Patchwork Patient Protection: Must We Choose a Single Pattern?

The health care system has been greatly influenced by the introduction and subsequent proliferation of managed care\(^1\) in the industry.\(^2\) In fact, the federal government and many state governments have encouraged the growth of managed care systems through legislation, in an attempt to address various problems in

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\(^1\) Managed care traditionally refers to "health care delivery arrangements that include cost containment strategies and risk allocation among payors and providers." Rebecca L. Jackson & Karen W. Levy, *Innovations in Managed Care, in Health Care Reform Law Institute* 249, 251 (1994). Initially, managed care originated with Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs), but today managed care is an element of most health care delivery systems. See id. at 252. See generally Carl H. Hitchner et al., *Integrated Delivery Systems: A Survey of Organizational Models*, 29 Wake Forest L. Rev. 273 (1994) (examining the development of integrated delivery systems).

An HMO is a prepaid plan that provides comprehensive services to its members by contracting with providers for a fixed fee. See Jackson & Levy, *supra*, at 252. Typically, enrollees in an HMO pay only a co-payment for services and must use the enrolled providers. See id. In a non-emergency, an enrollee would usually not receive any benefits if he or she failed to use an enrolled provider. See id. There are generally three models of HMOs: staff, group, and Independent Practice Association (IPA). See Sharon M. Glenn, *Comment, Tort Liability of Integrated Health Care Delivery Systems: Beyond Enterprise Liability*, 29 Wake Forest L. Rev. 305, 311-12 (1994). For a brief history of the development of HMOs, see Diana Joseph Bearden & Bryan J. Maedgen, *Emerging Theories of Liability in the Managed Health Care Industry*, 47 Baylor L. Rev. 285, 291-92 (1995).

A PPO is a prepaid purchasing arrangement for health care between an employer or insurer and particular providers. See Christine Gasparovich, Note, *Preferred Provider Organizations and Provider Contracting: New Analyses Under the Sherman Act*, 37 Hastings L.J. 377, 377 (1985). Typically, it is a 'closed' panel of providers contracted by the organization. See Jackson & Levy, *supra*, at 253. The PPO then contracts with payors for the panel to provide services to enrollees on a discounted, predetermined fee-for-service basis. See id.; see also Gasparovich, *supra*, at 378. Generally, members are not mandated to see an enrolled provider, but there are significant financial incentives to do so. See Jackson & Levy, *supra*, at 253.

Point of service plans (POSs) allow the enrollee to determine the level of benefits received by combining some elements of HMO and/or PPO plans with those of traditional indemnity plans. See id. at 253-54.

\(^2\) See William M. Sage & James M. Jorling, *A World that Won't Stand Still: Enterprise Liability by Private Contract*, 43 DePaul L. Rev. 1007, 1012 (1994) (noting that the shift to managed care has changed the landscape of the health care system). Most employers utilize a form of managed care in an attempt to keep coverage more affordable. See id. About half of California's population subscribes to an HMO that offers comprehensive care, merging insurance with medical care. See id. at 1013.

The attributes of managed care are constantly changing and the recent growth of managed care systems is partially due to the entry of profit-oriented business into the arena. See John K. Iglehart, *The Struggle Between Managed Care and Fee-for-Service Practice*, 331 New Eng. J. Med. 68, 65 (1994).

(a) Faced with the continuation of mounting costs of health care coupled with its inaccessibility to large segments of the population, the legislature has determined that there is a need to explore alternative methods for the delivery of health care services, with a view toward achieving greater efficiency and economy in providing these services.

(b) It is, therefore, the policy of the state to eliminate the barriers to the organization, promotion, and expansion for health maintenance organizations; to provide for their regulation by the state commissioner of health; and to exempt them from the operation of the insurance and nonprofit health service plan corporation laws of the state except as hereinafter provided.

(c) It is further the intention of the legislature to closely monitor the development of health maintenance organizations in order to assess their impact on the costs of health care to consumers, the accessibility of health care to consumers, and the quality of health care provided to consumers.

Minn. Stat. Ann. § 62D.01 subd. 2 (West 1996).} Although managed care's critics are skeptical of its potential for achieving long-term success in transforming the system,\footnote{For example, medical specialty groups, the American Medical Association, and some legislators are reluctant to joyfully embrace managed care as the core of a reformed health care system. See Iglehart, supra note 2, at 63. Many are motivated by the reluctance to limit an individual's freedom to choose his or her own doctor, while other medical groups are concerned that many physicians are losing their patients to managed care systems. See id. Joining those who are skeptical of managed care as a dominant delivery system for care, some liberal politicians fear that such a system may neglect the poor for the sake of profits, thereby sacrificing care. See id. at 65.}

Likewise, recent reports and studies suggest that it is still unclear whether managed care will ultimately lower health care costs beyond its temporary effect. See Gene Koretz, Look Again at Medical Bills, Bus. Wk., Aug. 28, 1995, at 24. Business Week recently reported the results of a nationwide survey of employers regarding health care costs. See id. The results revealed that employers saw an average increase of 6.5% in health care premiums in 1994. See id. Particularly, large employers experienced a 9.7% increase and small employers incurred a 6.2% increase in HMO premiums. See id.

Another commentator has expressed concern that if the result of the growth of managed care is a proliferation of corporate practices of medicine in which most physicians became employees, in a system in which protocol medicine was the norm, in an erosion of local voluntarism in hospital care, and in the elimination of cross-subsidization, creating additional obstacles to access for the poor, then a great deal would be lost.

Eli Ginzberg, The Destabilization of Health Care, 315 New Eng. J. Med. 757, 760 (1986).\footnote{President Clinton's health care reform proposal introduced in November 1993 strongly endorsed managed care plans as the favored delivery system for health care. See Iglehart, supra note 2, at 65. Other competing health care reform bills, such as}
The result is an increasingly competitive health care industry marked by the dominance of managed care. The growth of managed care as an option in the health care system has created a new environment in which we must consider the most effective way to protect patients from some of the consequences of managed care. In light of the increased commercialization of health care, it is appropriate to cast this discussion in terms of consumer protection.

Parts I and II of this Comment consider the effectiveness of traditional malpractice liability and contract-based approaches respectively as methods of protecting the consumer in today's market. Finally, Part III explores the trend towards an increased demand for information in the industry and the extent to which such information may protect the health care consumer.

I. MALPRACTICE LIABILITY AS CONSUMER PROTECTION

A. Identifying the Tortfeasor

Malpractice liability, as well as tort law in general, is a method of compensating an individual for injury incurred as a result of another's conduct. As such, it is primarily a retrospective system. An underlying objective of the system, however, is to deter conduct that will result in another's injury. Tort law requires that peoples' conduct conform to societal standards; it is, therefore, a code of behavior that is externally imposed upon individuals. Traditionally, malpractice law seeks to protect patients against uncompensated injury that is the result of a doctor's negligent treatment.

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those sponsored by Senator John Chafee (R-R.I.) and Representative Jim Cooper (D-Tenn.), also featured managed care as a primary mode of reform. See id.

6 See infra notes 96-101 and accompanying text.


8 See id. at 20, 26 (noting that tort law seeks to determine the appropriate party to bear the loss after an injury occurs).

9 See id. at 25. Imposing liability on certain conduct creates an incentive not to engage in that conduct if the actor realizes the potential for liability. See id.

10 See id. § 92, at 655, 656. "Tort obligations are in general obligations that are imposed by law—apart from and independent of promises made and therefore apart from the manifested intention of the parties—to avoid injury to others." Id. at 656. Tort law allows the community to establish an ideal allocation of responsibility and individuals must adhere to the standard set by the community. See Paul C. Weiler, Medical Malpractice on Trial 17 (1991); see also Walter Olsen, Tortification of Contract Law: Displacing Consent and Agreement, 77 Cornell L. Rev. 1043, 1044 (1992) (discussing the basic differences between tort and contract obligations).

A health care system dominated by managed care raises legal and policy issues that are not adequately addressed or remediable by the traditional medical malpractice system. For example, health care decision-making is more complex and involves more actors in a system pervaded by managed care than the traditional fee-for-service system. In particular, decisions regarding health care are being made by corporations, as well as the physician in contact with the patient. Although health care enterprises are increasingly dominant and control is shifting away from the individual doctor, accountability has not yet entirely shifted to these enterprises as liability is still generally associated with the practitioner. In recognition of this shift of control, however, managed care organizations are increasingly being held responsible under various theories of liability. Moreover, a systematized shift in lia-

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12 See Sage & Jorling, supra note 2, at 1014 (stating that the medical malpractice system is obsolete in the midst of the changing health care environment). Because of the changing context, more sophisticated procedures for resolving disputes and improving quality management are needed. See id.

13 See Frank M. McClellan, Medical Malpractice: Law, Tactics, and Ethics 63 (1994). Before the 1970s, physicians dominated the medical decision-making process and the doctor's profit motive was kept well below the surface. See id. Today's decision-making system is more complex and the competing values are more prominent. See id. A physician's medical and ethical judgments are more often overridden by cost concerns, and many individuals take part in the decision process. See id.

For example, physician incentives, which are financial arrangements that either reward or penalize physicians on the basis of their ability to meet the utilization objectives, are very controversial traits of managed care systems. See Wendy L. Krasner & Thomas J. Walsh, The Regulation of Physician Incentives, in Health Law Handbook 179, 179 (Alice G. Gosfield ed., 1995). Thus, these arrangements may result in a conflict between the physician's self-interest and the patient's interest. See id. See generally Bradford H. Gray, The Profit Motive and Patient Care: The Changing Accountability of Doctors and Hospitals (1991) (exploring how profit motives shape physicians' behavior and how the profit-seeking behavior is becoming more explicit and pervasive as health care continues to shift from a professional service to a major economic sector).

14 See Sage & Jorling, supra note 2, at 1013 (noting that judgments that affect delivery of care are made by both "front-line practitioners" as well as corporate enterprises); McClellan, supra note 13, at 63 (observing that besides the patient and treating physician, nurses, insurance company physicians, and even hospital administrators seek to influence care delivery); see also infra notes 27-31 and accompanying text.

15 See Sage & Jorling, supra note 2, at 1014. The majority of malpractice cases are still between a patient and an individual physician. See id. "'[T]he doctor no longer really controls health care, as in the days of solo practice, but, when it comes to quality, the doctor is still held accountable . . . . Control is shifting, structure is shifting, the pattern of care is shifting; but accountability is not.'" Id. at 1014 n.29 (quoting Donald M. Berwick et al., Curing Health Care: New Strategies for Quality Improvement 12 (1990)).

16 See id. at 1008-09. There are four prevalent theories for malpractice liability under which managed care systems have been found liable. See id. at 1009 n.7. The

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first two theories seek to hold the HMO vicariously liable based upon the physician's negligence, while the others hold the entity directly liable for its own negligence. See Glenn, supra note 1, at 314-37 (surveying vicarious liability, respondeat superior, ostensibly agency, and direct liability). For the most part, HMOs are being held liable under the same theories as hospitals. See Sage & Jorling, supra note 2, at 1009 n.7 (citing hospital and HMO liability case law).

The first theory is respondeat superior, in which a staff-model HMO would be held liable for the negligence of its physician-employees. See id. An employer may be held liable for the negligence of its employee where the employee was acting within the scope of his or her employment. See Restatement (Second) of Agency § 219 (1958). The application of this theory to a health care organization will depend upon the nature of the organization and the degree of control that it exerts over its physicians. See Glenn, supra note 1, at 320, 321; see also Schleier v. Kaiser Found. Health Plan of the Mid-Atlantic States, Inc., 876 F.2d 174, 177, 178 (D.C. Cir. 1989) (holding that a health care organization could be held vicariously liable for the negligence of a consulting physician to whom the patient was referred by the primary care-taker because the physician was answerable to the primary care-taker); Sloan v. Metropolitan Health Council of Indianapolis, Inc., 516 N.E.2d 1104, 1108, 1109 (Ind. Ct. App. 1987) (holding that an HMO could be vicariously liable for a physician's negligent failure to diagnose if the plaintiff could establish an agency or employer-employee relationship). But see Raglin v. HMO III, Inc., 595 N.E.2d 153, 156, 158 (Ill. App. Ct. 1992) (holding that an HMO could not be held vicariously liable for the negligence of its physicians because physicians and medical groups are independent contractors in relation to the organization); Mitts v. H.I.P. of Greater N.Y., 478 N.Y.S.2d 910, 911 (App. Div. 1984) (holding that a health care organization could not be held liable for malpractice because its medical group was an independent contractor).

Where respondeat superior is inapplicable, a health care entity may also be held vicariously liable under a theory of ostensibly agency. See Sage & Jorling, supra note 2, at 1009 n.7; Glenn, supra note 1, at 321. The thrust of this argument is that the organization created the appearance that an agency relationship existed. See Glenn, supra note 1, at 321-22. "One who represents that another is his servant or other agent and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent is subject to liability to the third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he were such." Restatement (Second) of Agency § 267 (1958); see also Decker v. Saini, 14 Employee Benefits Cas. (BNA) 1556, 1558-60 (Mich. Cir. Ct. 1991) (holding that an HMO could be held liable, under an ostensibly agency theory, for a physician's negligent failure to diagnose); Boyd v. Albert Einstein Med. Ctr., 547 A.2d 1229, 1234 (Pa. Super. Ct. 1988) (approving the ostensibly theory of liability where an HMO holds itself out as that the patient turns to the organization for care); Restatement (Second) of Torts § 429 (1965) (stating that the employer of an independent contractor is subject to liability for the contractor's conduct as if the employer himself acted).

Health care systems may also be responsible in tort for the breach of a duty directly owed to a patient. See Glenn, supra note 1, at 326. For example, an organization may be liable for injury resulting from the breach of its duty to select competent physicians. See Sage & Jorling, supra note 2, at 1009 n.7; see also McClellan v. Health Maintenance Org. of Pa., 604 A.2d 1053, 1059 (Pa. Super. Ct. 1992) (holding that HMOs owe a direct duty to their enrollees to hire competent primary care physicians); George D. Pozgar, Legal Aspects of Health Care Administration 143-69 (5th ed. 1993) (focusing on the duties of hospitals).

Finally, managed care institutions may be held directly liable for injuries resulting from their utilization review or other economically motivated behavior. See Sage & Jorling, supra note 2, at 1009 n.7. See also, e.g., Wilson v. Blue Cross of Cal., 271 Cal. Rptr. 876 (Ct. App. 1990) (finding that an insurance company's denial of coverage
bility to the enterprise is a viable option.\textsuperscript{17}

Thus, this shift in control has prompted many to suggest that reform of the malpractice system should include a corresponding systemic shift of liability from the individual physician.\textsuperscript{18} Many advocate "enterprise liability"\textsuperscript{19} as a way to reconcile traditional malpractice law with corporate control of modern health care models.\textsuperscript{20} In such a system, the focus of medical liability would be shifted to health care organizations on the premise that the threat of liability would provide incentives for such organizations to develop more effective quality assurance procedures.\textsuperscript{21} Additionally,

for hospitalization of a mentally ill patient was a substantial factor in the patient's subsequent suicide); Wickline v. State, 239 Cal. Rptr. 810, 819 (Ct. App. 1986) (holding that "[t]hird party payors of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms"). But see Corcoran v. United HealthCare, Inc., 965 F.2d 1321, 1322 (5th Cir. 1992) (holding that plaintiff's claim based upon an organization's "utilization review" decision was preempted by Employee Retirement Income Security Act (ERISA)); but see also Bearden & Maedgen, supra note 1, at 298-329 (surveying the extension of varying theories of vicarious and direct liability to managed care organizations); infra notes 40-41 and accompanying text.

\textsuperscript{17} See Abraham & Weiler, supra note 11, at 382. The theory of enterprise liability is rooted in traditional tort principles, which attempt to place the responsibility for injuries on the enterprise or individual who is in the best position to make a decision as to the risks and safety measures involved. See id. at 384. The adoption of an enterprise liability system would represent full legal recognition of the transformation of the health care system. See id. at 394.

\textsuperscript{18} See id. at 382; Sage & Jorling, supra note 2, at 1008.

\textsuperscript{19} Enterprise liability transfers liability for medical malpractice to the organization, rather than the individual physicians. See Glenn, supra note 1, at 306.

\textsuperscript{20} See Abraham & Weiler, supra note 11, at 436; Sage & Jorling, supra note 2, at 1008-9, 1008 n.5. The Clinton health care plan was reported and projected to include provisions for enterprise liability, but the final draft did not contain a proposal for federally mandated enterprise liability. See Glenn, supra note 1, at 305-06.

\textsuperscript{21} See Weiler, supra note 10, at 160. Because health care organizations, like hospitals and managed care systems, can most effectively lower the rate of unacceptabe injuries, they are the appropriate actors to bear accountability for injury. See id. at 160-61. Enterprise liability would focus liability on the part of the health care system with the best ability to improve the quality of health care. See Abraham & Weiler, supra note 11, at 411.

There are three major advantages of replacing the traditional malpractice system with an explicit, coordinated system of enterprise liability: fostering a sense of physician teamwork by improving the relations between clinical managers and providers; improving the quality of care; and fostering administrative and judicial efficiency in responding to malpractice claims. See Sage & Jorling, supra note 2, at 1019-21.

Critiques of an enterprise liability system assert that such a system further threatens physician autonomy and may not be as effective a deterrent applied to health care organizations as it is with hospitals because the organizations have a less centralized management structure than individual hospitals. See Barry R. Furrow, Quality Control in Health Care: Developments in the Law of Medical Malpractice, in Legal Medicine 1994 83, 113 (Cyril H. Wecht ed., 1994).

Imposing liability on the organizations would also provide an additional incen-
some suggest that organizations should voluntarily assume liability through contract, thereby creating voluntary enterprise liability.\textsuperscript{22} Regardless of whether health care enterprises voluntarily bear liability, they are likely to continue to incur liability through the continued application of common law principles.\textsuperscript{23}

B. Standard of Care: The Use of Utilization Review and Clinical Practice Guidelines

The extent to which malpractice liability protects the health care consumer is largely dependent upon the standard of care that the law imposes on a provider. Traditionally, "quality" care refers to the level and nature of care that a well-trained and well-regarded physician would employ in similar circumstances.\textsuperscript{24} As the customary practice of well-trained physicians continues to come under fire as defensive medicine and a misallocation of resources, the concept of "quality" care is being reevaluated in today's numerous health care debates.\textsuperscript{25} In today's system, "quality" care is, to a large extent, being redefined by health care statutes, judicial decisions, and agency regulations. For the organizations to choose the most qualified physicians, see Decker v. Saini, 14 Employee Benefits Cas. (BNA) 1556, 1560 (Mich. Cir. Ct. 1991).

\textsuperscript{22} See Sage & Jorling, supra note 2, at 1015. Enterprise liability is not necessarily imposed on the health care system by external forces. See id. at 1042. Rather, organizations can voluntarily assume liability and thereby create a system of accountability based on contract, which encourages collaboration, improves the quality of care, and reduces liability costs. See id. at 1042-43. Voluntary enterprise liability could be created through contracts between health care organizations and physicians by creating contractual indemnification. See Abraham & Weiler, supra note 11, at 429. Although voluntary enterprise liability will not solve all of the ills of the medical malpractice system, it will tend to move the "system in the same direction as the rest of the health care industry." Sage & Jorling, supra note 2, at 1043.

\textsuperscript{23} See Sage & Jorling, supra note 2, at 1008-09, 1009 n.7. Courts, in recognizing the increased role and duties of managed care organizations, are expanding the common law tort principles of medical liability, which only hold the care provider responsible. See Glenn, supra note 1, at 306. Thus, even in the absence of expressly mandated enterprise liability, the new health care delivery systems will likely be subject to medical liability. See id.

\textsuperscript{24} See Rand E. Rosenblatt, Equality, Entitlement, and National Health Care Reform: The Challenge of Managed Competition and Managed Care, 60 Brook. L. Rev. 105, 107-08 (1994). This is the basis for the traditional legal standard of care in medical malpractice claims. See Restatement (Second) of Torts § 299A (1965) (stating that one who practices the profession "is required to exercise the skill and knowledge normally possessed by members of that profession or trade in good standing in similar communities").


\textsuperscript{25} See Rosenblatt, supra note 24, at 108.
contracts, practice guidelines, and professional standards.26

Deviations from the accepted practice, the care which a qual-
ified physician would render, continue to be a necessary starting
point in assessing liability.27 The care that a patient receives from a
managed care organization, however, is influenced today by more
than the individual doctor.28 For example, managed care organiza-
tions are subject to many internal and external influences that ulti-
mately affect the quality and quantity of care provided. These
factors include internal efforts to control costs and to use resources
effectively, as well as external governmental regulations and market
pressures.29

Managed care organizations are based upon utilization man-
agement, which is a method of cost containment based upon more
efficient use of resources.30 Utilization review (UR) and clinical
practice guidelines are both efforts by managed care organizations
to control the quality, quantity, and cost of care provided to pa-
tients.31 As such, these efforts dictate the standard of care pro-
vided and play an important role in today’s health care decision-
making.

One of the primary cost containment measures used by man-
aged care organizations is UR.32 Through UR, organizations are

26 See id. at 111. To the extent that “quality” care is being redefined by these
sources, the interests and concerns of the various types of consumers should and must
be given consideration in making such policies that will ultimately affect them. See id.;
see also infra note 107 and accompanying text.
27 See Furtrow, supra note 21, at 84.
28 See McCLELLAN, supra note 13, at 63. “[T]he earlier untrammeled freedom of
the profession to determine how, where, and for how long patients would be treated
is being circumscribed by new rules, regulations, and protocols.” Ginsberg, supra
note 4, at 759-60.
29 In today’s commercial health care environment, pharmaceutical companies of-
fer discounts to plans depending upon how much of an influence such plans exert
over physician prescribing. See Elyse Tanouye, Big Drug Makers Regaining Control Over
Their Prices, WALL ST. J., July 12, 1995, at B4. If a plan doesn’t have much influence
and control over which drugs are prescribed by its providers, the drug companies no
longer offer the plan such discounts. See id. Thus, the possibility of receiving a dis-
count creates an economic incentive for a plan to persuade its physicians to prescribe
 certain drugs. See id.
30 See Glenn, supra note 1, at 332.
31 See id.; Alice G. Gosfield, Measuring Performance and Quality: The State of the Art
32 See John F. Bales, III & Lisa A. DeMarco, Selected Topics in Medical Malpractice
Litigation, in HEALTH CARE LAW 1993 381, 498-99 (1993). Utilization review is an ex-
ternal evaluation of the appropriateness of medical care provided based on clinical
criteria. See id. at 499. These evaluations may be conducted by traditional insurers,
purchasers, or organizations. See id.

Utilization review is a process of reviewing a provider’s treatment of a patient by
comparing the services provided with an established norm of treatment provided to
able to exert control over the medical services and care available and administered to their subscribers.\textsuperscript{35} Although there is traditionally a distinction between coverage and medical decisions,\textsuperscript{34} courts are beginning to recognize the convergence of the two in the managed care context, as coverage decisions increasingly have clinical consequences.\textsuperscript{35} For example, a federal court has acknowledged "that as the health care industry evolves, the line between arranging and paying for health care services and directly providing such services may become blurry."\textsuperscript{36}

Prospective\textsuperscript{37} and concurrent review,\textsuperscript{38} the types of UR most frequently used by managed care organizations, influence a patient’s choice among treatment options to a greater extent than a retrospective\textsuperscript{39} system, which is more characteristic of a traditional insurer.\textsuperscript{40} In particular, the knowledge that the plan will not cover a specific treatment is more likely to discourage a patient from following a doctor’s recommendation for that treatment than is the knowledge that there is a mere risk that the plan will not cover the

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\textsuperscript{33} See Bales & DeMarco, \textit{supra} note 32, at 499.
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\textsuperscript{34} See Corcoran v. United HealthCare, Inc., 965 F.2d 1321, 1331 (5th Cir. 1992) (holding that a state tort law claim was preempted by ERISA because the organization performing utilization review gave medical advice in the context of making benefit determinations).
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\textsuperscript{35} See Sage & Jorling, \textit{supra} note 2, at 1018.
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\textsuperscript{37} Prospective review of treatment requires prior approval for hospital admission in non-emergency instances and for a proposed length of stay in the hospital. See Richard A. Hinden & Douglas Elden, \textit{Liability Issues for Managed Care Entities, 14 Seton Hall Legis. J.} 1, 52 (1990).
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\textsuperscript{38} Concurrent review is a review of the medical care provided to determine the appropriateness of the treatment and the length of a hospital stay that is conducted at the same time as the treatment is being rendered. See McCLELLAN, \textit{supra} note 13, at 67; see also Hinden & Elden, \textit{supra} note 37, at 52 (stating that liability is more likely to result from concurrent than retrospective review).
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\textsuperscript{39} Retrospective review is an examination of the medical services provided that occurs after the treatment is completed. See McCLELLAN, \textit{supra} note 13, at 66; see also Hinden & Elden, \textit{supra} note 37, at 52 (stating that liability is less likely to result from retrospective review than the other types).
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\textsuperscript{40} See Corcoran v. United HealthCare, Inc., 965 F.2d 1321, 1332 (5th Cir. 1992) (acknowledging that an organization engaged by the plaintiff’s HMO to perform independent utilization review made medical decisions incident to benefit determinations).
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same treatment.\textsuperscript{41} Physicians have traditionally been accused of practicing defensive medicine and over-treating patients to avoid liability, thereby increasing medical costs.\textsuperscript{42} Cost containment procedures may have the opposite effect.\textsuperscript{43} Thus, rather than an over-use of medical resources, an under-utilization may result from cost containment activities. In certain instances, the internal cost containment goals of managed care organizations may threaten the quality of care provided.\textsuperscript{44} In that regard, managed care organizations may be subject to liability as a consequence of their cost containment activities.\textsuperscript{45}

\textsuperscript{41} See \textit{id.} at 1331-32; see also Wickline v. State, 239 Cal. Rptr. 810, 812 (Ct. App. 1986) (distinguishing between the withholding of payment and treatment).

\textsuperscript{42} See POZGAR, supra note 16, at 504-05. The practice of defensive medicine is fostered by the current malpractice system. See \textit{id.} at 504. Defensive medicine is either an over- or under-consumption of health care resources in an attempt to reduce the potential for litigation and provide a defense should litigation ensue. See \textit{id.} at 505. A Harvard study team found that physicians perceive a greater likelihood of being sued for malpractice than actually exists, and in response they tend to perform more tests, reduce the scope of their practices, and treat fewer high-risk patients. See \textit{id.} at 504.

Some critics also contend that the threat of malpractice liability encourages physicians to practice defensive medicine which, with new expensive medical technologies, has contributed to the rising health care costs. See MCCLELLAN, supra note 13, at 76; see also AMERICAN MEDICAL ASSOCIATION, FACTORS CONTRIBUTING TO THE HEALTH CARE COST PROBLEM 7-22 (1993) (arguing that in addition to defensive medicine, the following factors have contributed to the cost problem: the aging of the U.S. population; increasing health care fraud; lifestyle and social factors such as the use of alcohol, drugs, and tobacco; and the influence of poverty and violence).

\textsuperscript{43} See MCCLELLAN, supra note 13, at 74, 76. McClellan formulates an example to illustrate this point in which an HMO patient sees her ophthalmologist who diagnosed her with glaucoma. See \textit{id.} at 64. The ophthalmologist did not order a referral and a CT scan after considering the relative costs and the patient's physicians. See \textit{id.} The ophthalmologist acted in the same manner as most qualified professionals would have in these circumstances. See \textit{id.} The patient was later diagnosed with a brain tumor and lost her vision; this would have been prevented had the CT scan been performed earlier. See \textit{id.} McClellan suggests that a traditional fee-for-service physician would be more likely to order the test due to the threat of liability, i.e., practice defensive medicine. See \textit{id.} at 73-74. The reaction of the HMO physician, however, would likely be the opposite. See \textit{id.} at 74.

Cost containment measures are designed to address the issues of rising costs due to over-, and often unnecessary, utilization of health care resources, but may present other barriers to a system of sound decision-making. See \textit{id.} at 76. McClellan concludes that health care decision-making that balances the interests of cost and the patient's well-being is desired, but the final decision should be made by a well-trained physician who considers the patient's well-being to be his or her primary responsibility. See \textit{id.}.

\textsuperscript{44} See \textit{id.} at 75. Although the goals of quality health care and cost containment are not irreconcilable, cost containment strategies may induce decision-makers to make choices that conflict with the goal of maintaining high-quality care. See \textit{id.}

\textsuperscript{45} See Wilson v. Blue Cross of S. Cal., 271 Cal. Rptr. 876, 883 (Ct. App. 1990) (finding that there was a genuine issue of material fact as to whether an insurance com-
Managed care organizations also attempt to control the quality and cost of the care provided by using clinical practice guidelines. These guidelines, developed from outcomes research, are intended to aid physicians and patients in making decisions regarding the course of treatment for a particular condition. Thus, medical care based on customary practice is being replaced by care based on clinical practice guidelines developed from qualitative reviews. One of the legal implications of the use of clinical practice guidelines is their role in malpractice litigation. If an injury oc-

pany's denial of coverage through utilization review for hospitalization of a mentally ill patient substantially contributed to the patient's subsequent suicide; Wickline v. State, 239 Cal. Rptr. 810, 819 (Ct. App. 1986) (holding that "[t]hird party payors of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms").

See Gosfield, supra note 31, at 55. These types of guidelines are also commonly referred to as critical paths, practice guidelines, clinical pathways, and CareMaps. See id. at 56. These guidelines are described as "[e]ducational tools that enable physicians to obtain the advice of recognized clinical experts, stay abreast of the latest clinical research, and assess the clinical significance of often conflicting research findings;" and "[c]linical management tools that organize, sequence and time the major interventions of nursing staff physicians and other departments for a particular case type, subset or condition." Id. (quoting Rhonda Bergman, Getting the Goods on Guidelines, Hosp. & Health Networks, Oct. 20, 1994, at 70).

Thus, there is little consensus regarding the meaning of "practice guidelines." See Rosenblatt, supra note 24, at 130. There is a distinction between practice guidelines and medical review criteria, as the former are used to assist in making decisions regarding appropriate care and the latter are intended to be used by third parties to evaluate the appropriateness of the care for purposes of cost containment and quality assurance. See id. at 131.

The use of such guidelines is met with considerable debate, as evidenced by the disagreement regarding the guidelines for the treatment of cataract and hypertension patients. See Gosfield, supra note 31, at 56-57. Many medical specialty associations are beginning to evaluate the guidelines developed by various organizations. See id. at 57. At this time, however, there is no consensus on the appropriate methods and criteria with which to evaluate them. See Rosenblatt, supra note 24, at 132. The Institute Of Medicine issued a report that enumerated eight desirable characteristics of clinical practice guidelines, but these characteristics do not provide a practical and usable standard of evaluation. See id. at 132-33.

Hospitals, HMOs, professional organizations and specialist societies, insurance companies, and the government are currently involved in developing guidelines. See id. at 132; Furtow, supra note 21, at 86.


See Szczyniak, supra note 47, at 232-33. The purpose of clinical practice guidelines is to offer scientifically valid clinical alternatives to aid practitioners and patients in making medical care decisions. HHS Pain Guidelines: The Feds Say They Want a Revolution, Trends in Health Bus., Mar. 27, 1992, at 11T [hereinafter HHS Pain Guidelines]. The goal of such guidelines is to separate effective medical procedures and drugs from ineffective ones by distilling available outcomes research. See id.

See Gosfield, supra note 31, at 56-58.
curs where the care provided was within a recognized standard of proper care, negligence may be difficult to prove. To the extent that such guidelines are used as shields from liability, they represent a codified standard of care.

C. Standard of Care: Legislation

Clinical practice guidelines and UR prompt debate regarding the appropriateness of intruding upon an individual physician's exercise of medical judgment, which has traditionally been the cornerstone of health care decision-making. Increasingly, legislation may also threaten the attending physician's and patient's roles as the primary decision-makers. Although federal and state statutes regulate the accreditation of Health Maintenance Organizations (HMOs) by establishing the basic health care services that a plan must cover, some state statutes more specifically outline treatments that the HMO must provide. The debate surrounding new legislation relating to the appropriate length of a hospital stay for new mothers after delivery illustrates the threat posed by governmental regulation. Furthermore, the maternity stay issue provides

\footnotesize{50 See id. at 58. Maine launched a five-year experiment in January of 1992 to determine whether guidelines could reduce the potential for liability if physicians complied with state-issued practice guidelines. See HHS Pain Guidelines, supra note 48, at 1T. The legislature ordered the Bureau of Insurance and the Board of Licensure to establish the medical liability project and authorized them to formulate practice parameters with the aid of various medical professionals. See Me. Rev. Stat. Ann. tit. 24, §§ 2971, 2973 (West Supp. 1995). Physicians in the experiment, those who practice anesthesiology, emergency medicine, radiology, and obstetrics/gynecology, may use compliance with the guidelines as an affirmative defense in court. See id. §§ 2972, 2975(1). The Maine legislature has established practice guidelines for 20 procedures in these specialty areas for the experiment. See Bales & DeMarco, supra note 32, at 409. Approximately 400 physicians volunteered to participate in the program. See Mary Darby, Can Maine’s Malpractice Protection Project Convince Physicians to Utilize Guidelines?, MANAGED CARE L. OUTLOOK, Nov. 16, 1993, at 6. Regardless of whether the system results in a lower risk of liability, such a system may also have the effect of reducing malpractice costs by eliminating the need for dueling experts in court because the state law would establish the standard of care and a method of determining whether it was met. See id.}

The Maine Medical Liability Demonstration Project was intended to reduce medical costs associated with defensive medicine and the risks of malpractice claims. See id. Thus, malocurrence is immune from suit because a physician is protected if he or she takes the correct course of action, but a bad result nevertheless occurs. See id.


\footnotesize{52 See, e.g., N.J. Stat. Ann. §§ 26:2J-4.4, 26:2J-4.5, 26:2J-4.6 (West 1996) (mandating that an HMO provide, for example, "a left-sided colon examination of 35 to 60 centimeters every five years" for all patients over 45 and an annual mammogram for women over 49).}
a framework for exploring the impact of the various pressures on health care decision-making and the standard of care.

The newest legislation in this area, establishing minimum hospital stays for new mothers, is a direct response to a developing standard of care particularly within managed care systems.\textsuperscript{53} The cost containment measures and profit incentives of HMOs resulted in a trend of reducing the length of hospital stays of new mothers and their babies to less than twenty-four hours.\textsuperscript{54} In response to the trend towards these “drive-thru” deliveries, many state legislatures have recently passed or introduced legislation providing for a mandatory minimum hospital stay for new mothers and their babies.\textsuperscript{55}

\textsuperscript{53} See New Jersey Law Requires Minimal 48-Hour Stay for Women, Babies Following Childbirth, Health Care Daily (BNA), July 3, 1995, available in WESTLAW, BNA-HCD Database, 7/3/95 HCD d4 [hereinafter N.J. Law Requires Minimal Stay]. According to a study released on August 9, 1995, by HCIA, Inc., there is a greater likelihood that members of HMOs will be discharged quickly after delivery than subscribers to other private insurers or Medicaid. See Rapid Discharge After Cesarean Sections Lead to More Hospital Readmissions, 3 Health Care Pol’y Rep. (BNA) 1318, 1319 (Aug. 14, 1995). The study found that 57.7% of HMO members were sent home within 24 hours of delivery, while 35.9% of other commercial insurance and 39.3% of Medicaid enrollees were sent home within the same time period. See id.


Representatives of the American Medical Association and the American College of Obstetrics and Gynecology told the Senate Labor and Human Resources Committee on September 12, 1995, that “[i]nurance companies’ quest for profits is forcing an unsafe trend of early hospital releases of women and newborns following childbirth.” See id. In contrast, doctors representing prominent managed care organizations defended the medical soundness of early release guidelines, denied that profit motives lie behind the policy, and urged the committee not to mandate the length of hospital stays for newborns and their mothers. See id.

Similarly, although HMOs have an economic incentive to shorten the stays of newborns and their mothers, they have no incentive to continue such a practice if the policy subsequently caused additional health problems. See N.J. Law Requires Minimal Stay, supra note 53.

\textsuperscript{55} Maryland was the first state to adopt legislation mandating a 48-hour hospital stay after childbirth. See H.B. 888, 1995 Leg., 1st Sess. (Md. 1995). Maryland enacted this bill on May 25, 1995, citing an increase in the incidence of Phenylketonuria specimens, a cause of severe mental retardation resulting from hospital stays of less than 24 hours after childbirth. See id. Such tests are most accurate if performed 24 hours after the newborn’s first milk feeding. See Donna Leusner, New Moms Get Break Under Assembly Bill, STAR-LEDGER, May 23, 1995, at 1. The Maryland bill mandates that
The debate regarding the appropriateness of this type of legislation centers around the issue of control in health care decision-making.\(^{56}\) The legislation restricts a doctor's ability to make care determinations with his or her patient.\(^{57}\) In addition, whereas the accepted standard of care is traditionally set by the medical profes-


The New Jersey Legislature also recently passed a bill that mandates coverage "for a minimum of 48 hours of in-patient care following a vaginal delivery and a minimum of 96 hours of in-patient care following a cesarean section" N.J. Stat. Ann. § 26:2J-4.9(a) (West 1996). The legislation provides that if the plan provides for post-delivery care for the mother and newborn in the home, it need not provide the minimum in-patient care unless it is deemed medically necessary by an attending physician. See id. § 26:2J-4.9(b).


In September 1996, Congress passed the Newborns' and Mothers' Health Protection Act of 1996. See Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. 104-204, 110 Stat. 2874. Like the state legislation in this area, the federal law prohibits an insurance issuer that offers group health insurance from restricting coverage for a mother's and newborn child's hospital stay to less than 48 hours following a vaginal delivery and less than 96 hours following a cesarean section. See id. § 711. The statute, however, allows the attending physician and mother to decide that a hospital stay shorter than the established minimum is appropriate. See id. This exception reflects Congress' findings that a decision regarding the length of a hospital stay following childbirth should be made by the attending doctor and mother upon considering the unique circumstances, including the health of the mother and newborn and the availability of follow-up care. See id. § 602. The Senate hearings on the bill in September 1995 included testimony by three families who experienced tragedy allegedly as a result of the early-discharge policies. See Physicians Blame Insurance, supra note 54.

\(^{56}\) See Winslow, supra note 54, at B16. The New York Times reported that Susan Pisano, a spokeswoman for the Group Health Association of America, an organization representing HMOs, offered that doctors and patients, not legislators, were the appropriate actors to decide how long babies and their mothers should remain in the hospital. See id.

\(^{57}\) See Physicians Blame Insurance, supra note 54.
sion and enforced by tort law, this legislation imposes a standard upon the profession.

Another important issue relating to the appropriateness of legislation in this area is the extent to which a standard of care should be strictly codified. The medical standard of accepted practice traditionally develops through journals, the interaction of leaders of the profession, and collegial networks. This on-going dialogue within the profession regarding the efficacy of new technologies and procedures is antithetical to a strictly codified standard of care.

II. Contract Theories

A. Liability Based on Contract Theories

Although courts are historically reluctant to enforce an alleged contract for a result or a warranty of quality against a physician, it may be time to abandon such reluctance in today's health care context. The relationship between a patient and a physician is essentially a contractual one in which the patient agrees to pay the physician for services rendered and the physician agrees to use the professionally accepted standard of care. Accordingly, there can traditionally be no recovery for breach of contract or warranty against a physician unless there is a clear, express agreement to

58 See Furtow, supra note 21, at 86. Typically, the standard of care in a medical malpractice action is determined by the "'mode or form of treatment which a reasonable and prudent member of the medical profession would undertake under the same or similar circumstances.'" Richard A. Epstein, Cases and Materials on Torts 189 (citing Hood v. Phillips, 554 S.W.2d 160, 165 (Tex. 1977)).

59 See Physicians Blame Insurance, supra note 54. Sharon Levine, the Associate Director of Permanente Medical Group, Inc., suggests that "'[t]o freeze standards of care into statute through legislation will impede progress toward the dual goals of quality improvement and cost effectiveness.'" Id. Similarly, Richard Marshall, the chief of pediatrics for Harvard Committee Health Plan, stated that it is inappropriate to adopt an "'inflexible statutory standard for an exact number of hours for a hospital maternity stay.'" Id.

60 See Furtow, supra note 21, at 86.

61 See Weiler, supra note 10, at 94. Although a doctor-patient relationship is in many respects contractual, the function of tort law has traditionally been to flesh out the nature of the relationship. See id. See generally Jack W. Shaw, Jr., Annotation, Recovery Against Physician on Basis of Breach of Contract to Achieve Particular Result or Cure, 43 A.L.R.3d 1221 (1972) (surveying case law and policy arguments regarding whether to recognize express contracts to achieve a cure).

achieve a certain result or cure.\textsuperscript{63}

As the health care system attempts to adapt to the new competitive environment by producing and making data available to consumers,\textsuperscript{64} this attempt may expose managed care to increased liability on contract theories.\textsuperscript{65} The tension created by the demand for increased information and the potential liabilities based on the publication of such information has been partially addressed by only a few legislatures.\textsuperscript{66}

Health care systems that compete based upon various value predicates may be exposed to increased liability by virtue of the claims that they make about the quality of care the system provides.\textsuperscript{67} Advertising, a key to gaining customers in competitive industries, is increasingly used by managed care systems to gain subscribers.\textsuperscript{68} The advertising practices of HMOs are prescribed by statute in most states.\textsuperscript{69} HMOs’ increasing use of advertising and

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  \item \textsuperscript{63} See, e.g., Depenbrook v. Kaiser Found. Health Plan, Inc., 144 Cal. Rptr. 724, 726 (Ct. App. 1978) (holding that a plaintiff could sustain a breach of warranty claim against a physician if the physician made a clear, specific promise to achieve a particular result upon which the patient relied); Crafici, 407 N.E.2d at 637 (holding that a plaintiff could state a claim for breach of contract or warranty against a physician, especially in the context of elective procedures, where the plaintiff could establish a clear, express promise that is not to be confused with therapeutic reassurances); Bobrick v. Bravstein, 497 N.Y.S.2d 749, 751 (App. Div. 1986) (holding that in order to sustain a breach of contract or warranty claim against a physician or hospital, a plaintiff must be able to allege an express promise to effectuate a cure or achieve a specific result). But see Salem Orthopedic Surgeons, Inc. v. Quint, 386 N.E.2d 1268, 1271, 1273 (Mass. 1979) (holding that a claim of breached warranty or promise against a physician is essentially a claim of malpractice and cannot be sustained as a contract action); Sullivan v. O’Connor, 296 N.E.2d 183, 186 (Mass. 1973) (holding that breach of warranty claims against a physician are inherently suspect, but could be established with clear proof).
  \item \textsuperscript{64} See infra part III.
  \item \textsuperscript{65} See Gosfield, supra note 31, at 66, 67. Because the publication of performance data has the potential to result in an unintended warranty of quality or to subject managed care organizations to a standard higher than the law would ordinarily impose, many organizations are reluctant to publish such information and to use such qualifiers as “best” and “highest quality.” See id. at 66.
  \item \textsuperscript{66} See id. at 61.
  \item \textsuperscript{67} See id. at 68.
  \item \textsuperscript{68} See id. at 66 (noting that advertising among HMOs in California has greatly increased).
  \item \textsuperscript{69} For example, New Jersey’s “Health Maintenance Organizations Act” specifically addresses the issue of advertising by HMOs. See N.J. STAT. ANN. § 26:2J-1-42 (West 1996). The act explicitly prohibits HMOs from using untrue or misleading advertising or solicitation or any deceptive evidence of coverage. See id. § 26:2J-15(a). This section also defines untrue, misleading and deceptive for the purposes of the Act. See id. § 26:2J-15(a)1)-(3). The Act further requires that an HMO must file with the State Department of Health copies of all advertisements that will be available to residents of New Jersey. See id. § 26:2J-40(a). The advertisements must be filed at least 30
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other literature to persuade consumers to subscribe, however, will likely tempt competitors to stretch or coat the truth in some way.\textsuperscript{70}

Courts may be increasingly willing to look to a plan's advertisements, brochures, and other literature to create contractual duties to the consumer.\textsuperscript{71} The publication of performance data\textsuperscript{72} may create an implied, and often unintended, warranty of quality to individual or group purchasers.\textsuperscript{73} Therefore, managed care organizations may be exposed to liability for breach of contract based

days prior to the time that they will be made available within New Jersey or to its residents. \textit{See id.} The Commissioner of the State Department of Health may disapprove of any advertisement that he or she finds misleading, false, or uses scare tactics or unnecessarily confusing data. \textit{See id.; see also Fla. Stat. Ann. § 641.385 (West 1996) (permitting the Department of Insurance to order the discontinuation of a deceptive advertisement); Minn. Stat. Ann. § 62D.12 subd. 1 (West 1996) (prohibiting HMOs from using misleading or deceptive advertisements, solicitations, or evidence of coverage).}

In considering the possible liabilities resulting from HMO advertising, federal laws are also implicated. \textit{See 15 U.S.C. § 45(a) (1991) (declaring methods of unfair competition unlawful).}

In order to sustain an action based upon a health care organization's advertisements or other publications, the First Amendment of the United States Constitution must not protect the speech involved. \textit{See Gosfield, supra note 31, at 65.} Essentially, the plaintiff must establish that the statements were commercial speech rather than fully protected contributions to the marketplace of ideas. \textit{See id.}


\textit{See Boyd v. Einstein, 547 A.2d 1229, 1230 (Pa. Super. Ct. 1988).} The \textit{Boyd} court looked to the plan's advertisements, which guaranteed quality, to find the provider to be an ostensible agent of the plan. \textit{See id.} at 1231, 1232. In \textit{Boyd}, a widower brought suit against the HMO after his wife died while under the care of their HMO's participating physicians. \textit{See id.} at 1229, 1230. The decedent sought treatment from her primary care physician after finding "a lump in her breast." \textit{Id.} at 1230. The primary care physician ordered a mammogram and referred the decedent to a specialist in accordance with the procedures in the subscriber's agreement. \textit{See id.} The surgeon to whom the decedent was referred punctured the decedent's chest wall with a needle while performing a biopsy. \textit{See id.} The decedent was hospitalized for two days for treatment of the injury. \textit{See id.} In the weeks following the biopsy, the decedent notified her primary care physician of chest pain and fatigue, \textit{inter alia}. \textit{See id.} On the day of her death, the decedent's husband advised her primary care physicians of her worsening condition. \textit{See id.} After examining her at the hospital, the physicians released her and advised her to rest at home. \textit{See id.} Later that evening, she died in her home. \textit{See id.}

The court looked to the HMO's advertisements to find that the plaintiff raised a genuine issue of material fact as to whether the physicians involved were the ostensible agents of the HMO, thus exposing the HMO to vicarious liability. \textit{See id.} at 1231.

\textit{For a discussion of performance data, see infra notes 102-12 and accompanying text.}

\textit{See Gosfield, supra note 31, at 66.} In anticipation of this possibility, attorneys practicing in this area have an obvious preventive role. \textit{See id.}
upon claims that the organization failed to provide the quality of care promised.\textsuperscript{74}

An increased reliance by the courts on contract theories honors consumer expectations.\textsuperscript{75} Courts have held that allegations concerning the quality of the primary care physicians and the availability of specialist referrals are sufficient to state a claim for breach of contract where the services rendered differed from consumer expectations based on advertisements.\textsuperscript{76} Thus, the publication of performance and outcome data, while meeting the demands of consumers, may expose health care organizations to increased lia-

\textsuperscript{74} See id.; see also McClellan v. Health Maintenance Org. of Pa., 604 A.2d 1053, 1055 (Pa. Super. Ct. 1992). The plaintiff brought a suit against the managed care organization and the primary care physician on behalf of his wife, a deceased subscriber. See id. The decedent chose a primary care physician from the list of providers supplied by the HMO. See id. The primary care physician removed a mole from the decedent's back without performing a biopsy or histology exam even though the decedent told him of the marked changes in size and color that the mole had recently undergone. See id. The plaintiff's claim against the physician was based on the allegation that the physician's failure to perform the proper tests resulted in his or her failure to make a timely diagnosis of the decedent's malignant melanoma. See id. The plaintiff also alleged that the HMO was negligent in selecting the physician as a provider. See id.

In addition to these negligence claims, the plaintiff also sought recovery on a breach of contract and warranty theory. See id. The plaintiff alleged that the HMO expressly made representations regarding the qualifications of primary care physicians and the availability of consultations and treatment by specialists through referrals of the primary care physician. See id. The plaintiffs alleged that the HMO expressly made representations through contracts and other documents that the primary care physicians underwent vigorous screening and were required to meet strict criteria to be qualified as a primary care physician. See id. at 1062. Additionally, the documentation allegedly represented that the decedent's primary care physician underwent such screening and met the proper criteria and that the decedent would be referred to specialists as required for medical treatment. See id. Thus, the plaintiff alleged that the HMO breached the provisions for a competent primary care physician and appropriate referrals. See id.

The court held that these allegations sufficiently stated a breach of contract claim against the HMO and it remanded with instructions to reinstate the complaint. See id. at 1062-63.

\textsuperscript{75} See John D. Calamari & Joseph M. Perillo, The Law of Contracts § 1-4, at 9 (3d ed. 1987). One of "the foundation[s] of contract law...[is]...in the expectations engendered by, and the promisee's consequent reliance upon, the promise." Id.

\textsuperscript{76} See McClellan, 604 A.2d at 1062; see also Boyd v. Einstein, 547 A.2d 1229, 1231 (Pa. Super. Ct. 1988). The Boyd court looked to the plan's advertisements, which guaranteed quality medical services. See Boyd, 547 A.2d at 1231. The HMO at issue in Boyd particularly advertised that its participating physicians were competent and subject to a strict evaluation process. See id. The concurring opinion noted that it was unclear, based on the pleadings, upon which theory of recovery the plaintiff had relied. See id. at 1235 (McEwen, J., concurring). The concurring judge stated that the plaintiff's allegations supported a breach of warranty theory. See id. As well, the trial court stated that the gravamen of the complaint, despite the plaintiff's contention of vicarious liability, was a breach of warranty of quality. See id. at 1235 n.1.
bility by essentially heightening the standard of care.\textsuperscript{77}

B. Allowing Consumers to Bargain: Relying on Private Contracts

Contract law, which is based upon mutual assent, allows parties to define their respective obligations and rights.\textsuperscript{78} While the doctor-patient relationship is essentially contractual, however, the terms of the relationship have been defined almost exclusively by tort law.\textsuperscript{79} Thus, all plans must essentially conform to the same legal standards, thereby reducing the impact and effectiveness of consumer choice.\textsuperscript{80}

The use of private health care contracts would allow patients to customize their health care entitlements, providing individuals with a greater role in determining the quality, quantity, and cost of health care services purchased.\textsuperscript{81} Proponents of the private contract approach argue that patient entitlements should not be determined by statutes, common law courts, or unilateral contract terms of health plans or providers.\textsuperscript{82} Because individuals have differing needs and concerns, the enforcement of private contracts would empower individual consumers to pursue their interests.\textsuperscript{83} Therefore, the enforcement of private contracts would ultimately defer decisions regarding cost/benefit trade-offs inherent in health care to the patient/consumer.\textsuperscript{84}

\textsuperscript{77} See Gosfield, supra note 31, at 62, 66.
\textsuperscript{78} See Calamari & Perillo, supra note 75, § 1-4, at 8. The authors state that "[r]ecognizing the desirability of allowing individuals to regulate, to a large extent, their own affairs, the State has conferred upon them the power to bind themselves by expression of their intention to be bound, provided, always, that they operate within the limit of their delegated powers." Id. "Contract[ual] obligations are created to enforce promises which are manifestations not only of a present intention to do or not to do something, but also of a commitment to the future. They are, therefore, obligations based on the manifested intention of the parties to a bargaining transaction." Keeton et al., supra note 7, § 92, at 656.
\textsuperscript{79} See Weiler, supra note 10, at 94.
\textsuperscript{80} See Clark C. Havighurst, Public Choices, Private Choices, and American Health Policy, in Health Care Reform and Antitrust 61, 65 (1994).
\textsuperscript{81} See id. at 65, 66.
\textsuperscript{82} See id. at 66.
\textsuperscript{83} See id.
\textsuperscript{84} See id. at 65. Promoting the use of private contract would empower consumers to customize their health care entitlements. See id. at 67. Because all plans must conform to the same legal requirements, the choices currently available in the health care system are limited. See id. at 65. The use of private contracts would allow plans to create and consumers to choose alternative standards and requirements. See id. Havighurst argues that the current market does not provide consumers with sufficient options, particularly denying low-cost options. See id. at 63.

Weiler states that there are two possible approaches to substituting a voluntary contract approach to medical liability and suggests that it may be time to reevaluate
Serving up medical liability to private contract, however, would likely result in a trend towards less liability.\textsuperscript{85} Moreover, the safeguards that contract law provides against unfair bargains—for example, unconscionability, fraud, and coercion—would inadequately protect health care consumers because, given the nature of the interest, prospectively ensuring quality care is warranted.

III. \textbf{Arming Consumers with Information}

In many contexts, consumer protection legislation mandates the disclosure of material information by sellers, thereby ensuring that consumers can effectively protect their interests through bargaining.\textsuperscript{86} Similarly, in the health care context, the informed consent doctrine developed to ensure that patients be given the opportunity to make informed choices regarding their treatment.\textsuperscript{87}

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the judicial distaste for private efforts to alter the traditional tort model. See Weiler, supra note 10, at 95-96. The “wholesale approach” would allow patients free reign to negotiate tort liability with their doctors, while the “retail approach” would only loosen the restraints with respect to certain aspects of the liability problem. See id. at 96. Although arguments based on autonomy may justify the “wholesale approach,” if no-liability was an option, it could quickly become the norm. See id.\textsuperscript{85} See id.\textsuperscript{85} See, e.g., 15 U.S.C. § 1601 et seq. (1988). The Truth in Lending Law requires that creditors disclose important credit terms to potential debtors. See id.\textsuperscript{86} See Szczygiel, supra note 47, at 171. Although jurisdictions vary in their formulations, the doctrine generally requires that a patient be given enough information regarding a certain procedure and its risks to make a knowledgeable decision regarding the treatment. See id. at 190. “True consent to what happens to one’s self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each.” Canterbury v. Spence, 464 F.2d 772, 780 (D.C. Cir. 1972) (footnote omitted).

The scope of the duty to inform a patient is shaped by the right of self-decision; thus, all risks must be divulged that would be material to a reasonable patient’s decision. See id. at 786-87; see also Largey v. Rothman, 110 N.J. 204, 213, 540 A.2d 504, 509 (1988) (adopting the reasonable patient standard for disclosure).

Many states have also codified this requirement in their legislation. See, e.g., Alaska Stat. § 09.55.556(a) (Michie 1995); Ark. Code Ann. § 16-114-206(b) (Michie 1987) (adopting a standard based on the type of information that a similarly trained and experienced physician would provide); Cal. Health & Safety Code § 1645 (West Supp. 1996) (outlining the duty of disclosure regarding blood transfusions); Cal. Health & Safety Code § 1690 (West 1990) (outlining the duty of disclosure and specifying the type of information that must be given regarding hysterectomies); Cal. Health & Safety Code § 24173 (West 1992) (outlining the general requirements of providing patients with sufficient information to give informed consent); Neb. Rev. Stat. § 44-2816 (1993) (defining informed consent as consent based upon the information customarily given to similar patients). For example, the Alaska health care malpractice statute provides that:

A health care provider is liable for failure to obtain the informed consent of a patient if the claimant establishes by a preponderance of the evidence that the provider has failed to inform the patient of the common risks and reasonable alternatives to the proposed treatment or pro-\
\end{footnotesize}
Thus, for approximately three decades, courts have recognized that patients should have an active role in determining the course of medical treatment and that patients require certain information regarding treatment to make informed decisions.\textsuperscript{88} Given the changing nature of our health care system, the consumer's need for information has expanded because decisions on which plan to join may affect the quality and quantity of care ultimately received.\textsuperscript{89}

The ability of managed care to control health care costs is premised on the following assumption: because patients follow the directives of their physicians, an entity could control costs by telling physicians how to practice medicine.\textsuperscript{90} This theory, based on consumer ignorance, is outdated in the age of the "information superhighway."\textsuperscript{91} A more appropriate system would be premised on the assumption that patients will be well-informed regarding what the medical field has to offer.\textsuperscript{92}

Despite the underlying presumption of consumer ignorance, the growth and commercialization of managed care is encouraging

\footnotesize{\textsuperscript{88} See Szczygiel, \textit{supra} note 47, at 175-215 for a history of the development of the informed consent doctrine. Szczygiel divides his history into two developmental periods and traces the evolution of legal standards aimed at giving increased weight to patient autonomy in deciding whether to undertake the risks of any treatment. See id.

\textsuperscript{89} See Szczygiel, \textit{supra} note 47, at 171. Notions of patients' rights in determining the course of care continue to change and the doctor-patient relationship is increasingly being viewed as a cooperative one. See id. Today's model of health care decision-making, however, may hinder the progression toward full patient participation. See id.

\textsuperscript{90} See Bales & DeMarco, \textit{supra} note 32, at 421. Liability of physicians is, therefore, not only predicated on their ability to practice medicine, but increasingly on their ability to communicate effectively with their patients. See id. at 420.

\textsuperscript{91} See Rosenblatt, \textit{supra} note 24, at 133. Clinical practice guidelines and incentives used by managed care plans, for example, may affect the consumer's choice of a particular plan. See id.

\textsuperscript{92} See John C. Goodman, \textit{A Plan to Empower Patients}, \textit{Wall St. J.}, May 2, 1995, at A18. Goodman projects that the future successful managed care clinic will publicly disclose its cost-benefit standards so that individual consumers will be able to choose a plan depending on its general approach to care. See id.

\textsuperscript{91} See id. The Internet and other computer services feature various medical libraries and databases, diagnosis trees, and discussion groups centering on particular ailments that will increasingly provide consumers with information regarding what medicine has to offer. See id.

\textsuperscript{92} See id.
the development of a well-informed patient/consumer. As the health care industry rapidly changes to offer new delivery and financing systems, the industry is increasingly becoming commercialized. As patients become consumers, physicians become providers, and the new health care delivery systems are seemingly eroding the traditional doctor-patient relationship upon which physicians' identities and patients' trust have been based. This changing doctor-patient relationship necessitates a corresponding shift in the focus of a consumer's quality concerns. In addition,

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93 See infra notes 102-04 and accompanying text.

94 For the past two decades, the commercialization of medicine has been a dominant trend. See Patricia H. Werhane, The Ethics of Health Care as a Business, in HEALTH CARE ETHICS 394, 397 (John F. Monagh & David C. Thomasma eds., 1994) (arguing that exploitation, not commercialization, is the enemy of the health care system and that a market model would promote a more equal distribution of health care benefits). The health care system has evolved into an industry "with a trillion-dollar share of the economy" and has been transformed from a purely professional endeavor into a business. See Abraham & Weiler, supra note 11, at 394-96.

The health care industry is becoming a big business—a recent acquisition of MetraHealth by United HealthCare resulted in the creation of one of the country's largest health care companies. See Leslie Scism, United HealthCare Agrees to Acquire MetraHealth for Up to $2.35 Billion, WALL ST. J., June 27, 1995, at A2. The company is expected to provide services to over 14 million members, resulting in an annual revenue over $8 billion. See id. United HealthCare, which is one of the nation's largest owners and operators of HMOs, is expected to try to persuade a greater percentage of MetraHealth's 10.7 million members to enroll in HMOs. See id.

Additionally, the model of the modern health care system as a commercial enterprise is expanded wherein a physician is also a consumer of hospital services while remaining a supplier to the patient/customer. See Christopher H. Coulter, If Patients Are Now "Customers," What Does that Make Physicians?, PHYSICIAN EXECUTIVE, Feb. 1995, at 20.

HMOs represent competition in the health care field. See McCLELLAN, supra note 13, at 68. Competition in the industry was principally precipitated by the introduction of the HMO and the application of anti-trust laws. See id; Ginzerberg, supra note 4, at 760 (arguing that a competitive market is an opponent of cost control because advertising and marketing increase with the capacity of the market, and as the system is expanded, the duplication of services is encouraged).

95 See Coulter, supra note 94, at 19-20. Quality standards dictated by consumer demands and satisfaction threaten physicians. See id. The physician's role essentially changes because he or she is no longer only obligated to provide care to a patient, but is also obligated to deliver "quality" and to provide services that will be continuously measured and evaluated with an eye towards improving the clinical outcomes. See id.

The doctor-patient relationship is stretching to allow for the increased communication and coordination among providers and more informed and educated decision-making by patients. See Sage & Jorling, supra note 2, at 1012. "Today, most would not recognize Norman Rockwell's portrait of the family doctor." Dunn v. Praiss, 199 N.J. 564, 568, 656 A.2d 413, 415 (1995).

96 Competition among plans is also encouraging managed care systems to emphasize administrative accessibility and efficiency to its consumers. See Sage & Jorling, supra note 2, at 1019. This further evidences the changing nature of the doctor-patient relationship, as the first contact of most patients/consumers is often the health
as medicine is commercialized through initiatives such as cost containment and UR, courts are increasingly viewing patients as consumers in a competitive marketplace who are entitled to make informed judgments concerning their care.\footnote{See Bales & DeMarco, supra note 32, at 509. The impact of the current changes within the health care system will have unforeseen impacts on the relationship between the patient and physician and may have an impact on the patient's role. See Szczypiel, supra note 47, at 173. Current informed consent principles will have a minor role in the cost conscious system, which is marked by standardized treatments. See id. at 174. Cost containment will limit the choices with which both patients and physicians are faced and will change the type of information available to patients. See id.}

In the past, many changes within the health care system were driven by the desire and need to control costs.\footnote{See Aaron D. Twerski & Neil B. Cohen, Comparing Medical Providers: A First Look at the New Era of Medical Statistics, 58 Brook. L. Rev. 5 (1992) for a discussion of provider-specific information and data, which attempt to measure the success of specific providers as to a given procedure, and the role of such information in malpractice and informed consent actions. See also Douglas Sharrot, Note, Provider-Specific Quality-of-Care Data: A Proposal for Limited Mandatory Disclosure, 58 Brook. L. Rev. 85 (1992) (arguing that disclosure of provider-specific data would enhance patients' ability to make informed decisions regarding which physician or health plan to choose).} Today, the most recent debates regarding the health care system focus on the impact of the previous changes on the quality of health care provided.\footnote{See Gosfield, supra note 31, at 31.} Thus, within the new commercial setting of health care, purchasers are demanding "value" for their health care dollar and information upon which to choose a plan.\footnote{See id. Another motivation for the increased effort to develop information is the internal use of the information and the data to guide judgments regarding the management of care. See id. at 32.} As managed care matures as an option for the delivery of health care, organizations find themselves in a competitive industry in which they must compete for patients based on both the cost and quality of the health care provided.\footnote{See Sage & Jorling, supra note 2, at 1017.}

This commercial interest in the quality of health care has sparked a demand for data reflecting various quality measures.\footnote{See Gosfield, supra note 31, at 67; see also Norma Harris, How Hospitals Measure Up, Bus. & Health, Aug. 1994, at 20 (discussing how HMOs are increasingly being pressured by employers and individual consumers to report their efforts to provide quality care and that hospitals are likewise being demanded to demonstrate their quality of care).}

The concern for value has introduced a new vocabulary to the industry; among the common indicators of quality are "effectiveness," "clinical indicators," "performance measures," "outcomes," and "satisfaction." See Gosfield, supra note 31, at 31. The three traditional areas of quality assessment are the structure ("the physical envi-
Although the reliability and usefulness of the currently available information have been questioned, a uniform reporting system would transform the market. However, the quality concerns of the major types of consumers in the health care system—employers, governments, and individuals—are divergent, and until now, the efforts to produce and collect data have focused on the concerns of employers and other purchasing alliances. Reflecting the demands of a competitive market, the most recent efforts concerning performance data focus on comparative reporting.

As a result of this demand for information, there is a growing effort at various levels of government and within various parts of the health care system to collect, share, and evaluate data that pur-

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103 See Harris, supra note 102, at 20. "Report cards will transform the health care market." Id. (quoting Patrick Casey, the executive director of a coalition of employers). Report cards with a standardized reporting system, however, are likely years away. See Susan Brink & Rita Rubin, Managing Managed Care, U.S. News & World Rep., July 24, 1995, at 60.

104 There are two "consumers" of health care in our system—the purchaser of a plan and the ultimate patient—each with their own concerns regarding value. See Gosfield, supra note 31, at 37. Until now, the interest in value has been geared towards the interests of employers as purchasers of health care for its employees, as alliances and employers constitute the majority of purchasers in today's system. See id. at 33; Brink & Rubin, supra note 103, at 60.

All purchasers of health care—individuals, employers, and insurance companies—have an economic interest in choosing providers that offer quality services at a low price. See McCLELLAN, supra note 13, at 68-69. All purchasers also have an interest in considering the value of an increase in quality with its attendant increased cost. See id. at 69.

Employers and other alliances are concerned with access, efficiency, appropriateness of care, acceptable technical outcomes, and patient satisfaction. See Gosfield, supra note 31, at 37-38. Patients, as the ultimate consumers, are initially most concerned with the cost of the plan, the coverage of the plan, whether their physician is enrolled in a particular plan, and an overall sense of satisfaction. See id. at 38. Other concerns of individuals, which are factors when choosing a health plan, are convenience and other personal considerations. See Brink & Rubin, supra note 103, at 60.

Because individuals have differing needs and concerns, it would make more sense for the clinics to directly sell their services to individual consumers, not employers, so that individuals will be able to pursue their own self-interests in a competitive market. See Goodman, supra note 90, at A18.

While some of the recent efforts are coming closer to meeting the informational needs of the average individual consumer, the ratings and information currently available provide information more useful to employers, like cost statistics, rather than information that reveals which plan provides the best coverage for an individual with any specific health concern or problem. See Brink & Rubin, supra note 103, at 60.

105 See Gosfield, supra note 31, at 38.
ports to address the measures of quality that concern consumers.\textsuperscript{106}
In addition, legislatures are increasingly mandating that managed care systems publicly disclose certain data as a requirement for accreditation.\textsuperscript{107}

Pennsylvania was the first state to use its regulatory power to increase the information available to consumers concerning quality.\textsuperscript{108} In this regard, the Pennsylvania Legislature established a Health Care Cost Containment Council to aid in the collection and dissemination of data regarding the quality and cost of health care in the state.\textsuperscript{109} The legislation authorizes the Council to collect information from providers.\textsuperscript{110} The Council then issues reports to the public, as well as the legislature, that furnishes information comparing providers.\textsuperscript{111}

\textsuperscript{106} See id. The Wall Street Journal recently reported that an alliance of major buyers of health services, including public-sector as well as corporate purchasers and the overseeing body of Medicare, were planning to join together to develop measures for evaluating HMOs. See What's News, Business and Finance, WALL ST. J., July 3, 1995, at A2; see also Ron Winslow, Big Buyers of Health Care Unite to Rate HMOs, WALL ST. J., July 3, 1995, at A3 (endeavoring to provide health care consumers with information to help them choose a managed care plan).

\textsuperscript{107} See Gosfield, supra note 31, at 53-54.


\textsuperscript{109} See PA. STAT. ANN. tit. 35, § 449.2 (West Supp. 1996). The Act makes and adopts the following findings and policy:

The General Assembly finds that there exists in this Commonwealth a major crisis because of the continuing escalation of costs for health care services. ... Increasing costs are also undermining the quality of health care services currently being provided. ... Therefore, it is hereby declared to be the policy of the Commonwealth of Pennsylvania to promote health care cost containment and to identify appropriate utilization practices by creating an independent council to be known as the Health Care Cost Containment Council. It is the purpose of this legislation to ... encourage the development of competitive health care services in which health care costs are contained and to assure that all citizens have reasonable access to quality health care. It is further the intent of this act to facilitate the continuing provision of quality, cost-effective health services throughout the Commonwealth by providing current, accurate data and information to the purchasers and consumers of health care on both cost and quality of health care services and to public officials for the purpose of determining health-related programs and policies and to assure access to health care services. ...\textsuperscript{110}


\textsuperscript{111} See id. § 449.7. The Act requires the council to collect and disseminate data regarding all covered services, which are defined as

[a]ny health care services or procedures connected with episodes of illness that require either inpatient hospital care or major ambulatory service such as surgical, medical or major radiological procedures,
Because a consumer's decision about which managed care plan to subscribe to is likely to have an effect on the quantity and quality of care he or she ultimately receives, a patient's right to make an informed decision extends to the choice of a plan. To the extent that information similar to that mandated by Pennsylvania law allows consumers to make an informed choice regarding their health care, consumers are protected by the availability of such information.

CONCLUSION

The means chosen to protect health care consumers reflect a judgment regarding the appropriate actors to make health care decisions. For example, a decision to protect patients through legislation mandating particular services, such as minimum hospital stay provisions, rests upon the judgment that government has a proper role in deciding appropriate medical care. Similarly, systems fashioned around private contracting or the increased availability of information assume that the patient/consumer should be the primary decision-maker. Thus, the appropriateness of a health care consumer protection system is partially determined by whether it maintains proper roles for the various health care actors.

The traditional, and still primary, health care consumer protection mechanism is malpractice law. The traditional tort system, however, does not effectively protect patients/consumers in today's system. In response, other approaches are being debated and ex-

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id. § 449.5.

For every covered service performed in the state, the council must collect information about the patient, diagnoses, procedures performed, admitting and consulting physicians, health care facility, charges, and payments. See id. § 449.6.

The reports compare providers with information such as provider service effectiveness, cost, incident rates, mortality rates, infection rates, and readmission rates grouped according to the diagnosis, procedure, and severity. See id.

112 See Rosenblatt, supra note 24, at 133. For example, knowledge of practice guidelines may improve a patient's informed consent, participation in decision-making, and overall satisfaction with the plan. See id. The 1992 Institute Of Medicine Report also raises some interesting issues regarding informing patients of the practice guidelines for the purpose of making an informed choice as to which plan to join, as well as giving informed consent to a particular course of treatment. See id. Questions remain concerning the publication of such information, such as the extent of the information that should be available to patients regarding treatment options that are not covered by a particular plan. See id.; see ASSESSING HEALTH CARE REFORM 40 (Marilyn J. Field et al. eds., 1993) (noting that clinical practice guidelines may improve, inter alia, patients' informed consent and their role in health care decision-making).
permented with, resulting in the current patchwork protection of patients/consumers that has developed in the courts and legislatures. None of the current approaches to the exclusion of the others presents a comprehensive solution; each approach, however, has merits that should be recognized.

Thus, there is no need to choose a consumer protection system. Given the complexity of the evolving system, such a choice would likely leave some problems unaddressed and, therefore, some injuries uncompensated. Moreover, the law generally recognizes the varied nature of consumer injuries, as consumers in other areas of the economy have a variety of remedies at their disposal. Thus, the patchwork nature of the current state of affairs is not in itself problematic.

Some of the initiatives, however, further threaten the doctor-patient partnership as the core of treatment decision-making, which is endangered by managed care itself. Health care consumer protection, therefore, should endeavor to reflect the changing nature of the decision-making process while seeking to preserve the primary decision-making role of the doctor-patient partnership.

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