Attacking defensive medicine through the utilization of practice parameters

Michael Daly

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ATTACKING DEFENSIVE MEDICINE THROUGH THE UTILIZATION OF PRACTICE PARAMETERS

PANACEA OR PLACEBO FOR THE HEALTH CARE REFORM MOVEMENT?

Michael Daly*

INTRODUCTION

As our nation struggles to reduce the crushing burden of health care costs, no effort seems more urgent or seemingly painless than eliminating waste. The United States Department of Commerce recently released figures that estimated the nation's health care spending in 1993 as totalling $942.5 billion.\(^1\) The Department of Commerce also projected that annual health care spending, in the absence of significant health care reform, will nearly double in five years to $1.775 trillion in 1998.\(^2\) Yet, according to a study released last year by the National Medical Liability Reform Coalition, medical malpractice reform could save over $35.8 billion in so-called "defensive medicine"\(^3\) costs over the next five years.\(^4\) Understandably, eliminating the costs associated with defensive medicine has risen to the top of many analysts' lists as a logical and painless way to help curb this apparent crisis.

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* Third-year student at Southern Illinois University School of Law. Address correspondence to Mr. Daly at Southern Illinois University School of Law, c/o Law Journal Office, Lesar Law Building, Carbondale, Illinois 62901.


2 Id.

3 The United States Office of Technology Assessment defines the practice of "defensive medicine" as physicians' ordering of "tests and procedures, or avoidance of high risk patients or procedures, primarily (but no necessarily solely) to reduce their exposure to malpractice risk." Office of Technology Assessment, U.S. Congress, Defensive Medicine and Medical Malpractice 3 (July 1994).

Many commentators urge that our current medical malpractice system forces physicians to practice defensively to avoid malpractice liability and is directly to blame for much of the "waste" in the health care industry. Not surprisingly, many in the trial bar vehemently deny such a connection citing physician greed as the true evil and opposing any substantial change to the current malpractice liability regime. However, despite the legal and medical communities' inability to find a common ground on this issue, growing public sentiment for immediate cost containment has made radical reform a politically viable option.

What is not clear is to what extent true "liability-induced" defensive practice occurs and is separable from "fee-for-service-induced" practices and whether tort reform alone can improve this situation.

One reform proposal that is gaining momentum is the adoption of clinical practice parameters as the legal standard of care through the formation of statutory "safe harbors" for physicians. 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. To some, this approach represents one of the most direct and effective means of eliminating physician incentives to practice defensively. This proposal, however, fails to take into consideration the

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8 Liability-induced defensive medicine refers to clinical activities that are performed solely for the purpose of reducing the risk of medical malpractice liability without regard for other motivations such as reducing medical uncertainty or personal financial gain. See OTA REPORT, supra note 3, at 22.

9 Under a fee-for-service compensation scheme, physicians are paid according to the quantity and character of medical services provided and therefore are given an economic incentive to perform extra tests and procedures that are not medically necessary. See id. at 91-92.


11 Havighurst, supra note 10, at 87. Practice parameters are also referred to as "clinical guidelines," "practice guidelines," "practice policies," and "practice protocols." However, the American Medical Association (AMA) has adopted the term "practice parameter." See Hirshfeld, supra note 10, at 2886-87. For the sake of simplicity, this commentary adopts the AMA terminology throughout when referring to this concept.

difficulty of adapting practice parameters to form a legal standard of care or the inherent costs of implementing such a system.\textsuperscript{13}

This commentary first examines the impact of medical malpractice litigation on the practice of defensive medicine along with the proposal of adopting practice parameters as the legal standard of medical care. Next, it analyzes the feasibility and likely consequences of adopting practice parameters in place of expert medical testimony to establish the prevailing standard of care. Finally, it proposes an alternative reform model based on the increased utilization of health maintenance organizations coupled with binding medical malpractice arbitration as a more effective and “painless” means of economizing the costs associated with defensive medicine.

I. BACKGROUND

A. Medical Malpractice Litigation and Its Impact on the Practice of Defensive Medicine

Medical malpractice results from injury to a patient caused by a health care provider. However, not all medical injuries are due to malpractice.\textsuperscript{14} Medical malpractice occurs in a subset of injuries that result from a provider’s tortious or negligent conduct.\textsuperscript{15} Negligence is conduct that fails to meet the standard set by law for the protection of others against unreasonable risk of harm.\textsuperscript{16} The basic elements of a negligence action are: (1) the presence of a duty to conform to a required standard of care; (2) a breach of that duty; (3) actual injury to the claimant; and (4) a reasonably close connection between the breach of duty and the injury.\textsuperscript{17} The fundamental goals of the tort liability system are to compensate victims of negligence and to deter future occurrences of such conduct.\textsuperscript{18}

Patient claims of malpractice arise from a pool of alleged patient injuries, some of which are the result of provider negligence.\textsuperscript{19} The trial litigation system pares down the number of claims prosecuted through a process of information discovery, negotiated settlement, pretrial motion

\textsuperscript{13} See Hirshfeld, supra note 10, at 2886-89.
\textsuperscript{14} OFFICE OF TECHNOLOGY ASSESSMENT, U.S. CONGRESS, IMPACT OF LEGAL REFORMS ON MEDICAL MALPRACTICE COSTS 8 (Oct. 1993).
\textsuperscript{17} Sieradzki, Throwing Out the Baby with the Bathwater: Reform in the System for Compensating Obstetric Accidents, 7 YALE L. & POL’Y REV. 538 (1989).
\textsuperscript{18} OTA REPORT, supra note 14, at 8.
practice, court advocacy, and occasionally appellate review.\textsuperscript{20} The relative efficiency of the litigation system depends in large part on how closely the group of persons injured by malpractice match the group of persons ultimately compensated by liability damage awards.\textsuperscript{21} Establishing the causal link between a physician's acts or omissions and a patient's medical injury is, however, a difficult task.\textsuperscript{22} Many commentators in both the legal and medical communities have concluded that the current tort system does not effectively achieve these objectives and is in dire need of reform.\textsuperscript{23}

One contention is that the tort malpractice system is an inherently complex and redundant system that creates enormous organizational costs traceable to the litigation process.\textsuperscript{24} According to one estimate, 60 to 70 cents out of every dollar paid to plaintiffs in the form of malpractice damage awards is consumed by attorneys' fees, expert witness fees, court fees, and other trial associated costs.\textsuperscript{25} Medical malpractice litigation is also very time-consuming. Plaintiffs who pursue their claim through the trial process experience average delays of three or more years between the occurrence of an injury and actual receipt of a damage award.\textsuperscript{26} This process also imposes costs of time and emotional stress on defendant providers and plaintiffs that is difficult to quantify.\textsuperscript{27} Perhaps this is why only one-tenth of those with injuries due to medical negligence ever bring a claim at all.\textsuperscript{28}

Another contention is that the tort system fails to compensate fairly because awards to injured patients are erratic, unpredictable, and inconsistent.\textsuperscript{29} For example, jurors with little or no expertise in deciding malpractice claims, often base their decisions in large part on emotion rather than on the evidence presented and required procedural guidelines.\textsuperscript{30} As a result, providers do not receive clear signals about what constitutes negligent care and are unable to adjust their conduct accordingly.\textsuperscript{31} Exacerbating this problem is malpractice insurance that serves to insulate physicians from the economic disincentive provided by a malpractice damage award. Furthermore, physicians who operate under the traditional fee-for-service system are much

\textsuperscript{20} Id.
\textsuperscript{21} Id.
\textsuperscript{22} Bobbitt, O'Connor, & Easley, supra note 17, at 841.
\textsuperscript{23} See Phillips & Kalb, Replacing the Tort System for Medical Malpractice, 3 Stan. L. & Pol'y Rev. 210, 211-12 (1991); Johnson, Phillips, Orentlicher, & Hatlie, A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims, 42 Vand. L. Rev. 1365, 1367-75 (1989);
\textsuperscript{24} Sieradzki, supra note 18, at 554-55; Bobbitt, O'Connor, & Easley, supra note 17, at 876.
\textsuperscript{25} Sieradzki, supra note 18, at 555.
\textsuperscript{26} Id. at 556.
\textsuperscript{27} Id.
\textsuperscript{28} Id.
\textsuperscript{29} Johnson, Phillips, Orentlicher, & Hatlie, supra note 23, at 1368.
\textsuperscript{30} Bobbitt, O'Connor, & Easley, supra note 17, at 876.
\textsuperscript{31} Sieradzki, supra note 18, at 554-55.
\textsuperscript{32} Johnson, Phillips, Orentlicher, & Hatlie, supra note 23, at 1371.
more likely to be penalized for ordering too few tests or for not performing medical procedures than they are for utilizing "medically unnecessary" procedures. Physicians are therefore given strong incentives to utilize health care resources that are not medically necessary to reduce their perceived risk of malpractice liability to as close to zero as possible.

Nevertheless, whether and to what extent physicians alter their clinical practices to avoid the expense and discomfort of being sued is presently a matter of conjecture. The Office of Technology and Assessment (OTA) has recently released a long awaited study on the impact of malpractice liability on clinical practices. The OTA, however, found only limited evidence that true liability-induced defensive medicine exists, estimating that less than eight percent of all diagnostic procedures are attributable to malpractice liability. According to the OTA, the strongest evidence for the existence of liability-induced defensive medicine was found in a study of cesarean deliveries in New York state. This study examined the impact of malpractice risk on cesarean deliveries and found that a systematic relationship between the rate of cesarean surgical procedures and malpractice claim frequency exists. It is unknown to what extent the findings of this one study can be generalized to other states, specialties, and medical procedures. Therefore, despite many groups bandying around a number of defensive medicine cost estimates, the OTA came to the conclusion that no accurate measure of defensive medicine is currently possible. The primary reasons for this uncertainty 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. In fact, a number of recent studies suggest that financial incentives play a substantial role in the overutilization of health care resources.

For example, the Consumer Federation of America recently released a report that reviewed the medical industry's literature on the use and pricing

32 OTA REPORT, supra note 3, at 15. The phrase "medically unnecessary" is unfortunately, a very subjective and difficult concept to define but in this context is used to refer to clinical practices that yield either no medical benefit, an extremely low marginal benefit relative to the total cost of the practice, or outright injury to a patient. For a critical discussion of "medical waste," see Blumstein & Marmor, supra note 5, at 1546-51.

33 OTA REPORT, supra note 3, at 15.

34 OTA REPORT, supra note 14, at 17.

35 See generally OTA REPORT, supra note 3.

36 Id. at 1, 67.

37 Id. at 11. See Localio, Lawthers, Bengtson, Hebert, Weaver, Brennan, & Landis, Relationship Between Malpractice Claims and Caesarean Delivery, 269 J.A.M.A. 366 (1993).

38 OTA REPORT, supra note 3, at 11.

39 Id.

40 Id. at 1, 128-32, 155-59.

41 Id. at 22-23.

42 Id. at 104-05.
of services by physicians who own or have compensation arrangements with diagnostic testing facilities.\textsuperscript{43} The report noted that physicians who have financial ties with diagnostic facilities order 34\% to 96\% more tests than physicians who do not.\textsuperscript{44} Additionally, at least two other studies recently have been published in major medical journals examining the problem of fee-for-service financial incentives and physician self-referrals. One study found 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.\textsuperscript{45} Another study found 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.\textsuperscript{46} In light of such findings, the OTA has concluded that any meaningful attempt to reduce the utilization of medically unnecessary care will have to address provider compensation arrangements as well as reform the tort liability system.\textsuperscript{47} The reduction of all unnecessary medical care is not, however, the likely consequence of adopting a practice parameter-based safe harbor system and should be examined more closely to determine its ultimate economic merit before being implemented.

\section*{B. Practice Parameters as the Legal Standard of Medical Care}

The development of practice parameters is the result of a shift in the clinical medical culture away from unexamined reliance on professional judgment toward a more structured and definitive expression of accepted medical practices.\textsuperscript{48} Practice parameters also have been hailed as an effective means of improving patient care and reducing defensive medical costs.\textsuperscript{49} The use of practice parameters in clinical medicine, however, is not new. The earliest parameters were developed over 50 years ago by the American Academy of Pediatrics.\textsuperscript{50} In 1989, Congress established the federal Agency for Health Care Policy and Research (AHCPR), which is charged with developing and disseminating nationally recognized practice parameters.\textsuperscript{51}

\begin{thebibliography}{9}
\bibitem{Hillman:1992} Id.
\bibitem{OTA:1995} OTA \textit{REPORT, supra} note 14, at 19.
\bibitem{OTA:1995b} OTA \textit{REPORT, supra} note 3, at 140.
\bibitem{Garnick:1991b} Garnick, Hendricks, & Brennan, \textit{supra} note 48, at 2857.
\bibitem{OTA:1995c} OTA \textit{REPORT, supra} note 3, at 140.
\end{thebibliography}
In that same year, the AMA established the Practice Parameters Partnership with more than 65 other medical organizations to coordinate the development and implementation of the parameters to meet the anticipated future demand. To date, more than 1500 practice parameters have been implemented with hundreds more being developed every year.

The interest in practice parameters continues to grow because many physicians and policymakers believe that they offer the potential to control health care costs, improve the quality of patient care, and reduce the risk of malpractice liability. Indeed, the rationale for making practice parameters the legal standard of care in medical malpractice cases is logical and appealing. 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. In fact, some commentators have concluded that the practice of defensive medicine could effectively be eliminated by offering physicians a form of statutory safe harbor based on practice parameters. This conclusion is based on the belief that a system that immunizes physician conduct in compliance with an appropriate parameter would nullify the incentives to overutilize medical resources in an attempt to lower the risk of malpractice liability. To date, two states have passed legislation creating medical malpractice safe harbors for physicians who practice in accordance with selected practice parameters.

In 1991, Maine began a five-year demonstration project that created a statutory safe harbor for physicians by making state-developed or -adopted practice parameters admissible as an "affirmative defense" in malpractice proceedings. The Maine project grew from concerns expressed by state business leaders, health care providers, insurers, labor unions, and health advocates about the high cost of health care and medical malpractice claims in Maine. Its stated goals include reducing defensive medicine, practice variations, malpractice claims, and overall health care expenditures. So far, parameters for the Maine project have been developed for the practice areas of anesthesiology, emergency medicine, obstetrics/gynecology, and

54 Garnick, Hendricks, & Brennan, supra note 48, at 2857.
55 Hirshfeld, supra note 10, at 2887.
56 OTA Report, supra note 14, at 32.
58 OTA Report, supra note 14, at 32.
61 OTA Report, supra note 3, at 144.
radiology where the practice of defensive medicine is believed to be extensive.\textsuperscript{62}

For participating physicians, the Maine project gives practice parameters adopted by state advisory committees the force and effect of state law.\textsuperscript{63} Under the affirmative defense provision, a physician can assert the use of a parameter as evidence establishing the standard of care without the need for accompanying medical expert testimony.\textsuperscript{64} Therefore, if a physician asserts adherence to a practice parameter as a defense, the physician must prove only that the parameter was actually followed in treating the patient.\textsuperscript{65} The Maine law also prohibits plaintiffs from introducing a parameter as evidence that the physician failed to provide adequate care.\textsuperscript{66} Rather, a plaintiff must prove through expert testimony either: (1) that the physician failed to follow the parameter correctly; or (2) that the parameter used was not appropriate for the given case.\textsuperscript{67} Thus, if the plaintiff is unable to overcome this burden, the physician is relieved of liability.\textsuperscript{68}

Minnesota also has recently enacted legislation that creates a malpractice safe harbor for physicians who utilize practice parameters developed or adopted by a state commission in treating their patients.\textsuperscript{69} The Minnesota statute has the same general goals as the Maine project and also bars plaintiffs from introducing a parameter as evidence that a physician failed to meet the standard of care.\textsuperscript{70} Under the Minnesota law, however, approved parameters may be used as an "absolute defense" in malpractice litigation.\textsuperscript{71} How exactly the effect of an "absolute defense" differs from Maine's "affirmative defense" provision, if at all, remains to be determined.\textsuperscript{72} Moreover, according to the OTA, as of May 1994, the first round of parameters had yet to be implemented in Minnesota and therefore no evidence is available to gauge the program's effectiveness in reducing defensive medical practices.\textsuperscript{73}

II. ANALYSIS

As the existing medical malpractice system imposes high costs on society in its attempt to compensate for and deter negligence, it is reasonable

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\textsuperscript{62} \textit{Id.} Examples of practice parameters that have been adopted by Maine in each of these categories may be found in Appendices IV-VII of the \textit{GAO Maine Report}. See \textit{GAO Maine Report}, \textit{supra} note 60, at 42-95.

\textsuperscript{63} \textit{GAO Maine Report}, \textit{supra} note 60, at 19, 20.

\textsuperscript{64} \textit{Id.} at 20. \textit{See} ME. REV. STAT. ANN. tit. 24, § 2975 (West 1993).

\textsuperscript{65} \textit{OTA Report}, \textit{supra} note 3, at 144.

\textsuperscript{66} \textit{Id.}

\textsuperscript{67} \textit{Id.}

\textsuperscript{68} \textit{Id.}

\textsuperscript{69} \textit{Id.} at 145-46.

\textsuperscript{70} \textit{Id.} at 146.

\textsuperscript{71} \textit{Id.}

\textsuperscript{72} \textit{Id.} at n.9.

\textsuperscript{73} \textit{Id.}
to consider whether a more fair and efficient system can be fashioned. Currently, there is a growing movement in this country to eliminate the practice of defensive medicine by adopting practice parameters as the legal standard of medical care.\textsuperscript{74} Both Maine and Minnesota are examples of states that already have radically altered the medical malpractice equation by legislatively creating statutory "safe harbors" for physicians.\textsuperscript{75} Furthermore, at least one comprehensive health care reform bill is pending in Congress that calls for broad-based utilization of practice parameters as evidence of the standard of care and as a means of reducing medically unnecessary care.\textsuperscript{76}

While the adoption of a parameter-based malpractice system has the potential of reducing the occurrence of liability-induced medical practices, its expected benefits also must be balanced against the costs of its implementation. Unless a parameter-based system can be developed that is more efficient than the status quo or another alternative, its implementation will result in a "net economic loss" to society.\textsuperscript{77} Criticism of the ability of practice parameters to live up to this standard has most often formed along three lines of thought. First, practice parameters are technically incapable of dealing with the level of uncertainty inherent in many areas of clinical medical practice.\textsuperscript{78} Second, placing the parameter development and selection process in the hands of political bodies likely will result in accepted medical practice being distorted according to the influence of various interest groups.\textsuperscript{79} And third, specifying individual standards of care through practice parameters, even if technically possible, would prove prohibitively expensive relative to the cost of maintaining the status quo or adopting an alternative reform model.\textsuperscript{80}

A. Dealing a Fatal Blow to the Art of Medicine?

Many physicians worry that widespread implementation of practice parameters will result in the practice of "cookbook medicine."\textsuperscript{81} While practice parameters have been hailed as a means of reducing practice in-

\textsuperscript{74} See Garnick, Hendricks, & Brennan, \textit{supra} note 48, at 2856.
\textsuperscript{75} OTA \textit{REPORT}, \textit{supra} note 14, at 32.
\textsuperscript{76} See H.R. 3704, 103d Cong., 1st Sess. § 4025 (1993); S. 1770, 103d Cong., 1st Sess. § 4025 (1993).
\textsuperscript{77} The term "net economic loss" in this context refers to the situation where members of society are unable to maximize their level of economic satisfaction due to an inefficient allocation of demanded resources. See \textit{generally} R. Posner, \textit{ECONOMIC ANALYSIS OF THE LAW §§ 1.1, 1.2, at 6-12 (2d ed. 1977).}
\textsuperscript{78} Hirshfeld, \textit{supra} note 10, at 2888.
\textsuperscript{79} See \textit{generally} Blumstein & Marmor, \textit{supra} note 5, at 1567-69.
\textsuperscript{80} Id. at 1565-66.
consistencies and inappropriate care, concerns also have been expressed that rigid reliance on them will produce an undesirable uniformity in medicine that does not respect the differences in patients or clinical settings. The essence of this fear lies in the uncertain ability of practice parameters to convey something more than simplistic or rigid algorithms that ultimately do more harm than good. A leading commentator on the practice parameter movement has identified at least three fundamental areas in which practice parameters likely would prove inadequate as standards of care.

First, because uncertainty is an inherent and substantial facet of clinical medicine, "optimal" or "universal" standards of care cannot currently be defined with confidence. In fact, few clinical practices are supported by well-designed, definitive studies. Most leave open questions about the statistical significance of results, internal validity, and applicability of results to a clinical setting. Moreover, to the extent that practice parameters are derived from imperfect syntheses of medical data or treatment results, any parameter can be misguided. To the extent that parameters are based on the opinions of experts, they can dictate what is thought to be beneficial but not necessarily what has been proven to be beneficial. This is where medicine becomes an art as well as a science and it is not reasonable to expect that practice parameters will be able to capture and express the art of medicine for the foreseeable future, if ever.

Second, patients are almost never uniform in their medical problems. What is best for a broad spectrum of patients as a whole, as defined by a practice parameter, may not be appropriate for a number of individuals. Thus, a patient's unique medical history and personal circumstances may require significant deviation from the standards defined by the parameter to achieve the best results. As these differences can rarely be anticipated when a practice parameter is written, a parameter must have a certain amount of "flexibility" built into it to accommodate atypical patients. However, it is also this degree of flexibility that makes adopting practice parameters as judicial standards of care technically infeasible.

Finally, concerns also have been expressed about the ability to keep

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82 Id.
83 Id. at 2652.
84 See id. at 2651.
85 Id.
86 Id.
87 Id.
88 Hirshfeld, supra note 10, at 2887.
89 Woolf, supra note 81, at 2651.
91 Redelmeier & Tversky, Discrepancy Between Medical Decisions for Individual Patients and for Groups, 322 NEW ENG. J. MED. 1162 (1990).
92 Id.
93 Hirshfeld, supra note 10, at 2887. See also Garnick, Hendricks, & Brennan, supra note 48, at 2858.
parameters current and the possibility of stifling future innovations.\(^{94}\) Presently, production and dissemination of newly created parameters takes up to three years with immediate and continuous updating being necessary to maintain their viability.\(^{95}\) Researchers and medical educators also argue that widespread reliance on practice parameters may cause financial sponsors to be reluctant to fund studies of treatments that fail to receive recognition by parameter selection committees in turn discouraging future innovation.\(^{96}\)

Moreover, early exposure to practice parameters in medical school or residency training could hinder inexperienced physicians in the honing of clinical reasoning and decision-making skills basic to the practice of medicine.\(^{97}\)

**B. The Politics of Who Selects the Standard**

Many physicians view the widespread utilization of practice parameters as a threat to their professional autonomy and standing.\(^{98}\) Some also worry that their individual practices will be threatened by the restrictions of competing specialties as parameters become increasingly used to define the appropriateness of performing and billing for procedures.\(^{99}\) As Professor Eddy of Duke University has observed, if \"[p]ractice policies . . . are issued for the purpose of influencing decisions about health intervention,\" then \"whoever controls practice policies controls medicine.\"\(^{100}\)

Along these lines arises another difficulty. If practice standards become a matter of legislative mandate, to what degree will well-organized and funded lobbying groups be able to control the direction and scope of clinical medical practice? Conceivably every sector of the health care industry would be affected by these decisions and would perceive a tremendously large stake in the outcome of this process. Given the shear magnitude of the health care budget, this environment could also breed a new and frightening level of policy auctioneering.\(^{101}\) Another plausible concern is the likely creation of a new and costly layer of federal and/or state bureaucracies to administrate the development and selection of thousands, perhaps hundreds of thousands, of practice parameters.\(^{102}\)

**C. The Economics of Specifying Individual Standards of Care**

Ultimately, the most onerous hurdle for practice parameter proponents to clear may be an economic one. While the adoption of practice parameters

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\(^{94}\) Woolf, supra note 81, at 2650.

\(^{95}\) Id. at 2649. An example of this problem can be witnessed with Sweden’s abandonment of a 15-year national practice parameter program in part because it could not keep pace with rapid medical advances. Id.

\(^{96}\) Id. at 2650.

\(^{97}\) Id.

\(^{98}\) Id.

\(^{99}\) Id.


\(^{101}\) See, e.g., Blumstein & Marmor, supra note 5, at 1561.

\(^{102}\) See id. at 1554-55.
as a legal standard of care has the potential of reducing defensive medical practices, the costs of developing and implementing them easily could prove to be greater than the amount that could be saved.\textsuperscript{103} Currently, the total costs associated with the practice of defensive medicine are roughly estimated to be between $7 billion to $15 billion per year.\textsuperscript{104} The total costs associated with the administration of the entire medical malpractice system, including damage awards, malpractice insurance premiums, and defensive medicine are estimated to be between $13 billion and $25 billion per year.\textsuperscript{105} Yet, the highest of either of these figures represent less than three percent of the total United States health care budget. While, the current medical malpractice regime is not as efficient or predictable as one might hope, if excessive costs are the problem, then there seems to be little reason to implement a system that will very likely cost more than the problem it seeks to remedy.

The primary reason a parameter-based system would not be economically feasible is that the present state of parameter development does not enable a judicial trier-of-fact to determine reasonably specific, articulable standards of care for determining physicians' malpractice liability.\textsuperscript{106} To overcome this deficiency, it would be necessary to develop consistent processes for their research and development, standardized vocabularies for articulating their intended directives, and reliable formats for their dissemination, presentation, and updating.\textsuperscript{107} To meet this objective substantial resources would have to be expended by the medical, insurance, and legal communities to produce parameters tailored to fit the widely divergent goals of quality patient care, cost containment, and legal liability. Yet, without this level of specificity a court confronted with a practice parameter would have to conduct an investigation into the parameter's background and efficacy to determine the limits of a jury instruction.\textsuperscript{108}

Furthermore, the development of universally accepted parameters is complicated by the inherent diversity of medicine and the infeasibility of developing singular methods of guidance for highly complex areas of medicine.\textsuperscript{109} For example, the OTA has noted that there could be over 10 billion pathways for diagnosing even the most common medical problems.\textsuperscript{110} While some clinical problems may be amenable to a limited set of parameters that can be applied to a wide spectrum of patients, other clinical problems may require more sophisticated directives with numerous options for patients.

\textsuperscript{103} See id. at 1554-55, 1565-66.
\textsuperscript{104} See OTA REPORT, supra note 3, at 155-59.
\textsuperscript{105} Id.
\textsuperscript{106} Id. at 143.
\textsuperscript{107} Hirshfeld, supra note 10, at 2887.
\textsuperscript{108} Id.
\textsuperscript{109} Id.
\textsuperscript{110} OTA REPORT, supra note 3, at 143.
with different characteristics. \(^{113}\) Therefore, if a physician asserts compliance with a practice parameter that incorporates several treatment options as a defense, a plaintiff may assert that the physician did not follow the parameter properly or failed to pursue other available options for the patient. \(^{114}\) Then the litigation may revolve around whether the physician correctly followed the appropriate practice parameter rather than whether the physician merely adhered to a parameter in general. \(^{115}\) Obviously, if this situation were to become the norm, then much of the supposed benefits of a parameter-based system would be nullified as physicians still would be forced to justify their conduct in court and rely on inexperienced judges and juries to understand the intricacies of clinical medical decision-making. \(^{116}\)

In the final analysis, the proposal to create a practice parameter based malpractice system is, at best, premature and, at worst, irresponsible. The current technological level and number of parameters that are available for utilization simply are inadequate to replace the traditional tort liability scheme. \(^{117}\) While at the heart of this proposal is a supposed reduction in medical waste, it is difficult to imagine how the costs of developing, specifying, disseminating, and continuously updating universally accepted, individual standards of care for thousands of diseases could be less costly than maintaining the status quo. \(^{118}\) Moreover, given that many practices that are summarily included in the defensive medicine category result from profit incentives or have some medical benefit, \(^{119}\) it seems even more difficult to predict that a malpractice safe harbor alone would alter physicians’ behavior to reduce the amount of unnecessary medical care rendered. Adopting a practice parameter-based malpractice system therefore would be an economically unsound reform measure that should not be made for the foreseeable future.

III. PROMOTING MANAGED CARE AND BINDING MALPRACTICE ARBITRATION WOULD BE A BETTER MEANS OF ADDRESSING DEFENSIVE MEDICINE

A. Increased Utilization of Health Maintenance Organizations Would Provide Powerful Incentives Needed to Economize the Overutilization of Medical Resources

Historically, our health care system has been dominated by the Hippocratic ideal that any level of medical care that has a conceivable benefit

\(^{111}\) See supra notes 93-95 and accompanying text.

\(^{112}\) Hirshfeld, supra note 10, at 2887.

\(^{113}\) Id.

\(^{114}\) Id.

\(^{115}\) See OTA REPORT, supra note 3, at 143.

\(^{116}\) See Blumstein & Marmor, supra note 5, at 1566.

\(^{117}\) See supra notes 41-46 and accompanying text.
should not be withheld from a patient regardless of cost.\textsuperscript{118} During the past two decades, however, the persistent escalation of health care costs has spawned a great deal of interest in cost versus benefit analysis.\textsuperscript{119} This interest has led to experimentation and occasional deviations from the traditional system of insurance reimbursed fee-for-service health care.\textsuperscript{120} One of the most far-reaching changes has been the industry's increased reliance on "managed care" plans as an attempt to provide comprehensive, yet cost-effective medical care.\textsuperscript{121}

While the term "managed care" does not enjoy a universally agreed upon definition, it may be defined broadly as any organizational structure that combines both health care financing and delivery functions to reduce per unit costs of health care.\textsuperscript{122} Managed care organizations exist in several different forms and varying degrees of complexity, however, the vast majority fall within two basic formats: Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs).\textsuperscript{123}

Health Maintenance Organizations are organizations that, in return for prospective per capita payments (capitation), act as both an insurer and deliverer of specific medical services by a defined group of providers to enrollees.\textsuperscript{124} The operational structure of HMOs may be further categorized along two general models: (1) the staff model HMO; and (2) the group model HMO.\textsuperscript{125} Staff model HMOs, generally speaking, operate their own health care facilities and directly employ providers on a salaried rather than on a fee-for-service basis.\textsuperscript{126} Group model HMOs contract with medical provider groups, such as hospitals or associations of independent physicians, to provide health care services to their members on a prepaid basis while allowing the group to continue to treat non-HMO patients in their normal private practice settings.\textsuperscript{127}

Preferred Provider Organizations, on the other hand, contract with individual providers that agree to deliver medical services to plan participants on a predetermined, discounted fee-for-service basis in exchange

\textsuperscript{119} See id.; Blumstein & Marmor, supra note 5, at 1560-61.
\textsuperscript{120} See Hall, supra note 118, at 437.
\textsuperscript{121} See id. at 433; Comment, \textit{The Proper Extension of Tort Liability Principles in the Managed Care Industry}, 64 Temp. L. Rev. 977 (1991).
\textsuperscript{123} Comment, supra note 121, at 981.
\textsuperscript{124} OTA REPORT, supra note 3, at 162.
\textsuperscript{125} Chittenden, supra note 122, at 452.
\textsuperscript{126} Id.
\textsuperscript{127} Id.
for prompt payments and increased market share. PPO participants pay customary insurance "premiums" to the organization which, in turn, reimburses providers directly. Unlike HMO participants, PPO participants are not obligated to utilize a defined group of providers, but are encouraged to do so through lower deductible rates, increased benefits coverage, and reduced coinsurance levels.

Fundamentally, the managed care approach is predicated on the belief that financial incentives are the most effective means available to ensure overall health care cost containment. While the traditional fee-for-service system tends to encourage physicians to utilize resources that are not medically necessary to lower the risk of being sued or merely for personal gain, the managed care approach creates a direct and powerful incentive for providers to economize by internalizing the costs of overutilization. This effect also could be harnessed to substantially reduce unnecessary medical utilization whether it is the result of liability-induced practice behaviors or merely for physicians' financial gain. Moreover, as only about 17% of Americans currently are enrolled in HMOs, there is significant room for improvement. Increased investment and participation in managed care plans also could be promoted by offering tax or other economic incentives directly to HMOs, employers, and consumers.

While both the HMO and PPO models represent a substantial improvement in terms of cost containment over the traditional fee-for-service system, HMOs ultimately emerge as being even more efficient than PPOs because HMOs operate under "prospective payment" schemes. This compensation structure forces HMOs to provide their contractually obligated services while operating within a fixed budget determined solely by the number of plan participants and the revenues from their respective fees. Moreover, as physician control over reimbursement activities is still possible under the PPO model, HMOs appear to be the more promising means of minimizing unnecessary health care expenditures. Similarly, staff model HMOs should provide an even better illustration over group model

128 Comment, supra note 121, at 982; Chittenden, supra note 122, at 452-53.
129 Chittenden, supra note 122, at 452-53.
130 Id.
131 Id. at 436-47. This internalization effect is due to the combination of insurer and provider functions under one "roof" requiring that a managed care entity minimize utilization costs to maximize profits. See id.
133 OTA REPORT, supra note 3, at 15 n.7.
134 See generally H.R. 3222, 103d Cong., 1st Sess. § 12.1.7 (1993), S. 1579, 103d Cong., 1st. Sess. § 12.1.7 (1993) ("Managed Care Act of 1993" is an example of a proposal to provide tax incentives to encourage the formation of managed care organizations).
136 Id. at 436-37.
HMOs because their “in house” employment structure allows them to directly monitor and regulate resource utilization balanced by the liability risks of failing to give necessary care. As the staff model HMO arguably provides the most effective means for attacking unnecessary medical utilization, either liability- or profit-induced, without raising net health care expenditures, the staff HMO model will be the focus of this proposal.

At the heart of the HMO approach to health care delivery is the minimization of unnecessary medical costs. To achieve this goal, HMOs over the years have developed increasingly sophisticated cost containment strategies such as utilization review and financial incentive programs. Utilization review procedures are “external evaluations that are based on established clinical criteria and are conducted by third-party payers . . . to evaluate the appropriateness . . . of medical care.” Today, the success of utilization review procedures in containing health care expenditures is well established. All forms of managed care, as well as government programs such as Medicare and Medicaid, currently operate under some form of utilization review. HMOs, however, are particularly able to maximize its utility by combining prospective, concurrent, and retrospective procedures into a unified, comprehensive cost-containment strategy. In fact, aggressive utilization review procedures have been found to save, on average, almost nine dollars in total health care expenditures for every one dollar spent in the HMO setting. Another study has found that HMO physicians hospitalize patients as much as 40% less often than fee-for-service physicians with little increase in outpatient-ambulatory care.

HMOs also use financial incentives to shape the practice behavior of physicians to discourage unnecessary utilization of resources. Incentive plans are usually implemented in one of two ways: plans that reward based on the individual physician’s performance in not overutilizing organizational

138 Comment, supra note 121, at 983.
141 Comment, supra note 121, at 983.
142 Feldstein, Wickizer, & Wheeler, Private Cost Containment: The Effects of Utilization Review Programs on Health Care Use and Expenditures, 318 New Eng. J. Med. 1310, 1314 (1988). In a survey of claims data for 222 employee groups, utilization review was attributed with 12.3% lower hospital admissions, 8.0% shorter hospital stays, 11.9% lower hospital expenditures, and 8.3% lower total health care costs. Rates of utilization for high-intensity treatment regimens before beginning utilization review showed a savings of over $28 for every dollar spent after institution of utilization review procedures. Id. at 1312-13.
143 See Hall, supra note 118, at 483.
144 Id.
resources and plans that reward based on a group’s combined utilization performance. Incentive payments, depending on the HMO’s financial structure, can take a myriad of forms but often include cash bonuses, periodic salary increases, profit-sharing arrangements, increased dividends, stock options, and in-kind or fringe benefits.

However, as participation in HMOs has increased in recent years, there has been a corresponding growth in medical malpractice litigation against them. While medical malpractice claims historically have been directed at physicians, courts now recognize that health care delivery is no longer within the exclusive control of physicians and are beginning to hold organizational providers liable for injuring their patients. In 1965, the Illinois Supreme Court earned the distinction of being the nation’s first high court to recognize the doctrine of corporate medical negligence in the decision of Darling v. Charleston Community Hospital.

In Darling, the court concluded that hospitals have an independent responsibility to monitor the quality of medical care rendered by physicians appointed to their medical staffs even though they are not hospital employees. Darling led to a series of decisions holding that hospitals, as health care deliverers, have the general duty to supervise the provision of quality health care to their patients. Since then, with the advent of HMOs and their reliance on utilization review and provider incentives, courts are beginning to recognize the potential harm that cost-containment activities can cause if left unregulated by the law. Today, there are a variety of theories of HMO liability, sounding in both tort and contract, that are available. Examples of this trend toward expanded HMO liability may be examined in the landmark cases of Wickline v. State of California and Wilson v. Blue Cross of Southern California.

Wickline v. State of California was the first reported appellate court

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145 Id.
146 Id. at 493.
147 Chittenden, supra note 122, at 453.
149 Id. at 257.
150 See generally Ravenis v. Detroit Gen. Hosp., 234 N.W.2d 411 (Mich. App. 1975) (hospital must exercise reasonable care in providing complete medical records to physicians); Tucson Medical Ctr., Inc. v. Miseveh, 545 F.2d 938 (Ariz. 1976) (hospital owes a duty to patients to supervise the care rendered by physicians); Johnson v. Misericordia Community Hosp., 301 N.W.2d 156 (Wis. 1981) (hospital owes duty to patients to provide a qualified medical staff).
151 See Comment, supra note 121, at 999.
152 Chittenden, supra note 122, at 453. Possible theories for HMO liability include: (1) vicarious liability founded on principles of respondeat superior and ostensible agency; (2) direct liability for negligent provider selection and supervision; (3) direct liability for breach of contract, breach of warranty, or consumer fraud; and (4) direct liability for corporate negligence in the design or implementation of quality assurance or cost containment systems. Id.
decision in which the issue of potential health care payor malpractice liability was examined. In Wickline, a California Medicaid recipient underwent coronary artery bypass surgery and suffered post-surgical complications. While California's Medicaid agency (Medi-Cal) had previously authorized 10 days of post-operative hospitalization, the attending physician requested an eight-day extension due to complications. Medi-Cal's utilization review consultant, a board certified general surgeon, reviewed the request and authorized only a four-day extension. The attending physician did not appeal the decision, and the patient was discharged at the end of the four days. After discharge, the patient's complications persisted and the delay in diagnosis and treatment resulted in the amputation of her right leg. The patient sued Medi-Cal and a jury held Medi-Cal liable for negligently discontinuing her hospitalization and treatment and awarded her $500,000 for her injuries.

Primarily, Wickline addressed the issue of whether a health care payor could be held liable for "harm caused to a patient when [the state's] cost containment program ... is alleged to have affected the implementation of the treating physician's medical judgment." The trial court in Wickline ruled in favor of the plaintiff. The appellate court, however, reversed holding that an attending physician bears the ultimate responsibility for making patient treatment and discharge decisions and therefore has the duty to protest or appeal the denial of necessary patient care to the payor. The court also concluded that the California legislature had given explicit statutory authority to Medi-Cal to conduct prospective review of hospital stays as a cost-containment measure. Because Medi-Cal followed statutory procedures, the court did not impose a duty in favor of the insured despite Medi-Cal's faulty prospective review. Although the Wickline court ultimately declined to hold Medi-Cal liable for the patient's injury, commentators have often cited the court's dicta stating that third-party payors may

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156 Comment, supra note 121, at 991.
158 Id.
159 Id. at 814.
160 Id. at 815.
161 Id. at 816-17.
162 Id. at 811.
163 Id.
164 Id.
165 Id. at 819.
166 Id. at 820.
167 Id.
168 The Wickline court stated in dicta that "[t]hird party payors of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms." Id. at 819.
be held liable for defective utilization review procedures that cause injury to patients.169

Accordingly, in Wilson v. Blue Cross of Southern California,170 the same appellate court that decided Wickline ruled that a third-party payor may be liable for the death of a former psychiatric patient who died after the payor negligently refused to continue inpatient coverage.171 The plaintiffs' decedent in Wilson was hospitalized for 10 days after being diagnosed with major depression, drug dependency, and anorexia.172 His treating physician then recommended an additional three to four weeks of inpatient care.173 Blue Cross of Southern California, however, declined to pay for more than 10 days of care in accordance with its concurrent utilization review guidelines.174 After Blue Cross refused to continue coverage and the decedent was unable to pay the expenses himself, the hospital discharged him.175 The decedent committed suicide three weeks later.176 The decedent's parents then sued Blue Cross and its utilization review firm for negligence and breach of contract.177 The defendants were granted summary judgment based on Wickline's holding that a third-party payor is not liable when an attending physician fails to protest inappropriate treatment restrictions imposed by the payor.178 On appeal, however, the Wilson court ruled that "[t]here is substantial evidence that [the utilization review] decision not to approve further hospitalization was a substantial factor in bringing about the decedent's demise," and reversed and remanded the case for trial on that issue.179

The Wilson case is illustrative of the increased willingness of courts to hold insurers accountable for defects in the design or implementation of a cost containment program that results in patient injury.180 Yet, despite this trend, there are still significant barriers to holding HMOs liable for their harmful conduct toward enrollees.181 Perhaps the most significant barrier to

171 Id. at 882-83.
172 Id. at 877.
173 Id.
174 Id. at 881-82.
175 Id. at 882.
176 Id. at 878.
177 Id. at 876.
178 Id. Plaintiff's survivors filed suit against the physicians, the hospital, the insurer, and the utilization review organization, claiming breach of contract and tortious failure to pay for treatment. Id. at 880-81.
179 Id. at 883.
180 Comment, supra note 121, at 992.
181 Note, supra note 139, at 1321. At least two states, New Jersey and Missouri, have enacted statutes that provide broad immunity for HMOs against the medical malpractice actions of enrollees. See N.J. STAT. ANN. § 26:2J-25(c), 26:2J-25(d) (West Supp. 1987) (exempts all persons participating in
a common-law action for HMO negligence or breach of contract is presented by the Employee Retirement Income Security Act (ERISA). 182

ERISA is a comprehensive federal statute that controls the law of employee benefit plans. 183 ERISA applies to both employee welfare benefit plans and employee pension benefit plans. 184 An employee welfare benefit plan is a plan that is “maintained for the purpose of providing for its participants . . . medical, surgical, or hospital care or benefits.” 185 Its primary function is to establish standards for participation, funding, reporting, disclosure, and fiduciary responsibilities for both pension and welfare plans. 186 The difficulty with ERISA is that it has the ability to preempt state law actions brought by ERISA-covered employees attempting to hold HMOs liable for their harmful conduct. 187 This result is significant because, although ERISA contains provisions for judicial relief, injured plan participants generally are limited to declaratory judgments, injunctions, and recovery of accrued benefits. 188

ERISA’s preemption clause establishes that any state law which attempts to regulate ERISA-governed plans is preempted due to federal control of the field. 189 Congress, however, qualified the preemption clause with a “savings clause.” The savings clause allows states to enforce laws that regulate the “business of insurance.” 190 The savings clause is further qualified by a “deemer clause” that requires ERISA-governed plans not be deemed to be insurance companies for the purposes of state laws “purporting to regulate” the insurance industry. 191 While courts over the years have grappled with what specifically is meant by the “business of insurance,” and whether HMOs’ cost-containment activities “relate to” employee benefit plans, the current trend is to uphold broad ERISA preemption of these activities. 192

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HMOs other than actual providers from tort liability); Mo. REV. STAT. § 354.125 (1978) (exempts non-profit HMOs from medical malpractice liability).


185 Id. § 1002(1).


188 See Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 146-48 (1975) (ERISA’s enforcement remedies allow recovery only for benefits due under an ERISA-governed plan, not extracontractual or punitive damages).


192 Dowell, supra note 140, at 135; Chittenden, supra note 122, at 460.
For example, in *Union Labor Life Insurance Co. v. Pireno*, the United States Supreme Court addressed whether an insurance company’s use of utilization review procedures to evaluate the medical necessity of chiropractic procedures constituted the practice of insurance. The Court found that utilization review did not necessarily fall within ERISA’s definition of the “business of insurance” and set forth three factors relevant in determining whether a particular practice falls within the definition: (1) whether the practice “transferred or spread” a risk; (2) whether the practice was an integral part of the contractual relationship; and (3) whether the practice was limited to organizations within the insurance industry.

In applying the first criterion, the *Pireno* Court ruled that because an insurance contract already had been made at the time the utilization review was conducted, the review did not help to “transfer” the risk. Discussion of the second criterion focused on the fact that the contract between the chiropractic reviewers and the insurance company was separate and distinct from the one between the insurance company and its policyholders. Consequently, the Court held that utilization review activities were not an integral part of the insurance contract.

In applying the final criterion, the Court stated “it is plain that the challenged peer review practices are not limited to entities within the insurance industry.” The Court noted, however, that each factor is merely relevant to the determination of whether a practice falls within the business of insurance and therefore no single criterion is controlling.

Similarly, in *Pilot Life Insurance Co. v. Dedeaux*, the Supreme Court further ruled that “ERISA preempts state tort and contract actions in which a beneficiary seeks to recover damages for improper processing of a claim for benefits.” In reaching its decision, the Court concluded that the phrase “relate to” is to be given its “broad common-sense meaning, such that a state law ‘relate[s] to’ a benefit plan if it has a connection with or reference to such a plan.” The Court further explained that for a state law to regulate insurance, it “must not just have an impact on the insurance industry, but must be specifically directed toward that industry.”

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194 *Id.* at 122.
195 *Id.* at 129 (citing Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. at 211-15).
196 *Id.* at 130.
197 *Id.* at 131-32.
198 *Id.* at 132.
199 *Id.*
200 *Id.* at 129.
202 *Id.* at 48-49.
203 *Id.* at 47 (quoting Shaw v. Delta Airlines, Inc., 463 U.S. 85, 98 (1983)).
204 *Id.* at 50.
this analysis, the Court concluded that because state common-law actions are not specifically directed toward the insurance industry they cannot be considered to regulate insurance for the purposes of ERISA.  

An example of how the federal courts have applied this analysis specifically to managed care plans and their utilization review activities is the recent case of Corcoran v. United HealthCare, Inc.

Florence Corcoran was a long time employee of South Central Bell Telephone Company (Bell) and a member of Bell’s ERISA-governed employee health plan. During this time, Bell’s health plan was administered by Blue Cross and Blue Shield of Alabama (Blue Cross) and United HealthCare, Inc. (United), an independent utilization review firm. In 1989, Corcoran became pregnant and her obstetrician recommended complete bed rest due to medical problems that placed her pregnancy in a “category of high risk.” In the final weeks of her pregnancy, Corcoran’s obstetrician ordered her to be hospitalized so that the fetus could be monitored continuously. United, in spite of her physician’s recommendations, refused to preauthorize Corcoran’s hospital stay and instead authorized home nursing care for only 10 hours per day. Thirteen days later, during a period when the home care nurse was absent, the fetus went into distress and died.

Corcoran and her husband brought a medical malpractice and wrongful death action against United and Blue Cross in a Louisiana state court. The defendants removed the case to federal court under diversity jurisdiction and the potential application of ERISA to the claim. The defendants then moved for summary judgment, which was granted on the grounds that ERISA preempted the Corcorans’ state law cause of action. On appeal, the Court of Appeals for the Fifth Circuit affirmed the trial court’s decision relying heavily on Pilot Life. The Fifth Circuit ruled that ERISA preempted the Corcorans’ malpractice and wrongful death actions because United, in its capacity as an ERISA plan fiduciary, made “medical

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205 Id. at 50-51.
207 Id. at 1322.
208 Id. at 1323.
209 Id. at 1324.
210 Id.
211 Id. at 1324.
212 Id. The Corcorans “sought damages for the lost love, society, and affection of their unborn child. In addition, Mrs. Corcoran sought damages for the aggravation of a pre-existing condition and the loss of consortium caused by such aggravation, and Mr. Corcoran sought damages for loss of consortium.”
214 Corcoran, 965 F.2d at 1324-25.
215 Id. at 1339.
decisions" in determining Corcoran's available benefits under the plan. While the court recognized that its decision left a gap between the remedies available under state law and ERISA, it concluded that "[t]he result ERISA compels us to reach means that the Corcorans have no remedy, state or federal, for what may have been a serious mistake." The court explained that while "changes such as the widespread institution of utilization review would seem to warrant a reevaluation of ERISA . . . . Our system, of course, allocates this task to Congress, not the courts."

Decisions such as Pireno, Pilot Life, and Corcoran are significant because they have established a precedent of broad federal preemption that, while good for the managed care industry, leaves a majority of HMO enrollees without adequate compensation for injuries due to harmful HMO cost-containment activities. Therefore, an effective, yet equitable HMO-based proposal should incorporate a means of avoiding ERISA's preemption of enrollees' malpractice actions in exchange for any economic or other incentives given to encourage increased HMO utilization. To this end, several options are available that could accomplish that task. One option would be to amend ERISA directly to allow state law actions regulating harmful HMO conduct including compensatory and perhaps punitive damage awards. Another approach would be for the Supreme Court to reverse its current trend and carve out a judicial exception clearly recognizing HMOs as insuring entities subject to state regulation. Finally, the ERISA preemption question could be avoided altogether by utilizing alternative, nonjudicial forms of dispute resolution such as binding arbitration. This option is particularly promising because it obviates the politically charged process of amending ERISA while also removing enrollees' malpractice claims from the costly tort liability system. Moreover, this approach could be easily implemented through this HMO-based proposal by incorporating mandatory arbitration provisions into enrollees' health service contracts as a condition of enrollment.

B. Binding Malpractice Arbitration Is an Efficient Means of Reducing Defensive Medicine While Maintaining HMO Liability for Harmful Cost Containment Activities

The process of arbitration is a private fault-based alternative to court litigation in which the parties have agreed to refer their dispute to an impartial third person(s) who renders a decision based on the evidence and arguments presented by the parties. Arbitration is becoming increasingly

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216 Id. at 1331.
217 Id. at 1338.
218 Id.
219 Approximately 65% of employers in this country self-insure under the auspices of ERISA. Note, supra note 139, at 1313.
220 General Accounting Office, U.S. Congress, Medical Malpractice: Few Claims Resolved
recognized as a more efficient, yet equitable alternative to the traditional tort liability system.\textsuperscript{221} One commentator has identified four reasons why arbitration is a more efficient and attractive means of resolving disputes than trial litigation: (1) arbitrators, unlike trial judges and juries, are chosen for their expertise in a given field, which lends credibility to the process and ultimate decision; (2) arbitration offers a simpler, more expeditious, and less costly alternative to litigation; (3) arbitration is usually conducted in a less formal setting than a public courtroom, which reduces the stress and contentiousness of both parties; and (4) an arbitral award can be final and binding, which eliminates the risk and costs associated with the appellate review process.\textsuperscript{222}

Accordingly, this commentary proposes that broad-based utilization of medical malpractice arbitration would help ensure the increased utilization of HMO-delivered health care while contributing to an overall reduction in defensive medical costs. This commentary further proposes that, to implement this proposal, HMOs should be given federal statutory authority to incorporate mandatory binding arbitration clauses into their health services contracts as a condition of plan enrollment.\textsuperscript{223} A "federalized" approach is necessary because some states prohibit pretreatment arbitration agreements\textsuperscript{224} for medical malpractice altogether while others have very stringent revocation and disclosure provisions\textsuperscript{225} that would preclude the uniform implementation of such a proposal.

While broad-based utilization of medical malpractice arbitration may seem to be a radical approach to some (the trial bar in particular), arbitration historically has had the benefit of strong legislative and judicial approval.\textsuperscript{226} In fact, this nation's first modern arbitration statute was enacted by the New York legislature in 1920.\textsuperscript{227} Unlike arbitration under the common law, the

\textsuperscript{221} See Schor, Health Care Providers and Alternative Dispute Resolution: Needed Medicine to Combat Malpractice Claims, 4 OHIO ST. J. ON DISP. RESOL. 65 (1988).

\textsuperscript{222} See Comment, supra note 220, at 1114.

\textsuperscript{223} This authority could be provided by amending the Federal Arbitration Act, see infra notes 229-32 and accompanying text, or by incorporation into a federal health care reform bill with preemptive power over conflicting state laws. See Simpson, Compulsory Arbitration: An Instrument of Medical Malpractice Reform and a Step Towards Reduced Health Care Costs, 17 SETON HALL LEGIS. J. 457, 471 (1993).

\textsuperscript{224} OTA REPORT, supra note 14, at 40 (citing NEB. REV. STAT. § 25-2602 (1989); S.C. CODE ANN. § 15-48-10 (Law Co-op. 1976 & 1993 Supp.)).

\textsuperscript{225} See Comment, supra note 223, at 469-70.

\textsuperscript{226} Comment, supra note 220, at 1115. But see Broemmer v. Abortion Serv. of Phoenix, Ltd., 840 P.2d 1013 (Ariz. 1992) (agreement to arbitrate unenforceable because of failure to explain implications of waiver).

\textsuperscript{227} Comment, supra note 220, at 1115 (the current amended version of the 1920 statute may be found at N.Y. CIV. PRAC. L. & R. §§ 7501-7514 (McKinney 1980 & Supp. 1987)).
New York law enabled the parties to construct agreements that were binding, enforceable, and irrevocable for present as well as future disputes. In 1925, Congress also announced its approval of the arbitration process by passing the Federal Arbitration Act (FAA). Today, the FAA is still in force in its amended form and provides in section 2:

A written provision in any . . . contract evidencing a transaction involving commerce to settle by arbitration a controversy thereafter arising out of such contract or transaction, or the refusal to perform the whole or any part thereof, or an agreement in writing to submit to arbitration an existing controversy arising out of such a contract, transaction, or refusal, shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract.

Given the broad language of the FAA, HMO contracts that specify arbitration as the means of resolving disputes and affect interstate commerce fall under the purview of federal law and may be enforced in a state or a federal court. Also in 1955, the National Conference of Commissioners on Uniform State Laws published the Uniform Arbitration Act (UAA) in hopes of providing states with a model arbitration mechanism that was more procedurally sophisticated and versatile than the FAA. Currently, there are 43 states that have adopted the UAA or substantially similar statutes and 15 states that specifically authorize voluntary binding arbitration for medical malpractice cases. An example of one of the first

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228 Comment, supra note 220, at 1115.
232 Simpson, supra note 223, at 470; Comment, supra note 220, at 1117-18. See also Seymour, 732 F. Supp. at 988 (FAA creates a body of substantive law applicable in both state and federal courts).
233 Comment, supra note 220, at 1116.
234 The following states have adopted arbitration statutes: Alaska; Arizona; Arkansas; California; Colorado; Connecticut; Delaware; Florida; Hawaii; Idaho; Illinois; Indiana; Iowa; Kansas; Kentucky; Louisiana; Maine; Maryland; Massachusetts; Michigan; Minnesota; Missouri; Montana; Nevada; New Hampshire; New Jersey; New Mexico; New York; North Carolina; Ohio; Oklahoma; Oregon; Pennsylvania; Rhode Island; South Carolina; South Dakota; Tennessee; Texas; Utah; Vermont; Washington; Wisconsin; and Wyoming. Id. at 1116-17 n.22.
235 The following states have adopted arbitration statutes that specifically authorize medical malpractice actions: ALA. CODE § 6-5485 (1993); ALASKA STAT. § 09.55.535 (1993); CAL. CIV. PROC. CODE § 1295 (West 1993); COLO. REV. STAT. § 13-64-403 (1993); FLA. STAT. ANN. § 766.207 (West 1993); GA. CODE ANN. § 9-9-61 (Michie 1993); 215 ILCS 5/155.20 (1994); LA. REV. STAT. ANN. § 9:4231 (1993); 1993 MICH. PUB. ACTS 78, § 2; N.Y. CIV. PRAC. L. & R. § 7551 (McKinney 1993); OHIO REV. CODE ANN. § 2711.21 (Anderson 1993); S.D. COD. LAWS ANN. § 21-25B1 (1994); UTAH...
and largest state-based efforts to promote the increased use of medical malpractice arbitration is Michigan’s Medical Malpractice Arbitration Act (MMAA).

In 1975, the Michigan legislature established the arbitration program primarily as an attempt to lower the cost of and the disposition time for medical malpractice claims. Under its original provisions, the MMAA limited suits against health care providers or their agents to claims sounding in negligence, breach of contract, breach of warranty, or lack of informed consent. Prior to treatment the patient was provided with a brochure outlining the agreement to arbitrate, which carried a presumption of validity when signed. Patient participation was voluntary and the arbitration agreement could be revoked at any time within 60 days of discharge. The arbitration panels were required to consist of three people: an attorney; a physician or other member of the medical community; and a lay person. The panel’s decisions were based on a majority ruling that was binding on all parties unless fraud was alleged, the panel exceeded its authority, or the hearing was conducted in a manner that prejudiced a party’s substantive rights.

However, in 1993, the Michigan legislature responded to claims that the original arbitration scheme was inadequate and repealed the original MMAA in favor of a new voluntary binding arbitration scheme for cases with a projected value of less than $75,000. Under the new provisions, medical malpractice cases are now heard by a single arbitrator selected by the parties and whose decision is non-appealable. The new scheme also does not allow for live testimony by the parties or of witnesses, nor do Michigan’s court rules on information discovery apply. Finally, the arbitration agreement must include a waiver of the right to trial and appeal.

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242 GAO Arbitration Report, supra note 220, at 3.
243 Comment, supra note 236, at 160-61, 163 (citing 1993 Mich. Pub. Acts 78, § 2912(g)).
244 Id. at 163, 164, 177 (citing 1993 Mich. Pub. Acts 78, § 2912(g)(3)(a), (d)).
245 Id. at 164 (citing 1993 Mich. Pub. Acts 78, § 2912(g)(3)(a), (b), (c)(i)-(v)).
designate the process for selecting an arbitrator, and apportion the costs between the parties.\textsuperscript{246} Given the MMAA’s radical departure from the traditional tort litigation model, it is not surprising that the MMAA has come under legal fire on several occasions.\textsuperscript{247} However, in \textit{Morris v. Metriyakool},\textsuperscript{248} the Michigan Supreme Court resolved many of the questions concerning the enforceability of a binding medical malpractice arbitration scheme.

In the cases comprising the \textit{Morris} decision, the Michigan Supreme Court addressed three issues in upholding the constitutional and common-law validity of the MMAA. The plaintiffs first argued that the MMAA’s required inclusion of a medical member on arbitration panels created an impermissible risk of bias under the due process clauses of the state and federal constitutions.\textsuperscript{249} In support of this argument, the plaintiffs submitted affidavits of insurance underwriters stating that physicians and health care administrators would have a substantial and contrary interest because malpractice insurance premiums could be affected by the outcome of a case.\textsuperscript{250} The court, however, held that the panel’s composition did not violate constitutional due process standards because the plaintiffs failed to show even the potential for actual bias in the form of a direct economic or monetary interest by a medical member panelist.\textsuperscript{251}

The plaintiffs next argued that MMAA arbitration agreements were contracts of adhesion\textsuperscript{252} and therefore their right to a jury trial and to court access was infringed because they did not “voluntarily, knowingly, and intelligently” waive these rights when they signed the agreement.\textsuperscript{253} The court rejected this argument finding that the essence of arbitration is the waiver of such rights and that no ordinary person would reasonably expect to receive a jury trial after signing such an agreement.\textsuperscript{254}

\textsuperscript{246} \textit{Id.} (citing 1993 Mich. Pub. Acts 78, § 2912(g)(1)(a)-(d)).
\textsuperscript{248} 344 N.W.2d 736 (Mich. 1984).
\textsuperscript{249} \textit{Id.} at 738-39.
\textsuperscript{250} \textit{Id.} at 739.
\textsuperscript{251} \textit{Id.} at 740.
\textsuperscript{252} An adhesion contract is a standardized form contract offered to consumers on a “‘take it or leave it basis’ without affording [the] consumer [a] realistic opportunity to bargain.” \textit{Black’s Law Dictionary} 40 (6th ed. 1991).
\textsuperscript{253} \textit{Morris}, 344 N.W.2d at 741.
\textsuperscript{254} \textit{Id.} at 742-43.
Finally, the plaintiffs argued that the arbitration agreement they signed amounted to constructive fraud and was unconscionable because it failed to disclose the composition of the arbitration panel, the fact that medical members may be biased against plaintiffs, and the possibility that insurance rates could be affected by medical malpractice awards. The court again rejected the plaintiffs' arguments holding that failure to make these disclosures did not rise to the level of fraud and that the agreement could not be considered unconscionable for failing to include mere "recommendations" that the plaintiffs found important.

While it can be said the MMAA has passed the scrutiny of the Michigan courts, practically speaking it has not been regarded as a success. According to a study done by the U.S. General Accounting Office (GAO), the MMAA's greatest weakness has been a lack of participation by patients and health care providers alike. The GAO study concluded that relatively few patients or providers chose arbitration because the program is voluntary and generally without incentives. For example, between 1976 and 1989, Michigan patients filed about 800 malpractice arbitration claims as compared to an estimated 20,000 litigation initiated claims. Moreover, only about half of Michigan's nearly 300 hospitals carry malpractice insurance underwritten by Michigan licensed insurance companies, which are required to participate in the program. Additionally, under the original system, physicians were not required to offer arbitration as an option, but if they did, then it had to be done at or before the time of treatment. This requirement proved to be awkward as physicians were forced to discuss the possibility of malpractice with their patients prior to treatment. Under the new provisions, the parties may agree to arbitrate at any time after notice of the intention to file suit has been given. This, however, only eliminates the problem of presenting the option prior to treatment, it still provides little incentive for plaintiffs to consistently choose arbitration over court litigation. In light of this deficiency, the GAO study offered two suggestions for increasing participation in the Michigan program: (1) provide economic incentives to consumers in the form of reductions in health insurance pre-

255 Id.
256 Id. at 743.
257 GAO Arbitration Report, supra note 220, at 3.
258 Id.
259 Id. at 4.
260 Id. at 6.
261 Comment, supra note 236, at 173-74.
262 Id.
263 Id. at 175 (citing 1993 Mich. Pub. Acts 78, § 2912(g)(1)).
264 Id. at 175-76.
miums; and (2) incorporate mandatory binding arbitration agreements into health care plans prior to enrollment.265

Nevertheless, there are a number of positive results that the MMAA project was found to produce. The GAO study also found that the MMAA system significantly improved claim resolution times, lowered the average amount of damage awards, and slightly lowered the cost of defending malpractice claims.266 Specifically, during 1987 and 1988, the median time for resolution of arbitrated claims was 19 months compared to 35 months for litigated claims; the median arbitration award was $43,120 compared to $69,500 for litigated claims; and the costs of defending an arbitrated claim were $17,509 compared to $17,798 for a litigated claim.267

Thus, the Michigan arbitration program, despite significant design limitations, represents an important step toward broad-based application of binding arbitration as a means of streamlining the medical malpractice system and encouraging physicians to practice less defensively. Furthermore, there are other examples of malpractice arbitration programs that have proven successful, which could be used as models for implementing this proposal. Perhaps the best example is the malpractice arbitration program currently being used by two California-based HMOs, Kaiser Permanente (Kaiser) and the Ross-Loos Medical Group (Ross-Loos).268

In the 1940s, the Ross-Loos Medical Plan, California’s first HMO, pioneered the concept of medical malpractice arbitration.269 During the medical malpractice “crisis” of the 1970s, Kaiser also began to incorporate mandatory binding arbitration provisions into its HMO contracts.270 Currently, Kaiser and Ross-Loos have over eight million HMO plan participants in 16 states, 85% of whom have chosen health care plans with mandatory arbitration provisions.271 While neither Kaiser nor Ross-Loos have released much information documenting the success of their arbitration programs, Kaiser has allowed the GAO to analyze at least some of its arbitration statistics.272

According to the GAO, Kaiser has decreased its average claim resolution time from 33 months for litigation to 19 months for arbitrated

266 Id. at 8.
267 Id. at 8-9.
271 Id.
272 See GAO Malpractice Report, supra note 268, at 6-8.
claims. Moreover, court trials can often last several weeks but arbitration hearings normally last only two to four days, which has led to a 22% overall reduction in Kaiser’s malpractice defense costs. The reason most often offered for Kaiser’s success is that, unlike Michigan’s voluntary arbitration scheme, Kaiser’s members must agree to mandatory arbitration as a condition of plan enrollment with no provisions for revocation. While mandatory arbitration agreements occasionally have run afoul of state constitutional and common-law provisions in the past, the validity of Kaiser’s program was upheld by the California Supreme Court in Madden v. Kaiser Foundation Hospitals.

In Madden, the plaintiff, a California state employee and member of a Kaiser HMO, brought a medical malpractice action against Kaiser for negligently exposing her to serum hepatitis during a blood transfusion. Previously, the state had negotiated a medical services contract with Kaiser that included a mandatory arbitration clause for all malpractice claims. The plaintiff attempted to avoid enforcement of the arbitration requirement arguing that she was unaware of the contract clause when she chose the plan and, therefore, it was unenforceable against her. A California trial court ruled in favor of the plaintiff denying a motion by Kaiser to compel arbitration. Kaiser appealed to the California Supreme Court which overturned the lower court’s order.

The Madden court first examined the plaintiff’s argument that the state did not have the authority to bind her to an “extraordinary” remedy such as arbitration. The court, however, ruled that a state has implied authority, as the agent of its employees, to agree to arbitrate malpractice claims arising under state-sponsored health plans. The court reasoned that public policy favors and recognizes arbitration as a reasonable means of resolving disputes such as medical malpractice claims.

273 Id. at 6.
274 Id.
275 See id. The Kaiser arbitration program involves a panel of three arbitrators—one selected by the enrollee, one by Kaiser, and one neutral member selected by the other two. At the arbitration hearing, both parties, with or without an attorney, can present evidence and argue their cases before the panel, which renders a final, binding decision that is nonappealable absent fraud or other substantial defect in the process. Roberts, Alternative Resolution Takes Less Money, Time: So Arbitrate or Negotiate—Just Don’t Litigate, 5 MANAGED CARE L. OUTLOOK 1, 2-4 (1993).
277 Id. at 1181.
278 Id.
279 Id.
280 Id.
281 Id. at 1188.
282 Id. at 1183-84.
283 Id. at 1184.
284 Id. at 1182.
Second, the court ruled that Kaiser’s inclusion of a mandatory binding arbitration clause in its medical services contract did not create an unenforceable adhesion contract. The court noted that in this case, the plaintiff had ample opportunity to bargain over the terms of her health contract because she was able to choose from a “menu” of plans some of which did not require arbitration. The court also noted that the plaintiff had an opportunity to contract individually for medical care instead of selecting a state-sponsored plan.

Finally, the court rejected the argument that enforcement of compulsory arbitration agreements necessarily violates the state constitutional right to a trial by jury. The court explained that “to predicate the legality of a consensual agreement upon the parties’ express waiver of jury trial would be as artificial as disastrous.” The court further noted that similar arbitration agreements have been upheld by other courts, and that failure to do so in this case would “frustrate the parties’ interests and destroy the sanctity of their mutual promises.”

Thus, Kaiser’s HMO-based arbitration program demonstrates that incorporation of binding medical malpractice arbitration into HMO medical contracts is a legally valid and enforceable means of removing medical malpractice claims from the costly tort litigation system. Furthermore, mandatory binding arbitration would help ensure the increased utilization of HMOs by significantly streamlining the medical malpractice system for all involved parties. Patients would benefit from the lower cost and difficulty of prosecuting malpractice claims and from the overall higher rate of compensated injuries as compared to the tort litigation system. HMOs would benefit from faster claim resolution times, lower average damage awards, lower defense costs, and would be able to maintain their relationship with enrollees during and after the resolution of claims. Physicians also would

285 Id. at 1185-87. See also supra note 254 (defining a contract of adhesion).
286 Id. at 1186.
287 Id.
288 Id. at 1186-88.
289 Id. at 1187.
290 Id. at 1187-88.
291 Another way to encourage participation would be to discount the cost of HMO plans that mandate arbitration. This approach provides an immediate and tangible economic incentive that is likely to persuade patients to substitute arbitration for their common-law remedies. HMOs also could offer enrollees the ability to opt out of mandatory provisions by paying more for a litigation option. This option would be similar to conventional insurance plans that allow enrollees to purchase reduced co-payments and deductibles or increased coverage. Comment, supra note 236, at 179.
292 See Simpson, supra note 223, at 457. According to several studies the success rate for medical malpractice plaintiffs in the tort litigation system averages less than 33%. Id. Moreover, only 1 in 10 patients injured by provider malpractice ever initiate and pursue a claim. See supra note 28 and accompanying text.
293 See supra notes 273-74 and accompanying text.
benefit from being able to defend their professional judgment and challenge the merits of a claim in a forum that is less threatening than the courtroom. To the extent that arbitration decreases physicians' anxiety about malpractice liability, then defensive medical practices also should be reduced.  

CONCLUSION

Currently, there is a radical health reform movement that is gaining momentum in the United States. One of the most troubling though less prominent reform proposals is the erection of statutory safe harbors based on the adoption of practice parameters as the legal standard of medical care. The rationale given for implementing this proposal is an imperative need to eliminate the costs associated with defensive medicine. 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.

Nevertheless, there is some merit to the belief that a practice parameter-based safe harbor system could eliminate some of the incentives for physicians to practice in ways that reduce the risk of malpractice liability. The fundamental difficulty with adopting such a proposal, however, is that the cost of developing and implementing parameters that are sufficient to establish a legal standard of care would be prohibitively large. While no empirical data is currently available to definitively establish this conclusion, this conclusion may be supported by comparing the relatively small portion of the health care budget that defensive medicine or the medical malpractice system represents to the likely costs of developing, specifying, disseminating, and continuously updating universally accepted individual standards of care for thousands of diseases.

Ultimately, it is recommended that this radical step need not and should not be taken for the foreseeable future. Rather, the current malpractice regime should be maintained as is or an alternative reform model such as increased utilization of HMOs coupled with binding malpractice arbitration should be promoted. Promoting HMOs as the preferred method of delivering health care would substantially reduce the incentives for physicians to overutilize medical resources by internalizing the costs as well as benefits of utilization. Furthermore, binding malpractice arbitration provides a private, relatively uncomplicated forum within which patients and providers can resolve their medical disputes more quickly, inexpensively, and consistently than traditional trial litigation. Therefore, incorporating these complementary proposals into a unified, broad-based effort to reduce defensive medical costs offers a more feasible and economically sound solution than attempting to adopt practice parameters as the legal standard of medical care.

294 See Roberts, supra note 275, at 3-5.