

Virtual Mentor

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Case in Health Law

Cost Containment and Physician Obligations: Mandates for Patient Advocacy

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Lois Wickline had limited financial resources and education when she began receiving treatment for back and leg pain from her family practitioner, Dr Daniels. Initially, Dr Daniels prescribed physical therapy, but Ms Wickline did not benefit from this treatment, so he admitted her to Van Nuys Community Hospital for a consultation with Dr Polansky, a vascular surgeon.

Upon examination, Dr Polansky determined that Ms Wickline had Leriche's syndrome. Consistent with the standard of care for that condition, he decided that surgical artery excision and graft placement were necessary. Ms Wickline, who was insured through Medi-Cal, California's Medicaid program, obtained Medi-Cal authorization for the procedure.

Ms Wickline was admitted to the hospital on January 6, 1977. The next day, Dr Polansky performed the surgery using the right groin as the surgery site. Postsurgically, Ms Wickline experienced a clot within the graft. She was taken back to surgery, where the incision was reopened and the clot removed. After this episode, Ms Wickline experienced a "stormy" recovery that included pain, vascular spasm, and hallucination episodes [1]. On January 12, again consistent with the standard of care, Dr Polansky performed a lumbar sympathectomy in an effort to relieve Ms Wickline's spasms.

Ms Wickline was scheduled to be discharged on January 16. On that day, however, Dr Polansky determined that it was medically necessary for her to remain in the hospital for an additional 8 days. He based his assessment on the belief that he could save Ms Wickline's legs if she remained under close observation so that, if any emergent condition occurred, it could be treated immediately. He also expressed concerns about possible additional clotting and infection.

Dr Polansky and the hospital filed the required Medi-Cal forms, requesting approval for the additional stay and supplying the clinical rationale and justification for the extension. The Medi-Cal medical consultant who reviewed the case rejected Dr Polansky's request, granting instead a 4-day extension. Although it was possible for Dr Polansky to appeal, he abided by Medi-Cal's decision and discharged Ms Wickline on January 21. Ms Wickline protested the discharge, but she did not prevail.

Following her discharge, Ms Wickline began to experience significant pain in her right leg and, as the pain increased, the leg “got bluish” [1]. After twice calling physicians, she was told to go to the emergency room at the hospital and was admitted when she got there. Dr Polansky’s colleague, Dr Kovner, who had assisted in the previous surgeries, examined Ms Wickline and found she was experiencing “unrelenting pain” in her right leg, an open and infected wound in the original incision area, a mottled foot on the affected side, and a significantly cooler right lower extremity [1]. The next day, Dr Polansky examined Ms Wickline and concluded that she had developed severe clotting in her right leg. There was no circulation to that leg, and she had developed an infection at the surgery site.

Dr Polansky could not remove Ms Wickline’s clot surgically because the infection raised the possibility of additional clotting and septicemia. Instead he treated Ms Wickline with antibiotics and anticoagulants, but her condition did not improve. With medical treatments exhausted, Dr Polansky performed a below-the-knee amputation on February 8. This surgery failed to effectively address her clinical condition, and, on February 17, Dr Polansky performed an above-the-knee amputation. Both amputations were within the standard of care at the time.

Ms Wickline sued the Medi-Cal program through the State of California, claiming that she was negligently discharged from the hospital prematurely and, as a result, suffered the damage of complete occlusion of her infra-renoaorta and subsequent amputation of her leg.

Disposition: *Wickline v State of California*

At trial, the jury found in favor of Ms Wickline. An appeal was filed and the appellate court reversed the ruling, finding that the process of review by Medi-Cal was appropriate. It also found that the primary responsibility for assessment and decision making for clinical care rested with the treating physician and that he or she could not avoid that responsibility by deferring to financial considerations associated with decisions of the insurer or payor [1].

The appellate court first noted that the escalating costs of health care required that public and private payors implement cost-containment measures. Included in these measures were prospective utilization reviews like the one performed by Medi-Cal in Ms Wickline’s situation.

The court then noted that both the common (ie, judge-made) law and the state’s statutory (ie, legislative) law required that, “All persons are required to use ordinary care to prevent others being injured as a result of their conduct.” These laws constituted the negligence rule used by the state in deciding medical injury cases.

Regarding the procedure by which the Medi-Cal reviewers assessed Ms Wickline’s case, the appellate court concluded that it was adequate and conformed to the requirements of state law. The decision to deny the 8-day hospital extension had been based upon the Medi-Cal consultant’s skill, knowledge, training, and experience in the medical field. There was no obligation on the part of the Medi-Cal consultant to seek additional

information beyond what was contained in the paperwork filed by Dr Polansky and the hospital.

With respect to physician responsibility, however, the court held that, “As to the principal issue before this court, i.e., who bears the responsibility for allowing a patient to be discharged from the hospital, her treating physicians or the health care payor... it was for the patient’s treating physician to decide the course of treatment that was medically necessary to treat the ailment” [1]. Further, the court wrote in no uncertain terms that:

It was also...the physician’s responsibility to determine whether or not acute care hospitalization was required and for how long...[T]he patient’s physician is in a better position than the [payor] to determine the number of days medically necessary for any required hospital care. The decision to discharge is, therefore, the responsibility of the patient’s own treating doctor [1].

The court then emphasized that physicians must act in the patient’s best medical interest regardless of payor decisions and will be held responsible for this advocacy, writing that:

...the physician who complies without protest with the [cost-containment] limitations imposed by a third-party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient’s care. He cannot point to the health care payor as the liability scapegoat when the consequences of his own determinative medical decisions go sour [1].

Hence, the state’s Medi-Cal program, which complied with the prospective utilization review process as defined by law, was found not to be liable. The primary responsibility for the welfare and outcome of Ms Wickline and her treatment was Dr Polansky, and he could not transfer that liability to the state.

Commentary

Cost containment is a standard consideration in health care delivery today. Yet, as shown by this case, the law requires physicians to consider the clinical implications of treatment or denial of treatment for the patient, regardless of the financial consequences or potential limitations payors attempt to place upon care delivery. The law therefore recognizes the primacy of patient welfare as the mandate of physicians and will hold them accountable for fulfilling that responsibility.

Clinical medical ethics pronouncements strongly support this legal perspective. The *AMA Code of Medical Ethics*, Opinion 8.054, “Financial Incentives and the Practice of Medicine,” states that:

[Physicians] first duty must be to the individual patient. This obligation must override consideration of the reimbursement mechanism...Physicians should...advocate for incentives that promote efficient practice, but are not designed to realize cost savings beyond those attainable through efficiency. As a counterbalance to the focus on

utilization reduction, physicians should also advocate for incentives based on the quality of care and patient satisfaction [2].

The AMA specifically notes in a separate policy statement that it “strongly opposes, and will take appropriate action necessary to restrict, third-party cost-containment strategies that jeopardize patient health and the quality of care” [3].

Physicians have faced greater and greater cost-containment pressures with the advent of managed care and increasing costs. Yet even in this environment, where arguably physicians do not have the discretion in care provision and decision making they might have had in the past, they are still mandated to consider the patient’s welfare first and will be held liable for patient injury regardless of managed care payment decisions [4-6].

In this particular case, Ms Wickline was entitled to have her physicians consider only the clinical aspects of her situation when determining how much health care to provide her. Perhaps more importantly, Dr Polansky had a duty to advocate aggressively for her care through the Medi-Cal system. Although the opportunity was available for him to request additional hospitalization coverage for her care, he did not, which may have resulted in her negative clinical sequelae. It should be explicitly noted that Ms Wickline, a patient and participant in the Medi-Cal program, was particularly vulnerable due to her socioeconomic status and limited education—she was very much in need of educated medical advocacy on her behalf. The court might have been exercising some hindsight bias in the matter when it wrote that Dr Polansky was in the position to consider—and according to medical ethics guidance, should have aggressively placed—his patient’s individual interests above the cost of the care necessary to protect those interests. The court believed that since he thought that Ms Wickline needed an extended period of observation as an inpatient, it was incumbent on him to pursue that course of care to the best of his ability.

Although the State of California was the lone defendant in Ms Wickline’s case, today Dr Polansky would likely be at least 1 of the defendants in the case. He would be subject to the vagaries of the medical malpractice system and might or might not prevail, depending upon a wide array of clinical and nonclinical factors [7, 8]. Further, under the current state of law, if Dr Polansky were under contract with a managed care organization to provide for Ms Wickline’s care, it would be likely that he would face liability alone, regardless of whether or not the managed care organization refused to cover the recommended hospital stay as Medi-Cal did in the actual case [1, 2].

Overall, physicians have a legal and ethical obligation to consider the patient’s welfare, regardless of cost-containment or payor considerations. This obligation requires aggressive advocacy for clinical care provision that is in the patient’s best interest. Although circumstances may make it inconvenient, difficult, and even potentially arduous, it is an appropriate duty. It merely puts into action the social contract that allows us the privilege to practice medicine in exchange for the trust patients place with us to achieve their health care goals.

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