Leveraging Our Strengths: Reinforcing Pay-for-Performance Programs as the Solution for Defensive Medicine

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Introduction 

The recent focus on the high cost of health care has resulted in two pervasive trends aimed at controlling expenses: 1) pay-for-performance (P4P) or physician incentive programs, which aim to reduce the misuse and overuse of medical services, and 2) defensive medicine, a practice by providers which attempts to lower malpractice liability.1 P4P emerged as a result of cost-controlling initiatives by employers; it links provider reimbursement with adherence to certain criteria aimed at reducing costs and increasing quality.2 Simultaneously, many providers, concerned with the high cost of malpractice insurance, have begun practicing defensive medicine.3 To protect

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1 See Stacy L. Cook, Will Pay for Performance be Worth the Price to Medical Providers? A Look at Pay for Performance and its Legal Implications for Providers, 16 ANNALS HEALTH L. 163, 163 (2007) (noting that the focus on quality has led the industry to link physician compensation to measurable performance, reacting to the globalization of medical services and the increase in both technology and consumerism); see also Michael Daly, Attacking Defensive Medicine Through the Utilization of Practice Parameters: Panacea or Placebo for the Health Care Reform Movement 16 J. LEGAL MED. 101, 102 (1995) (stating defensive practices by physicians are responsible for substantial “waste” in the health care system and referencing a study by the National Medical Liability Reform Coalition, which found avoidable costs of defensive medicine could total $35.8 billion over the next five years).

2 Cook, supra note 1, at 164 (outlining the four common elements of pay-for-performance systems: “(1) adherence to clinical guidelines; (2) collection of data from the healthcare provider; (3) measurement of the provider’s performance; and (4) acknowledgement of the provider’s performance with recognition and pay.”).

3 Daly, supra note 1, at 105 (noting that traditionally, physicians are “more likely to be penalized for ordering too few tests or for not performing medical procedures than they are for utilizing ‘medically unnecessary’ procedures [and] are therefore given strong incentives to utilize health
themselves against malpractice claims, these providers avoid high-risk procedures and patients, and order clinically-excessive tests, procedures, and medications. Despite their common catalyst, the desire to control costs, P4P and defensive medicine have conflicting ends, resulting in increased costs for the ultimate payer of health care services—the consumer.

P4P programs have extended into the insurance market, with both for-profit and not-for-profit insurers relying on P4P and similar physician incentive programs to reduce unnecessary services while maintaining a high quality standard of care. Government entities, including Medicare and Medicaid, have studied these programs as potential methods of increasing quality of care while decreasing government expenditure. By establishing clinical guidelines and measuring provider performance with concrete data, payers—including private insurers, employers, and government entities—are able to influence the delivery of medical care and consequently control cost. Since P4P programs have become common across the spectrum of payers in the health care system, any meaningful attempt at controlling the effects of defensive care resources that are not medically necessary to reduce their perceived risk of malpractice liability to as close to zero as possible.

4 Daly, supra note 1, at 106. The findings include that physicians with ties to diagnostic facilities order 34% to 96% more tests than physicians who do not; that self-referring physicians ordered about 1.7 to 7.7 times as many imaging examinations and charged about 1.6 to 6.2 times more for the examinations than physicians who referred only to outside radiologists, and that physician-owned physical therapy facilities had 39% to 45% more visits per patient and 30% to 40% higher revenues than non-physician-owned facilities. Id.

5 Daly, supra note 1, at 132 (“Yet, currently, there are no definitive means of determining what clinical practices represent true liability-induced defensive practices as compared to practices that produce only marginally beneficial care or that arise out of financial incentives inherent in the fee-for-service system.”).

6 Cook, supra, note 1, at 167 (describing P4P programs of private insurers including Harvard Pilgrim Health Care, which implemented an incentive program for specialized care, including adult diabetes and pediatric asthma, linking a rate increase to demonstrated improved performance). The Integrated Healthcare Association is a California initiative formed by medical directors, physician groups, and purchasers and including six health plans. Id. One of the plans, PacifiCare Health systems paid $14 million in bonuses to 124 out of 130 of its medical groups in 2004 as a result of improved performance. Id.

7 Cook, supra, note 1 at 165-67 (highlighting the work of Bridges to Excellence and the Leapfrog Group, two employer groups formed to influence the quality and affordability of health care by providing incentives for efficiency and quality improvement and the work of health plans in creating individualized incentive programs for high-cost diagnoses and chronic conditions).

8 Cook, supra note 1, at 174-75 (describing the traditional measures of pay-for-performance as patient satisfaction, information technology, and process-oriented or outcome-oriented clinical measures).
medicine should build upon the clinical guidelines established in P4P programs.9

While P4P programs have increased in popularity, courts are now suggesting that payers may be held responsible for injury sustained by a patient as a result of physician adherence to clinical guidelines when those guidelines are found to be irresponsible.10 The threat of the extension of malpractice liability to payers should not only encourage payers to institute quality driven P4P programs but also dissuade providers from the practice of defensive medicine.11 One tort reform proposal advocates for the implementation of practice parameters to establish a legal standard of medical care, building upon the idea that set clinical guidelines would be a powerful way to promote quality care.12 These guidelines, if reinforced by statute, regulation, or case law, could deter providers from the practice of defensive medicine while supporting the goals of a high quality, evidence-based health care system.13

While the two trends of P4P and defensive medicine seem to serve a consistent end of reducing the overall cost of health care, their conflicting means present a systemic problem for the industry.14 Spearheaded by two distinct branches of the health

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9 Daly, supra note 1, at 116 (noting cost containment strategies by HMOs are becoming increasingly sophisticated and all forms of managed care, including government programs, implement similar strategies).

10 Wickline v. California, 192 Cal.App.3d 1630, 1645 (1987) ("The patient who requires treatment and who is harmed when care which should have been provided is not provided should recover for the injuries suffered from all those responsible for the deprivation of such care, including, when appropriate, health care payers. Third 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 as, for example, when appeals made on a patient's behalf for medical or hospital care are arbitrarily ignored or unreasonably disregarded or overridden.").

11 Daly, supra note 1, at 102 ("To some, this approach [a practice parameter-based safe harbor system] represents one of the most direct and effective means of eliminating physician incentives to practice defensively.").

12 Daly, supra note 1, at 107 ("Because practice parameters are designed to guide clinical practice in ways that improve quality and reduce costs, it would seem to follow that they could be applied as the legal standard of medical care.").

13 See Daly, supra note 1, at 107 (noting a statutory safe harbor based on practice parameters could eliminate the fear of malpractice liability that leads to the practice of defensive medicine while guiding clinical practice to increase quality of care).

14 OFFICE OF THE ASST. SEC. FOR PLANNING AND EVALUATION, U.S. DEPT. OF HEALTH AND HUMAN SERVICES, ADDRESSING THE NEW HEALTH CARE CRISIS: REFORMING THE MEDICAL LITIGATION SYSTEM TO IMPROVE THE QUALITY OF HEALTH CARE 8 (2003) ("The liability system is not an effective way of improving quality. In many cases it does not provide a useful guide to what care should be, and does not provide a guide to providers or to patients.").
care system, these trends highlight the separate motivations of payers and providers as they attempt to address two distinct causes of increasing health care costs. This examination seeks to demonstrate that while the widespread use of defensive medicine identifies a real need to address the cost of malpractice liability, the cost and quality control of P4P will provide physicians with an incentive to adhere to responsible clinical guidelines, reducing their risk of malpractice liability. It is through physician incentive programs like P4P that payers have an opportunity to discourage the use of defensive medicine by continuing to reward providers who adhere to high standards of care rather than those whose fear of malpractice liability guides clinical decision making.

This note will look first to the history of defensive medicine and P4P programs as attempts to control cost and address quality in health care. Second, it will address relevant case law targeting both providers and payers as liable parties in malpractice actions. Lastly, it will endorse the establishment of practice parameters through the coupling of P4P programs with guidelines aimed at curbing the practice of defensive medicine as a responsible proposal for tort reform.

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15 William M. Sage, *Malpractice Reform as a Health Policy Problem*, 12 WIDENER L. REV. 107, 113 (2005) (citing a study published in the Journal of the American Medical Association in 2005, which found 93% of the doctors surveyed in obstetrics, orthopedic surgery, neurosurgery, general surgery, radiology, and emergency medicine said they sometimes or often practice defensive medicine, but noting that because physicians are supportive of tort reform they may inflate the amount of defensive medicine they practice); C. Paul Wazzan et. al., *An Economic Analysis of The Impact of Pay-For-Performance Initiatives on Physicians, Patients and Insurance Providers* 3 IND. HEALTH L. REV. 357, 360 (2006) ("Proponents of P4P systems essentially believe that if physicians (or hospitals) are competing-on [sic] a relative basis to their peers-for increased monetary rewards, this form of induced competition will force them to take actions not merely for the sake of the patient, but also for their own financial good.").

16 Wazzan, *supra* note 15, at 360 (recognizing the link between P4P bonuses and increased quality of care).

17 Sage, *supra* note 15, at 113 (noting the physicians who felt least secure in their malpractice coverage were those most likely to admit to practicing defensive medicine).


20 Daly, *supra* note 1, at 102 ("Practice parameters are systematic statements of appropriate clinical procedures to be taken by physicians in the diagnosis and treatment of diseases. A practice parameter-based safe harbor system would allow physicians who practice according to the 'letter' of a practice parameter to avoid malpractice liability in the event of patient injury.").
History

The United States spends more on health expenditures per capita than any other developed country in the world.\textsuperscript{21} With costs over $6,500 per person per year, health expenditures account for 16% of the United States economy.\textsuperscript{22} These costs have increased exponentially over the last 30 years, from a per capita cost of $356 in 1970 to $6,697 in 2005.\textsuperscript{23} One contributor to the cost of health care is the cost of medical malpractice claims, including direct costs such as payments made on claims, legal costs, and insurance administration.\textsuperscript{24} A 2001 estimate found the direct costs associated with medical malpractice to be $6.5 billion, accounting for 0.46% of total health care spending.\textsuperscript{25}

These estimates, although seemingly insignificant given the total U.S. health expenditures, do not account for the so-called “indirect costs” of medical malpractice, including the impact on provider behavior.\textsuperscript{26} One study indicated that over 76% of physicians feel that malpractice litigation has damaged their ability to provide quality care.\textsuperscript{27} With over three quarters of physicians believing that malpractice liability limits

\textsuperscript{21} THE HENRY J KAISER FAMILY FOUNDATION, HEALTH CARE COSTS: A PRIMER 2 (2007) (citing in 2004 U.S. health spending was approximately 13% higher than the next highest spending country, and is 90% higher than its “global competitors.”). This study also notes “as a share of GDP, health care spending in the United States also exceeds that of any of its European counterparts by several percentage points.” Id.

\textsuperscript{22} Id. (“The United States spent nearly $2 trillion on health care in 2005. Spread over the population, this amounts to $6,697 per person. This $2 trillion represents about 16 percent of the nation’s total economic activity, referred to as the gross domestic product or GDP.”).

\textsuperscript{23} Id. (highlighting while other sectors of the economy tend to average out, keeping pace with general economic growth, health care does not, and at the current rate of growth, the Centers for Medicare and Medicaid Services project expenditures at nearly one-fifth of the U.S. Gross Domestic Product).

\textsuperscript{24} See generally MICHELLE M. MELLO, UNDERSTANDING MEDICAL MALPRACTICE INSURANCE: A PRIMER, THE ROBERT WOOD JOHNSON FOUNDATION (2006) (stating that direct costs of malpractice include payments made on claims, legal costs, and insurance costs).

\textsuperscript{25} Id. at 4 (noting reliable estimates of the cost of malpractice are elusive, yet estimating that in 2001, payouts for malpractice claims amounted to $4.4 billion, legal defense costs amounted to $1.4 billion, and insurance administration to $700 million, totaling $6.5 billion).

\textsuperscript{26} Id. (describing the indirect costs of malpractice as those that arise when physicians supply more services than they would in the absence of a threat of malpractice liability).

\textsuperscript{27} OFFICE OF DISABILITY, AGING, AND LONG-TERM CARE POLICY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ADDRESSING THE NEW HEALTH CARE CRISIS: REFORMING THE MEDICAL LITIGATION SYSTEM TO IMPROVE THE QUALITY OF HEALTH CARE 7 (2003) (noting by their own admission, 79% of physicians said they had ordered more tests than they would have if their decisions were based only on medical necessity, 24% of physicians referred
their ability to offer a higher *quality* of services, their response is to offer a higher *quantity* of services.\(^{28}\) This modification in provider behavior is known as "defensive medicine" and includes medically unnecessary diagnostic tests, treatments, and prescriptions ordered by physicians primarily out of a fear of liability rather than adherence to norms of good medical practice.\(^{29}\)

Not all instances of defensive medicine result in a negative outcome for the patient; for example, clinically unnecessary tests could reveal an asymptomatic illness, or clinically unnecessary prescriptions could have unintended positive outcomes.\(^{30}\) Provider judgment in cases of defensive medicine, however, is by definition clouded by the fear of malpractice liability.\(^{31}\) If the goal of high quality health care is to promote clinically appropriate decision-making, decisions based primarily on the avoidance of malpractice liability will reduce the quality of care a patient receives and could directly and negatively impact a patient's health.\(^{32}\)

While the outcomes of defensive medicine could be positive or negative with regard to a patient's health, both forms increase costs.\(^{33}\) As payers reimburse providers for clinically unnecessary services, they must redistribute that increased cost to the entire

patients to specialists more often than they believed was medically necessary, 51% of physicians recommended invasive procedures more than they believed was medically necessary, 41% of physicians prescribed more medications than they would have based only on medical necessity).\(^{28}\) *Institute of Medicine, Rewarding Provider Performance: Aligning Incentives in Medicare* 1 (2006) ("[C]urrent payment policies reinforce the existing organizational structure and delivery processes of the American health care system by paying according to the number and complexity of services by setting rather than recognizing the relative value of those services.").\(^{29}\) U.S. Congress, OTA, *Defensive Medicine and Medical Malpractice*, OTA-H-602 at 13 ("Defensive medicine occurs when doctors order tests, procedures, or visits ... primarily (but not necessarily solely) to reduce their exposure to malpractice liability.").\(^{30}\) *Id.* at 23 ("One explicit goal of the medical malpractice system is to deter doctors and other health care providers from putting patients at excessive risk of bad outcomes. To the extent that it exists, defensive medicine that improves outcomes contributes to the deterrence goal.").\(^{31}\) *Id.* at 22 ("Over time, many procedures originally performed out of conscious concern about liability may become so ingrained in customary practice that physicians are no longer aware of the original motivation for doing them and come to believe that such practices are medically indicated.").\(^{32}\) *Id.* at 23 ("[T]he malpractice system may also encourage physicians to order risky tests or procedures that both raise health care costs and on balance do more harm than good for patients.").\(^{33}\) U.S. Congress, OTA, *Defensive Medicine and Medical Malpractice*, OTA-H-602 at 23 (noting that defensive medicine can be both wasteful and costly for the system).
Although there is no current, reliable estimate of the impact of defensive medicine on health care cost, providers report undertaking the practice of defensive medicine on a consistent basis. Logically, that increase in medical services rendered implicates an increased cost to the system. One study, focusing on states that the American Medical Association identified as having a volatile malpractice environment, revealed that 70% of emergency room physicians, 59% of obstetrician/gynecologists, and 55% of general surgeons "often" order more tests than medically indicated. A publication of the Department of Health and Human Services estimated that the costs of defensive medicine are between $70-126 billion per year.

At the same time, the United States health care system is in a self-diagnosed state of crisis, failing to provide consistent, high-quality health care to its consumers. Nearly 100,000 people die each year as a result of preventable medical errors. With

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34 Daly, supra note 1, at 114 (outlining the relationship between managed care and provider reimbursement and concluding costs associated with the utilization of resources that are not medically necessary are redistributed across the group of subscribers).


36 David M. Studdert et. al., Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment, 293 J. AM. MED. ASS'N 2609, 2609-17 (2005).

37 Id. (describing the study of how often physicians alter their clinical behavior because of the threat of malpractice liability, the objective of which was to study the prevalence and characteristics of defensive medicine among physicians practicing in high-liability specialties during a period of substantial instability in the malpractice environment.) A mail survey of physicians in 6 specialties at high risk of litigation (emergency medicine, general surgery, orthopedic surgery, neurosurgery, obstetrics/gynecology, and radiology) in Pennsylvania in May 2003 concluded that out of a total of 824 physicians (65%) who completed the survey, nearly all (93%) reported practicing defensive medicine. Id. "Assurance behavior" such as ordering tests, performing diagnostic procedures, and referring patients for consultation, was very common (92%). Id.


39 INSTITUTE OF MEDICINE, CROSSING THE QUALITY CHASM 1 (2001) ("The U.S. health care delivery system does not provide consistent, high-quality medical care to all people. Americans should be able to count on receiving care that meets their needs and is based on the best scientific knowledge--yet there is strong evidence that this frequently is not the case. Health care harms patients too frequently and routinely fails to deliver its potential benefits.").

40 INSTITUTE OF MEDICINE, TO ERR IS HUMAN: BUILDING A SAFER HEALTH CARE SYSTEM 1
rapidly advancing technology, an aging population, and poor organizational infrastructure, the system cannot maintain its current levels of care, let alone attempt to increase the quality of care that Americans receive. In response to the call to increase quality, the health care industry has attempted to implement systemic change to the way in which patients receive care.

The alignment of payment policies with quality improvement through P4P programs is one attempt to increase quality of care through fundamental system change. Current fee-for-service payment systems in health care reinforce deficiencies by paying for services based on quantity, rather than evidence-based quality. A 2004 study of the impact of payment systems on clinical decision making concluded that "providers are paid more for doing more and are not penalized when the provided services are of little or no value or, worse yet, negatively affect health outcomes." This structure provides an incentive for those providers who practice defensive medicine, providing reimbursement for services rendered without primary consideration to medical necessity.

In response, government entities and private payers have begun to explore and implement P4P programs which incentivize provider adherence to clinical guidelines.

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(2000) (noting that more people die in a given year as a result of medical errors than from motor vehicle accidents (43,458), breast cancer (42,297), or AIDS (16,516)).

Id. Three particular cases of medical errors highlighted horrifying results: "The knowledgeable health reporter for the Boston Globe, Betsy Lehman, died from an overdose during chemotherapy; Willie King had the wrong leg amputated; and Ben Kolb was eight years old when he died during "minor" surgery due to a drug mix-up."

Institute of Medicine, Crossing the Quality Chasm 39 (2001) (noting six aims for an improved health care system: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equitability).

Institute of Medicine, Rewarding Provider Performance: Aligning Incentives in Medicare (2006) (suggesting that quality improvement efforts have been limited by current payment systems).

Id. at 4 (suggesting that the fee-for-service structure in the Medicare program rewards excessive use of services, high-cost procedures, and lower quality care).

Id. at 33 (demonstrating that under a per-capita system, where providers are paid a fee per patient enrolled, payments for non-vital services were lower than under a fee-for-service payment structure).

Id. ("In some cases, the incentives embodied in fee-for-service payments may encourage the delivery of unnecessary or even harmful services that can raise fundamental concerns about cost and safety.").

Institute of Medicine, Rewarding Provider Performance: Aligning Incentives in Medicare 3 (2006) (finding that the private sector is responsible for more than 100 reward and incentive programs and that the Centers for Medicare and Medicaid Services has begun to
In the public sector, certain pilot projects to assess the feasibility of pay-for-performance programs provide bonus payments to hospitals among the top performers in the Medicare system as measured through quality outcomes. Other Medicare related programs require that bonus payments to high performers are instead determined by the costs saved by the Medicare system. Similar programs in the private sector provide bonuses to physician groups or hospitals based on clinical measurements, patient experiences, and investment in information technology.

While these programs have become common, negative associations with controlling patient care persist. Some physicians, reluctant to adhere to clinical guidelines set by health-plans, see the requirements of compliance as a burden that outweighs the potential benefit of bonus payments. Furthermore, P4P programs may result in increased liability for payers who sponsor the programs that impact physician decision-making. This increased liability presents a conflict for providers attempting to adhere to clinical guidelines of P4P programs, while at the same time practicing defensive medicine out of a fear of malpractice claims.

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48 Id. at 38 (demonstrating that in the first year of the Premier Hospital Quality Incentive Demonstration, data among the 262 participating hospitals demonstrated significant improvement in five clinical areas aimed at increasing quality).

49 Id. (describing a demonstration project between the Centers for Medicare and Medicaid and Premier, Inc., which resulted in positive results among the 262 participating hospitals with statistically significant improvement in all five clinical areas examined.).

50 CENTER FOR STUDYING HEALTH SYSTEM CHANGE, CAN MONEY BUY QUALITY? PHYSICIAN RESPONSE TO PAY FOR PERFORMANCE, No. 102 (2005) (documenting an Integrated Healthcare Association program, which coordinated the pay-for-performance programs of seven California health plans representing 35,000 physicians and 6.2 million patients, and resulted in approximately $40 million in performance based bonuses).

51 CENTER FOR STUDYING HEALTH SYSTEM CHANGE, CAN MONEY BUY QUALITY? PHYSICIAN RESPONSE TO PAY FOR PERFORMANCE, No. 102 AT 2 (2005).

52 Id. (noting that many physicians believe pay-for-performance payments simply redistribute money already in the system and do not increase payments for quality services rendered); Cook, supra note 1, at 173 (arguing that, for many providers in Medicare, performance payments may not be worth the extra burden of technology and labor and may actually discourage Medicare participation).

53 Cook, supra note 1, at 180 ("Pay for performance programs will likely increase the risk of liability of health plans and managed care organizations for selection and retention of participating physicians.").

54 Daly, supra note 1, at 105 ("The primary reasons for this uncertainty [the ability to accurately measure defensive medicine] are the inability to separate liability-induced clinical practices from fee-for-service induced practices or to determine what practices are medically unnecessary or just of marginal benefit.").
Facts

As courts rule on medical malpractice claims, they are faced with the decision of whether to extend liability to payers who have set clinical guidelines through incentive programs like P4P. 55 In Wickline v. California56, a patient enrolled in Medi-Cal (California's Medicaid program) was prematurely discharged from the hospital, causing the necessary amputation of her leg. 57 Under Medi-Cal, non-emergency hospitalization requested by an attending physician must be authorized for a specified number of days by a Medi-Cal consultant. 58 After the amputation, Lois Wickline sued the State of California, alleging that the cost containment program utilized by Medi-Cal affected the implementation of the judgment of her treating physicians, indirectly causing her injury. 59 During the trial, a specialist caring for Lois Wickline, Dr. Polonsky, testified that in his opinion, the Medi-Cal consultants were more interested in the State's financial interest than in Lois Wickline's well being. 60 Nevertheless, Dr. Polonsky admittedly did not seek a second extension or challenge Medi-Cal's decision because he believed that Medi-Cal "had the power to tell him, as a treating doctor, when a patient must be discharged from the hospital." 61

55 Daly, supra note 1, at 116. As participation in managed care organizations has increased, so has the growth in medical malpractice litigation against them, and courts are now holding payers liable for policies that injure patients. Id.
57 Wickline, 192 Cal. App. 3d at 1637 (noting that an attending Medi-Cal consultant authorized a four day extension of Lois Wickline's post-surgical inpatient care rather than the eight day extension requested by her attending physician, which resulted in the development of an infection, culminating in the necessary amputation of her leg).
58 Id. at 1638-39 (stating that Dr. Glassman, the Medi-Cal consultant in the Wickline case had no recollection of the request that he approved, but upon refreshing his memory by examining the form, stated that he authorized four days instead of the requested eight because there was nothing on the form that suggested Wickline was seriously or critically ill. Further noting that Dr. Glassman did not consult with a specialist, although one was available).
59 Id. at 1633 (quoting Wickline's complaint, "an employee of the State of California, while acting within the scope of employment, negligently discontinued plaintiff's Medi-Cal eligibility, causing plaintiff to be discharged from Van Nuys Community Hospital prematurely . . . and as a result of said negligent act, plaintiff suffered a complete occlusion of the right infra-renoaorta, necessitating an amputation of plaintiff's right leg").
60 Id. at 1640 (noting Dr. Polonsky's testimony that his belief in the priorities of the Medi-Cal Consultants influenced his decision not to request a second extension of Wickline's hospital stay).
61 Wickline, 192 Cal. App. 3d at 1640 (noting that Dr. Polonsky testified that "had Wickline's condition, in his medical judgment, been critical or in a deteriorating condition . . . he would have made some effort to keep her in the hospital beyond that day even if denied authority by Medi-Cal and even if he had to pay her hospital bill himself").
The court in *Wickline* recognized the gravity of its decision, noting that this case was the first attempt to extend liability to a health care payer in a medical malpractice claim.\(^6^2\) The court further recognized that cost-containment programs like Medi-Cal's utilization review system are an attempt to control health care costs by reducing unnecessary services.\(^6^3\) Though the court in *Wickline* ultimately ruled that the State of California was not liable, the court also supported the extension of liability to third party payers "when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms."\(^6^4\) In extending liability to payers, the court not only reinforced the importance of physician incentive programs in establishing the standard of care, but also laid the foundation for tort reform that provides a defense for physicians who act in accordance with medically appropriate clinical guidelines.\(^6^5\)

In a subsequent Virginia case, *Lancaster v. Kaiser*\(^6^6\), a patient covered by an Employee Retirement Income Security Act (ERISA) plan filed a malpractice claim on behalf of her daughter against her daughter's physicians and Health Maintenance Organization (HMO) for the failure to diagnose a malignant brain tumor.\(^6^7\) During the

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\(^6^2\) *Id.* at 1647 ("While we recognize, realistically, that cost consciousness has become a permanent feature of the health care system, it is essential that cost limitation programs not be permitted to corrupt medical judgment.").

\(^6^3\) *Id.* at 1643 ("Appellant contends that the decision to discharge was made by each of the plaintiff's three doctors, was based upon the prevailing standards of practice, and was justified by her condition at the time of her discharge. It argues that Medi-Cal had no part in the plaintiff's hospital discharge and therefore was not liable even if the decision to do so was erroneously made by her doctors.").

\(^6^4\) *Id.* at 1645, 1646 (asserting no viable cause of action against it for the consequences of that discharge action). The court held that "the physician who complies without protest with the limitations imposed by a third party payor [sic], when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care," and further held that "Medi-Cal did not override the medical judgment of Wickline's treating physicians at the time of her discharge. Therefore, there can be no viable cause of action against it for the consequences of that discharge action." *Id.*

\(^6^5\) *Wickline*, 192 Cal. App. 3d at 1645 (1987) ("The patient who requires treatment and who is harmed when care which should have been provided is not provided should recover for the injuries suffered from all those responsible for the deprivation of such care, including, when appropriate, health care payors [sic].").


\(^6^7\) *Lancaster*, 958 F. Supp. at 1137 (noting the background of Paige Lancaster's illness and the subsequent litigation). Paige Lancaster, age 11 years old, visited a clinic in 1991, complaining of nausea and severe daily headaches on the right side of her head, which persisted for the next four years, and upon a diagnostic test finally being ordered, a tumor covering 40% of her brain was found. *Id.* Lancaster's physicians prescribed medication to treat her pain, but never ordered diagnostic tests or consulted with a specialist. In 1996, when Lancaster did finally receive an MRI.
time that Paige Lancaster was being treated by Drs. Campbell and Pauls, her HMO, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser), and the medical group to which the physician belonged, engaged in a financial incentive program to reward physicians for avoiding excessive treatments and tests. Lancaster's complaint argued that Kaiser should be liable for the "establishment of guidelines and cost standards which worked against the full and prompt diagnostic assessment of Lancaster's brain tumor within the accepted standard of care and for its failure to establish policies, protocols, guidelines and standards for an adequate diagnostic assessment of Lancaster's continuing headaches."70

While the issue in dispute was whether the claims against both the physicians and Kaiser were preempted by ERISA, and thus could properly be removed to federal court, the court paid particular attention to the effect of Kaiser's administrative policy on the physicians in the group.70 In its decision, the court noted that the effect of such policies is to "constrain health care costs by denying supposedly unnecessary medical treatment and, thus, both may affect the quantity, as well as the quality, of benefits provided to a patient."71 While the court recognized the ERISA preemption and thus was not at liberty to extend liability to Kaiser, their attention to the role of Kaiser's financial incentive program indicated the legal community's interest in addressing the role provider incentive programs play in medical malpractice claims. The presence of

from her physicians, at the suggestion of a school psychologist, the test revealed a tumor over 40% of Lancaster's brain. Id.

68 Id. at 1140 ("Consistent with an HMO's goal of containing health care costs, the Incentive Program is ostensibly designed to encourage physicians to refrain from prescribing unnecessary and costly medical procedures and tests.").

69 Id. at 1141 (alleging four counts of negligence and one count of actual and constructive fraud). Count I (negligence) alleges that Campbell 'deviated from the accepted standard of medical care'

Count II (negligence) alleges that Pauls breached his duty to act as a reasonably prudent medical practitioner . . . Count III (negligence) alleges that Kaiser 'is [indirectly] liable [by virtue of] respondeat superior for the negligence of Campbell and Pauls' and directly liable 'for the establishment of guidelines and cost standards which worked against the full and prompt diagnostic assessment [of Lancaster's brain tumor] . . . Count IV (negligence) alleges that the Medical Group "is liable for the negligence [of Campbell and Pauls by virtue of] respondeat superior' and 'is further negligent for the establishment of guidelines and cost standards which work[ed] against [Lancaster] receiving a proper diagnosis and treatment . . . Count V (actual and constructive fraud) alleges that each defendant 'made an actual misrepresentation of a material fact knowingly and intentionally . . . with the intent to mislead . . . Barbara Lancaster.' Id.

70 Id. at 1147 (finding that the financial incentive program "inappropriately influenced Campbell and Pauls to take certain non-medical factors, most notably their incomes, into account when prescribing treatment").

71 Lancaster, 958 F. Supp. at 1148.
this interest is even more apparent when coupled with California’s extension of liability in the Wickline decision.\textsuperscript{72}

Although Wickline and Lancaster aptly demonstrate the tragic consequences of P4P programs directing physician decision-making, the expense of defensive medicine is not as easily demonstrated by litigation.\textsuperscript{73} A recent report by the United States General Accounting Office (GAO) concluded that studies documenting the practice of defensive medicine could not be reasonably relied upon because they were too limited in scope.\textsuperscript{74} Conversely, the GAO does cite five independent studies with the opposite conclusion.\textsuperscript{75}

Several of these studies examined Medicare beneficiaries treated for new heart attacks or heart disease and concluded that tort reforms enacted by the sampled states had some impact on reducing malpractice pressure for physicians and hospitals, which in turn lowered expenditures in the form of previously overused services.\textsuperscript{76} Other studies cited in the report explored health expenditures generally and highlighted the impact of tort reform as a means to curbing defensive medicine associated with cesarean versus vaginal birth.\textsuperscript{77} These studies were mostly conducted through reviews of physician records, and although they conclude that the impact of defensive medicine is relatively low, one study highlighted physician responses to scenarios that revealed

\textsuperscript{72} Wickline, 192 Cal. App. 3d at 1645 (reinforcing the importance of physician incentive programs in establishing the standard of care and laying the foundation for tort reform that provides a defense for physicians who act in accordance with medically appropriate clinical guidelines).

\textsuperscript{73} Daly, supra note 1, at 105 (concluding that the uncertainty in documenting the practice of defensive medicine is the “inability to separate liability-induced clinical practices from fee-for-service-induced practices or to determine what practices are medically unnecessary).\textsuperscript{74}

\textsuperscript{74} U.S. GEN. ACCOUNTING OFFICE, GAO-03-836, MEDICAL MALPRACTICE INSURANCE: IMPLICATION OF RISING PREMIUMS ON ACCESS TO HEALTH CARE (2003) (stating that the limited results of studies controlled by state or specialty cannot be applied across the health care system).

\textsuperscript{75} Id. at 53 (describing seven research studies designed to measure defensive medicine prevalence and costs, but noting that none of the results should be generalized to all patients and procedures).

\textsuperscript{76} Id. Daniel P. Kessler and Mark B. McClellan conducted three studies, the first in 1996, which found that tort reforms enacted between 1985 and 1990 reduced hospital expenditures for Medicare patients with a new heart attack or new ischemic heart disease by 5 to 9%; the second in 2000, which found that direct tort reforms reduced hospital expenditures for those same patients by 4%; and the third in 2002, which found that reforms reduced malpractice pressure and hospital expenditures in those same cases. Id.

\textsuperscript{77} Id. A 1994 study by the United States Congress, Office of Technology and Assessment found that defensive medicine causes less than 8% of diagnostic procedures and a 1999 study in the Journal of Health Economics found that a $10,000 reduction in malpractice premiums could result in a 1.4 to 2.4% decline in the cesarean section rate for some mothers, and a total cap would reduce the number of cesarean sections by 3% and total obstetrical charges by 0.27%. Id.
particularly costly instances of defensive medicine in certain specialties. While this study conducted by the Office of Technology and Assistance (OTA) concluded that when generalized, defensive medicine accounted for less than eight percent of diagnostic procedures, it also found that in certain scenarios, such as head trauma, the rate could be as high as twenty-nine percent. However, as conflicting as the evidence of defensive medicine may be, exemplified by the GAO Report, many tort reforms have had a direct cost saving impact based on reducing the fear of malpractice liability.

One proposed reform to the medical malpractice system is the development of practice parameters to define a legal standard of care that could be used to protect physicians in litigation. This reform initiative not only seeks to address the use of defensive medicine as a method to reduce liability, but could be incorporated into existing P4P structures set up by payers. As proposed, the practice parameters would be established by a state to guide clinical decision-making and would be coupled with statutory safe-harbors, which would either serve as an affirmative defense to a malpractice claim or release a physician from liability.

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78 See U.S. GEN. ACCOUNTING OFFICE, GAO-03-836, MEDICAL MALPRACTICE INSURANCE: IMPLICATION OF RISING PREMIUMS ON ACCESS TO HEALTH CARE 54 (2003) (noting two general measurements by researchers: (1) the review of clinical records to compare treatment approaches and health care expenditures to malpractice pressure, and (2) the presentation of hypothetical clinical scenarios to physicians who choose a treatment and provide a rationale for their decisions); See also U.S. CONGRESS, OTA, DEFENSIVE MEDICINE AND MEDICAL MALPRACTICE, OTA-H-602 at 8 (1994) (documenting the annual national cost of defensive caesarean deliveries in cases of prolonged or dysfunctional labor in women between thirty and thirty-nine years of age as approximately $8.7 million and the annual national cost of defensive radiologic procedures in children between five and twenty-four years of age arriving in emergency rooms with apparently minor head injuries as roughly $45 million).

79 U.S. CONGRESS, OTA, DEFENSIVE MEDICINE AND MEDICAL MALPRACTICE, OTA-H-602 at 56 (1994) (noting that the proportion of physicians citing “malpractice concerns” as the most important reason for performing a procedure ranged from 4.9% in a back pain scenario to 29.0% in a head trauma scenario).


81 Daly, supra note 1, at 102 (noting that “a parameter-based safe harbor system would allow physicians who practice according to the ‘letter’ of a practice parameter to avoid malpractice liability in the event of patient injury”).

82 Daly, supra note 1, at 107 (stating that many physicians and policymakers see the establishment of practice parameters as a way to control cost, improve quality, and reduce liability risk).

83 Daly, supra note 1, at 108 (highlighting a Maine statute, which provides that a physician can assert the use of a practice parameter to establish the standard of care without using expert testimony, and a Minnesota statute, which provides practice parameters as an absolute defense in malpractice claims).
Another option is to expand the already successful programs of P4P and include restrictions on the use of defensive medicine. Rather than relying upon statutory practice parameters, a state could give already existing P4P programs legal standing to establish the standard of care, providing a defense or a release from liability for participating providers. This adaptation of the existing practice parameters reform model links the quality-focused P4P programs of private payers to statutory safe-harbors for providers, providing a disincentive for the practice of defensive medicine. Allowing payers to establish practice parameters for both the financial incentives of P4P and for indemnification for providers against malpractice liability could provide an effective deterrent to defensive medicine, while maintaining a cause of action for injured patients and promoting high-quality care.

Analysis

In both Wickline and Lancaster, the courts were reluctant to suggest that holding a payer liable for administrative policies that led to patient harm would protect a physician from liability. In Wickline, the court seems to hold physicians to a higher standard for their own decision-making. The court’s ruling suggests that physicians cannot avoid liability simply because they complied with guidelines imposed by third-party payers in contradiction to their own sound medical judgment. While the court holds a physician’s medical judgment in high regard when establishing the standard of care, it fails to take the next step in holding the payer, in this case the State of California, liable for practices that would induce a physician to act in opposition to sound medical judgment.

Moreover, the Lancaster court notes that the incentive programs in question are so pervasive that they may lower the standard of care for medically sound decision making. Daly, supra note 1, at 116 (noting HMOs use financial incentive programs like P4P to shape the behavior of physicians and discourage the use of unnecessary medical services).

85 Daly, supra note 1, at 106.
86 Id.
87 See id.
88 Wickline, 192 Cal. App. 3d at 1647 (stating adherence to the policies in question would not release a physician from liability when the decisions were contrary to good medical practice). Lancaster, 958 F. Supp. at 1140 (outlining the seemingly altruistic goals of the incentive program).
89 Wickline, 192 Cal. App. 3d at 1645-1646 (describing a heightened role for physician judgment).
90 Wickline, 192 Cal. App. 3d at 1645-1646; Lancaster, 958 F. Supp. at 1148 (demonstrating a physician’s judgment should outweigh other considerations, including payment policies of insurers, when directing medical care).
91 See Wickline, 192 Cal. App. 3d at 1647.
making, calling into question the way in which liability for providers can ultimately be assessed. The prevalence of P4P in policies of both public and private payers could have an eventual impact on the legal standard of care. Since the standard of care in malpractice cases is generally established through expert testimony, the ongoing expansion of P4P programs could affect not only the universal legal standard of care as established by the admission of clinical guidelines as evidence, but the testimony of experts themselves who have been held to P4P standards in their own work, and have accepted these standards as good medical practice. The expansion of P4P to include practice parameters would codify this development of establishing malpractice liability through guidelines developed by payers and significantly reduce the court's reliance on medical expert testimony.

Both Wickline and Lancaster highlight the comparative power of providers and payers as entities making medical judgments. In the twenty years since Wickline, the courts have not pushed the envelope of payer responsibility any further, maintaining that the physician is the ultimate decision maker in concerns of patient care. Since the courts have consistently focused on provider liability, it is unlikely that the extension of liability to payers alone would have a significant impact in reducing the overall costs of medical malpractice. The payers, however, would have an economic interest in more seriously considering potential liability from administrative policies. In establishing P4P programs for providers, third party payers, in light of their own malpractice liability, must consider the quality of care patients receive through these administrative

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92 Lancaster, 958 F. Supp. at 1148 n.34 (citing the cost containment program at issue could diminish the objective benchmark of competent care).
93 Cook, supra note 1, at 197 (noting a party to the action in a malpractice case may introduce clinical guidelines as the applicable standard of care).
94 Cook, supra note 1, at 198 (noting clinical guidelines can provide the court with more tangible evidence than expert testimony alone).
95 Daly, supra note 1, at 108 (describing the limited role of expert testimony under the Maine safe harbor statute to demonstrate the physician failed to properly follow the practice parameter or that the parameter used was not appropriate for the facts of the case).
96 See Wickline, 192 Cal. App. 3d at 1647; Lancaster, 958 F. Supp. at 1148 (comparing the decision-making power of physicians and payers, ultimately deciding that physicians have a duty to adhere to sound medical judgment in the face of payer protocol to the contrary).
97 Daly, supra note 1, at 123 (noting that recent attempts to expand liability to payers have been preempted by ERISA, leaving a majority of HMO enrollees without options for challenging harmful cost-containment practices).
98 Wickline, 192 Cal. App. 3d at 1647.
99 Id. (holding that third party payers can be held liable when medically inappropriate decisions result from defects in cost containment mechanisms, suggesting for the first time that payers have an economic interest in designing those programs to prevent harm to patients).
policies. Although <i>Wickline</i> declines to make payers solely responsible for the harm done by physicians in adherence with payer policies, it does open the door to payer liability in P4P programs.

The distinction in P4P plans between treatment-limiting incentives and quality-promoting incentives is incredible. Both <i>Wickline</i> and <i>Lancaster</i> highlight policies that reward the limited use of diagnostic testing, and while this form of physician incentive program is not unusual, the push towards quality will hopefully encourage P4P standards in a different direction. Many P4P programs have adapted to promote increased preventive medicine and diagnostics to reduce costs down the line.

As outlined by the Institute of Medicine, it is not only the overuse of medical services, but the misuse and underuse of services that accounts for a decrease in health care quality. The industry is moving towards a high-quality, evidence-based approach which rewards effectiveness and efficiency.

The practice of defensive medicine, conversely, is both overbroad and under-inclusive. This dichotomy presents a challenge to the quality-driven focus of the health care industry. If physician practices are both overbroad and under-inclusive, they are lacking the efficiency and effectiveness that is a valuable commodity in today's

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100 Id.
101 Daly, <i>supra</i> note 1, at 118-19 (noting that although the court found Medi-Cal was not liable for Wickline's injury, the dicta of the decision holding third-party payers liable has been widely acknowledged).
102 See <i>INSTITUTE OF MEDICINE, CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY</i> (2001) (noting the goals for improving the health care system include both quality and efficiency, which may be in conflict when high quality care does not equal an increased quantity of care).
103 Id.
105 Id.
106 Id.
107 <i>U.S. CONGRESS, OTA, DEFENSIVE MEDICINE AND MEDICAL MALPRACTICE, OTA-H-602</i> AT 2 (1994) (discussing defensive medicine as an attempt to reduce malpractice liability). By encouraging an increased use of medical services based on the fear of malpractice liability, rather than good medical practice, the practice of defensive medicine is overbroad, bringing unnecessary services to a sweeping range of people. Id. At the same time, the practice is under-inclusive because physicians, seeking to avoid high-risk patients, are eliminating a segment of the patient population, arguably the section that would require wider diagnostic testing, treatment, and prescribing. Id.
health care market. At its best, defensive medicine is a wasteful practice resulting in high costs. At its worst, however, it may subject individuals to unnecessary medical services that could result in harm. By authorizing more diagnostics, physicians are subjecting patients to the risk of simple human error; promoting unnecessary treatments could leave the ultimate cause of symptoms unnoticed, and over-prescribing could lead to drug resistance and ineffectiveness. While it may seem that both trends, provider incentives on the one hand and defensive medicine on the other, are equally dominating in the health care market, the quality-driven focus of the industry promotes P4P programs over defensive medicine practices.

The adaptation of a tort reform initiative like the establishment of practice parameters could provide a solution to the problem of defensive medicine while building on the existing structures of P4P. While practice parameters have been proposed as a government response to the malpractice crisis, charging a commission or state agency with the establishment of clinical guidelines that reflect the standard of medical care, their proposal is strikingly similar to the P4P standards established by current public and private payers. Both Wickline and Lancaster make clear that the court is interested in the extension of liability to payers whose policies are responsible for patient harm. The converse of that conclusion is that adherence to the policies, when based on sound medical practice, should provide an affirmative defense for physicians, similar to the practice parameters proposed in recent tort reform initiatives. This proposal would allow payers to continue to promote high standards

109 Id.
111 U.S. CONGRESS, OTA, DEFENSIVE MEDICINE AND MEDICAL MALPRACTICE, OTA-H-602 AT 2 (1994) (noting one view of defensive medicine as a “convenient explanation for practices that physicians would engage in even if there were no malpractice law”).
112 U.S. CONGRESS, OTA, DEFENSIVE MEDICINE AND MEDICAL MALPRACTICE, OTA-H-602 AT 23 (1994) (describing the good and bad outcomes of defensive medicine, noting that the malpractice system may also encourage physicians to order procedures that may not only raise costs, but do harm to patients).
114 Daly, supra note 1, at 107 (articulating the use of practice parameters and safe harbor statutes to provide an affirmative defense to malpractice claims for providers who follow clinical guidelines when making patient care decisions).
115 Id.
116 See Lancaster, 958 F. Supp. at 1148 (noting both policies implicated in Wickline and Lancaster were adverse to the standards of patient care); Wickline, 192 Cal. App. 3d at 1647.
117 Cook, supra note 1, at 197-98.
of care while aiming to control costs, and would incentivize the establishment of sound clinical guidelines to prevent economic loss as a result of a successful malpractice claim.\textsuperscript{118}

**Conclusion**

With unsustainable costs and increasing concerns over quality of care, our health care system must seek out and reward practices that are successful and curb those which are exacerbating the problem. In order to effectively promote the goals of high quality health care and deter inefficient spending that increases costs across the system, P4P standards should be strengthened to act as a deterrent to the practice of defensive medicine. Adapting a tort reform proposal, like the use of practice parameters, will enable payers to address increasing cost and promote high quality without depriving patients of their right to compensation should malpractice occur.

The practice of defensive medicine is directly converse to the goals of P4P programs. The estimate of its overall impact may be small, but defensive medicine is a costly, wasteful practice that contributes to increasing the cost of health care with little regard to quality. Programs like P4P can help to stem the spread of defensive medicine by continuing to reward quality, promote efficiency, and perhaps play a larger, more definitive role in the reform of the medical malpractice system.

\textsuperscript{118} Wickline, 192 Cal. App. 3d at 1647; Lancaster, 958 F. Supp. at 1148.