MONEY AND MEDICINE | RICHARD D. CARROLL AND DAVID P. PRUETT

Appellate Courts Hold Key to Liability for Doctors

There exists a popular sentiment that managed care organizations interfere with the provision of health-care services, either directly, by refusing to authorize desired care, or indirectly, by creating financial disincentives to the patients' physicians, who generallly receive a fixed payment for providing medical services, unrelated to the amount or expense of the medical care provided. Currently, there is public discussion regarding changing federal laws which grant broad immunity from liability to the managed care organizations. This immunity from liability lays in the Employee Retirement Insurance Security Act ("ERISA"), which prohibits an action for damages against an ERISA plan; this applies to most managed care plans as they are provided through the plan members' employers.

While the debate regarding how to handle the plans themselves drags on, the physicians who are entrusted with patient care responsibilities are faced with a variety of liability theories in addition to the traditional claim for "medical malpractice." These theories include breach of fiduciary duty, intentional inference with contract, and fraud. These theories of liability share a common theme; the allegation that the physician was more concerned about his or her pocketbook than the patient's care and therefore failed to provide a service that would have cut into the physician's profits. Because the physician's payment for any particular patient is fixed, any test or treatment that should have been provided would be a direct loss to the doctor. Hence, there is a built-in financial disincetive to provide care.

These theories presume that the doctors will actually profit more by denying medically necessary, but expensive, care. However, managed care supporters argue that "good medicine" is cost-effective medicine, and preventive care will result in lower costs overall. This leads to consideration of the integrity of practitioners and the appropriateness of managed care. Many courts permit the financial disincentive theory, allowing plaintiffs to at least present the idea to the jury. Therefore, it is incumbent on defendants to respond.

The financial disincentive concept, by the very nature of the fixed payment systems, could be alleged in virtually all malpractice actions in the managed care context. The plaintiffs need only base a claim on the allegation that there was a failure to provide appropriate medical services. With this concept of "motive" introduced into an arena previously governed by the "standard of care," physician negligence may be characterized as intentional harm with pecuniary origins, engendering a serious attack upon the individual, personal integrity and character of the defendant doctor. Even more seriously, such allegations threaten insurance coverage that the doctor may have purchased to defend and indemnify him or herself, in the event of a negligent act or omission; by law the insurance companies cannot pay indemnity for intentional torts, and will frequently deny coverage or reserve the righ to deny coverage when these types of managed care allegations are raised.

These theories of liability are particularly threatening, as they present uncertain standards potentially greater damage exposure at trial. Many plaintiffs' attorneys argue that the financial disincentives theory eliminates the limits of liability ordinarily afforded to health-care providers under the Medical Injury Compensation Reform Act or ("MICRA"). Many of those lawyers also assert that the disincentives theory is an adequate basis to allow the award of punitive damages against the individual physicians. These theories, therefore, may dilute the goals and purposes of MICRA.

The Legislaute enacted MICRA in 1975 to help insure the quality of the state's health care. The Legislature stated that the rising cost of medical malpractice insurance was creating serious problems for the health-care system in California, and threatened to limit the availability of medical care. The Legislature believes that this created the very real possiblity that some physicians would practice without insurance, leaving patients who might be injured by these doctors with the prospect of uncollectible judgments.

Regarding managed care plans, also in 1975, the Legislature enacted the Knox-Keene Health Service Plan Act (the "Knox-Keene Act"), authorizing and promoting managed care plans. (Health & Safety Code Section 1340, et seq.) In doing so, the Legislature has recognized that in excess of 16 million Californians are members of health service plans authorized pursuant to Knox-Keene's provisions (Health & Safety Code §1342.1(a)(1).) The Legislature declared that "it is in the public interest" to promote such contracts under Knox-Keene (Health & Safety Code §1342.6.) and provided for the financing of these plans by fixed payment ("capitation" and "shared-risk") methods of compensation. (Welfare & Institutions Code §14087.3(d).). The Health & Safety Code §1348.6, states, "Nothing in this section shall be construed to prohibit contracts that contain incentive plans that involve general payments, such as capitation payments, or shared-risk arrangements that are not tied to specific medical decisions." A central feature of the plans is the transfer of financial risk associated with the provision of medical care from the patient to the physician. (Health & Safety Code §1342(d).)

By participating in a Knox-Keene health plan, and allegedly behaving negligently, a physician is now faced with a theory of liability based upon the receipt of payments as specifically authorized by statute, creating a "no-win" situation. The doctor has been encouraged by the Legislature to participate in the plan; the plan sets compensation; yet, this arrangement leaves the doctor open to accusations of both bad medicine and improper financial motives.

The inclusion of the disincentive theory can bolster otherwise weak claims of medical negligence, based upon the popular suspicion, of as well as dislike and distrust, for managed care plans.

The law has been interpreted myriad ways. The California courts addressed breach of fiduciary duty, in *Moore v. The Regents of the University of California* (1990) 51 Cal.3d 120, (hereafter "*Moore*"). In Moore, the defendant physicians removed the patient's body tissues and cells for research purposes. This research was designed to develop lucrative biotechnology with a predicted market value of $3 billion. The court held that the physicians had a fiduciary duty to disclose their financial interest in using the patient's body tissues in the context of obtaining consent to the surgical procedure (*Moore*, at pp. 131-132)

It is from this language that plaintiffs draw support for their contention that the existence of a doctor's personal economic interest indicates the existence of a fiduciary duty. In a managed setting care, the economic interest is the doctor's personal stake in the profits realized by the individual doctor, profits which decrease when the doctor orders medical treatment for the patient.

However, the application of the *Moore* anlysis to managed care cases is called into question by the opinion itself. Regarding the meaning of the term "fiduciary duty," the court explained that the term "fiduciary" signifies only that a physician must disclose all facts material to the patient's decision. A physician is not the patient's financial adviser: The reason why a physician must disclose possible conflicts is not because he has a duty to protect his patient's financial interests, but because certain personal interests may affect professional judgment. (Id. at p. 131, fn. 10) The court stated that "fiduciary duty" was synonymous with the duty to obtain informed consent, stating: "This cause of action can properly be characterized either as the breach of a fiduciary duty to disclose facts material to the patient's consent or, alternatively, as the performance of medical procedures without first having obtained the patient's informed consent." (Id. at p. 129) Therefore, an argument can be made that *Moore* has limited application in a managed care setting, where the issue is not typically failure to appropriately advise regarding a recommended procedure, but rather, a failure to recommend a procedure at all.

Plaintiffs also assert a theory of interference with the parties' contract for the plan to provide necessary medical services. The law in this area is unclear. However, it would appear that because the doctor is not a "stranger" to the contract, and is expected to provide medical care paid for by contract, the doctor could not be liable for "interference." (*Applied Equipment Corp. v. Litton Saudi Arabia Ltd.* (1994) 7 Cal. 4th 503, 513-514.) Finally, plaintiffs also assert a theory of fraud based upon the financial disincentive analysis. However, such a theory circumvents the specificity in pleading requirements for fraud, including a false representation, which is generally absent in a failure to treat case.

Trial courts have allowed such a theory to proceed, indicating a belief that the incentives themselves indicate a potential for fraud that should be explored in discovery. However, despite their often imperfect fit with the factual scenarios presented, some courts permit cases to proceed on the foregoing theories. Because the cases alleging these types of theories are becoming more common, it is time for the appellate courts to provide some guidance regarding if and how such theories of liability may be brought against doctors. Clarification of the standards will best serve both the interests of both physicians and patients, by defining the expectations imposed in this environment.

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■ Richard D. Carroll says that jury selection is the time to spot and fend off possible sympathy for the plaintiff. See Litigator Q&A, Page 1.