Association (IPA) Model HMOs contract with a network of physicians or medical groups, which then use existing hospitals and facilities. In the IPA model, the IPA makes the decisions about the care received by subscribers. A common characteristic of all HMOs is that subscribers may receive payment for health care services only if they are rendered by the HMO's doctors.

In our experience, IPA model HMOs engender the most complaints because that model places the greatest financial incentives on doctors to limit care.

33. PPOs consist of panels of physicians or hospitals that provide health care services to members. Members pay monthly premiums to the PPO, which then pays a discounted rate to the physician or hospital used by the member. Members may also be responsible for a copayment or yearly deductible. Members can use both PPO and non-PPO doctors and hospitals, but economic incentives are used to sway the member toward the PPO providers.

34. For the purposes of this Article, "member" will be used interchangeably with "subscriber" and "enrollee." All three terms are used by HMOs to denote an individual covered by the HMO.

manner in which the service is rendered. The ability to attract consumers with low monthly premiums while managing to keep health care expenditures down has proven to be very lucrative, allowing most HMOs to go public and become for-profit organizations.³⁵ Health Net, California's second-largest HMO behind Kaiser Permanente, posted 1996 revenues totalling \$108 million.³⁶

Before managed care, in the age of FFS indemnity insurance, the average doctor-patient relationship looked something like the following. A woman, let's call her Wendy, could walk into her doctor's office confident that her doctor would provide her with the best medical care available. Wendy's only concern was that her doctor might overtreat her, because she knew that her doctor could make more money with more treatment. She knew how her doctor was compensated because she paid the doctor directly, as she was personally responsible for at least twenty percent of the total bill.³⁷ Wendy's relationship with her doctor was completely transparent because she knew about any conflict of interest that might be present. If she felt the doctor overtreated her, or if she was unhappy, she could simply pay the bill and choose another doctor. This rarely came to pass because Wendy had been going to her doctor for many years and had developed a friendly and meaningful relationship.

Unfortunately, this relationship between Wendy and her doctor is difficult, if not impossible, to find today. As medical costs spiraled continuously upward in the 1980s, critics began clamoring that something needed to change.³⁸ The "solution" that Wall Street and business exec-

35. Of California's largest HMOs, only its largest, Kaiser Permanente, has remained a non-profit organization. The importance of the classification is evidenced by the fact that for-profit HMOs generally apply less than 75% of the premiums received by subscribers to medical care expenditures, while non-profit HMOs generally use 98% of premiums toward actual medical care. See generally Froma Harrop, *Health Care Conspiracy Ought to Make You Sick*, SACRAMENTO BEE, Jan. 22, 1996, at B7, available in 1996 WL 3279893 (discussing financial incentives for HMOs to reduce care for sick patients).

36. See Jamie Clary, *Top 100 List Unique and Comprehensive Undertaking*, NASHVILLE BUS. J., June 16, 1997, at 33, available in 1997 WL 9081245.

37. The most common indemnity insurance arrangement under FFS was an 80-20 plan, where the insurance company paid 80% of the bill and the patient was responsible for the remaining 20%.

38. During the 1980s, health care costs in the United States tripled, and by the year 2000 are expected to reach \$1.7 trillion, about 18% of the Gross National Product. See Leonard A. Hagen, Comment, *Physician Credentialing: Economic Criteria*

utives sold to Congress and health care leaders was the HMO system, which attempts to treat the delivery of medical care and treatment as a business. Health care continues to be taken over by huge, publicly-traded corporations that have instituted the same type of business and accounting practices that are used in other industries. After all, if other forms of business, like the automotive and electronic industries, have succeeded by rationing, streamlining, and cost-cutting, why not health care? The answer to that question is simple. It cannot work because the health care industry is unlike any other business. Health care deals with real people with real lives, not pork bellies or microchips.

In what other industry does the consumer become a "financial liability rather than . . . a financial opportunity" as soon as the consumer wants to use the product?³⁹ Most companies make money when their customers use services, but that is not the case in managed care. When patients get sick and utilize care, HMOs lose money, and that causes doctors to lose money. In fact, once the patient needs health care, especially if that care is continuing or otherwise expensive, the HMO is financially better off if the patient dies, because its costs basically cease where family funeral expenses begin.

In what other industry, besides, of course, the funeral industry, is a company better off once the consumer dies? In what other industry does the corporation refuse to stand behind its product and accept accountability, instead hiding behind a poorly interpreted federal loophole⁴⁰ that denies patients and their families any remedy?⁴¹ What would it be like to lose your spouse in an automobile accident caused by a faulty gas tank and discover that the court can only order the automobile manufacturer to make restitution by replacing the cost of the faulty gas tank? That is exactly the case with managed health care

Compete with the Hippocratic Oath, 31 GONZ. L. REV. 427, 428-29 (1996).

39. DENNIS ROBBINS, *INTEGRATING MANAGED CARE AND ETHICS* 35 (McGraw-Hill 1998).

40. *See* Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001-1461 (1994). ERISA covers the majority of HMO patients and effectively prohibits a patient from recovering in court the damages caused by improper denial or withholding of care by the HMO. *See id.* Those covered by ERISA can only recover the amount of the treatment or procedure that was denied. *See id.* A few of the very narrow exceptions to ERISA are public employees, school teachers, church workers, and those who pay their HMO directly. *See id.*

41. When consumers are denied a remedy to seek redress for negligent, or even intentional, conduct, studies have shown significant increases in the severity of such conduct. *See generally* Gary T. Schwartz, *Reality in the Economic Analysis of Tort Law: Does Tort Law Really Deter?*, 42 UCLA L. REV. 377 (1994)(discussing, *inter alia*, the increase in automobile fatalities and accidents in jurisdictions employing no-fault systems).

today. Human life has been devalued to the point that it has no value in the current system.

As is becoming painfully, and in some cases deadly, obvious, health care is unlike any other business and is not fit for many business practices because it deals with people—not products—and real lives and families are at stake.⁴² Profits must occasionally take a back seat. The transparent, moral doctor-patient relationship is essential to the health care delivery system, and, as such, it is at a crossroads. In order for the doctor-patient relationship to survive, the same standards that apply to doctors need to be applied to the HMOs that try to control the doctor-patient relationship by challenging doctor decisions and denying care.

The influx of HMOs into the health care system has placed three enormous pressures on its central and essential delivery point, the doctor-patient relationship: (1) financial incentives not to treat patients, (2) restrictions on doctor disclosures, and (3) the use of further cost containment methods such as gatekeeping and utilization review. Such pressures amount to economic experimentation on humans by HMOs. Even worse, the HMOs will not disclose this fact, and there is no consent because the patients have no idea that they are economic laboratory animals for the different studies done by HMOs to determine the best way to cut health care costs. This Article discusses each of these pressures in turn.

A. Undisclosed Financial Incentives that Deter Care

The predominant method by which HMOs have attempted to cut health care costs while still making a profit for their stockholders has been by changing how doctors are paid.⁴³ Generally, these can be placed into two categories: basic payment methods and incentives that add to or detract from the basic payment methods.⁴⁴

42. See *Managed Health Care Improvement Task Force, Draft Executive Summary* (Jan. 5, 1998) (on file with author). A recent study conducted by Governor Wilson's Task Force on Managed Care found that 42% of the insured population had experienced at least one major problem with their HMO, 22% of which reported that the problem led to a deterioration in their health, and 6% of which stated that the problem resulted in permanent disability. See *id.*

43. See generally Marsha S. Gold et al., *A National Survey of the Arrangements Managed-Care Plans Make with Physicians*, 333 *NEW ENG. J. MED.* 1678 (1995) (reporting on a study of the managed care payment arrangements in twenty metropolitan areas nationwide).

44. See generally Stephen R. Latham, *Regulation of Managed Care Incentive Pay-*

Medical groups and their doctors are generally paid in one of three ways: FFS, salary, or capitation. Traditional FFS has been largely eliminated and replaced by discounted FFS, such as the type found in PPOs. Salary methods are used only in Staff model HMOs. Capitation, however, has exploded with the rise of managed care.

In a capitated contract, the medical group and/or the doctor is paid a set payment per member per month by the HMO. Often the doctor receives the same amount of money for each member each month, regardless of whether the patient is healthy or ill or whether the doctor sees the patient or not. Consequently, the emphasis has been shifted to the quantity of patients enrolled with the doctor, because the more capitated patients for which a doctor provides, the more monthly payments the doctor receives. This has forced doctors to become insurers themselves as the risk of patients getting sick has been shifted from the HMO to the doctor, who hopes that all of his or her patients do not get sick at the same time.

Doctors, for the most part, have been forced to accept these contracts in order to stay in business. To be a doctor, one needs patients, and HMOs, not doctors, now control a large portion of the patients.⁴⁵ The amount of capitated payments can range dramatically. In practice, we have personally seen capitated rates as high as thirty-five dollars per member per month and as low as five dollars per member per month. The capitated amount is intended to cover the cost of the patient's medical treatment for the month, often including testing, referrals to specialists, or even necessary hospitalizations.

Capitation alone creates an undisclosed financial incentive for the doctor *not* to see the patient, resulting in an impermissible conflict of interest between the patient's health and the doctor's financial interests.⁴⁶ After all, the doctor does not get paid to actually see the pa-

ments to Physicians, 22 AM. J.L. & MED. 399, 400-11 (1996) (discussing the different types of incentive payments made to physicians by HMOs and the potential conflicts of interest that arise).

45. See Michelle M. Kwon, Comment, *Move Over Marcus Welby, M.D. and Make Way for Managed Care: The Implications of Capitation, Gag Clauses, and Economic Credentialing*, 28 TEX. TECH L. REV. 829, 835 (1997). Some estimates place the total managed care population at close to 140 million people. See *id.*

46. There are those who will argue that this is irrelevant because doctors have a conflict of interest under FFS as well—the conflict between the patient's health and the doctor's maximization of profits by overtreating. This is an oversimplified argument at best. At least under FFS doctors and patients had the same goal, which was to heal the patient as quickly as possible. Patients had that goal for obvious reasons, while doctors wanted to heal patients quickly for more ulterior reasons—to be able to treat the next patient and to give the patient an incentive to return. In contrast, managed care pits the patient's goals directly *against* those of the doctor. See Ronald

tient, because the doctor gets paid the same regardless of whether the patient comes in. Worse for the doctor, and thus for the patient, if the patient does come in and needs medical care that exceeds the capitated amount, it comes directly out of the doctor's pocket. The large, publicly-traded HMOs, the entities most capable of absorbing these medical costs, have secretly altered the risk apportionment and shifted it all to the doctors, leaving the patient out of the picture. This can have no other effect than to disconnect the doctor-patient relationship.

There are two basic financial incentive schemes that modify the basic payment methods: risk pools and withholds. Risk pools are large sums of money consisting of patient premiums withheld from capitated payments. The distribution of this money, to which doctors should already be entitled, is normally tied to complex formulas taking into account money saved by reducing referrals, hospital usage, testing, and employment of specialists.

Withholds are either percentages or set dollar amounts that an HMO deducted from the doctor's or group's capitated payments and set aside to ensure that the physician is paying her bills.⁴⁷ These set-asides are supposed to be used as funds for outside referrals or by the HMO as a type of bonus scheme, whereby the HMO sets a target number for health care expenditures. The HMO can and will simply keep the withhold for "expenses" if the doctor or group exceeds the target or if the HMO deems such retention necessary. Doctors are obviously losers in this equation, but they will not be as adversely affected as the chronically ill and those patients who are sick and in need of care.

The practical effects of withholds and risk pools are the same as those associated with capitation. They create an undisclosed, inherent conflict of interest,⁴⁸ which functions as a very real incentive to HMOs to force doctors to undertreat patients, especially if a doctor is in dan-

Bronow, *HMO Physicians' Shared Risk Pools Are Dangerous to Patients' Health*, 10 No. 1 HEALTHSPAN 9, 10-11 (1993). After all, "[w]ould you rather have one extra test to confirm the cause of your chest pain or one less test so the corporation may show a higher profit?" *Id.* at 11.

47. Note the practical effect of the withhold. If a doctor is "capped" (i.e., signs a capitated contract) for five dollars per month, he or she could receive even *less* if there are any withholds involved, which is more than likely. Thus, a mere one or two dollars may be what the doctor has allocated for all your health care for the month. What kind of medical care do you think one dollar per month buys?

48. *Cf. supra* notes 10-29 and accompanying text (discussing patients' expectations in terms of the doctor-patient relationship).

ger of going over the amount remaining in the risk pool, in which case the doctor would be individually responsible. These incentives have shifted the financial risk of costly medical care to doctors and away from the HMOs. HMOs do not add any value to the health care equation, because as "insurers" they no longer assume any of the financial risk of costly or prolonged medical care.

B. Restrictions on Doctor Disclosures

The financial incentives just described, and others like them, create a conflict of interest for the physician and seriously damage the trust that must be inherent in the doctor-patient relationship. HMOs have aggravated the situation and have further torn at the moral covenant between doctors and patients by forbidding doctors from disclosing their financial arrangements to their patients.

A standard part of the HMO-physician contract are provisions that forbid doctors from revealing their financial arrangements or criticizing the HMO. These clauses attempt to restrict what the physician can communicate to his or her patient during the course of the doctor-patient relationship. Such clauses can be classified as restricting three major categories of speech by the physician: (1) disclosing to the patient how the physician is paid, (2) telling the patient about all treatment options and what other health payors may cover, and (3) engaging in public health care debate.⁴⁹ Although recent federal and state legislation prohibits HMOs from restricting doctors from discussing treatment alternatives with patients, HMOs still expressly or impliedly, through economic credentialing⁵⁰ and not-for-cause terminations, enjoin all other types of communication between doctor and patient. The fundamental effect of any restriction on disclosure is to place added strain on the doctor-patient relationship.

49. See Julia A. Martin & Lisa K. Bjerknes, *The Legal and Ethical Implications of Gag Clauses in Physician Contracts*, 22 AM. J.L. & MED. 433, 443 (1996) (providing a comprehensive look at gag clauses); Jennifer L. D'Isidori, Note, *Stop Gaggling Physicians!*, 7 HEALTH MATRIX 187 (1997) (discussing the legal ramifications of gag provisions on the doctor-patient relationship); Nancy J. Picinic, Note, *Physicians, Bound and Gagged: Federal Attempts to Combat Managed Care's Use of Gag Clauses*, 21 SETON HALL LEGIS. J. 567 (1997) (discussing federal attempts to prevent use of gag clauses in physician-MCO contracts); see also Diane S. Swanson, Comment, *Physician Gag Clauses—The Hypocrisy of the Hippocratic Oath*, 21 S. ILL. U. L.J. 313 (1997) (discussing the conflicts of interest arising from physician gag orders mandated by HMOs).

50. Economic credentialing is essentially the process of employing and terminating doctors based on their ability to keep hospitalizations and other medical costs down. See Hagen, *supra* note 38, at 441-43.

One of the key aspects of an "ideal" doctor-patient relationship is open and honest communication.⁵¹ Implied or implicit communication restrictions eliminate any remnant of trust between doctor and patient because they restrict the physician's ability to fully communicate any apparent conflict of interest or the availability of options, some of which might be life-saving, to the patient. This is especially true for physicians who are already under the pressure of having to choose between their patients and their families under the capitation/withhold payment scheme. Furthermore, barriers to the free flow of information can eliminate trust between doctors and patients even if the patients are not covered by the HMO. The patient will hear about the payment methods and information restrictions from some source and will never be able to trust his or her doctor again. Any time a doctor tells a patient that he or she does not need to see a specialist or does not need an expensive MRI (magnetic resonance image), the patient will not know whether that is the doctor's honest opinion, or if the doctor is unable to give an honest opinion because of a contractual communication restrictions.

C. Gatekeeping and Utilization Review

In addition to the aforementioned financial incentives and gag clauses, HMOs use other cost-containment methods to further reduce medical expenditures and increase shareholder profits. Two of the most common methods are gatekeeping and utilization review.

Gatekeeping is a term used to denote the HMO practice of using primary care physicians as "gatekeepers" of the rest of the HMO's resources. When subscribers enroll with an HMO, they must choose a primary care physician, through whom subscribers must go to receive medical care. The primary care physician acts as rationer of health care resources, deciding who receives referrals to specialists or further testing and who does not. The obvious problem with this is that the gatekeeper physician, who controls access to all medical care for his or her patients, is most likely capitated and bound by a gag clause in his or her contract.⁵² Thus, even if the patient accurately suspects that her

51. See Emanuel & Dubler, *supra* note 21, at 324.

52. See Susan L. Goldberg, *A Cure for What Ails? Why the Medical Advocate Is Not the Answer to Problems in the Doctor-Patient Relationship*, 1 WIDENER L. SYMP. J. 325, 337-72 (1996) (discussing the various problems with gatekeeping).

HMO has tampered with the doctor-patient relationship and forced her doctor into an irreconcilable conflict of interest, the patient cannot discuss this with her doctor and cannot go anywhere else to receive covered medical care.⁵³

Another, less obvious, problem with this approach is that it often forces primary care physicians, the vast majority of whom are general or family practitioners, into medical roles for which most are unfit or not competent to handle.⁵⁴ As gatekeepers, the primary care physicians are often asked or economically forced to examine conditions or perform procedures that are beyond their areas of expertise. For example, in a recent study involving the twenty most commonly encountered skin conditions, only fifty-four percent of primary care physicians were able to make the correct diagnosis, while over ninety percent of dermatology residents and students made the correct diagnosis.⁵⁵

The flip side of gatekeeping is utilization review. "Utilization review . . . is the process by which [the HMO] determines if medical services are appropriate and necessary."⁵⁶ Additionally, the process delays any immediate action that the doctor has recommended for the patient. Thus, even if the doctor resolves the conflict of interest and determines that the patient needs to see a specialist, the HMO may still overturn the doctor's decision and either significantly delay the action or deny the referral altogether.⁵⁷ This lack of trust on the part of the HMO with respect to the doctor's decisions, in light of the measures already taken by the HMO to ensure the doctor's awareness of cost-containment, weakens and frustrates the doctor's faith in the system and the patient's faith in the doctor *and* the system.

53. See generally Edmund D. Pellegrino, *Ethics*, 271 JAMA 1668, 1669 (1994) (discussing the ethical questions surrounding the gatekeeper physician system).

54. This directly conflicts with the competence requirement of the "ideal" doctor-patient relationship. See Emanuel & Dubler, *supra* note 21 and accompanying text, at 324.

55. See Bronow, *supra* note 46, at 11. By forcing doctors into roles for which they are unfit, HMOs can actually increase costs, such as additional visits due to misdiagnosis, subsequent referrals, additional testing, wrongly prescribed medications, and the likelihood of more expensive treatment that may have been unnecessary had there been a correct diagnosis made earlier by a qualified specialist in the field. See *id.*

56. See Vernellia R. Randall, *Managed Care, Utilization Review, and Financial Risk Shifting: Compensating Patients for Health Care Cost Containment Injuries*, 17 U. PUGET SOUND L. REV. 1, 27, 41-65 (1993) (summarizing the various avenues of liability that patients have available to them, as well as the barriers standing in their way).

57. The irony associated with utilization review is that in many HMOs, nurses or even non-medical personnel are supposed to second-guess a doctor's determination of medical necessity.

In light of the ideal doctor-patient relationship as discussed in Part I,⁵⁸ it is abundantly clear that managed care and its incentives, restrictions, and cost-cutting methods have wreaked havoc on the doctor-patient relationship. In today's managed health care climate, it is practically impossible for four of the six Cs of the doctor-patient relationship to exist: there is virtually no choice, less competence, no communication, and an ever-present, inherent conflict of interest. Sadly, the prospects for the remaining two Cs, compassion and continuity, appear bleak indeed. As a result, we are facing a break-up of the doctor-patient relationship.

III. FROM BREAK-UP TO MAKE-UP: THE KEY TO RESTORING THE DOCTOR-PATIENT RELATIONSHIP

The key to healing the rift in the doctor-patient relationship can be reduced to one simple concept: accountability and disclosure. If we are to restore the doctor-patient relationship to its former status as one of the most revered institutions in history, accountability should be imposed on all parties involved: accountability to themselves, to each other, and to society at large. Without accountability, there can be neither responsibility nor change.⁵⁹ The following are our proposals for accountability.

A. *Patient Accountability*

The American consumer has been seduced by a bombardment of HMO advertising into believing that we should not have to pay for quality health care. We have been led to believe that if we hold jobs where our employers provide for health care or merely pay the low, low price of a few dollars per month, then we should have access to the best health care available. In so doing, we have forgotten the old maxim: Nothing good in life comes for free. To truly reform the system, the patient needs to be reentered into the payment system. When the patient is an integral part of the payment system, the patient has control

58. See *supra* notes 10-29 and accompanying text.

59. See generally DOUGLAS G. BAIRD ET AL., *GAME THEORY AND THE LAW* 13-14 (1994). After comparing no-fault tort regimes with traditional liability schemes, the authors conclude it "is hardly startling . . . [that] individuals are more likely to be careless in a world in which people are not liable when they act carelessly." See *id.* at 14.

over both the treatment received, and the provider thereof, in addition to having the ability to weed out incompetent or unsatisfactory doctors through normal market forces.

Moreover, the patient would be forced to become more involved in the health care system and would ask questions before becoming ill. In turn, this would force HMO benefit booklets and evidences of coverage to be more clear in delineating that which they will and will not cover. In addition to the aforementioned differences from other businesses, health care is unique in that while everyone needs health insurance, evidenced by the fact that everyone who can afford it buys it, ninety percent of the population never really needs it because ninety percent of the population is generally in good health. Consequently, because we buy health care thinking that we will never really need it, we do not do sufficient research prior to the purchase thereof. We are sure that the average American spends a great deal more thought on a car purchase or even that of a personal computer than is spent on health insurance, even though the potential consequences of a misinformed choice of health insurance are infinitely more devastating. Most of us are unaware of the coverage limitations of our individual policies until it is too late to do anything about it. The consumer *must* become more involved in, and more knowledgeable about, the health care system. This involves demanding disclosure from HMOs about how their doctors, laboratories, and hospitals are paid and what portion of premiums paid are actually applied to medical care.

B. Doctor Accountability

Doctors should think twice before they accept conflicting capitated contracts from HMOs. They should be free to compete personally for patients, while at the same time not allowing HMOs to "own" patients and control where they receive their medical care. If it were the case that doctors were free to compete personally for patients, patients would be free to shop around for their medical care and would become more involved in the system.

Employers could be completely removed from the equation, and the tax breaks currently given to employers for their employees' health care could be passed on to the individual. Market forces would then drive prices down to a level where both sides could function. The result would be real people, real prices, and, more importantly, a return to the transparent relationship between doctor and patient.

In the absence of the above radical reform, doctors must at least maintain a transparent relationship with their patients. Patients have an absolute right to know how their health care dollar is used and how

their doctor is paid. HMOs should disclose to patients how their doctors are paid, any actual or potential conflicts of interest, and inform their patients of *all* treatment alternatives, including those not covered by their individual plans.

C. HMO Accountability

In order to allow patients and doctors to have a fully transparent relationship, HMOs should be prohibited from including disclosure restrictions in their contracts with doctors and should not be allowed to terminate doctors without good cause. If economic credentialing and the threat of retaliatory termination were not held over doctors' heads, the doctor's moral obligation, indeed his or her natural instinct, to make the patient's health and interests the top priority could again prevail.

In addition to being accountable to doctors, HMOs must be held accountable to their patients. The only way to hold HMOs accountable to the consumer is to allow patients access to the court system. Currently, HMOs are like tyrants hidden behind the walls of a fortress with an artificial moat between them and the townspeople. The moat must be removed, and the castle walls must be torn down.⁶⁰

The moat is ERISA, the Employee Retirement Income Security Act of 1974,⁶¹ which effectively shields HMOs from being held accountable to any of their members who receive their health insurance through a private employer.⁶² ERISA is a deadly statute of unintended consequences,⁶³ which allows HMOs to make money hand over fist while denying

60. See Jamie Court, Commentary, *Close the HMOs' Favorite Loophole*, L.A. TIMES, Jan. 21, 1998, at B7 (stating that the only means by which patients can be protected is to allow HMOs to be sued in court).

61. See *supra* note 40 and accompanying text (discussing ERISA).

62. See *supra* note 40 and accompanying text. ERISA was enacted to protect the pension benefits of employees. See 29 U.S.C. § 1001(a) (1994). Unfortunately, it has been misconstrued to cover all employer-provided benefits, including health care. In so doing, it has created a loophole that HMOs have been quick to exploit. More specifically, ERISA requires that any action be brought in federal court, and limits the remedy available to the consumer to the price of the treatment or procedure denied. See *id.* § 1332(a)(1), (e)(1).

63. See *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49, 49-65 (D. Mass. 1997) (discussing the need to amend ERISA). In speaking of ERISA and its powerlessness, the *Andrews-Clarke* district court stated the following: "Enacted to safeguard the interests of employees and their beneficiaries, ERISA has evolved into

more and more care. ERISA harms doctors by improperly making them litigation targets when, in fact, the HMO is responsible for the decisions giving rise to the cause of action. As a result, patients are injured because they cannot be made whole.

The few consumers who are not subject to ERISA⁶⁴ still have to get past the castle walls to get to the tyrant. The walls in this metaphor represent the binding arbitration clauses imposed by HMOs on their members, which basically require that the members relinquish their constitutional rights by signing on the dotted line.⁶⁵ Such clauses are inserted into the HMO policies, which are in all respects contracts of adhesion. Once this happens, the only recourse patients have is the internal grievance process of the HMO, which ultimately ends in a private, costly⁶⁶ arbitration hearing with arbitrators selected at least partially by the HMO.⁶⁷ Taking our defective gas tank analogy at the beginning of Part II one step further, this is like having the president of the automobile manufacturer as the judge presiding over the bench "trial." This judge then determines whether his own company needs to be held accountable to the consumer. These costly arbitration proceedings effectively chill the patient's ability to seek redress and irreparably damages patients' trust in the system's ability to do justice.

By removing the artificial barriers that surround the HMOs and forcing HMOs to be held accountable to their members and to society at large, we can foster greater competition between those HMOs that do not cheat and are honestly committed to providing their members with quality care while trying to keep unnecessary costs down. After all,

a shield of immunity that protects health insurers, utilization review providers, and other managed care entities from potential liability for the consequences of their wrongful denial of health benefits." *Id.* at 53.

64. ERISA does not apply to public (state-level and below) employees, church workers, and those who pay their HMO directly for health coverage. *See* 29 U.S.C. § 1003(b) (1994).

65. Although this is more a subject for a separate paper, it is worth noting that Thomas Jefferson considered the right to a jury trial among the most fundamental of rights. *See* THOMAS JEFFERSON ON POLITICS AND GOVERNMENT (visited February 5, 1998) <<http://etext.virginia.edu/jefferson/quotations/jeff1520.htm>>.

66. Arbitration proceedings are significantly more expensive than going to court for most patients because they have to pay both their attorneys and the arbitrator(s). Further, patients are actually forced to *double-pay*, because their taxes go toward funding the court system, to which they are denied access.

67. Until January 1998, Kaiser Permanente in effect used its own arbitrators to resolve disputes with members. *See* Ron Shinkman, *Kaiser Sets New Grievance Process*, MOD. HEALTHCARE, Jan. 19, 1998, at 24. Most HMOs require a panel of three arbitrators to be used with each party choosing their own arbitrator, who then in turn agree on a third. For an example of how HMOs can use this system to the detriment of consumers, see *Engalla v. Permanente Med. Group, Inc.*, 938 P.2d 903 (Cal. 1997).

what does a company that is doing things the right way have to fear from the consumer or the court system? The best deterrent to keep companies from taking advantage of consumers is the potential club carried by a wronged consumer with access to the court system.⁶⁸

Critics will say that removing these barriers will simply result in overcrowding the court system. That is simply not true. Since *Fox v. Health Net*,⁶⁹ my sister's case where the jury found that the HMO acted with fraud, oppression, and malice in denying a breast cancer treatment and awarded a record \$89 million verdict, our office has helped 140 other families receive treatment that was originally wrongfully denied by their HMO. In that time, we have only been forced to file five lawsuits against HMOs. Not only is that great tort reform, but it is even better for the doctors and patients who are involved.⁷⁰ Removing these barriers would actually keep doctors and patients *out* of the courtroom, and would put them back in the operating room where they belong.

IV. CONCLUSION

Our ultimate goal should be to put patients above profits, and to dust off the collective moral conscience that is currently buried under stacks of stock certificates and quarterly returns. All players in the health care delivery system—patients, doctors, and industry persons—need to participate in accordance with the same standards and ethical precepts set forth by Cardinal Bernardin.

The current system, which holds doctors to a different standard than the number-crunchers who interfere with the doctors' judgment and medical decisions on a regular basis, is grossly unfair. Not only do HMOs question the judgment and experience of doctors, but they force

68. See BAIRD, *supra* note 59, at 14. Under the current laws, HMOs operate in what is effectively a no-fault system. Thus, it should surprise no one that HMOs are so callous with regard to the health of patients and the relationship between patients and their doctors. See *id.* The District Court of Massachusetts agreed, stating that "the practical impact of ERISA . . . is to immunize [the insurance company] from any potential liability for the consequences of their denial of benefits." See *Andrews-Clarke*, 984 F. Supp. at 55-56.

69. No. 219692, 1993 WL 794305 (Cal. Super. Ct. Dec. 28, 1993).

70. See Joanne B. Stern, *The HMO Experience (As Seen By A Health Care Lawyer)*, 1 DEPAUL J. HEALTH CARE L. 395, 407 (1996) (proposing that "[l]arge damage awards and the concomitant publicity just might embarrass the industry to reform itself, as it has in many product liability cases").

doctors into incredibly difficult situations each time a patient becomes ill.⁷¹

Equally unfair is the license that has been given to HMOs by poorly-written decisions and misconstrued statutes which enables HMOs to make patients the victims of economic experimentation without their consent or knowledge. Patients need to research and pay attention to the health care they purchase, but how can they when the health care industry is allowed to conceal the conflicts that it imposes on the delivery of health care—conflicts that may not just be unfair, but fatal. Currently, patients are not allowed access to the information that they need to make proper, informed decisions, such as where their health care dollar goes and how much their primary care physicians receive from their premiums.⁷² Without this crucial information, and without the ability to hold HMOs accountable, consumers cannot wield their market power to force HMOs out of business.⁷³

If we are to restore the moral fiber to the doctor-patient relationship, we need to tear down the industry-supplied barriers that are ripping at its soul. If honesty and transparency are made priorities in the health care delivery system, then the doctor-patient relationship can be reconciled, and we can once again use the phrase “health care” as something other than an oxymoron.

71. In order to prevent this, here are five steps that doctors should take before contracting with an HMO: (1) read and understand the liability risks they may be taking on by agreeing to an HMO contract; (2) make sure there are no conflicts of interest that can pit them against their patients; (3) be leery of contract termination clauses that allow terminations for something other than good cause, because these clauses can be used against patient advocates; (4) know whether or not they are being economically credentialed by the HMO or entities associated with the HMO; and (5) make sure their contract does not require them to be a witness on behalf of the HMO against their patients should a matter be litigated.

72. With this in mind, we recommend that patients ask these five questions before joining an HMO: (1) what percentage of the monthly HMO premium actually goes to medical care providers (doctors, hospitals, laboratories, etc.); (2) how much money is actually received by your primary care physician from your premium for your care?; (3) does the HMO's contract with your doctor allow it to terminate the contract if your doctor overutilizes services?; (4) do the HMO doctors receive bonuses at the end of the year from the HMO if they limit referrals to specialists or hospitals?; and (5) what are the most frequently requested procedures that the HMO routinely denies on the basis that they are “experimental/investigational” or “not medically necessary”?

73. See Stern, *supra* note 70, at 407.