CUTTING FAT OR CUTTING CORNERS, HEALTH CARE DELIVERY AND ITS RESPONDENT EFFECT ON LIABILITY

Kenneth R. Pedroza

"No one can serve two masters; for either he will hate the one and love the other, or he will be devoted to the one and despise the other. You cannot serve God and mammon." –Matt. 6:24

Over time the health care delivery system in the United States has been evolving. In the face of the rising costs of health care, consumers have increasingly opted to enroll in managed care organizations (MCOs) which promise to provide health care at a decreased cost.[1] But, with the new form of health care delivery have come some alterations in the basic assumptions the tort liability system applies to the doctor-patient relationship.

Under the traditional fee for service delivery system, the doctor had the final say on patient procedures, the doctor kept the patient's interests tantamount, the doctor and patient benefited from additional treatment, and the doctor was the source of liability in the event sub-standard care injured the patient.[2] The tort system assumed this model was in place, and liability attached under appropriate circumstances.[3]

As health care delivery has increasingly shifted to managed care, the traditional assumptions of the fee for service system are no longer valid. Under MCOs, doctors increasingly lose the exclusive treatment authority.[4] Also, doctors' interests may diverge from those of their patients, and patients' interests are thus not always held paramount.[5] As courts tried to fit this new form of health care into old liability systems, problems arose. Consequently, an adjustment in our tort system is necessary to bring liability in line with the current aspects of managed care.

For a new liability system to benefit society, it must not only impose liability on the faulty actors as a means of compensating the injured, but it must

---

1. "Managed care is a comprehensive term describing a system of health care cost containment that deviates from the traditional health care delivery system by substituting pre-arranged fee structures and utilization review procedures for fee-for-service billing. The aim is to reduce the price and quantity of health care services." James P. Freiburg, *The ABCs of MCOs: An Overview of Managed Care Organizations*, 81 ILL. B.J. 584 (1993).

2. *See infra* notes 119–26 and accompanying text.

3. Randall Bovbjerg, *The Medical Malpractice Standard of Care: HMOs and Customary Practice*, 1975 DUKE L.J. 1375, 1377, 1390, 1396–1397 (1975); Gary T. Schwartz, *A National Health Care Program: What Its Effect Would Be on American Tort Law and Malpractice Law*, 79 CORNELL L. REV. 1339, 1361 (1994).

4. *See infra* notes 145–47 and accompanying text.

5. *See infra* notes 164–65 and accompanying text.

also deter undesirable activities by creating the proper incentive structure. The current tort system in the field of medical malpractice suffers because it poorly compensates the injured,[6] and poorly deters the self-interested actions of an MCO.[7]

This Note will investigate ways in which the medical malpractice liability system can be altered to account for the new forms of health care delivery developing in America. After tracing the history of rising health care costs in Section I, this Note will discuss the different forms of MCOs that have developed and the incentive structure created by the new forms of health care delivery in Section II. Finally, MCOs' increasing exposure to liability will be discussed, and a proposal for holding MCOs jointly liable with doctors for malpractice when the MCO bears the financial risk of loss or gain will be made in Sections III and IV, respectively.

I. HEALTH CARE COST

The amount of money spent on health care in the United States is staggering. In 1988, health care allotments comprised 11.2% of the Gross National Product (GNP), but only one year later, the percentage escalated to 11.6% ($604 billion), an increase of $60 billion.[8] In 1990, the United States spent $2,511 per person on medical care, totaling $647 billion.[9] Figures show we spend far more on health care than other industrialized countries.[10] The percentage of the GNP spent on health care continued to grow through 1992, reaching twelve percent by year's end, and it is expected to swell to sixteen percent by the year 2000.[11] In fact, the percentage of the GNP spent on health care rose to fourteen percent by 1993, totaling $942.5 billion.[12] Although there are many reasons for the increase in cost and spending on health care in the United States, this Note will limit its inquiry to those related to the fee for service care.[13]

---

6. *See infra* notes 190–91 and accompanying text.

7. *See infra* notes 196–212 and accompanying text.

8. 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, 6 n.3 (1993).

9. Timothy S. Jost, *Policing Cost Containment, The Medicare Peer Review Organization Program*, 14 U. PUGET SOUND L. REV. 483, 484 (1991).

10. *Id.* In 1987, the U.S. spent 11.2% of our GNP on health care. A comparison shows the U.S. spends more as a percentage of GNP than other developed nations. Other countries listed according to the percentage of their GNP spent on health care include the U.K.–6.1%, Japan–6.8%, Germany–8.2% and Canada–8.6%. *Id.*

11. Daniel P. Sulmasy, *Physicians, Cost Control, and Ethics*, 116 ANNALS INTERNAL MED. 920, 920 (1992).

12. Joseph R. Biden, *Tenth Survey of White Collar Crime*, 32 AM. CRIM. L. REV. 1, i n.2 (1995). *See also* Ellen M. Yacknin, *Helping the Voices of Poverty to Be Heard in the Health Care Reform Debate*, 60 BROOK. L. REV. 143, 144 n.7 (1994).

13. Fee for service health care is based on a payment system in which the doctor is paid for each service rendered. Elaine Lu, *The Potential Effect of Managed Competition in Health Care on Provider Liability and Patient Autonomy*, 30 HARV. J. ON LEGIS. 519, 524 (1993). In contrast, a capitation system will pay the provider a fixed sum for total health care, regardless of whether the care is given frequently or not given at all. Tayebe Shah-Mirany, *Malpractice Liability of Health Maintenance Organizations: Evolving Contract and Tort Theories*, 39 MED. TRIAL TECH. Q. 357, 360 (1993).

A. *Fee for Service System*

1. Reimbursement

To better understand why health care costs escalate under a fee for service regime, it is important to appreciate the underpinnings and incentives present in such a regime. Through the 1970's, doctors were reimbursed by insurance companies or Medicare for all services that were "medically necessary."[14] The incentive structure for the patient and the doctor went hand in hand when a third party was paying for the services; treatments promising any incremental benefit, no matter how small, were undertaken not only because they were in the patient's best interest, but because the doctors were taught to place the patient's welfare second to none.[15] Simultaneously, doctors benefited from the increased accrual of charges. Each additional procedure was an individual source of profit for the physician.[16]

Neither the patient nor the doctor had any incentive to contain costs.[17] In fact, doctors had an incentive to steadily increase charges for medical services until they reached the upper bound of reimbursement.[18] This resulted in tremendous inflation of the cost of medical services, leading to today's soaring medical bills.[19]

2. Defensive Medicine

Reimbursement is not the only cause of rising costs. Physicians operating under a fee for service regime have the option of practicing "defensive" medicine so as to avoid lawsuits.[20] Costs escalate when an incentive structure to conduct

---

14. David D. Griner, *Paying the Piper: Third Party Payor Liability for Medical Treatment Decisions*, 25 GA. L. REV. 861, 881 (1991). *See also* Barry R. Furrow, *Medical Malpractice and Cost Containment, Tightening the Screws*, 36 CASE W. RES. L. REV. 985, 986 (1986) (hospitals were paid for the actual charges incurred); Randall, *supra* note 8, at 14, 16; Harvard Law Review Association, Note, *Rethinking Medical Malpractice in Light of Medicare Cost-Cutting*, 98 HARV. L. REV. 1004, 1005 (1985) (doctors were paid their reasonable costs). Usual, customary and reasonable (UCR) costs were paid by private insurers based on either the set UCR charge, the median amount customarily charged by the doctor, or the doctor's actual charge, whichever was less. Randall, *supra* note 8, at 14 n.41. Consequently, doctors increased fees until they reached the UCR maximum. *Id.* at 16.

15. *See, e.g.*, Griner, *supra* note 14, at 881. *See also* Bovbjerg, *supra* note 3, at 1396; Kenneth Jost, *Still Warring Over Medical Malpractice*, 79 A.B.A. J. 68, 71 (1993) [hereinafter Jost, *Still Warring*]; Timothy S. Jost, *The Necessary and Proper Role of Regulation to Assure the Quality of Health Care*, 25 HOUS. L. REV. 525, 526 (1988) [hereinafter Jost, *Regulation*]; E. Haavi Morreim, *Cost Containment and the Standard of Medical Care*, 75 CAL. L. REV. 1719, 1731 (1987); Harvard Law Review Association, *supra* note 14, at 1009–10.

16. Griner, *supra* note 14, at 881. *See also* Jost, *Still Warring*, *supra* note 15, at 71.

17. Paulette M. Macon, *Cost Containment vs. Standard of Care: Between Rock and a Hard Place*, 39 MED. TRIAL TECH. Q. 205, 214 n.35 (1993).

18. *Id.* This is so because the physician was reimbursed on a usual, customary and reasonable basis. *Id.* at 213. Simply, this meant the doctor was compensated by the insurance company for a percentage of the lesser of either the doctor's usual charge or the prevailing customary rate in the community. *Id.* The UCR rate was supposed to be unknown, but as doctors raised their rates, the maximum reimbursement levels were readily realized. *Id.* at 214. Not only private insurance, but the Medicare program worked on a UCR basis before the introduction of the Diagnosis Related Group (DRG) system. *Id.* at 213, 215.

19. *See supra* notes 8–12 and accompanying text. *See also* BARRY R. FURROW ET AL., THE LAW OF HEALTH CARE ORGANIZATION AND FINANCE 325–26 (1991).

20. Jost, *Still Warring*, *supra* note 15, at 71. Defensive medicine is a treatment practice in which the impetus for further treatment is not as much to benefit the patient as it is to avoid

excessive testing and undertake any procedure with incremental benefit to the patient is coupled with a doctor's overtreatment as a means of preventing malpractice liability.[21] It is difficult to quantify exactly how substantial a factor defensive medicine is in cost escalation.[22] While the threat of malpractice liability is very serious,[23] commentators have argued "defensive medicine may well be encouraged less by the threat of medical malpractice than by the reward of cost- and charge-based reimbursement."[24] This is due to the fact that malpractice liability attaches only when sub-standard care is given to a patient, resulting in injuries.[25] Although excessive testing and treatment will surely prevent some malpractice claims, less expensive care with fewer tests could also meet the applicable standard, thereby exempting the doctor from liability.[26] Nevertheless, at a minimum, a fear of malpractice liability will encourage doctors to conduct extra testing as a means of preventing a future malpractice suit.[27]

3. Technology

Regardless of the uncertain impact of the fear of medical malpractice liability on cost escalation, technological innovations and their use in the medical community play a more prominent role in the rising cost of medical care.[28] The use of expensive new technologies partially accounts for the rising cost of medicine today for several reasons. First, under the fee for service delivery system, doctors have an incentive to order more tests and use the newest and best technology.[29] This is because the doctors receive compensation based on the procedure, with no incentive to economize.[30] Alternatively, because the medical sciences are imprecise, a natural tendency is to use expensive tests and new technologies in an effort to create greater certainty in an unsure world.[31] Additionally, in the opinion of some commentators, the use of expensive

---

malpractice liability by overtreating. Harvard Law Review Association, *supra* note 14, at 1012.

21. *See supra* notes 14–18 and accompanying text. *See also* Jost, *Still Warring*, *supra* note 15, at 71 (American Medical Association estimates defensive medicine costs about $25 billion per year).

22. Jost, *Still Warring*, *supra* note 15, at 71.

23. *See* FURROW ET AL., *supra* note 19, at 330; Harvard Law Review Association, *supra* note 14, at 1012.

24. Jost, *supra* note 9, at 495. *See also* Jost, *Still Warring*, *supra* note 15, at 71.

25. W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 32, at 187 & n.36 (5th ed. 1984 & Supp.); Jost, *supra* note 9, at 495.

26. Jost, *supra* note 9, at 495.

27. Whatever level of increased cost this would cause in a fee for service delivery system would be difficult to distinctly quantify. The tendencies of physicians, such as offering patients treatment with any incremental benefit, the physician's disdain for uncertainty, or the patient's insistence on more testing or greater certainty, would tend to overlap with any measurement of increased costs due to defensive medicine. Jost, *Still Warring*, *supra* note 15, at 71.

28. *See* Jost, *supra* note 9, at 491–92.

29. Furrow, *supra* note 14, at 997. Furrow feels technology and tests are used even when there is no demonstrated benefit. *See also* Jost, *Still Warring*, *supra* note 15, at 71; Morreim, *supra* note 15, at 1719; Randall, *supra* note 8, at 16.

30. Randall, *supra* note 8, at 14–15.

31. Jost, *Still Warring*, *supra* note 15, at 71 (arguing that new technologies are sometimes used even before they are fully understood).

technologies like artificial hearts and CAT scanners "may be responsible for as much as fifty percent of health sector inflation."[32]

4. Treatment Care

In addition to the advent of new technologies, the practice of defensive medicine, and the incentive structure inherent in a fee for service system, the type of health treatment also has had an effect on the increase in the cost of medical care. There are two types of treatment service: preventive care and treatment (curative) care.[33] Preventive care is proactive and attempts to head off ailments or disease before they become full-blown.[34] Treatment service, on the other hand, is reactive and is given when prevention is no longer possible and the symptoms have developed into a disease that must be treated.[35] Just as a fee for service delivery system gives the doctor an incentive to overprescribe, commentators argue a similar incentive is created to engage in treatment service.[36] "[P]hysicians and hospitals [have] tended to de-emphasize preventive care, which was not as lucrative as treatment services."[37] In fact it is postulated that one reason an MCO can deliver care at a decreased costs is due in part to their preventive care philosophy.[38]

The underpinnings of the fee for service system will serve as a lens with which to view managed care organizations. The underpinnings are based on the reimbursement system, the option to practice defensive medicine, the option to use advanced technologies, and the use of treatment (curative) services rather than preventive care. The unique incentives created by the elements of a fee for service delivery system will serve to highlight the difference between a fee for service system and a managed care system. When these factors are reevaluated under a managed care organizational structure in Section II of this Note, the true effects of these two systems become readily apparent.

---

32. Paul E. Kalb, *Controlling Health Care Costs by Controlling Technology, A Private Contractual Approach*, 99 YALE L.J. 1109, 1112 (1990). *See* Schwartz, *supra* note 3, at 1361 n.93 (fee for service encouraged the development and use of technologies which contributed "to the remarkable increase in per capita medical costs").

33. Edward Hirshfeld, *The Case for Physician Direction in Health Plans*, 3 ANNALS HEALTH L. 81, 92 (1994); *cf.* Aki Yoshikawa et al., *Health Care in America: Armageddon on the Horizon? How Does Japan Do It? Doctors and Hospitals in a Universal Health Care System*, 3 STAN. L. & POL'Y REV. 111, 130 (1991) (differentiating between preventive and curative care).

34. Einer Elhauge, *Allocating Health Care Morally*, 82 CAL. L. REV. 1449, 1481 (1994) (preventive care is meant to prevent serious illness).

35. *Id.* Curative care is given to treat serious illness. *Id.*

36. David Orentlicher, *Symposium National Health Care Reform: The Legal Issues: Health Care Reform and the Patient-Physician Relationship*, 5 HEALTH MATRIX 141, 159 (1995) (noting the greater use of preventive care in HMOs as compared to fee for service); Randall, *supra* note 8, at 15.

37. Randall, *supra* note 8, at 15. This incentive is highlighted in isolation not only to exemplify its existence, but also as a means of making the contrast between a fee for service and a capitation system more striking. None of these incentives work in a vacuum, but acknowledging their existence furthers the analysis and critical comparison of the two health care delivery systems.

38. FURROW ET AL., *supra* note 19, at 382. *See also* ROGER C. HENDERSON, INSURANCE LAW 14 (1989).

B. Who Is Paying for the Increased Costs?

Beginning in the first half of the 19th century, the number of hospitals greatly increased in the United States.[39] The number of hospitals steadily rose from 1873, when only 178 hospitals existed with a total of 35,064 beds, to 6,665 hospitals with a total of 907,133 beds by 1929.[40] Yet with the Great Depression came a drop in hospital receipts and an attendant rise in deficit spending for hospitals.[41] While the American Hospital Association reacted to this economic crisis by creating the Blue Cross system in an effort to guarantee payment of hospital costs,[42] Blue Shield was conceived to allow guaranteed payments of medical services beyond that of hospitalization.[43] Then, after World War II, employers began giving health insurance as an employee benefit.[44] The rising need and popularity of health insurance spawned the development of commercial insurance companies.[45] Blue Shield had been offering insurance on a service benefit and community rating system.[46] Because other insurance companies were offering incentives that Blue Cross and Blue Shield plans did not include, Blue Cross and Blue Shield abandoned some of their previous policies, including community rating.[47] By abandoning community rating, the price of health insurance increased and those who could not afford the supplemental amount were left without insurance.[48]

As the price of insurance grew, so did the gap between the insured and the uninsured. In 1965, Congress responded to the insurance gap through the creation of Medicare and Medicaid.[49] At their inception, Medicare and Medicaid provided reimbursement to doctors on a charge basis.[50] This meant the providers could treat and be secure that their reasonable costs of treatment would be compensated.[51] At the same time, private insurance reimbursed medical care on a fee for service basis.[52] Neither system offered any incentive for doctors or patients to economize their treatments.[53]

In reality, the economic incentives of these reimbursement systems facilitated their overuse as neither the patient nor the doctor faced the true price of the medicine. Under Blue Cross, physicians were paid eighty percent of the usual, customary and reasonable cost of care (UCR).[54] The individual or the employer paying only one-fifth of the actual cost of treatment did not realize the

---

39. Randall, *supra* note 8, at 10–11.
40. *Id.* at 11.
41. *Id.*
42. *Id.*
43. *Id.*
44. *Id.* at 12.
45. *Id.*
46. *Id.* at 12–13. This means that the premiums were based on a community standard and not on the individual basis. *Id.* at 13 n.34. The service benefit further guaranteed payment for selected services. *Id.*
47. *Id.* at 12-13.
48. *Id.* at 13.
49. *Id. See also* Harvard Law Review Association, *supra* note 14, at 1005 (Medicare as assistance for the elderly).
50. Randall, *supra* note 8, at 13.
51. Harvard Law Review Association, *supra* note 14, at 1005.
52. Randall, *supra* note 8, at 14.
53. *Id.* at 15.
54. *Id.* UCR costs were paid by private insurers based on either the set UCR charge, the median amount customarily charged by the doctor, or the doctor's actual charge, whichever was less. *Id.* at 14 n.41.

true costs of the care they were choosing.[55] Additionally, as the UCR payment schedules for individual procedures became known, doctors raised their fees until they hit the upper limit.[56] The consequences of these actions were far-reaching. The price of Medicare and private insurance increased beyond projections.[57] By 1970, the price of Medicare was double what had been projected.[58] Between 1970 and 1980, Medicare expenses increased from $4.95 billion to $37 billion.[59] Between 1965 and 1987, total health care costs rose from $42 billion to $500 billion.[60]

The effects of the soaring cost of health care transcended many arenas and altered our system of health care delivery. Employers found it increasingly difficult to simultaneously offer health care benefits and continue to compete in the international markets[61] as substantial portions of their costs went towards the payment of health care.[62] As Americans become concerned with the rising cost of health care, the phrase "managed care" is repeatedly praised as a cure for the systemic problems.[63] Recent polls of major U.S. employers show that seventy four percent conduct utilization review (UR).[64] With the number of employers offering managed care options on the upswing, the face of the health care delivery system in America is changing.[65]

The rapid proliferation of managed care organizations has dramatically altered both physician incentives and the doctor-patient relationship.[66] These changes fundamentally affect the incentive structure of the fee for service delivery system. Yet, our medical malpractice system, which is premised on the fee for service system, has not undergone a parallel transformation.[67] To critically analyze our liability system in relation to our new approaches to health care delivery, this Note will present a brief description of the basis of managed care and the attendant incentives created.

II. MANAGED CARE AND COST CONTAINMENT

Managed care and cost containment practices come in a variety of shapes and sizes. For the purpose of this Note, the exact form of the organization will not be given much detail. Instead, the analysis will focus on the incentive structure of managed care and cost containment in relation to medical malpractice liability.[68] Three types of cost containment will be examined: the

---

55. *Id.* at 15.
56. *Id.* at 16.
57. Harvard Law Review Association, *supra* note 14, at 1005.
58. *Id.*
59. *Id.*
60. Carla J. Hamborg, Note, *Medical Utilization Review: The New Frontier for Medical Malpractice Claims?*, 41 DRAKE L. REV. 113, 114 (1992).
61. Morreim, *supra* note 15, at 1720–21.
62. *Id.* Corporations pay approximately one-third of the nation's health care costs. *Id.*
63. Hamborg, *supra* note 60, at 114.
64. *Id.* at 114–15. Utilization review is a cost containment and quality control measure by which a doctor's treatment decisions are reviewed to determine their necessity. *Id.* at 115. This can be done either before or after the treatment is actually administered. *Id.* at 116.
65. Randall, *supra* note 8, at 22 (number of HMOs increased 900% over a 15-year period, accompanied by an increasing overall enrollment).
66. *See infra* notes 156–73 and accompanying text.
67. *See infra* notes 181–99 and accompanying text.
68. Managed care organizations are complex and varied. An in-depth treatment of all of the organizations is beyond the scope of this Note. Instead, a brief discussion of the most

Medicare Diagnosis-Related Group (DRG), Health Maintenance Organizations (HMOs), and Preferred Provider Organizations (PPOs).[69]

A. Forms of Managed Care

1. Medicare

One of the first wide-scale attempts to contain medical costs was the Medicare Diagnosis-Related Group, more commonly referred to as the DRG system.[70] DRG was created in an era when the costs of the Medicare program far outran any predictions.[71] Congress tried to slow the inflationary trend in the maintenance of the Medicare system through the introduction of the DRG system in 1983.[72] The DRG system tried to alter the incentives previously created when Medicare compensated doctors for their "reasonable cost" of services.[73] These cost- and charge-based reimbursement practices included no incentive to contain costs, as there was little risk of not being compensated.[74] As a result, the costs of Medicare grew tremendously.[75]

Through its adoption of the DRG system, Congress attempted to reverse the trend toward overconsumption. Instead of reimbursing doctors and hospitals for the actual charges incurred, under the DRG system Medicare pays a pre-set amount to the doctor or hospital regardless of the care that is given.[76] The system is based on the assumption that treating patients with the same symptoms and the same problems categorized into diagnostically related groups should cost roughly the same amount; thus, Medicare will pay a prospectively determined price per admission for the health care, including tests, diagnostic procedures, and x-rays.[77] The DRG system reimburses patient care irrespective of the actual length of time in the hospital, or the services required.[78]

That the DRG program has significantly altered the incentive structure under the cost- and charge-based reimbursement leaves unanswered what incentives this new system creates. Seemingly, DRGs have caused an about-face in the delivery of health care; the hospital must act efficiently in order to supply care to the Medicare patient for less than the allotted DRG sum. As long as the hospital can supply care below the DRG amount, it will continue to generate a

---

widely-used organizations will be presented, with the impact of those organizations being attributed to managed care organizations in general.

69. References to managed care organizations in general will include attributes of any of the three groups as they serve to contain costs and attempt to restrict care, but will not specifically refer to any one form of managed care.

70. FURROW ET AL., *supra* note 19, at 391–92. *See also* Harvard Law Review Association, *supra* note 14, at 1005.

71. Harvard Law Review Association, *supra* note 14, at 1005.

72. FURROW ET AL., *supra* note 19, at 391–92; Furrow, *supra* note 14, at 986; Jost, *supra* note 9, at 487; Morreim, *supra* note 15, at 1721; Harvard Law Review Association, *supra* note 14, at 1005–06.

73. Harvard Law Review Association, *supra* note 14, at 1005.

74. Furrow, *supra* note 14, at 986.

75. Jost, *supra* note 9, at 487–88. Between 1967 and 1982, payments to hospitals rose from $2.8 billion to $30.9 billion (11 times) and payments for doctors' care rose from $.43 billion to $12 billion (28 times). *Id.* at 486.

76. Harvard Law Review Association, *supra* note 14, at 1006. *See also* Furrow, *supra* note 14, at 986; Jost, *supra* note 9, at 487.

77. Harvard Law Review Association, *supra* note 14, at 1006.

78. *Id.*

surplus, which is its means of survival and growth.[79] But, unlike the fee for service system, where the incentive was toward overconsumption, a DRG system threatens underconsumption.[80]

"[T]he DRG-based system creates a strong incentive for hospitals to decrease the total cost of services provided to patients, primarily by narrowing the scope of services ordered by physicians, including hospitalization and 'ancillary services.'"[81]

The fear is that pressures on future treatments will be towards decreased use of drugs, tests, and hospitalization at the expense of the quality of care.[82] Under the DRG system the physician thus assumes a new role in the delivery of health care as he is relied on by the managed care organization, or cost cutting group, for its financial stability.[83]

The physician, once only a fiduciary to the patient, is thus now concerned with the well-being of other actors in the health care delivery system.[84] Although treatment decisions are made solely by the physician, the indirect (or sometimes direct) pressures on physicians to contain costs can serve as powerful influences in the decisionmaking process.[85]

The DRG system was introduced in a time of soaring health care costs and runaway expenses.[86] While cost consciousness is presumably a desired goal, it is less clear that our tort system should be altered to account for the new reimbursement regime and the resultant incentives and pressures. This issue can better be addressed after examining the other managed care options.

---

79. Furrow, *supra* note 14, at 986.

80. *Id.* at 987. *See also* Harvard Law Review Association, *supra* note 14, at 1006. Some feel the DRG system will cause both underconsumption and overconsumption. Jost, *supra* note 9, at 490–91. This is so because Medicare under the DRG system allows reimbursement per hospital admission, thus creating an incentive for overutilization of hospital admissions as a means of boosting total hospital revenue. *Id.* at 491. Some also feel hospitals will begin to determine patients are sicker and thus subject to a higher paying DRG category. FURROW ET AL., *supra* note 19, at 395 (this tendency is known as "DRG–creep").

81. Harvard Law Review Association, *supra* note 14, at 1006.

82. Furrow, *supra* note 14, at 987.

83. *Id.* at 986.

84. Schwartz, *supra* note 3, at 1362.

85. Furrow, *supra* note 14, at 987. Furrow feels the pressure can be as powerful as a set of rules, exerted through the restriction of staff privileges or positions. *Id.* When these pressures become prevalent, the line between medicine and economics becomes blurred. *Id.* Pressure can be applied on the doctor as a means of encouraging compliance with cost containment practices through a variety of practices such as the power over staff privileges, shifting the risk to physicians in capitation type systems, admonishing physician behavior through the use of lists, or offering physicians economic incentives to contain costs like bonuses for minimal referrals or withholding as much as 20% of the physician's salary and paying this amount at the end of the year depending on the doctor's success at cutting costs. *See, e.g.*, William A. Chittenden III, *Malpractice Liability and Managed Health Care: History and Prognosis*, 26 TORT & INS. L.J. 451, 481 (1990); Randall, *supra* note 8, at 30–32; Schwartz, *supra* note 3, at 1365; Ron Winslow, *Studies Find Heart-Attack Patients Get Poorer Care in Plans Curbing Specialists*, WALL ST. J., Oct. 27, 1994, at B8 (noting financial penalties for excessive specialist referrals); Ron Winslow, *Is Victory in Sight in Health-Care War*, WALL ST. J., Feb. 27, 1995, at A1 (noting "policies that reward doctors for ordering fewer medical procedures").

86. FURROW ET AL., *supra* note 19, at 391.

2. Health Maintenance Organizations

Health Maintenance Organizations (HMOs) are one of the most widely-used forms of cost containment outside of the publicly administered DRG program. As costs rise in the delivery of health care, HMOs have become more popular.[87] A 1987 survey showed that of 160 million Americans receiving employee health insurance, sixty percent opted for managed care, while in 1980, only five to ten percent chose a managed care scheme.[88] As the costs of health care rise, and more Americans are unable to afford insurance, the attractiveness of HMOs becomes ever more apparent.[89]

The reduced cost of an HMO results from the form of its delivery. HMOs work on a capitation basis, which necessarily discourages utilization, and reduces the cost of health care.[90] Capitation is quite similar to the DRG system. The HMO will set a flat rate for participants.[91] Again, like the DRG system, it is up to the HMO physician to deliver care below the capitation rate.[92] The fee is paid to the HMO regardless of how often the patient seeks care. Thus, if the cost per patient rises above the fee collected, then the HMO will lose money.[93]

This analysis of HMOs and capitation can be further broken down into several distinct types of HMOs.[94] Three such types are the Staff, Group and Independent Practice Association (IPA) Models.[95] Under the Staff Model, the HMO employs the physician, who practices at HMO facilities.[96] Instead of receiving a fee for service, the HMO doctors are paid a salary.[97] In the Group Model HMO the HMO does not employ the physicians, but instead contracts with the physician to provide services for the HMO subscribers.[98] The payment scheme in a Group Model HMO for the contracting physician is on a capitation basis.[99] The last common model is the Independent Practice Association (IPA). The IPA Model has the greatest resemblance to the fee for service system. Individual doctors form a group contract with an HMO to provide health care for

87. Michael C. Thornhill, *Managed Care at Risk*, 13 WHITTIER L. REV. 359, 359 (1992).

88. Barry R. Furrow, *The Changing Role of the Law in Promoting Quality in Health Care: From Sanctioning Outlaws to Managing Outcomes*, 26 HOUS. L. REV. 147, 150–51 (1989) (this number includes both HMOs and Preferred Provider Organizations).

89. The permanency of managed care is so apparent that the American Medical Association, a long-time opponent of managed care, has begun education programs relating to managed care for its members. *See, e.g.*, Freiburg, *supra* note 1, at 589.

90. Furrow, *supra* note 88, at 148.

91. HENDERSON, *supra* note 38, at 14.

92. Furrow, *supra* note 88, at 148.

93. *Id.*

94. The three most widely accepted HMOs are the Group, Staff and Individual Practice Association (IPA) Models. Of course any HMO can change some of its basic features, forming a hybrid, but a mere introduction to the features of different HMOs is the purpose of this analysis.

95. *See, e.g.*, Chittenden, *supra* note 85, at 452; Freiburg, *supra* note 1, at 586; Schwartz, *supra* note 3, at 1362; Shah–Mirany, *supra* note 13, at 358–60.

96. Chittenden, *supra* note 85, at 452; Freiburg, *supra* note 1, at 586; Shah–Mirany, *supra* note 13, at 359.

97. Chittenden, *supra* note 85, at 452; Freiburg, *supra* note 1, at 586; Schwartz, *supra* note 3, at 1362; Shah–Mirany, *supra* note 13, at 359.

98. Chittenden, *supra* note 85, at 452; Freiburg, *supra* note 1, at 586; Schwartz, *supra* note 3, at 1362; Shah–Mirany, *supra* note 13, at 359.

99. Chittenden, *supra* note 85, at 452; Freiburg, *supra* note 1, at 586; Shah–Mirany, *supra* note 13, at 359-60.

the subscribers.[100] Instead of having the physician practice on a capitated basis, the HMO will bargain with the IPA for a reduction in fees.[101] Then the HMO will send patients to be cared for on a discounted fee for service basis.[102] As the terms of any HMO can be altered, the elements of the actual HMO may differ from the three prototypes, but a basic understanding of the structure and features found in these three types will foster a more informed discussion.[103]

3. Preferred Provider Organizations

The last major form of managed care is the Preferred Provider Organization (PPO). A PPO is an insurance service-benefit plan.[104] Recently, the popularity of PPOs has grown as consumers seek out more cost effective health care options.[105] PPOs are quite similar to IPA Model HMOs in the sense that the care giver contracts to provide services to the members of the PPO. The PPO actively negotiates lower rates for their patients.[106] In exchange for lower rates for care, the PPO offers a participating preferred provider a greater volume of patients.[107] Often, the list of preferred providers that the subscribers have to choose from in order to take greatest economic advantage of their insurance plan is made up of those doctors "who have historically admitted fewer patients and discharged them more quickly."[108] In other instances, the provider's contract may agree to "comply with aggressive cost-cutting measures like utilization review."[109]

Factors other than the discounted fee for service basis of payment and the incentive to use the preferred doctors add great variance to the specific form of PPO. Traditionally, PPOs have not used a capitation system similar to HMOs, so the financial risk of overconsumption by the patient remains with the PPO.[110]

---

100. Chittenden, *supra* note 85, at 482; Freiburg, *supra* note 1, at 586; Schwartz, *supra* note 3, at 1362; Shah–Mirany, *supra* note 13, at 360.

101. Chittenden, *supra* note 85, at 482; Freiburg, *supra* note 1, at 586; Shah–Mirany, *supra* note 13, at 360.

102. Chittenden, *supra* note 85, at 482; Freiburg, *supra* note 1, at 586; Shah–Mirany, *supra* note 13, at 360.

103. Some commentators feel the difference between the IPA and Group Model is becoming blurred, as the basic structures are altered. *See, e.g.,* Chittenden, *supra* note 85, at 452. For the purposes of this note, the greater focus will be on the Group Model and Staff Model. Because the physician operates as an employee of the HMO or on a capitation basis, these two models may be referred to collectively as managed care. Although the distinction between the two may be important in an individual case, the incentive structure and distinctions from the fee for service will be assumed to be the same.

104. Griner, *supra* note 14, at 872. A service-benefit plan differs from an indemnity plan in that the third party payor agrees to pay for total health care of the subscriber for an established premium. *Id.*

105. *See, e.g., id. See also* Chittenden, *supra* note 85, at 453. Some feel that HMOs and PPOs are becoming the dominant form of health care delivery. *See, e.g.,* Thornhill, *supra* note 87, at 359.

106. Griner, *supra* note 14, at 872. *See also* Freiburg, *supra* note 1, at 587; Schwartz, *supra* note 3, at 1362.

107. Freiburg, *supra* note 1, at 586; Schwartz, *supra* note 3, at 1362. Although patients are not required to use only the participating preferred doctors, there are financial incentives to do so through co-payments and reduced or decreased deductibles. *See, e.g.,* FURROW ET AL., *supra* note 19, at 388; Randall, *supra* note 8, at 22.

108. Griner, *supra* note 14, at 872.

109. *Id.*

110. Freiburg, *supra* note 1, at 587. When the consumer overutilizes services in a PPO, the doctor is still paid on a discounted fee for service basis for the individual treatment procedures. The PPO, on the other hand, will lose money when the cost of care for individual

Yet, like all MCOs, the form can be easily altered by contract or agreement.[111] One such altered agreement in existence today is the limited-risk PPO.[112] These organizations essentially shift a portion of the financial risk of overconsumption and the financial burden of care to the provider.[113] Other alterations are inevitable as times change and the medical market requires new and different responses. PPOs have faced relatively little regulation, leaving open the possibility of numerous variations such that the PPO can take whatever shape the actors in the health care delivery system wish.[114]

As costs escalate in the delivery of health care, the development and proliferation of managed care organizations and cost containment practices will continue. Three basic forms of managed care in the United States are the DRG system under Medicare,[115] the HMO models,[116] and the PPO models.[117] These three systems have changed not only the reimbursement schedules, but also the relationships between all the parties.[118] This Note next examines how the incentives of all the actors in the delivery of health care have been altered under these new systems described collectively as Managed Care Organizations (MCOs), and whether this should affect liability for medical malpractice.

B. Incentive Structure of MCOs

Traditionally, under the fee for service health care delivery system, physicians had an incentive to overtreat the patient.[119] Procedures offering incremental benefit, no matter how small, were undertaken because both the doctor and patient received benefit from the treatment.[120] The cost of this incentive system was felt as the health bill for the United States continued to expand.[121] Increasingly, Americans were unable to afford expensive procedures or insurance, and thus went untreated.[122]

---

patients exceeds the premium payment. This creates an incentive for the PPO to try to manage care either through active utilization review or careful scrutiny of the doctors chosen as preferred providers so that physicians with a propensity to overconsume are not listed as a preferred provider. Although patients are not required to go only to the preferred providers, many, in fact, will because of the financial incentives created by the PPO in the form of reduced cost, lessened co-payments, or decreased deductible.

111. Although this may be true, there now exist statutory restrictions on the extent to which some of the MCOs can be altered to shift the financial risk. *See* 42 C.F.R. § 417.120(b)(4) (1995).

112. Randall, *supra* note 8, at 24.

113. *Id.* Under this type of PPO, the system more closely resembles a capitation system than an insurance service-benefit plan with discounted fee for service payments. Further references to PPOs will assume the full-risk PPO, or one in which none of the financial risk is shifted to the physician but borne instead by the PPO. Capitation type systems will be discussed with MCOs, while any specific reference to a limited-risk shifting PPO will be made explicitly.

114. *Id.* at 23. *See also* Freiburg, *supra* note 1, at 587.

115. *See supra* notes 70–86 and accompanying text.

116. *See supra* notes 87–103 and accompanying text.

117. *See supra* notes 104–14 and accompanying text.

118. *See infra* notes 119–73 and accompanying text.

119. *See supra* notes 14–19 and accompanying text. *See also* FURROW ET AL., *supra* note 19, at 412.

120. FURROW ET AL., *supra* note 19, at 327.

121. *Id.* at 325–27.

122. *See* Randall, *supra* note 8, at 13.

With rising costs and discontent, MCOs developed to cure the problems present under a fee for service regime.[123] Although MCOs' primary concern is containing costs, there is more to MCOs than just cost containment that distinguishes managed care from a fee for service delivery system.[124] Previously, under a fee for service delivery system, the doctor or hospital was in charge of the management of care. Doctors were not opposed to making a profit, but they also had a fiduciary relationship with the patient.[125] If the fiduciary relationship was breached, then liability might attach.[126] However, when the doctor-patient relationship is altered, and a third party without a treatment relation to the patient is introduced, several factors not previously part of the equation become relevant.[127] The incentive structure of MCOs will thus be viewed in light of both cost containment and the new relationship created between the parties.

As a means of containing costs, MCOs have to deliver health care below a capitation level or pre-arranged fee.[128] When the costs of patients exceed the amount allotted either for patients under a DRG system or a capitation system, the MCO will lose money.[129] Losing money on some patients is considered acceptable as long as a sufficient number of the patients are being treated below a prescribed level.[130] But the incentive structure created is for the MCO to use fewer resources per patient as a means of realizing a greater profit.[131] This incentive structure is generally acceptable, as long as doctors meet the standard of care, and provide care with the patient's best interest in mind. Once the standard of care drops below an acceptable level as a means of increasing profit for the MCO, physicians place themselves in the precarious position of exposing themselves to malpractice liability.[132]

When a patient goes to a doctor for treatment, the assumption is that the doctor will provide treatment likely to cure his ailment. When physicians are pressured into underutilization,[133] there is a danger that the quality of care provided will fall below the legally required standard.[134] Although diminishing the number of procedures used will not always cause harm to a patient,

123. *See id.* at 18 (DRGs). *See also* Griner, *supra* note 14, at 882 (describing managed care).

124. Under managed care there is the addition of a contractual relationship between the doctor and a third party payor that was never present in the fee for service system. Randall, *supra* note 8, at 19.

125. *See, e.g.*, FURROW ET AL., *supra* note 19, at 430; Schwartz, *supra* note 3, at 1360.

126. *See, e.g.*, FURROW ET AL., *supra* note 19, at 430; Schwartz, *supra* note 3, at 1361.

127. Randall, *supra* note 8, at 19 (noting the novelty of the physician-third party payor, a new relationship, and of the duties arising out of the relationship).

128. *See, e.g.*, Jost, *supra* note 9, at 490; Lu, *supra* note 13, at 528–29.

129. *Cases of Care Abuses by HMOs Reported on Rise Across Nation*, ARIZ. DAILY STAR, June 19, 1994, at B10.

130. *Id.* This is because profit is measured as the difference between enrollment fees and overhead paid out for services to its members. *Id.*

131. Jost, *supra* note 9, at 490 (incentives for Medicare). *See also* Freiburg, *supra* note 1, at 584 (incentive to use fewer resources); Furrow, *supra* note 88, at 148 (incentives for HMOs); Lu, *supra* note 13, at 528–29.

132. Furrow argues that before accepting cost containment strategies, we must be sure the quality of care does not suffer. *See, e.g.*, Furrow, *supra* note 88, at 149.

133. Pressure can be applied on the doctor through a variety of means. *See supra* note 85.

134. Jost, *Regulation*, *supra* note 15, at 527; Randall, *supra* note 8, at 24. In fact, evidence is surfacing to suggest that hospitals reimbursed under a DRG system and HMOs are providing poorer care. Furrow, *supra* note 88, at 148.

eventually, decreased utilization will be carried to the extent of dropping medical services below the standard of care, causing harm to a patient.[135]

These are the cases which should cause concern. When cost containment is driven to the point of causing injury, the utility of cutting costs has been taken too far. Having discussed the general incentive structure towards underservice, this Note next examines its effect on the two primary groups in the health care delivery system: the doctor and the third party payor.

1. Financial Risk

Under the different MCOs, the financial risks of treatment can remain with the MCO or be shifted to the treating physician.[136] For example, under an MCO like the Staff Model HMO or the IPA Model HMO, the MCO contracts with both patients and physicians.[137] The organizations pay the doctors on either a flat rate or a discounted fee for service basis.[138] Patients have access to care that is covered under their contract.[139] Thus, when patients use a lesser quantity of service, the MCO profits. On the other hand, because their income is fixed, when doctors and patients overutilize medical services, the MCO loses money.[140] Thus, the financial risks of health care remain with the MCO. When an MCO bears the financial risk of success or failure, it will be referred to in this Note as a "non-shifted" MCO. Under this type of regime, the MCO will pressure doctors to lessen their utilization so the MCO does not lose money.[141]

In contrast to the non-shifted MCO is the "fully-shifted" MCO. Such an organization is similar to the Medicare DRG system or a Group Model HMO. Under this type of system, the MCO contracts with patients and physicians, thus shifting the financial risk of success or failure to the caregiver.[142] The doctor must either treat the patient under the capitation level or bear the financial loss of treatment.[143] In this scenario, the MCO no longer has any incentive to try to control the level of utilization of the contracting doctor, as the MCO no longer bears the financial risk of overconsumption.[144] These alternate incentives created by the risk shifting will be pivotal in the determination of whether a new liability system should govern the MCO.

a. Third Party Payor Incentives

The role of a third party payor and corresponding incentive structure will depend to a large extent on the form of the MCO. In a regime where the third

135. Randall, *supra* note 8, at 24.
136. *See, e.g.*, Freiburg, *supra* note 1, at 585 (describing HMOs that retain the financial risks); Shah-Mirany, *supra* note 13, at 360 n.7 (describing how an IPA model HMO could shift the financial risks to the physician).
137. *See supra* notes 87–103 and accompanying text.
138. *See supra* notes 87–103 and accompanying text.
139. *See supra* notes 87–103 and accompanying text.
140. *See supra* notes 87–103 and accompanying text.
141. *See supra* note 85.
142. *See supra* notes 70–103 and accompanying text.
143. *See supra* notes 70–103 and accompanying text. *See also* Shah-Mirany, *supra* note 13, at 360.
144. *See, e.g.*, Shah-Mirany, *supra* note 13, at 360 n.7 (discussing the financial risk in both a capitation and a fee for service system, and noting that when the MCO is acting under a capitation system the MCO has no concern about utilization since the physician bears the risk of financial success or failure).

party payors retain a substantial share of the risk, they will have an incentive to control physician behavior.[145] Having control over a physician's prescription power is closely linked to the survival of the organization.[146] As third party payors exert control over physicians, they intrude into a decisionmaking domain once patrolled only by physicians.[147] Yet, MCOs need to continually worry about their own financial solvency,[148] whereas doctors have previously focused only on the patient's welfare.[149]

Thus, when MCOs are developed as a means of making a profit,[150] and a substantial portion of the financial risk is borne by the MCO, the doctor should expect pressure to contain costs.[151] Through the use of a variety of means ranging from economic incentives to admonishing behavior or denying staff privileges, the third party payor will be able to exert enough pressure to affect the decision of the treating physician.[152]

As the third party payor's role shifts from bearing a substantial portion of the risk (non-shifted), to shifting the risk to the treating physicians (fully-shifted), the incentives of the third party payor also change. When the risk is shifted entirely to the doctor, the third party payor has no incentive to decrease utilization of procedures.[153] The MCO compensation is unchanging, based on the amount of care given.[154] Under a fully-shifted risk arrangement, the third party payor exerts no pressure and plays no role in a treatment decision.[155]

---

145. Even though doctors' fees may only account for a small portion of the health care bill, they are estimated to have control over 70–90% of health care expenses. *See, e.g.*, Griner, *supra* note 14, at 868; Lu, *supra* note 13, at 528-29 (doctors influence 70% of health care spending).

146. *See, e.g.*, Griner, *supra* note 14, at 869; Lu, *supra* note 13, at 528–29.

147. Griner, *supra* note 14, at 869.

148. Lu, *supra* note 13, at 528–29. This is not meant to insinuate that doctors under a fee for service delivery system are not concerned with their financial well being. In fact they are. But, when a health care system is set up for profit, the profit incentive may not be as evenly balanced with the best interests of the patient, as is present in a doctor patient relationship. This effect may be exacerbated as long as MCOs are not liable for the pressure they put on doctors' decisionmaking when malpractice occurs.

149. FURROW ET AL., *supra* note 19, at 327 (noting that doctors have historically been predisposed to spend money on the patient regardless of cost in the hope of benefiting the patient).

150. MCOs can be established primarily for the purposes of making a profit. *See, e.g.*, Randall, *supra* note 8, at 25.

151. *See, e.g.*, Griner, *supra* note 14, at 869 ("third party payors must be able to exert control over the physician to survive"); Lu, *supra* note 13, at 528–29; Macon, *supra* note 17, at 206 (noting that doctors are placed in a position of either maintaining their fiduciary duty to the patient or falling subject to the pressures of the MCO and complying with the cost cutting guidelines).

152. *See supra* note 85. Thus, the number of actors affecting a medical decision has changed drastically. No longer is the physician the sole decisionmaker as she was under the fee for service system. Now, she must accept influence from third party payors. But when it comes to doling out liability for medical malpractice, the third party payor is willing to back down and allow the treating physician to take the blame for any decisions made.

153. *See supra* notes 70–103 and accompanying text. *See also* Shah–Mirany, *supra* note 13, at 360.

154. *See supra* notes 70–103 and accompanying text. *See also* Shah–Mirany, *supra* note 13, at 360.

155. As will be seen later, when a third party payor plays no role in affecting the treatment decision of a treating physician, there is no reason for holding the MCO jointly liable in a medical malpractice suit.

The structure of the MCO will have a large effect on both the incentives created and the resulting actions of third party payors. With a greater proportion of the financial risk being borne by the third party payor comes an increased incentive to take an active role in containing costs and monitoring, which may entail pressuring physician treatment decisions. As the financial risk is shifted from the third party payor, it will be increasingly incurred by the treating physician of an MCO. The incentive structure will place the physician in a very different light than that found in the fee for service system.

b. Physician Incentives

Doctors are often referred to as the "gatekeepers" of medical care.[156] They determine how patients are to be treated, and for how long.[157] Physicians have a fiduciary duty to the patient and face liability for decisions that deviate from the applicable medical standard of care.[158] These were the traditional underpinnings of the fee for service delivery system.[159] But, with the inception of managed care has come an alteration in not only the incentive structure, but in the manner in which medical care is given as well.[160] As the MCO characteristics deviate further from a fee for service regime, so will the incentive structure and the basic assumptions on which society has traditionally based medical care.

1. Gatekeeper

In a non-shifted MCO, physicians will have little incentive to contain costs.[161] Conversely, the third party payor will bear the risk, will attempt to control physician behavior, and will contain costs.[162] As the measures used by MCOs to control physician treatments begin to affect physician decision making, the first premise of traditional care has been altered; the physician is no longer the "gatekeeper," because she shares that role with a third party payor.[163] The third party payor pushes the doctor to use less,[164] while the doctor attempts to make medical decisions with all the players' interests in mind.[165] Seemingly, the second premise of traditional medical care has also been eroded, as the physician

156. Griner, *supra* note 14, at 868. *See also* Sulmasy, *supra* note 11, at 920.
157. Griner, *supra* note 14, at 868.
158. *See, e.g.*, FURROW ET AL., *supra* note 19, at 430; Schwartz, *supra* note 3, at 1360.
159. *See supra* notes 14–38 and accompanying text.
160. *See, e.g.*, Freiburg, *supra* note 1, at 588 ("Managed care intrudes upon the traditional physician-patient relationship."); Griner, *supra* note 14, at 907 (predicting that due to the fact that physicians are losing their role as the sole decisionmaker and that MCOs are basing treatment decisions largely on economics rather than the patient welfare, society will eventually hold the MCOs liable).
161. *See supra* notes 145–52 and accompanying text.
162. Pressure can be applied on the doctor as a means of encouraging compliance with cost containment practices through a variety of measures. *See supra* note 85.
163. Griner, *supra* note 14, at 868. *See also* Schwartz, *supra* note 3, at 1363; Sulmasy, *supra* note 11, at 92.
164. *See, e.g.*, Jost, *supra* note 9, at 490.
165. FURROW ET AL., *supra* note 19, at 430 (doctors have a fiduciary duty to put the patient's interest above any financial gain); Schwartz, *supra* note 3, at 1360 (under a fee for service system the doctor only took the patient's interests into account). The second foundation of traditional health care under a fee for service regime is thus effectively removed. The physician traditionally only had to think of the best interests of the patient. This cost escalating system has been replaced with MCOs that force doctors to think of the ulterior effect of treatment decisions on groups like third party payors. This reality is more acutely focused as the pressures on cost containment come to bear increasingly on the doctor.

is no longer keeping the patient's interests tantamount. Incremental benefit to the patient is no longer the only goal, because doctors have the additional duty to manage a patient's care for the third party payor in an effort to contain costs and keep the MCO financially stable.[166] Thus, when the financial risk is not shifted to the doctor, the third party payor will try to influence the physician's behavior through informal sanctions and economic incentives.[167] Almost all of the traditional premises of the fee for service delivery system are altered under a non-shifted MCO. The physician is not the sole decisionmaker, the patients' interests are not held above all other interests, yet the doctor is still the sole bearer of medical malpractice liability.[168]

By contrast, in the fully shifted MCO, where all or substantially all the financial risk is shifted from the third party payor to the health care provider, similar incentives are present, except they are self-imposed.[169] Physicians want to control costs in order to maintain fiscal success.[170] Cost containment is balanced against the patient's interest as treatment decisions are made.[171] However, the greatest difference between the non-shifted and the fully-shifted risk MCO is the physician's role as gatekeeper. Under a full shift of the risk, not only are the incentives self-imposed by the doctor, but the third party payor is not expressly affecting medical decisionmaking.[172] With one of the basic tenets of the traditional health care delivery remaining (the doctor as gatekeeper), there may be enough support to hold up the traditional medical malpractice system.[173]

---

166. *See supra* notes 145–52 and accompanying text. The third underpinning of the fee for service system is removed. The doctor and patient no longer benefit from each incremental treatment procedure.

167. *See supra* note 85.

168. Lu, *supra* note 13, at 532. Medical malpractice liability has seldom been extended to include third party payors. This Note will discuss this issue in greater detail *infra* at notes 200–12 and accompanying text.

169. Capitation systems under an HMO or the Medicare DRG system of reimbursement serve as examples of full financial risk shifting. In both programs, the physician or hospital is paid a fixed amount without the possibility of its increase being dependent on the care required. In this situation the health care provider bears the risk of providing care at less than the prospectively determined amount needed to make a profit, or of exceeding the prospective payment and operating at a loss.

170. *See supra* notes 141–44 and accompanying text.

171. This is strikingly different than the fee for service system where extra procedures amounted to increased profit for the doctor. Under an MCO that has shifted substantially all the risk to the physician under a capitation system, the physician gives care above the capitation rate at a cost to himself. There is no chance of increased payment, and the only effect is a decrease in profits or increase in deficit spending.

172. *See supra* notes 141–44 and accompanying text. Inherent in any MCO will be an altered decisionmaking process as more weight is placed on cost containment as a means of reducing costs to pass along to the consumer. As far as a proposal for a new liability system is concerned though, the type of alteration becomes quite significant. In an MCO with a full risk shift, the physician is no longer receiving direct pressure from the third party payor in the determination of a treatment agenda. If the rationale for imposing joint liability for medical malpractice decisions on doctors and third party payors is to bring the liability in line with medical decisionmaking (or pervasive influence), then in an MCO with fully shifted risk, the rationale is clearly absent. The reciprocal reasoning would seem to readily apply when a third party payor does in fact pressure a medical decision, leading to medical malpractice. This Note examines this scenario *infra* at notes 318–30 and accompanying text.

173. The traditional tenets of health care are based on the fee for service delivery system. These include the physician as the "gatekeeper," the patients' best interests remaining tantamount to any other concern, and the physician being ultimately the only entity responsible for negligent medical decisions.

2. Approach to Liability

Based on the amount of the financial risk that is shifted under the MCO, the incentive structure of the physician will be altered.[174] Under a system that shifts no financial risk, the physician will be controlled by third party payor incentive schemes and pressures.[175] This type of MCO causes a breakdown in the traditional concepts of health care.[176] The incentive structure for a physician in an MCO where substantially all the financial risk is shifted to the doctor is strikingly different than a scheme where the MCO bears the risk.[177] In the fully-shifted MCO, all the incentives and pressures are self-imposed.[178] Although some of the foundation of the traditional health care system can be seen to crumble, the notion of doctor as "gatekeeper" remains intact.[179] Because of this, the MCO shifting all the financial risk and the MCO shifting no risk, although producing similar incentive structures, will force different conclusions when determining whether or not physicians should be held solely liable for a negligent decision in the delivery of medical care.[180]

III. MEDICAL MALPRACTICE—THE CURRENT SYSTEM

The medical malpractice standard is rooted in the traditional concept of a fee for service system.[181] The physician is expected to be the sole decisionmaker as the patient's loyal fiduciary.[182] The standard of care requires the doctor to "use the knowledge, skill and care ordinarily possessed and employed by members of the profession in good standing."[183] When the physician drops below standards of acceptable care for the community and an injury results, the tort system will seek to compensate the patient for her injuries.[184] Plainly, the liability system can be seen to work towards goals of both compensation and deterrence.[185]

Professor Jost sees the interplay of both goals as supporting the maintenance of a strong malpractice standard of care.[186] He feels that while state legislatures are trying to limit medical malpractice recoveries and lessen the liability for professionals and institutions, managed care has simultaneously developed.[187] Just as the institutional guarantee of quality through the tort system is being lessened, "the financial incentives that have encouraged delivery of high

174. *See supra* notes 156–73 and accompanying text.
175. *See supra* notes 156–73 and accompanying text.
176. *See supra* note 173.
177. *See supra* notes 136–55 and accompanying text.
178. *See supra* notes 156–73 and accompanying text.
179. *See supra* notes 156–73 and accompanying text.
180. *See infra* notes 318–30 and accompanying text.
181. *See, e.g.*, Bovbjerg, *supra* note 3, at 1377, *passim*; Schwartz, *supra* note 3, at 1361.
182. *See, e.g.*, FURROW ET AL., *supra* note 19, at 430; Bovbjerg, *supra* note 3, at 1395–96; Lu, *supra* note 13, at 531 (MCOs threaten to upset the traditional fiduciary doctor-patient relationship); Schwartz, *supra* note 3, at 1360.
183. KEETON ET AL., *supra* note 25, at 187 & n.36. *See also* Morreim, *supra* note 15, at 1725.
184. Harvard Law Review Association, *supra* note 14, at 1008.
185. Neil J. Squillante, *Expanding the Potential Tort Liability of Physicians: A Legal Portrait of "Nontraditional Patients" and Proposals for Change*, 40 UCLA L. REV. 1617, 1623–24 (1993).
186. Jost, *Regulation*, *supra* note 15, at 528.
187. *Id.*

quality care are being removed."[188] A strong malpractice system is needed to insure that quality remains constant.

Similarly, as MCO cost constraints have affected physician decisionmaking, the question has been posed whether such constraints should be used by a doctor as a defense to a malpractice suit. Most commentators have argued there is little support for such a proposition, as it would only lower the quality of care.[189]

The quality of care rationale must stand strong due to the ineffective nature of the compensation rationale.[190] Not only do few of the injured file suits, but of those filing suit, even fewer recover.[191]

Because the compensation function is so ineffective, the deterrent/quality control function of the tort system must persevere. Accordingly, physicians are not allowed to use cost constraints as a defense to a malpractice suit.[192] Yet, society is asking the doctor, pressured by an MCO's cost constraints, to make medical decisions as if she had a full range of choices, but simultaneously not allowing her to use her decreased range of options in the system as a defense.[193] Essentially, we ask doctors to treat patients within the rubric of an MCO, while we continue to assess their malpractice liability by the traditional standard of health care delivery. The incentives and tensions between MCOs and the medical malpractice liability system place the doctor in an inherently precarious position.[194] The best way to rectify this situation may not be to absolve the doctor of liability, but to make the MCO jointly liable for injuries caused through cost containment.[195]

---

188. *Id.*

189. Morreim, *supra* note 15, at 1724–25. The author posits the question, if resources are becoming stratified, should the standard of care find similar stratification? *Id.* at 1724. The answer has been "an emphatic 'no.'" *Id. Cf.* Jost, *Regulation*, *supra* note 15, at 528. Jost argues that now more than ever we need a strong medical malpractice system, in light of cost-containment practices. *Id.*

190. Commentators set the range of injured patients actually filing suits at 10–20%. *See, e.g.*, Jost, *Regulation*, *supra* note 15, at 574 (setting the percentage at 20%). *See also* FURROW ET AL., *supra* note 19, at 34 (citing New York statistics of one out of every eight injured patients filing claims); Jonathan J. Frankel, *Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures,* 103 YALE L.J. 1297, 1298 (1994) (not setting a percentage); Furrow, *supra* note 14, at 992 (setting the percentage at 10%); Randall, *supra* note 8, at 42–43 (Many patients do not file suit because of the difficulty of proving negligence. No percentage was offered for the number of injured patients not bringing a claim.).

191. *See, e.g.*, Jost, *Regulation*, *supra* note 15, at 574 (setting the percentage at 40%). *See also* FURROW ET AL., *supra* note 19, at 34 (in New York only one of 16 negligently injured patients received compensation); Frankel, *supra* note 190, at 1298 (not setting a percentage); Furrow, *supra* note 14, at 992 (not setting a percentage); Randall, *supra* note 8, at 42–43 (arguing that even if a suit is brought, establishing fault against the doctor is problematic).

192. Morreim, *supra* note 15, at 1724.

193. *See, e.g.*, Frankel, *supra* note 190, at 1317; Harvard Law Review Association, *supra* note 14, at 1022 (concluding that current law should be modified to account for the new cost-cutting initiatives).

194. Beyond placing the physician in a precarious position, it seems unjust to hold the physician solely liable for medical decisions that are the product of many other actors and decisionmakers.

195. Many factors influence a determination of whether liability should extend to third party payors. The primary factors relevant to this inquiry will be the allotment of risk in the MCO, whether the physician is acting as the sole "gatekeeper," and whether the patient's interests are tantamount. As these factors are balanced and measured, a determination of how

By insisting on our old medical malpractice system, the treating physicians in MCOs have been placed in a compromising position. They are asked to use less than all the resources available, but are then judged as if they had the option to use all these resources.[196] Doctors are being asked to expose themselves to greater threats of liability for serving society by decreasing the cost of medicine in America. Two options are available to rectify this situation. Society can either accept cost containment on a nationwide basis or MCOs can begin to share in liability for negligent medical decisions as their role becomes a substantial factor in the decisionmaking process.[197] The latter option is central to the thesis of this Note and seems the best option. An expansion of liability to include the MCO is not original. Lawyers have tried to include MCOs in lawsuits in the past, but for various reasons they have failed.[198] As courts recognize MCOs' inequitably favorable position, they will increasingly extend liability to MCOs.[199]

A. Past Liability of MCOs

A proposal for extending liability to MCOs seems necessary because our current tort system is not equipped to deal with developments in health care.[200] Additionally, liability of MCOs for medical malpractice is almost undeveloped.[201]

In the past, limiting rules have allowed a suit to be brought against a doctor, but not against an organization.[202] Courts felt that since groups could not practice medicine, group negligence was impossible.[203] This view is premised on the idea that the doctor serves as the sole decisionmaker ("gatekeeper"), and any

---

far away from our traditional health care delivery system the particular MCO has come can be readily made. For a discussion of these factors see *infra* notes 318–30 and accompanying text. For the purposes of this discussion, a realization that our current tort system deals with MCOs ineffectively is sufficient.

196. Frankel, *supra* note 190, at 1317.

197. If cost containment were accepted on a societal level, then doctors would be able to deny treatment while maintaining an unwavering loyalty to the patient. Also, because society had decided to cut costs, particular treatments would be unavailable to everyone. Doctors would still satisfy the role of sole "gatekeeper" because treatment options would in fact no longer be options. A doctor might say, "I am sorry Mr. Peters, but nobody is allowed that treatment anymore." In this situation two of the basic tenets of the traditional practice of medicine remain: the physician as "gatekeeper," and the physician as fiduciary for the patient. Thus the traditional medical malpractice system should also remain. *See generally* Sulmasy, *supra* note 11, at 922. This idea and its in-depth treatment is beyond the scope of this Note, but it does exemplify how cost containment can be treated by a traditional medical malpractice regime. Yet, when the basic assumptions of traditional health care are changed, the malpractice system becomes ineffectual.

198. *See infra* notes 200–12 and accompanying text.

199. The purpose of this Note is to study the dominant MCO structures and their incentives as a means of deciding the best rationale for extending liability, instead of merely applying it randomly without consideration of its downstream effects. Commentators believe that recent court decisions will spawn numerous new theories. Thornhill, *supra* note 87, at 359. Liability risks for MCOs will expand as they play an increasingly larger part in the delivery of health care. *Id.*

200. Frankel, *supra* note 190, at 1317.

201. William J. Curran & George B. Mosley, III, *The Malpractice Experience of Health Maintenance Organizations*, 70 NW. U. L. REV. 69, 71 (1975) (HMO liability is seen as almost nonexistent); Lu, *supra* note 13, at 532. *See also* Furrow, *supra* note 88, at 152 (in the past the doctor has been faced with the brunt of malpractice actions).

202. Frankel, *supra* note 190, at 1318.

203. *Id.* at 1318–19.

faulty choices belong to the doctor alone.[204] Additionally, the doctor is thought to have the final say in the treatment procedure.[205] The doctor is the "captain of the ship" and any treatment decision must be met with the captain's approval.[206] As "captain," the onus is on the doctor to act as advocate for the patient and see that the proper care is approved.[207] When the doctor gives in to an organization by denying care, then liability would attach, because the doctor abdicated his responsibility.[208]

Whether release of liability of the MCO is based in the concept of doctor as "gatekeeper" or "captain of the ship," it is becoming increasingly apparent that these perceptions do not apply across all systems of health care delivery. As relationships between the parties change, so should our liability system.[209] Physicians are increasingly beginning to share treatment decisions with MCOs as utilization review and cost containment strategies become dominant forms of cutting costs.[210] The change and its effects are on the horizon.[211] Some jurisdictions have already reacted to the changing face of medical care with a corresponding change in liability.[212]

B. A Changing Jurisprudence

Due to the fact that so few courts have decided whether third party payors can be held liable for their cost containment practices,[213] a unified response to the issue has not developed.[214] Even the courts that have addressed the issue have not succinctly distilled a duty of care or standard for liability.[215] Jurisdictions have

204. *Id.* at 1320; Lu, *supra* note 13, at 532. This will create future problems as there are clearly more actors involved in the decision than just the doctor. *See, e.g.*, Corcoran v. United Healthcare, Inc., 965 F.2d 1321 (5th Cir. 1992), *cert. denied*, 506 U.S. 1033 (1993).

205. Morreim, *supra* note 15, at 1749–50 (the doctor makes the final medical decision, and should not be corrupted by cost consciousness).

206. Interview with Bruce Woodling, M.D., head of utilization review at Community Memorial Hospital, in Ventura, Cal. (Dec. 21, 1994).

207. *Id.*

208. *Id.* The doctor serves as the patients' advocate. When required treatments are disapproved by the MCO or other organization, then it is the doctor's duty to appeal until satisfactory accommodations are made. *Id.*

209. Liability has been sought on other terms as well in the past through theories such as vicarious liability, agency, contract, and corporate negligence. As the focus of this Note is on developing an expansion in liability for medical malpractice, these theories are beyond its scope. For a more thorough treatment of these theories, see Chittenden, *supra* note 85; Frankel, *supra* note 190; Lu, *supra* note 13; Shah-Mirany, *supra* note 13; Thornhill, *supra* note 87.

210. Commentators believe that although the doctor may retain the final say, this is merely a formality. Griner, *supra* note 14, at 907. With the pressure applied on physicians to cut costs, there is effectively more than one actor making a decision. *See, e.g., id.* (equating a command and a request with attendant consequences). *See also* Freiburg, *supra* note 1, at 589 (questioning whether physicians should face liability when their treatment determinations are over-ridden by an MCO).

211. Eventually, the different forms of liability will be explored and expanded as managed care continues to grow in America. *See, e.g.*, Freiburg, *supra* note 1, at 589. *See also* Thornhill, *supra* note 87, at 359.

212. *See infra* notes 213–81 and accompanying text.

213. Thornhill, *supra* note 87, at 359, 366 (lawyers are just now beginning to recognize HMOs and PPOs as liability sources).

214. *Id.* at 366 (the law is still evolving in this area).

215. *See, e.g.*, Wickline v. State, 228 Cal. Rptr. 661 (Ct. App. 1986) (holding that some utilization review could find liability, but that utilization was not satisfied in the case at hand); Wilson v. Blue Cross, 271 Cal. Rptr. 876 (Ct. App. 1990) (same court deciding that the defendant had breached a duty of care, but neglecting to identify what constituted the duty of care). *See also* Frankel, *supra* note 190, at 1309.

declined to extend liability for cost containment procedures for a variety of reasons.[216] In the past, third party payors relied on courts' findings that corporations were not licensed physicians, and thus were unable to make medical decisions[217] in order to absolve them of medical malpractice liability. Third party payors have also escaped liability when courts determined that only doctors have the final say in the treatment of patients,[218] or when claims of negligence or medical malpractice have been statutorily preempted.[219] Yet, with the changing face of the medical delivery system has come a new wave of medical jurisprudence. The same courts that deny relief to plaintiffs on the facts, send out warnings of future liability.[220] As lawyers become aware of these new sources of liability, the number of cases going to juries will certainly increase.

1. Wickline v. State: Opening the Door

In 1976, Lois Wickline, 48 years old,[221] was treated by a family practitioner for problems in her back and legs.[222] Because Wickline did not respond to the treatment, her primary physician had her admitted to a hospital and arranged for a surgeon specializing in peripheral vascular surgery, Dr. Polonsky, to meet with her.[223] Dr. Polonsky diagnosed her as suffering from Leriche's syndrome,[224] which is caused the obstruction of the terminal aorta.[225] Lois Wickline's blockage occurred at a "point where the aorta divides into two common iliac arteries which descend, respectively, into each leg."[226] In Dr. Polonsky's opinion, the only prudent procedure would be a removal of a portion of the aorta and replacement with a Teflon graft.[227] Lois Wickline agreed to the surgery and Medi-Cal approved the procedure.[228] On January 7, 1977, Dr. Polonsky removed a portion of Wickline's aorta and replaced it with the graft.[229] That afternoon, Dr. Polonsky "was notified that Wickline was experiencing

216. Whether the doctor has the final say, a corporation cannot practice medicine or the MCO is statutorily preempted from liability. *See infra* notes 217–19 and accompanying text.

217. Sloan v. Metropolitan Health Council, Inc., 516 N.E.2d 1104, 1107 (Ind. Ct. App. 1987) (holding that a state statute forbade the practice of medicine except for licensed physicians).

218. *See, e.g., Wickline*, 228 Cal. Rptr. at 670. *See also* Morreim, *supra* note 15, at 1719.

219. *See* Corcoran v. United Healthcare, Inc., 965 F.2d 1321 (5th Cir. 1992) (preempted by ERISA), *cert. denied*, 506 U.S. 1033 (1992); Visconti v. U.S. Health Care, 857 F. Supp. 1097 (E.D. Pa. 1994) (preempted by Employee Retirement Insurance Security Act of 1974, 29 U.S.C.A. § 1144); *but see* Randal R. Munn, *Managed Care/Utilization Review Liability*, NEV. LAW., Aug. 1993, at 23. The author argues that ERISA has become ineffective with respect to utilization review decisions, and can no longer "serve its noble purpose of safeguarding the interests of employees." *Id.* at 26.

220. *Wickline*, 228 Cal. Rptr. at 670. The court indicated in dicta that although Medi-Cal would not be held liable, patients harmed during treatment "should recover for the injuries suffered from all those responsible for the deprivation of such care, including, when appropriate, health care payors." *Id.*

221. *Id.* at 663.

222. *Id.*

223. *Id.*

224. *Id.*

225. *Id.* In Lois Wickline's case, it was a thickening of the walls of the abdominal aorta. *Id.*

226. *Id.*

227. *Id.*

228. *Id.* at 664. She was given authorization for the surgery and a 10-day stay at the hospital, from the date of her admittance on January 16, 1977. Medi-Cal is the medical assistance program in California. *Id.*

229. *Id.*

circulatory problems in her right leg."[230] Dr. Polonsky took Lois Wickline back into the operating room to remove the clot responsible for the problem.[231] Wickline's recovery was incomplete; she suffered from pain, spasms in the lower back and periods of hallucination.[232] Five days after the original surgeries, Dr. Polonsky "performed a lumbar sympathectomy,"[233] a procedure in which nerves on both sides of the spinal chord are removed as a means of opening up the arteries and preventing the spasms from causing further complications. When it came time to release Wickline, Dr. Polonsky and the team of other physicians working with him felt "it was medically necessary" for her to stay an additional eight days after her pre-authorized discharge date.[234] Dr. Glassman, a Medi-Cal consultant, reviewed the request for an extension of Lois Wickline's hospital stay, but only approved a four day extension.[235] This decision was based in part on the patient's temperature, bowel movements, and her diet,[236] which were irrelevant to her circulatory problem.[237]

Dr. Polonsky discharged Wickline on January 21, 1977.[238] During the next few days Wickline was beset with pain and discomfort in her right leg.[239] The pain worsened in the following days, with her leg taking "on a whitish, statue-like marble appearance."[240] After communications with the doctors, and a lack of response to treatments, Wickline was readmitted to the hospital, nine days after her discharge.[241] Her leg had turned gray due to the clotting and lack of circulation. After attempting to save her leg through hospital treatment, Dr. Polonsky felt it was necessary to amputate her leg below the knee.[242]

Lois Wickline brought suit against Medi-Cal for negligence in its review process. She claimed she was negligently discontinued as a Medi-Cal recipient causing the loss of her right leg.[243] Her claim was substantiated by the testimony of Dr. Polonsky who testified to medical causation.[244] Wickline also argued that the Medi-Cal consultant breached the professional standard of care by not examining Wickline's chart or asking further questions of the "on-site nurse" so as to better understand the situation.[245]

---

230. *Id.*
231. *Id.*
232. *Id.*
233. *Id.*
234. *Id.*
235. *Id.* at 665. Dr. Glassman did not look at any report on Lois Wickline; instead, he made his decision not to allow the requested eight day extension purely based on a conversation with an "on-site nurse." *Id.*
236. *Id.* at 666. Medi-Cal makes specialists available, like vascular surgeons, so the consultants have a source of information when they are unsure of a particular treatment procedure. *Id.*
237. *Id.*
238. *Id.* at 667. It was thought that Dr. Polonsky made the discharge within the confines of the appropriate medical standards of practice. *Id.*
239. *Id.*
240. *Id.*
241. *Id.*
242. *Id.* at 668. The first amputation proved unsuccessful, requiring a second amputation above the knee. *Id.*
243. *Id.* at 662.
244. He opined, "to a reasonable medical certainty, had Wickline remained in the hospital for the eight additional days, as originally requested by him and her other treating doctors, she would not have suffered the loss of her leg." *Id.* at 668.
245. *Id.* at 666.

The court concluded that even with Dr. Glassman's seemingly negligent review decision, the final say in a discharge is in the control of the treating physician.[246] In closing the door to recovery, the California Court of Appeals felt the treating doctor was in the advantageous position of having greater control over the situation than the Medi-Cal consultant, and thus could more readily make a second request for an extension when the first one failed, or just deny the discharge altogether.[247] The court determined that the doctor's responsibility is his patient and any action taken should be grounded in sound medical judgment regardless of whether a third party payor approves or disapproves of the proposed treatment scheme.[248]

Yet, as this opinion seems to shut the door on the liability of third party payors, the court forewarned it will not always remain shut. The court stated: "[a] patient who requires treatment and who is harmed when care which should have been provided is not provided should recover for the injuries suffered from all those responsible for the deprivation of such care, including, when appropriate, health care payors."[249]

Thus, the third party payor may be held liable for inappropriate medical decisions, conditioned on the understanding that doctors have the final say in the treatment decisions.[250] One must wonder: if this case was not sufficient to warrant liability, then in what situation would a decision resulting from cost containment strategies be deemed negligent?

2. Wilson v. Blue Cross:[251] Getting Inside

On the strength of the *Wickline* decision, many third party payors used the court's rationale as support for their utilization review or cost containment practices, because in the end the doctor was the person making the final decision as to the patient's treatment.[252] This lasted until the California Court of Appeals revisited the issue in *Wilson*, except this time the defendant was a private insurance company, not Medi-Cal.

Howard Wilson was admitted to a Los Angeles hospital on March 1, 1983 due to depression, anorexia and drug dependency.[253] Wilson's doctor determined a stay of three to four weeks would be required, but after ten days, Blue Cross decided they would no longer cover him.[254] When the doctor told Wilson of the

246. *Id.* at 670.
247. *Id.* The primary physician is the "captain of the ship." *Id.*
248. *Id.* at 670–71. The court indicated that a doctor will not be relieved of liability by third party payors when the physician's decision causes the unwanted consequences. The patient's interests are to be considered tantamount. *Id.*
249. *Id.* at 670. *See also* Chittenden, *supra* note 85, at 477 (recognizing the possibilities of the *Wickline* dicta); Morreim, *supra* note 15, at 1746–47 (author makes a similar proposal for extending liability).
250. Because the third party payor can affect the medical decisionmaking process, the *Wickline* court did not wish to foreclose the chance of future liability. *See* Frankel, *supra* note 190, at 1305.
251. Wilson v. Blue Cross, 271 Cal. Rptr. 876 (Ct. App. 1990).
252. *Wickline*, 228 Cal. Rptr. at 670.
253. 271 Cal. Rptr. at 877.
254. *Id.* There was even some doubt as to whether Wilson's insurance agreement with Blue Cross Blue Shield of Alabama would allow any concurrent utilization review. *Id.* at 881. The contract apparently allowed up to 30 days of hospitalization for nervous or mental disorders as long as a physician believed it was appropriate. Confusion came in because Wilson was reviewed by Blue Cross of California under their regular practice. *Id.* at 880–81.

insurance company's denial of future coverage, and that he would have to finance his own stay, Wilson was unhappy and "cried while talking to an aunt about the determination that he was to be released from the hospital because the insurance company would not pay for the benefits."[255] Not being able to afford a stay at the hospital, Wilson was released from the hospital.[256] On March 31, 1983, Howard Wilson committed suicide.[257]

Wilson's parents brought, among other claims, a suit for negligent utilization review on the part of Blue Cross in the denial of further hospitalization for their son.[258] The trial court granted Blue Cross summary judgment based on *Wickline*.[259] In revisiting a claim for negligent utilization review, the Court of Appeals was presented with a chance to clarify its early decision in *Wickline* and to give legal significance to its earlier dicta.[260]

In a decision that diverged from a long line of cases exempting third party payors from liability for utilization review decisions[261] based on cost containment practices, the California court held Blue Cross and Western Medical[262] were not entitled to summary judgment because the decision to release Wilson could serve as a substantial factor causing his death.[263] Dr. Taff, Wilson's psychiatrist, testified to a "reasonable medical probability" that Wilson would not have committed suicide if he had stayed in the hospital for the period of time Dr. Taff had recommended.[264]

Determining that Blue Cross and Western Medical could be liable for negligent utilization review, the *Wilson* court seemed to step back from their earlier decision in *Wickline*.[265] In differentiating the two decisions, the Court of Appeals explained the earlier decision but still left many questions unanswered.[266]

In distinguishing the two cases, the court identified three main differences.[267] First, in *Wickline*, the decision to release Lois Wickline met the medical standard of care which was set by the California Administrative Code, while the decision to release Howard Wilson raised a triable question of fact for a jury.[268] If the denial of a continued stay in the hospital was a substantial factor in

255. *Id.* at 882.
256. Dr. Taff told Mrs. Wilson that Western Medical had "terminated" her son's stay in the hospital. Due solely to the fact that the insurance company would not cover Wilson, Wilson was released. *Id.*
257. *Id.* at 878.
258. *Id.* at 881.
259. *Id.* at 878.
260. Thornhill, *supra* note 87, at 365–66.
261. *See, e.g.*, Corcoran v. United Healthcare, Inc., 965 F.2d 1321, 1327 (5th Cir. 1992), *cert. denied*, 506 U.S. 1033 (1992).
262. Western Medical was the utilization review company.
263. *Wilson*, 271 Cal. Rptr. at 883. *See also* RESTATEMENT (SECOND) OF TORTS § 431 (1965); Chittenden, *supra* note 85, at 479.
264. 271 Cal. Rptr. at 882.
265. Frankel, *supra* note 190, at 1308 (arguing the "court rewrote *Wickline* in the process [of deciding *Wilson*]").
266. 271 Cal. Rptr. at 878–80. *See* Frankel, *supra* note 190, at 1309 (arguing that in assuming there was a breach of the duty of care, the court avoided defining the duty for the process of utilization review).
267. 271 Cal. Rptr. at 879.
268. *Id.* at 883. *See also* Thornhill, *supra* note 87, at 365–66 (defining the standard of care in *Wickline* as being lower based on a California administrative statute, while the standard in *Wilson* is that of California's negligence law).

Wilson's discharge from the hospital, then Blue Cross would have deviated from accepted practice of the medical community.[269] Taken literally, the analysis in *Wilson* sets the outer limit of liability for utilization procedures. Thus any time the medical standard of care is met, the third party payor performing utilization review will have presumptively acted reasonably and be absolved from liability for cost containment decisions. This seems like an obvious and mundane insight, but when more fully explored, one can see this is a basic tenet to our health care delivery system from which deviation should not be taken lightly.

Beyond the medical decision meeting the requisite standard of care, the *Wilson* court also differentiated the two decisions based on the presence of statutory regulation and public policy.[270] Wickline was being cared for under Medi-Cal. The California Administrative Code offered exceptions to normal tort liability when grounded in the public policy of the Welfare and Institutions Code.[271] Thus, "the state's duty was not determined by normal tort liability, but by the statute and provisions of the California Administrative Code."[272] The *Wilson* case was instead based on a private insurance agreement.

Related to both the tort liability issues and the medical decision meeting the physician's standard of care, the *Wilson* court further distinguished *Wickline* in determining "the Medi-Cal review process was not permitted to corrupt medical judgment."[273] The court in *Wickline* forewarned third party payors that causing a denial of care for patients will result in liability when applicable.[274] The *Wilson* court felt triable issues existed as to whether the insurance company's decisions to deny payment did in fact cause injury to Wilson.[275]

With the *Wickline* decision sufficiently distinguished, the *Wilson* court had to overcome only one additional stumbling block before it could impose liability on the insurer. Its earlier decision had indicated that the doctor was the final arbiter of discharge decisions.[276] Due to this fact, it appeared that the third party payor would always be shielded from potential liability by the treating physician's decision. Instead of addressing the merits of this proposition, the court declared that their previous discussion was merely dicta,[277] and so it was free to impose liability in the *Wilson* case. Furthermore, they stated the "legitimate rationale of *Wickline* was that the normal tort responsibility principles...were modified by the provisions of the California Administrative Code...," so the release of Lois Wickline met the medical standard of care in the community.[278]

Once the court had identified exactly what *Wickline* did and did not stand for, one would assume the *Wilson* decision would become strikingly clear and its impact obvious. This was not the case. The *Wilson* court recognized the

269. 271 Cal. Rptr. at 879.
270. *Id.*
271. *Id.*
272. Griner, *supra* note 14, at 889. *See also* Thornhill, *supra* note 87, at 365–66. The California Administrative Code requires a lesser standard of care than does California negligence law. *Id.*
273. 271 Cal. Rptr. at 879.
274. *Wickline*, 228 Cal. Rptr. at 670.
275. 271 Cal. Rptr. at 885.
276. 228 Cal. Rptr. at 670–71.
277. 271 Cal. Rptr. at 880. *See also* Frankel, *supra* note 190, at 1308.
278. 271 Cal. Rptr. at 880.

"connection between utilization review decisions and medical outcomes,"[279] but once this was realized the court presumed a breach of the duty of care by Blue Cross and proceeded to the causation element.[280] By failing to define the duty of care for the insurance company in their utilization review decision, the court has left the lawyer wondering how to properly advise his client.

The duty question is just one of the attendant quandaries the *Wilson* court left unanswered. The issue of causation, including cause in fact and proximate cause, is equally unclear. As duty is more central to the thesis of this Note, its discussion follows a brief sketch of causation.

C. Causation in Negligent Utilization Review

In determining the impact *Wilson* will have on utilization review in the future, it is important to further explore the requisite elements of negligence. Two such discrete elements are cause in fact, or the "but for cause," and proximate or legal cause.[281]

1. Cause in Fact

A case resting merely on proof that a third party conducted a utilization review decision not in accordance with accepted standards of care for the community will not satisfy the necessary causation elements to win the case.[282] One must prove the actions of the third party payor amounted to the actual cause of the harm.[283] This is sometimes called the cause in fact or the "but for" cause.[284]

The issue of cause in fact relates to the original confusion of the *Wickline* holding. In *Wickline*, the court seemed to indicate that third party payors could not be held liable because the doctor was the person making the decision whether to release, while the third party payors merely made decisions as to payment for such proposed treatments.[285] Couched in causation terms, "the decision by a third party payor cannot be the cause in fact of an injury because it does not deny treatment; it only denies payment for the treatment."[286] Thus, when either the patient declines treatment, or the doctor declines to treat the patient, then that actor will serve as the cause in fact.[287]

The *Wickline* characterization of cause in fact made liability of third party payors nonexistent. The *Wilson* court, however, viewed causation in terms of the "substantial factor" doctrine.[288] This test for cause in fact opens the door to

279. Frankel, *supra* note 190, at 1309.
280. *Id.*
281. KEETON ET AL., *supra* note 25, at 165 & n.4. *See also* DAN B. DOBBS, TORTS AND COMPENSATION PERSONAL ACCOUNTABILITY AND SOCIAL RESPONSIBILITY FOR INJURY, § 2, at 107 (2d ed. 1993).
282. DOBBS, *supra* note 281, at 197.
283. *Id.*
284. *Id.*
285. Wickline v. State, 228 Cal. Rptr. 661, 670 (Ct. App. 1986).
286. Griner, *supra* note 14, at 900.
287. *Contra* Linda V. Tiano, *The Legal Implications of HMO Cost Containment Measures,* 14 SETON HALL LEGIS J. 79, 89 (1990) (arguing that if the *Wickline* court had taken a closer look at causation, it would have found Lois Wickline's injury inevitable, because the doctor that checked her three days after the hospital stay proposed by the doctors found no "material or substantial change in her condition").
288. Griner, *supra* note 14, at 900.

imposing liability for negligent utilization review. Whenever such a decision serves as a substantial factor in a patient's denial of care, leading to an injury that would have otherwise been prevented through the means of proper utilization review, then the causation element will be met.[289] Cause in fact inherently attempts to determine the relation of the third party payor's actions to the resultant injury of the patient. "But for" the utilization review denial of treatment to the patient, the patient would have been alright. However, even if the third party payor's utilization review process or decision was negligent, if the injury was inevitable, then liability should not fall on the third party payor.[290]

2. Proximate Cause

Assuming one can prove actions are so causally related or connected as to satisfy cause in fact, the lawyer still has to overcome the proximate cause issue. Proximate cause was set up as a way to limit recovery to those cases where the actions of the defendant and the injury of the plaintiff are so closely related as to justify holding the defendant liable.[291] In a sense, all of one's actions will have future ramifications. Proximate, or legal cause, is a policy decision where the court should decide to draw the line of liability.[292] This idea can best be illustrated through an example.

Suppose a doctor performs an operation with the intent of sterilizing Mr. Fallow.[293] Mr. Fallow later fathers a child, who grows up and sets fire to the plaintiff's garage.[294] Should the doctor be liable to the plaintiff for the burning of the garage?[295] Although the surgeon is undoubtedly a cause in fact, because without a negligent attempted sterilization, the child would have never been born and burned down the garage, there is some doubt as to whether the public would find it in its best interest to hold the doctor liable for such actions.[296]

Some commentators have described the determination of where to limit liability as a test of foreseeability.[297] Under such a test one can only be held liable for "those harmful consequences which result from the operation of the risk,...the foreseeability of which rendered the conduct negligent in the first place."[298] In light of *Wilson*, this seems to take on increased significance, because the majority of utilization review decisions will apparently have foreseeable effects due to the fact that so few people pay for their own medical care.[299]

---

289. In a perverse way this may mean that wealthy patients may not have a claim for negligent utilization review in the sense that the denial of coverage may serve as less of a substantial factor if the patients are perfectly capable of paying for their own health care. For an analogically similar argument, *cf.* Sulmasy, *supra* note 11, at 920 (arguing that physicians should not take part in rationing of health care because the lines drawn will be according to wealth rather than the more equitable yardstick of technological rationing).

290. Griner, *supra* note 14, at 901.

291. *See, e.g.*, Palsgraf v. Long Island R.R., 162 N.E. 99 (N.Y. Ct. App. 1928).

292. *See* DOBBS, *supra* note 281, at 107.

293. Example taken from *id.* at 219–20.

294. *Id.*

295. *Id.*

296. *See id.*

297. Griner, *supra* note 14, at 902–03.

298. Marshall v. Nugent, 222 F.2d 604, 610 (1st Cir. 1955), *quoted in* Griner, *supra* note 14, at 902–03.

299. Griner, *supra* note 14, at 906 (citing statistics that only 27% of the health care in the United States was paid out of pocket in the 1980's).

Once foreseeability has been removed as a means of avoiding a finding of proximate cause, all that is left is the theoretical conceptualization of proximate cause as a public policy limit to liability. In *Wilson*, defendant Western Medical argued that health care cost containment was an issue of such broad reaching public policy that their conduct should be exempt from liability.[300] In rejecting this argument,[301] the California Court of Appeals provided third party payors with constructive notice that such decisions will be met with liability regardless of their social utility.[302] Essentially, as long as the decision can reasonably lead to the denial of care which would injure the patient in some form, public policy would not dictate limiting liability merely because rising health care costs are such a dominant national issue.

Proximate cause rewoven in terms of foreseeability will leave the jury with the power to extend or limit liability based on their determination.[303] There is no clear method to determine how a court will decide all these elements of causation. However, the *Wilson* decision may indicate that a change in the health care delivery system will foster change in our understanding of the different elements of causation. Third party payors will no longer be exempted from cause in fact because the physician or the patient made the final say in the treatment decision. Rather, the third party payor will be held to have satisfied the cause in fact determination any time their decision amounts to a "substantial factor" in the injury of the patient. Likewise, the Wilson court has put third party payors on notice that public policy grounds will not exempt their utilization review decisions from liability. The Wilson court has thus taken a profound step in advancing liability of third party payors for negligent utilization review decisions that play a substantial factor in causing harm.

The analysis of causation assumes a prior breach of a duty of care to the patient, without which the court will not have an occasion to reach the causation issue. A discussion of this duty necessarily follows.

D. Duty of Care

Prosser and Keeton describe the professional standard of care as requiring a doctor to "use the knowledge, skill and care ordinarily possessed and employed by members of the profession in good standing."[304] As previously discussed, this notion of duty is rooted in the traditional fee for service regime.[305] The basic tenets of this type of duty assumed the doctor kept the patient's interest supreme, the physician was the sole gatekeeper, and any extra medical treatment could benefit both the patient and the doctor.[306] Thus, when a doctor dropped below the medical community standard of care, resulting in injury to the patient, liability attached.[307] The interests of the patient and the physician were thought be in total

300. Wilson v. Blue Cross, 271 Cal. Rptr. 876, 884 (Ct. App. 1990).
301. *Id.*
302. *Id.*
303. Seemingly, when third party payors try to contain costs, they should know these practices will have an effect on the patient. When proximate cause is understood in terms of foreseeability, cases will be more likely to avoid summary judgment and get to a jury.
304. KEETON ET AL., *supra* note 25, at 187 n.36. *See also* Morreim, *supra* note 15, at 1725.
305. *See supra* notes 181–85 and accompanying text.
306. *See supra* notes 156–73 and accompanying text.
307. *See supra* notes 156–73 and accompanying text.

agreement, thus anything not acceptable to the medical profession similarly would not be acceptable to the tort system.

Change has brought about different assumptions of the doctor-patient relationship.[308] The new form of health care delivery has not been met with a new liability system.[309] Because of this, courts are struggling to try to fit our new health care delivery into our old system of liability.[310] A tort system that better accounts for the change in medicine would not only better compensate victims, but would also foster incentives and accountability that the current system no longer does.[311]

Entrenched within the issue of the level of care required of the doctor is the issue of medical decisionmaking itself.[312] Medical care has assumed that there was only one "gatekeeper" in the past.[313] But, as times have changed, so have the people making and affecting decisions of medical treatment.[314] As lawyers see the options available through decisions like *Wilson,* which gives injured patients the option of suing both the doctor and the third party payor when they have been a substantial factor in causing injury, the number of lawsuits will inevitably increase.[315]

> These cases are significant, not only because of the prevalence of utilization review and the financial stakes involved, but also because they illustrate most directly the clashes between the institutional realities of the new cost-conscious medical practice culture and the ideological supports of the old one. The litigants in these cases spar over the extent to which a lay financing entity has appropriated to itself distinctly medical authority by substituting its own expertise for that of the treating physician. At issue is nothing less than the definition of medical decisionmaking itself.[316]

A new approach to the standard of care is needed to better deal with the changing times. A standard based on rationale can better foster change and society's wishes than piecemeal change through case law.

IV. MEDICAL MALPRACTICE: A NEW PROPOSAL

Proposals for the change of the medical malpractice system can not be undertaken lightly. The change will affect not only liability of doctors and third party payors, but the effects will be felt through differing treatment procedures, medical care premiums and incentive structures.

---

308. *See supra* notes 145–73 and accompanying text.
309. *See supra* notes 181–212 and accompanying text.
310. While the *Wilson* court took a bold step in denying summary judgment for Blue Cross, it stymied the evolution of a new tort standard by side-stepping the duty issue. It assumed a breach of duty without defining what constituted the breach. Because of this, lawyers are unsure how much credence to give the decision. *See, e.g.*, Wilson v. Blue Cross, 271 Cal. Rptr. 876, 880 (Ct. App. 1990); Frankel, *supra* note 190, at 1309.
311. *See infra* notes 317–29 and accompanying text.
312. Frankel, *supra* note 190, at 1303.
313. *See supra* notes 181–99 and accompanying text.
314. *See supra* notes 119–80 and accompanying text.
315. *Cf.* Frankel, *supra* note 190, at 1322.
316. *Id.* at 1303.

This Note has explored the differences between a fully-shifted and non-shifted regime when describing the incentive structure of the financial risk-shifting mechanism.[317] This difference is pivotal to an imposition of liability.[318]

A tort system should compensate victims as well as create a productive incentive structure. An expansion in liability to third party payors would do just that. If third party payors were held liable when they serve as a substantial factor in a negligent medical decision, then their actions would fall in line with traditional medical thinking.[319] Yet, the reason for expanding liability does not play an equal role in every MCO that practices cost containment. In a regime where the financial risk is shifted to the doctor, the MCO is not concerned over whether the doctor treats above or below the capitation level.[320] The MCO has a fixed income based in premiums, not related to decreased utilization or cost containment. In this situation the doctor is the sole "gatekeeper," prescribing medicine or treatment as he sees fit. Any interests the doctor holds out above the patient's interest are of his own creation, and are not imposed by another party. Therefore, this proposal would exempt fully-shifted MCOs from an extension of liability.[321] The current malpractice system that deals with these traditional relationships and incentives can deal with this situation.

The traditional malpractice system becomes ineffective when the relationships between all the parties are changed. When the medical care delivery system no longer recognizes the physician as sole "gatekeeper," acting as a loyal fiduciary for the patient, then the doctor should not be exclusively liable. In contrast to the fully-shifted MCO, which should be exempt from the liability expansion, the MCO that retains the risk is a better candidate for imposition of liability. In this type of MCO, the third party has an incentive to control the doctor's treatment patterns as a means of controlling costs.[322] The financial success of an MCO retaining the risk is tied to the ability of the third party payor to "exert control over the physician."[323] With this incentive structure, the third party payor uses pressure and disincentives to shape favorable cost-constraining

317. *See supra* notes 136–73 and accompanying text.

318. The goal of this Note is not to promote expanding liability as a means in itself. Liability is only a portion of the purpose of the tort system. The other purpose a standard of care can serve is to insure quality in health care. This can be done by using the tort system as an incentive to further societally approved actions.

319. The substantial factor test has its caveats. If, for example, an insurance company denies payment for treatment that is not part of the insurance agreement, liability cannot attach. The substantial factor test is in line with the *Wilson* court's reasoning. *See, e.g.*, Wilson v. Blue Cross, 271 Cal. Rptr. 876, 883 (Ct. App. 1990). Although the substantial factor test goes to the legal cause analysis, the same rationale would offer support to the proposition that the entity that is a substantial factor is making the medical decision. If that treatment decision does not fall in line with the standards of the medical community, liability may attach.

320. *See supra* notes 142–44 and accompanying text.

321. All doctors must decide for themselves whether they will act as loyal fiduciaries towards their patients. When a doctor enters an MCO that has fully shifted the financial risk to the doctor, the doctor stands in a position to make the greatest profit or loss. In this situation, financial incentives are self-imposed. When liability for malpractice attaches it should be to the doctor alone. This is because the doctor is standing in his traditional position with regard to the patient. When the relationships between the parties have not changed, neither should the liability. *See supra* notes 169-73 and accompanying text.

322. *See supra* notes 145–52 and accompanying text.

323. *See, e.g.*, Griner, *supra* note 14, at 868–69; Lu, *supra* note 13, at 528–29; *supra* note 85.

actions from their physicians.[324] The result is that MCOs make money, while physicians are asked to try to care for the patient as cost effectively as possible. As a result, sooner or later cost containment may turn into malpractice, and the doctor, not the MCO, may be left facing liability.[325]

A malpractice system allowing for an extension of liability to MCOs for negligent decisionmaking would go a long way toward ensuring a higher quality of medicine.[326] This would not only keep M.B.A.s from making the M.D.'s decision, it will again refocus the attention on the patient, not on the financial benefits.[327]

Expansions of liability are generally not met with much favor today. But, as one explores the underpinnings and incentives of both types of health care delivery and the current medical malpractice system, the need for change is quite apparent. Doctors have seen their traditional role eroded with the advent of managed care. Equity requires that managed care institutions should therefore assume part of the doctors' liability. An analysis of such a proposal is not complete unless it addresses the system's effect on society.

In the case of MCOs retaining the financial risk of care, the threat of liability for negligent decisionmaking will cause MCOs to encourage care by their treating physicians in accordance with the community standard of care. This will effectively give greater credence to physician treatment decisions[328] and insure that third party payors can not use doctors as liability scapegoats. This should not raise the price of medical care, unless the MCOs affected by this change are currently treating below the standard of care. MCO assumption of the financial risk of care may cause the price of defensive medicine to rise, but MCOs should remember if they do not substantially affect a negligent decision they will not be found liable. Thus, defensive medicine amounts to letting the physician decide the treatment routine.

Any time treatment does not deviate from the community standard, liability will obviously not attach. This alone should allay fears that a new proposal will tremendously expand liability. Instead, the new proposal would extend liability to fit the health care delivery system and newfound incentives of

---

324. The pressures and incentives come in a myriad of forms, from the power over staff privileges and shifting the risk to physicians in capitation type systems, to admonishing physicians' behavior through the use of lists or offering physicians economic incentives to contain costs (bonus schedules based on a cost-contained and capitation differential). *See, e.g.*, Chittenden, *supra* note 85, at 481–82; Furrow, *supra* note 14, at 989–99; Randall, *supra* note 8, at 30–32.

325. Although cost-effectiveness is invaluable in these days of rising medical costs, it may not be as attractive if it leads to sub-standard care. This seems inevitable as an MCO tries to make a profit at the expense of decreased utilization. *See, e.g.*, Randall, *supra* note 8, at 24 (managed care may not infringe on the total quality of health care, but it surely will cause some sub-standard care).

326. It would not only encourage MCOs to deliver medical care in accordance with the community standard, but it would also allow the injured patients the recourse they deserve.

327. Cost containment is a very important endeavor, but it is not more important than a patient's health. A better form of cost containment could come through increased emphasis on efficiency during medical training.

328. If a physician's decision is not interfered with by the third party payor, the physician will remain the sole liability source. In the event the third party payor denies the proposed treatment by the physician, and the doctor accepts the denial, then both are liable if the decision rises to the level of negligence. Thus, the third party payor will not interfere in the doctor's treatment nearly as much as before with borderline cases due to the increased risk of liability. Saving hundreds of dollars in utilization is not worth losing thousands in a lawsuit.

our day.[329] By bringing our tort system and our changing health care delivery system into line, the malpractice liability system will again serve its dual function as a means of compensation and of quality control.

V. CONCLUSION

The cost of medicine has been on the rise in this country for quite some time. The reasons for this rise are numerous. The few highlighted in this Note serve as mere examples to compare with the cost containment practices of MCOs.

MCOs have tried to decrease the cost of medicine by restricting utilization and changing the habits of doctors who practiced under the fee for service health care delivery system. These are much needed tools in these days of escalating health costs, but what price should we pay for cheaper medicine? This country may never reach complete agreement on this issue. But one solution accommodating a smoother transition to greater MCO activity is a change in our tort system.

The medical malpractice liability system was rooted in the traditional fee for service health care delivery system. The assumptions were inherently taken from this form of delivery: the physician is a loyal fiduciary for the patient, the physician is the sole "gatekeeper," extra treatment procedures will benefit both the patient and the physician, and the physician should be the source of liability for negligent medical decisions. But, as our practice of health care delivery in this country has shifted, the liability system has remained constant.

The tort system does not merely serve as a means of compensation for the injured, it serves as a moral agent in our society, shaping people's actions. Thus, a proposal of liability must be well reasoned, not only allowing recovery to individuals, but also creating incentives for others to abide by. Extending liability to MCOs who retain the financial risk of the treatment, and serve as a substantial factor in a negligent treatment decision, will do just that. As a result MCOs will increasingly leave medical decisions to the medical doctors. The physician will again become the sole gatekeeper. And most importantly, the patient's treatment quality will not be compromised for the sake of increased profit.

Doctors have been placed in a precarious position in a cost containment world. They have been asked to give care under restricted utilization, yet have their actions measured as if they were acting under traditional conditions. The medical malpractice system should recognize that doctors are no longer acting under traditional conditions, and the parties making medical decisions should pay for the costs of injury. As MCOs realize the increased chance of liability, in all likelihood they will give doctors greater freedom to treat patients. Yet, this Note should not be understood as calling for the return of a fee for service system of heath care delivery. Nor should it be understood as encouraging doctors to conduct unnecessary testing or treatment as a means of boosting revenue. These practices are as morally reprehensible as justifying the denial of necessary medical care on the basis of the bottom line of an MCO account. Greater efficiency is without a doubt a necessary part of any developing form of health care.

329. If MCOs are taking on the role of the medical decisionmaker, they should also take on the role of the malpracticing physician when it comes time to attach liability.

When efficiency dictates sub-standard care, cost containment should not be tolerated. A liability system making the person that profits from such containment pay for the injuries would best create an incentive structure for a quality of care that will meet the community standard. Cutting fat is fine, but when MCOs cut corners, liability should attach.