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Quality in the Physician-Patient Relationship: Legal Trends as Facilitators of Business Trends

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ESSAY

QUALITY IN THE PHYSICIAN-PATIENT RELATIONSHIP: LEGAL TRENDS AS FACILITATORS OF BUSINESS TRENDS

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INTRODUCTION: BUSINESS AND LEGAL FACTORS IN THE GROWTH OF MANAGED CARE

As the growth of managed care promotes a new kind of physician-patient relationship, physicians face dramatically altered financial incentives. The new incentives may change the ways in which physicians focus on quality of patient care, since managed care can exert pressures on physicians through capitation and other financial arrangements to limit the amount of health care services that they provide in the interests of cost control. Physicians now realize financial rewards by considering efficiency rather than exclusively quality or quantity of care.

The business environment that has spawned the growth of managed care reflects powerful economic forces that are not likely to disappear. Quality of patient care will be addressed not by delaying these changes, but by steering them toward desired outcomes. To accomplish this goal, an understanding of the larger environment promoting the business changes in health care is crucial.

Evolution in the business side of health care can be seen as a response to changes in the legal environment. In various ways, recent legal changes have promoted the growth of managed care and related developments, including the new physician-patient relationship. Of particular significance, legal changes have fostered vertical integration of health care services and combinations of providers and payors, which have made the growth of managed care possible. To understand the likely impact that the new health care environment will have on quality of care, it is essential to understand the nature of these legal changes and the way they interact with the business and economic forces at work.

A key aspect of the growth of managed care is the consolidation of once independent physician practices and other health care providers into larger entities. This integration results from the role of managed care organizations, predominantly health maintenance organizations (HMOs), in overseeing both the provision of and payment for health care services.

In accomplishing this combined role, larger organizations with more resources have a strong advantage over smaller ones, more so than when insurers merely paid for health care services. With size comes bargaining strength. As these payors grow in size, physicians find it increasingly advantageous to join larger groups, whether controlled by physicians, hospitals or entrepreneurs, in order to achieve bargaining parity. The same holds true for hospitals and other kinds of providers. The strongest bargaining position in relation to HMOs is held by large provider organizations that integrate physicians and hospitals.

Over the past several decades, important legal barriers to such consolidation have diminished. At the same time, various legal incentives for physicians to practice in larger entities have arisen. The incentives result from legal efforts to combat perceived abuses under traditional fee-for-service medicine delivered by smaller independent practices, such as kickbacks for referrals, abusive self-referrals, and disregard for costs. In fighting these abuses, the law has promoted a radically altered business environment. By understanding these changes, it is possible to better understand how the law has guided the business of health care and how it may also deal with patient care quality under a new managed care-based system.

I. THE SHIFT AWAY FROM THE TRADITIONAL FOCUS ON PHYSICIAN BUSINESS AUTONOMY

The changes in health care that have promoted managed care and business consolidation are dramatic when viewed against the historical structure of the industry. Physicians as a group have traditionally guarded their independence fiercely, and the medical profession has resisted efforts to reorganize private practices into larger combinations, especially when those combinations are not wholly controlled by physicians. The notion of independent practice has been closely linked with the outcome of high quality care, based on the concept that clinical autonomy is not possible without business autonomy.

Other segments of the health care industry have traditionally structured themselves around this paradigm of independent practice physicians. Hospitals have affiliated with physicians as medical staff members who use hospital facilities for their independent practices rather than as direct hospital employees. Health insurance companies have reimbursed physicians as independent businesses providing services that are separable from those of hospitals, laboratories, and other institutional and ancillary providers. Medicare has mirrored private insurers in reimbursing physicians on a fee-for-service basis for each service rendered.

The new environment, in contrast, is based on the notion that the payors for health care services, insurers and employers, should exert a direct influence over the way in which the services are provided. Payors exert this influence by "managing" care. They require patients to first see a primary care physician who decides whether there should be treatment by a specialist or hospital. Referral decisions by these primary care providers are closely reviewed by the payor, with such reviews frequently involving detailed examination of the physician's clinical judgment. Primary care physicians are also rewarded financially for limiting their referrals in two ways. First, they are paid through capitation, a set amount per patient per month with no extra payment for additional treatment. Second, some HMOs pay bonuses that directly reward low referral rates.

If physicians wish to have access to managed care patients, they must acquiesce in these financial arrangements that may create intrusions on their clinical autonomy. Moreover, as the prevalence of managed care grows, the pool of patients available to be treated under traditional fee-for-service arrangements shrinks. Physicians will find that they have no choice but to accept these limitations if their practices are to remain viable. The new physician-patient relationship thereby spreads.

A consequent economic pressure may lead to limits on physician business autonomy that mirror the limits on clinical autonomy. As managed care organizations grow in market share, individual physician practices can exert less bargaining power, since managed care organizations have the leverage of threatening to replace them with other physicians if a practice refuses to accept their conditions. In addition, these companies may find it more efficient to negotiate with a few large practice groups rather than separately with many smaller ones. The result is that physicians face strong incentives to join networks that negotiate with managed care companies on behalf of many of them at once. Such networks may be controlled by hospitals, by private entrepreneurs or venture capitalists, or by large integrated networks based at one or a number of hospitals. Some networks are controlled by physicians, but often these entities have difficulty obtaining sufficient capital to survive. By joining any of these kinds of networks, physicians face the prospect of working as employees or contractors of a large organization. Business autonomy is then significantly reduced, even if clinical autonomy is not impaired.

Large physician networks that negotiate group contracts with managed care organizations present a dramatically different business environment from individual practices that accept fee-for-service payments from patients and insurers. In such large networks, the physician-patient bond may be

less personal. The laws governing physician practice arrangements would not have encouraged such a business structure a few decades ago. Today, it has become increasingly difficult legally to maintain the old environment.

II. TRADITIONAL LEGAL PROTECTION OF PHYSICIAN AUTONOMY: THE CORPORATE PRACTICE OF MEDICINE DOCTRINE

Dating mostly from the 1920s, the legal doctrine prohibiting the "corporate practice of medicine" limited the growth of physician networks by prohibiting the employment of physicians by non-physicians. Under the doctrine, physicians could not practice medicine under the employ of anyone other than another practitioner licensed in the same jurisdiction. In particular, a business corporation could not employ physicians as it would other employees. If physicians were to work for a larger entity, they could do so only as independent contractors who retain their business autonomy. The rationale for this rule was that non-physicians are not competent to oversee clinical care when they supervise physicians, so such oversight might impair quality.[1] The linkage of business independence with quality of care was thereby institutionalized in most states laws.[2] Employment by an integrated health care network would be impossible under the doctrine, unless the network were structured as a large physician practice, a serious practical impediment in many cases.

In recent years, the corporate practice of medicine doctrine has significantly eroded. Most states now recognize exceptions for health maintenance organizations that hire physicians,[3] and many permit exceptions for hospitals that employ physicians.[4] Some states permit employment by nonprofit corporations engaged in the provision of health care services.[5] Federal legislation enacted in 1988 permits employment of physicians by HMOs that meet federal certification standards.[6] Moreover, enforcement of those limitations that remain has tended to be limited,

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1. *See* Garcia v. Texas State Bd. of Medical Examiners, 384 F. Supp. 434, 438-39 (W.D. Tex. 1974), *aff'd mem.*, 421 U.S. 995 (1975).

2. *See* A. Rosoff, *The Business of Medicine: Problems with the Corporate Practice of Medicine Doctrine*, 17 COLUM. L. REV. 485, 497 (1987).

3. *See, e.g.*, 40 PA. CONS. STAT. ANN. § 1554(b)(3)(i) (1995) (Pennsylvania Health Maintenance Organization Act). This Act permits HMOs to provide physicians' services through direct employment. *Id.*

4. *See* People v. John H. Woodbury Dermatological Inst., 85 N.E. 697 (N.Y. 1908).

5. *See* People v. Pacific Health Corp., 82 P.2d 429 (Cal. 1938).

6. 42 U.S.C. § 300e-10(a) (1988).

enforcement of those limitations that remain has tended to be limited, with most cases dating back to the 1930s or 1940s.[7] Therefore, the most serious legal roadblock to physician network formation has eroded in many states.

III. LEGAL TRENDS ENCOURAGING PHYSICIAN INTEGRATION

Other trends have created outright incentives to physician integration. The antitrust laws, as they apply to price fixing, permit greater flexibility for integrated businesses that constitute a single entity than for multiple independent operations. In the context of health care, this result has meant that a large network may be able to establish a unified fee structure for all of its physician members, while a collection of independent practices may not. In *Arizona v. Maricopa County Medical Society*,[8] the Supreme Court held that a joint association of independent physician practices that set maximum prices violated the federal Sherman Act.[9] The Court reasoned that any joint agreement on pricing among competing businesses is prohibited and that independent practices are competing businesses.[10] It pointed out that if the physicians had pooled their practices into a large network, they could have escaped liability for price fixing.[11] However, as autonomous business competitors, they could not.

The federal prohibition, enacted in 1977 and strengthened in 1987, against remuneration in return for referrals of Medicare or Medicaid business permits much greater latitude for larger integrated health care organizations than for individual autonomous practices.[12] Within an integrated network, referrals from one provider to another are not, in fact, referrals, since the same overall provider is rendering the service. One network physician can refer patients to a colleague without impediment under this law. Conversely, an independent physician referring a patient to another independent practitioner is making a referral to another provider; therefore, the financial relationship between them is subject to much greater scrutiny. To be legally integrated, the network must tie physicians together in ways that pool financial risk and reduce separate business autonomy. The most direct method of integration is

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7. The last reported case applying the doctrine in Pennsylvania was decided in 1938. *See* Neill v. Gimbel Bros., 199 A. 178 (Pa. 1938).

8. 457 U.S. 332 (1982).

9. 15 U.S.C. § 1 (1994).

10. 457 U.S. at 356-57.

11. *See id.* at 357.

12. 42 U.S.C. § 1320a-7b(b) (1988).

prosecution under the law.[13] If physicians retain business autonomy and refer between one another, any remuneration that passes to a referring physician from the beneficiary of the referrals can be seen as kickback. In other words, the anti-kickback law permits a referring physician to be paid as an employee by a hospital, clinic or other organization to which he or she refers patients, but if the physician remains independent, substantial restrictions apply.

The prohibition against self-referrals contained in the federal Stark Amendments, which became effective in 1992 and 1995, also rewards health care business integration.[14] Under this law,[15] a physician may not refer patients for certain designated ancillary health care services to facilities in which he or she has an ownership interest or with which he or she has a compensation arrangement. However, there are exceptions for employment compensation and for ownership involving group practices. For example, a single physician who owns shares in a physical therapy clinic would be subject to the prohibition, but a physician employed by a health system that also owned the clinic would be permitted to make referrals, provided that the employment compensation does not reward the volume or value of referrals.

The laws concerning hospital staff privileges have also evolved to encourage hospitals to foster physician-hospital combinations. Physicians applying for or holding hospital staff privileges as independent practitioners have numerous legal protections against denial or termination of privileges without due process.[16] The hospital must provide notice and a hearing in order to refuse or restrict clinical privileges under the laws of most states and under private accreditation rules.[17] Hospitals have increasingly employed physicians to render some kinds of services, primarily in the hospital-based specialties of radiology, pathology, anesthesiology and emergency medicine, rather than relying on independent medical staff members to provide them. Physicians who are employed by a hospital can be required to waive due process rights concerning restriction or revocation of staff privileges as a condition of employment, and courts have upheld such contractual limitations on

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13. 42 C.F.R. § 1001.952(d) (1994).

14. 42 U.S.C. § 1395nn(b)(3) (1995).

15. *Id.*

16. *See, e.g.*, Rao v. St. Elizabeth's Hosp., 488 N.E.2d 685, 695 (Ill. App. Ct. 1986); McElhinney v. William Booth Memorial Hosp., 544 S.W.2d 216 (Ky. 1976).

17. JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGS., ACCREDITATION MANUAL FOR HOSPITALS 66 (1994).

rights that would otherwise apply.[18] Therefore, hospitals may achieve more control over their medical staffs by implementing employment arrangements than by permitting their physicians to remain independent.[19]

Finally, with regard to managed care, most states have enacted laws explicitly permitting the establishment of managed care arrangements. HMOs are permitted to combine the provision and financing of health care services, and preferred provider organizations (PPOs) are permitted to steer patients to specific providers.[20] Prior to the enactment of these statutory protections, insurers were generally prohibited from playing these roles. Once formed, managed care organizations have been able to create large health care networks that limit the ability of member physicians to practice autonomously.

IV. INCENTIVES FOR QUALITY IN THE NEW PHYSICIAN-PATIENT RELATIONSHIP

Without these legal trends, it is unlikely that present marketplace changes in health care would have occurred. Vigorous enforcement of the corporate practice of medicine doctrine, for example, would make it impossible for health care networks to employ physicians. Integrated networks of physicians can bargain more easily with HMOs in a unified manner without facing liability for price fixing. The safe harbor in the fraud and abuse statute and the exception in the Stark Amendments covering employment give integrated systems an advantage over independent practices in structuring financial arrangements that include both referring and referred-to physicians. Moreover, without legislation permitting the creation of HMOs and PPOs, these payor arrangements would be impossible in many states, and the very basis for marketplace changes in health care would be thwarted.

Legal changes are effectuated by judges and by legislatures. Both respond in their own way to public policy concerns. The legal trends permitting and encouraging physician integration, therefore, represent

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18. *See* Desai v. St. Barnabas Medical Ctr., 510 A.2d 662 (N.J. 1986); Williams v. Hobbs, 460 N.E.2d 287, 292 (Ohio Ct. App. 1983).

19. Mateo-Woodburn v. Fresno Community Hosp., 270 Cal. Rptr. 894, 904 (5th Dist. 1990).

20. *See, e.g.*, 40 PA. CONS. STAT. ANN. § 1554 (describing the activities in which HMO's can engage); 31 PA. CONS. STAT. ANN. § 152.2 (1992) (recognizing the function of PPO's to provide incentives to enrollees to use the services of providers that have entered into contracts with the PPO).

increasing acceptance of this business trend by these policy makers. Perhaps concerns about skyrocketing medical costs have brought about more tolerance of controls on medical practice. Perhaps policy analysts have encouraged acceptance of new business arrangements. In any event, health care marketplace changes have been facilitated and even fostered by the legal system, which in turn responds to underlying public attitudes.

The same legal system that has responded favorably to health care consolidation and its creation of a new physician-patient relationship has also historically served as the public's guardian of health care quality. Licensing of physicians and hospitals, statutory requirements for peer review in hospitals, and malpractice liability rules are all ways in which the law oversees the quality of patient care. There is no reason to suspect that health care quality will not continue to be a legal concern.

The legal trends facilitating managed care and health care integration have not negated health care quality oversight. In fact, various new mechanisms for safeguarding quality are evolving. For example, the trend in many states has been to hold managed care organizations liable in negligence for patient harm resulting from any economic incentives that they create for physicians to undertreat.[21] Similarly, physicians have been held liable for failing to vigorously pursue appeals of managed care review decisions that have denied approval for necessary hospitalization or referrals.[22] Of particular significance, courts continue to enforce the general rule that the legal and ethical obligation of physicians is to look after the best interests of the patient regardless of the payment arrangement and its implications for physician reimbursement.[23] Systems for governmental quality regulation of managed care organizations are also developing in many states as they did in an earlier era for hospitals.[24]

V. BUSINESS INCENTIVES FOR QUALITY IN THE NEW PHYSICIAN-PATIENT RELATIONSHIP

From a business perspective, integrated health care will affect the physician-patient relationship, but in ways that may be positive as well as negative. It will lessen the opportunity for many of the abuses characteristic of fee-for-service medicine that recent legal trends have

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21. *See, e.g.*, Bush v. Dake, No. 86-25767 NM-2 (Mich. Cir. Ct., Saginaw Cty. 1989).

22. *See, e.g.*, Wilson v. Blue Cross of So. Cal., 271 Cal. Rptr. 876, 883-84 (Cal. Ct. App. 1990); Wickline v. State of Cal., 239 Cal. Rptr. 810, 819 (Cal. Ct. App. 1986).

23. *See, e.g.*, *Wilson*, 271 Cal. Rptr. at 876.

24. Regulations governing HMO quality in Pennsylvania, for example, are published at 28 PA. CODE § 9 (1994).

sought to address, such as fraud and abuse in referrals, abusive self-referrals, price fixing among competing physicians, and the need for creative financing arrangements to control costs and to increase access to health care. In addition, from a clinical perspective, health care consolidation will promote quality of care through better coordination of care within large integrated organizations.

Will integrated health care compromise quality in other ways? There are certainly strong financial incentives for it to do so in the interests of cost control. However, there are strong counter-pressures to maintain quality, as well. These include the ability of large organizations to better coordinate care, their need to accept unified responsibility for oversight of clinical services across specialties and levels of care, and their incentives to focus on medical necessity and effectiveness. Competition between integrated systems will also promote quality in response to market pressures, since demonstrated quality is likely to produce a better competitive position.

CONCLUSION: IMPLICATIONS OF LEGAL AND BUSINESS CHANGES FOR THE PHYSICIAN-PATIENT RELATIONSHIP

What does this analysis of legal changes as facilitators of business trends indicate about the future of the physician-patient relationship and fate of health care quality? First, it says that the present business trends go deeper than a short-term change promoted by a few large organizations. They reflect increasing tolerance, and even encouragement of managed care and of consolidation in health care by the legal system and by the policy makers who influence it. This legal attitude has been developing for several decades, and it reflects reactions to abuses under the old business structure. The new business environment for health care, therefore, is likely to remain.

Because the business changes have not developed in isolation, their consequences can only be fully understood in their larger context. In particular, the effect on quality will depend both on competitive pressures and on the evolving legal environment. As the review of quality incentives demonstrates, it will not be abandoned, but the focus of quality concerns will be redirected.

The combination of business and legal pressures that has maintained and supported the new health care business environment will have to address quality in the new physician-patient relationship. The nature of the potential abuses has changed from those characteristic of smaller independent providers to those of large integrated organizations, but the means are in place to address the new ones as well as the old ones. This

is not to say that the mechanisms will work as quickly or as effectively as the public needs. It is to say, however, that the integrity of the new physician-patient relationship can only be understood in the context of the legal and business influences that have brought it about.

The very existence of the new business structure reflects concern with threats to the integrity of the old physician-patient relationship. New quality control mechanisms are evolving to safeguard the integrity of the new relationship. The new mechanisms may take time to fully develop, and they may require promotion and advocacy by those concerned with the quality of health care. The history of recent industry changes, however, indicates that economic pressures to cut costs and to limit treatment will not be the only incentives governing the system. A complex interaction of business pressures and changing legal rules has guided the evolution of health care to this point, and it is likely to continue to do so.