

## The Impact of Health Care Delivery Changes on Professional Liability

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### Abstract

*Rising health care costs have caused managed care to seek out cost control measures. As a result, health care delivery methods have been altered in an effort to reduce costs. This paper addresses the reasons for changes in health care delivery as well as the professional liability implications and mitigation techniques associated with these changes. The changes specifically addressed in this paper are the hospitalist movement, restricted access to specialty services, and the use of formularies. This paper concludes that the changes in health care delivery have altered professional liability in the medical field and that awareness of existing liability mitigation techniques is paramount.*

### Introduction

Over the past two decades, cost containment objectives have led to a push for changes in health care delivery. In response, health care organizations such as hospitals and Health Maintenance Organizations have worked to provide innovative and cost effective methods of health care, many of which have impacted the way in which medical care is offered. The resulting changes have impacted the professional liability landscape as well as the profitability of managed care organizations and hospitals.

Physicians' liability stems from the legal theories of strict liability (*Res Ipsa Loquitur*) and negligence. Because managed care organizations employ physicians as independent contractors, managed care organizations are statutorily sheltered from the vicarious liability associated with physicians (Arlen and Macleod, 2005). The result is that managed care can place increased risk on physicians by directing and influencing physicians' actions and operations while simultaneously assuming little or no culpability related to liability (Arlen and Macleod, 2005).

Opinions related to managed care's liability implications vary. Aizer, Currie, and Moretti (2004) argue that, compared to individual physicians, managed care organizations have superior information and experience due to the size and scope of managed care operations. The result is more cost effective treatments developed among managed care organizations relative to those achieved through individual practices. Therefore, the influence of the managed care organization with limited liability can be beneficial to the health care system. However, alternative arguments contend that autonomous managed care organizations lead to decreased incentive for physician expertise (Arlen and Macleod, 2005). The purpose of this paper is to examine some key changes in the manner that health care is delivered and to consider advantages and disadvantages related to issues such as cost effectiveness and patient care. Most importantly, this paper examines how these specific changes in the health care landscape have affected professional liability exposures. Finally, this paper discusses liability mitigation techniques related to professional liability exposures that have emerged, due in part, to the changes in the health care landscape.

### **Hospitalists**

Hospitalists are defined as physicians whose primary professional focus is the general medical care of hospitalized patients (Pantilat, 2006). In the hospitalist model, a hospitalist becomes the patient's physician during hospitalization with the outpatient physician resuming care of the patient after discharge (Auerbach, Davis, and Philips, 2001). From 1996 until 2006, the number of physicians practicing hospital medicine rose from a few hundred to approximately 14,500 (Rowland, 2006). Current trends suggest this number will continue to increase so that by 2010 there will be approximately 30,000 hospitalists (Rowland, 2006).

Rising health care costs have pressured managed care organizations to seek cost effective methods of health care delivery. In 2006, health care expenditures in the United States exceeded \$2

trillion (California HealthCare Foundation, 2008). Hospital care and physician/clinical services in 2006 were by far the largest sources of expenditures and accounted for 52 percent of national health care spending (California HealthCare Foundation, 2008). The hospitalist model, which has been shown to decrease factors such as length of hospital stay, has been perceived as a potential cost mitigation mechanism (Diamond, Goldberg, and Janosky, 1999). Managed care's desire for cost control has consequently contributed to the popularity of the hospitalist model and the potential cost savings associated with the model.

The hospitalist model also has appealed to physicians that value the time saving and scheduling benefits of the hospitalist model. The strain of running a medical practice coupled with intermittent hospital visits is alleviated by the hospitalist model (Darves, 2003). Additionally, physicians have expressed satisfaction with the hospitalist model and indicated that burnout is an unlikely outcome of the hospitalist model (Tascio, 2007). These unexpected social considerations associated with the hospitalist movement have influenced physician's attitudes related to treatment and health care delivery preferences. As a result, the way that health care is delivered has been impacted.

There are many cost advantages associated with the hospitalist model. One study found that, during a six-week period, hospital stays at Tufts-New England Medical Center averaged 3.45 days while total hospital cost per admission was \$2,332. When the hospitalist model was implemented for the same period in the following year, average hospital stay and total cost per admission was reduced to 2.19 days and \$1,775 respectively (Gregory, Baigelman, and Wilson, 2003). In a separate study at a 500 bed teaching hospital, full time faculty hospitalists cared for a study group of patients. When compared to the same period of the previous year, the hospitalist model reduced median length of stay by one day, median cost of care by \$587, and 14 day readmission rates by 5.26 percent (Diamond, Goldberg, and Janosky, 1999).

On the other hand, some studies have suggested that the model is not cost effective. For example, the study conducted at Tufts-New England Medical Center concluded that the hospitalist model was not economically viable due to the influence of *per diem* reimbursement (Gregory et al, 2003). Showstack, Katz, and Weber (1999) expressed additional concern with the hospitalist model, contending that costs associated with post hospitalization must be considered when evaluating the effectiveness of the hospitalist model.

There are various sources of liability exposure for physicians participating in the hospitalist model. Miscommunication between primary care physicians and hospitalists regarding a particular patient can lead to malpractice claims (Volpe, 1999). Negligent referral, or the referral of a patient to a hospitalist with inadequate training to deal with a patient's particular infirmity, is another source of liability brought about by the hospitalist model (Volpe, 1999). Patients who do not get properly "referred" back to their primary care physician, or patients lost to follow up, are yet another source of liability that stems from the hospitalist model (Volpe, 1999).

Hospital professional liability also has been affected with the advent of the hospitalist model. For example, laborists are specialized obstetric physicians that can be classified as hospitalists (*Health Strategies and Solutions*, 2005). Hospitals that have laborists programs can reduce liability exposure by ensuring that "back up" is in place for physicians that deliver babies (Darves, 2009). Conversely, hospitals can incur liability through hospitalists acting as independent contractors. For example, in *Gilbert v. Sycamore Municipal Hospital*, the Illinois Supreme Court ruled that hospitals could be held vicariously liable for the actions of physicians acting as independent contractors (Levin, 2005).

In an effort to reduce the effect of the hospitalist model on physician liability, various medical professionals have proposed effective mitigation strategies. In general, a commitment to high quality, safe care is the best protection for hospitalists against legal liability (Egan, 2008). Publications like the

*American Journal of Medicine* have addressed specific problems with the hospitalist model and have suggested methods that help alleviate miscommunication problems. Surveys and increased scrutiny have been presented as additional mitigation methods which serve to improve standard of care and accountability (Volpe, 1999).

### **Restricted Access to Specialty Services**

During the early 1990's, rising health care costs prompted managed care organizations to implement cost control measures specifically designed to stem the growth of enrollees' health services utilization. Techniques such as prior authorization requirements, gate keeping and utilization reviews were implemented increasingly until the late 1990's. By 2000, however, competitive market forces and additional social considerations forced the creation of less restrictive health insurance products. The resulting removal of the restrictive measures implemented throughout the 1990's led to dramatic increases in the use of specialized physicians and treatments (Mays, Claxton, and White, 2004).

As a result, many health care organizations have reintroduced prior authorization requirements and other cost control measures for numerous plans (Mays et al, 2004). For example, in 2002-2003, Aetna reinstated prior authorization requirements for PPO's and HMO's in northern New Jersey. A sharp increase in health care use which resulted from abolition of prior authorization requirements in 2001-2002 was cited as the reason for the 2002-2003 reinstatement (Mays et al, 2004). BlueCross BlueShield in Syracuse experienced similar results to that of Aetna (Mays et al, 2004).

The general reinstatement of restrictive health plans has not been embraced by all of the health care industry. Historical consumer dissatisfaction with prior authorization requirements and the ensuing negative cost effects have made some health care organizations reluctant to re-embrace prior authorization (Sipkoff, 2006). As a result, certain plans have implemented quasi-prior authorization requirements as an alternative to the reinstatement of standard prior authorization requirements.

Quasi-prior authorization requirements allow access to specialty physician and specialty services up to a predetermined threshold (Mays et al, 2004). In addition, various plans maintain virtually no prior authorization requirements with the exception of exceptionally costly procedures like cosmetic surgery and diagnostic imaging (Sipkoff, 2006).

The re-emergence of prior authorization requirements has impacted physician's professional liability exposure. This is especially true in the realm of providing diagnostic services. Physicians frequently use diagnostic imaging techniques including Magnetic Resonance Imaging (MRI) and Positron Emission Tomography (PET) scans in an effort to identify and diagnose various medical ailments. The increased restrictive nature of many health plans has reduced the ability of physicians to freely refer patients for PET scans, MRI scans, and other valuable specialty treatments. Some health plan officials view PET and MRI scans as valuable tools for physician liability mitigation (Sipkoff, 2006). Consequently, the reduced ability to freely refer patients for specialty treatments has degraded the professional liability position of physicians.

necessity of diagnostic scans as a liability mitigation technique has been illustrated in an assortment of legal settings. For example, the Texas Medical Liability Trust reported the story of a 56 year old man who suffered from various ailments and was scheduled for a diagnostic MRI scan. However, the MRI scan was not performed until the man's medical condition had deteriorated considerably. The man successfully won a malpractice claim due in part to the failure to obtain an emergent MRI scan (*Texas Medical Liability Trust, 1998*). As this example illustrates, restricted access to specialty treatments such as diagnostic scans can have a major impact on physician professional liability exposure.

With regard to prior authorization mechanisms, physicians have few options for mitigating this liability risk. In response to a managed care plan's denial to authorize a service, physicians may offer

these services at cost to the patient, but this option is not likely to be exercised for the more expensive diagnostic tests. In the longer run, physicians may actively participate in the managed care plan's development of treatment protocols to ensure that necessary diagnostic tests are less likely to be denied.

## **Formularies**

Rising prescription drug costs have shifted more of the financial burden associated with prescription drugs toward managed care organizations. In 2006, \$216.7 billion were spent on prescription drugs compared to just \$40.3 billion in 1990 (*Kaiser Family Foundation, 2008*). Further, in 1990, only 26 percent of the costs associated with prescription drugs were paid for by private insurers, while in 2006, 44 percent of these costs were paid for by private insurers (*Kaiser Family Foundation, 2008*). A consequence of these trends has been the development of cost alleviation techniques, such as the implementation of formularies, that specifically address prescription drugs.

A drug formulary is a list of drugs selected as most useful in patient care based both on clinical consideration and cost consideration (*Hoadley, 2004*). To a certain extent, drug formularies remove prescribing power from physicians and place them in the hands of managed care. Formularies are classified as open or closed depending on the number of drugs covered and may contain cost sharing tiers (*Hoadley, 2004*). Opened and closed formularies as well as tiered formularies promote cost sharing incentives for patients. Ultimately, these cost sharing incentives help to reduce costs for health care organizations (*Hoadley, 2004*).

Formularies induce a tradeoff between ability to obtain specifically prescribed drugs and overall affordability of prescriptions in general (*Hoadley, 2004*). For example, for medical conditions like bi-polar disorder, depression, or hypertension, treatment decisions are relatively individualized: a drug that works for one patient may not work for another. In these cases, a less restrictive formulary is beneficial

(Hoadley, 2004). However, restrictive formularies may be tolerated by patients with medical conditions such as arthritis and allergies, which require less stringent prescribing decisions (Hoadley, 2004).

Additional evidence suggests that physicians participating in managed care plans feel patient out of pocket expense is more important than the overall cost of the drug (Shrank et al, 2006). Formularies therefore present physicians with the difficult decision of prescribing drugs that are both affordable and effective.

When a patient's health is compromised due to prescribing decisions, physicians can be held liable. In psychiatrics, for example, medical malpractice allegations have included negligence in prescribing resulting from decisions regarding drug choice, dosage, and frequency of use (Melonas, 2005). Prescription of off-label drugs can also lead to malpractice claims resulting from failure to obtain informed consent and general negligence (Riley and Basilius, 2007). The cumulative impact of formularies and their influence on prescribing decisions has been an altered professional liability landscape.

Many effective professional liability mitigation strategies regarding prescribing decisions exist. In some specialized areas of medicine, information gathering, communication, and documentation are critical because they encourage thoughtful decision making with the patient and heighten the prescriber's awareness of potential liability sources (Melonas, 2005). Rigid and regular monitoring of patients by the prescribing physician can also help mitigate abandonment claims and reduce professional liability exposure. Additionally, physicians can make prescribing decisions with the patient's knowledge or consult literature reviews related to specific prescription drugs (Riley and Basilius, 2007). As with prior authorization measures, physicians may also take a more active role in developing formularies to ensure their adequacy.

## **Conclusion**

Many factors have led to a change in the way that health care is delivered. In most cases, the driver behind this change is the desire to reduce costs associated with health care delivery. The techniques discussed here - the hospitalist model, restricted access to specialty physicians, and changes in prescribing habits - have all emerged as a result of cost saving ambitions. In some cases, cost benefits as well as social benefits have been realized as a result of these changes. In other cases however, patient care and cost control have suffered as a result of the changes in health care delivery. Additionally, the landscape of physician professional liability has been altered as a direct result of these changes in health care delivery.

Physician awareness of the professional liability implications resulting from changes in health care delivery is paramount, regardless of arguments for or against managed care's influence and subsequent limited liability. The hospitalist model can lead to malpractice claims through, but not limited to, miscommunication and patient abandonment. Restrictive health care plans and alterations in prescription drug methodologies can also affect physician's professional liability. Physicians, however, have the ability, if not the responsibility, to counteract this increased liability exposure through mitigation techniques.

Proper communication tops of the list of mitigation strategies. Studies have shown that direct correlation exists between malpractice claims and patient communication issues (Finkelstein and Saxton, 2003). Patients should be made aware of reasons behind specific prescribing decisions or specialty care referrals. Dialogue between primary care physicians and specialty physicians, such as hospitalists, is also vital for liability mitigation. Physician's professional liability may be further reduced by enhanced communication within the managed care environment in the form of more active involvement with the further development of cost saving measures.

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