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Monitor Mania: Physician Regulation Runs Amok!

Evan J. Ellman*

I. INTRODUCTION

Doctors used to be the stars at the center of the health care universe, and all the players — the nurses, the hospital administrators, the medical support personnel — revolved around them. “Doctors’ orders” were paramount. In life, as in law, the doctor was truly the “captain of the ship.”

In the new health care order which has emerged in the last decade, doctors find themselves at the center of a different sort of constellation. Their decisions and judgments are monitored, reviewed, and questioned by a variety of the very players who used to defer unquestioningly to those decisions. The physician has become the target of review by a variety of agencies, committees, organizational entities, peers, and colleagues, each with its own angle of attack.

The doctor’s head is in a vise, and the squeeze is on. From one side, the not-so-veiled threat of a medical malpractice suit lurks beneath the surface of most doctor-patient relationships, constituting an implicit form of critical monitoring by patients and their lawyers. This constant fear of litigation urges the doctor to avail

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In Illinois, case law has eroded this doctrine. “The surgeon’s own acts, which most directly affect the life and well being of a patient, charge him with his own awesome responsibility. He should not also be saddled with the role of guarantor of the patient’s safety from the negligence of others.” Foster, 119 Ill. App. 3d at 1059, 313 N.E.2d at 259.

2. This fear of a malpractice suit has so permeated the doctor-patient relationship that it gave rise to the following cartoon in a recent NEW YORKER: A doctor is depicted talking to his partially disrobed patient in the office examining room. In the caption, he states: “We medical practitioners do our very best, Mr. Nyman. Nothing is more sacred to us than the doctor-plaintiff relationship.”
himself of the latest in technology and the highest caliber medicine, regardless of cost. On the other hand, cost constraints, which are of paramount concern to the hospital, the government, and private payors, mandate that cost considerations be a priority in making medical decisions.3

This Article will provide an overview of the different forces and entities which monitor and question the treatment decisions and practice patterns of physicians. It will discuss the myriad of reviewing entities which exist at the behest of the state government, the federal government, the private associational entities, the private institutional health care provider, and third-party reimbursers. This Article will also review the panoply of doctor-monitoring activities which are ostensibly designed to improve the quality and efficiency of health care in America, questioning what impact these entities have on the independence of medical judgments and, ultimately, on quality of care.4

II. HISTORICAL BACKGROUND

The entrance of the United States government into the health care arena with the enactment of Medicare and Medicaid legislation in 19655 heralded the beginning of the government's prolonged and wanton spending spree on medical costs.6 As part of President Lyndon Johnson's "Great Society," Medicare and Medi-

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3. For a discussion of this issue, see Note, Rethinking Medical Malpractice Law in Light of Medicare Cost-Cutting, 98 HARV. L. REV. 1004 (1985).

4. The sheer quantity of regulatory entities and the missions with which they are charged bespeaks an area too varied to allow the author to make one consistent value judgment, or one recommendation for a solution. The reader will, no doubt, draw his/her own conclusions as the "big picture" emerges.

5. See Social Security Amendments of 1965, 42 U.S.C. §§ 1395 to 1395ccc (Supp. 1989) (referred to as "Medicare"). Medicare, title 18 of the Social Security Act, provides health care payment by the government for citizens over 65 who are eligible for Social Security, and for certain disabled persons. Medicare is entitled Health Insurance for the Aged and Disabled Act, 42 U.S.C. §§ 1395 to 1395ccc (Supp. 1989). Medicaid, title 19 of the Social Security Act, created a program and provided grants to the states to provide for medical care to the indigent. Although Medicare and Medicaid are different programs, this Article will refer to both as "Medicare."

6. See STATISTICAL ABSTRACT OF THE UNITED STATES, BUREAU OF THE CENSUS, U.S. DEPT. OF COMMERCE 96 (105th ed. 1985) [hereinafter STATISTICAL ABSTRACT OF THE UNITED STATES]. In 1965, 6.1% of the gross national product was spent on health care. That percentage rose to 10.5% in 1982, and was 11.5% in 1988, or $2,130 per person, per year. Id. See also Califano, The Health Care Chaos, N.Y. Times, Mar. 20, 1988, § 6 (Magazine), at 44. In dollars, that means that last year Americans spent more than $550 billion on health care, and over $300 billion in 1982. Medicare has, for many years, been the fastest growing part of our federal budget. Malcom, In Health Care Policy, The Latest Word is Fiscal, N.Y. Times, Oct. 23, 1988, § 4 (Magazine), at 3.
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caid were introduced to ensure that the aged and the needy would have access to the same high quality medical care as the rest of society. Legislators and politicians fashioned laws which assured hospitals, nursing homes, doctors, pharmacists, and a host of medical paraprofessionals reimbursement for their “reasonable costs,” whatever those costs might be, in the treatment of the poor and the aged. Treatment for the poor previously had been performed free of charge, with time being donated by physicians working in clinics, and hospital costs subsidized by paying patients. With the advent of Medicaid, no patient was indigent. Everyone could pay.

Congress appeared to have no idea what it was committing the taxpayers to paying for when it assumed financial responsibility for this medical care. Nor did Congress anticipate the many factors which would escalate its financial commitment, including skyrocketing costs, exponentially increasing populations of poor, who were covered by Medicaid, as well as new knowledge and technology which enabled the prolongation of life, and thereby prolongation and escalation of Medicare coverage. Moreover, Congress did not fully anticipate the way the programs would be flagrantly abused by health care providers eager to gorge at the public trough.

10. During 1986 and 1987 alone, the price of American health care increased at more than twice the rate of inflation, and three times the overall rate in 1983. The rise in physician’s fees for services was so steep in 1987 that Medicare had to increase premiums that people pay for physician care by 40%. See supra note 6.
11. The number of Medicare beneficiaries has increased by two million people in the last three years alone. Statistics provided by the Health Care Financing Administration, Washington, D.C.

By 1987, excess billing by physicians alone, defined as physician charges over and above those considered reasonable by the government, cost the Medicare program $2.7 billion dollars. A group called “Citizen Action,” which monitors records maintained by the Health Care Financing Administration, found that in 1987, an average of $38.11 excess billing was billed to Medicare on each of the 70.3 million doctor bills processed by the Medicare program. See Doctors’ Medicare Fees Criticized, Chicago Tribune, Oct. 4, 1988, at 10, col. 1.
At first, the medical profession resisted the entrance of the government into health care. Physicians feared government involvement in medicine and decried "creeping socialized medicine." But little by little, physicians became accustomed to the increased income that resulted when they began to receive government checks for treating patients who previously would have been treated free of charge. Ironically, it is now the American Medical Association ("AMA") which is spearheading the campaign to urge further expansion of the same Medicaid program it originally opposed.

As it turned out, Medicare/Medicaid proved to be a bonanza for doctors and hospitals. Medical schools became glutted with students and applications as more and more people looked to the medical profession as a sure passage to financial success. In search of wealth in the "land of opportunity," doctors from all over the world, particularly third world countries, rushed here to avail themselves of our government's largesse.

As much as the doctors enjoyed this additional income, the government found its financial commitment expanding beyond its most liberal projections. It became starkly apparent that the Medicare/Medicaid programs provided a strong financial incentive for hospitals and doctors to maximize their usage of medical treatments, procedures, tests, and surgeries because they could be fully


14. Among physicians, surgeons particularly benefitted from the government's generosity because surgeries are among the most costly form of medical treatment. A surgeon operating in a teaching hospital would be paid not only for the surgeries he performed, but those performed by medical residents as well. For such physicians, Medicaid enabled them to earn thousands of additional dollars weekly for surgeries which had previously gone uncompensated.

15. See Expansion of Medicaid is Proposed, Chicago Tribune, Feb. 17, 1989, at 1, col. 2. "A coalition led by the A.M.A. . . . proposed an overhaul of the Medicaid program to expand coverage to 11 million more poor Americans, improve benefits and raise reimbursement rates for physicians and hospitals." Id.

16. So noticeable was the influx of foreign doctors after the passage of Medicare legislation that the AMA began to keep statistics on the numbers of foreign medical school graduates practicing in the United States, including their countries of origin. Beginning in 1970, the AMA began publication of a pamphlet entitled "Physician Characteristics and Distribution in the United States." As of 1970, there were 57,217 foreign doctors practicing in the United States, out of a total of 334,028 doctors. By 1986, out of a total of 552,716 doctors, the number of foreign doctors practicing in the United States was 123,090, an increase of over 100% in 15 years.

17. By 1975, just five years after the program's inception, expenditures reached $4.95 billion, slightly more than twice the amount that had been projected for that year in 1965. By 1980, Medicare expenditures approached $37 billion. See *Statistical Abstract of the United States*, supra note 6.
reimbursed by the government. The more procedures that were ordered and performed, the more money that flowed to doctors and hospitals alike.

As the Medicare "boondoggle" played on, doctors and hospitals emerged as new "deep pockets" in personal injury litigation. Never before has one profession so relentlessly attacked another profession as lawyers have attacked doctors via medical malpractice litigation. Any attempt to reform the tort laws to make it more difficult to sue doctors has been met by plaintiff-oriented lawyers' claims that the doctors have not done enough to police themselves, and that there is a rise in medical negligence claims because there is more malpractice being committed. Regardless of whether the malpractice crisis represented more litigiousness toward doctors or truly an insurgence of faulty medical practice and derelict self-discipline, physicians reacted by "covering them-

18. Providers were reimbursed on a retrospective fee-for-service basis of reimbursement, where all providers were paid a "reasonable charge," defined as "the customary charge for similar services generally made by the physician or other person or organization furnishing the covered services, and also the prevailing charges for the locality for similar services." S. REP. NO. 404, 89th Cong., 1st Sess., reprinted in 1965 U.S. CODE CONG. & ADMIN. NEWS, 1943, 1949.

When the Reagan Administration proposed an increase in Medicare premiums of 38.5% for 1988 (the largest in Medicare's history), Congressman Fortney ("Pete") Stark of California charged that "the current fee-for-services payment system gives doctors a key to the treasury." See 15 Health Law. News Rep., Oct. 1987, at 1. See Comment, Reagan Administration Health Legislation: The Emergence of a Hidden Agenda, 20 HARV. J. ON LEGIS. 575, 586 (1983). The "reasonable cost" provision constituted an "open-ended, cost-based, and cost-generating" reimbursement program. Id.

19. For example, the rapid growth in the number of coronary bypass surgeries performed each year, which were reimbursed at a rate of $25,000 per surgery, can in part be attributed to Medicare's willingness to pay for it. Studies performed by the National Institutes of Health and the Veterans Administration concluded that a whopping 60-80% of the 250,000 coronary bypass surgeries performed each year are unnecessary in that they gain no increase in lifespan for the patient beyond what could be achieved with medical management. Califano, supra note 6, at 44.


22. For a discussion of this viewpoint, see Report of The Illinois Medical Malpractice Task Force to Governor James R. Thompson (1985) (available in Loyola University of Chicago School of Law Library) (a report of the Illinois Medical Malpractice Task Force which accuses doctors and hospitals of failing to adequately police their profession, thereby giving rise to more actual malpractice).

selves," ordering all possible diagnostical tests and treatments so as to be in the best possible defensive position in case of a malpractice suit.24 A happy alliance was formed between physicians and hospitals, both eager to maximize income and minimize risk of liability by practicing the most expensive, most procedure-oriented medicine in history.25

Throughout the 1970s and early 1980s, more medicine seemed to be equated with better medicine. More treatment was certainly better financially for the health care providers, who were generally able to bill third parties for most of the costs of medical services to patients.26 Medicine became big business. The world of doctors and hospitals enlarged and gradually began to be referred to as the "health care industry."27 Many advances in surgical techniques and medical technology were spurred on by this frenzy of medical activity. And the United States government was bankrolling it.28

Something had to give. The spending spree could not continue. Limiting who could qualify for coverage under Medicaid and Medicare has not been politically feasible.29 The government has

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24. See Harris, Defensive Medicine: It Costs, But Does It Work?, 257 J.A.M.A. 2801, 2801-02 (1987). “Failure to diagnose has been a classic basis for negligence actions against physicians. To avert missed diagnoses, physicians apparently make widespread use of blood chemistries, bone films, and other routine tests.” Id.

The Harris article provides a quantitative analysis of the costs of defensive medicine. “From 1983 to 1984, Reynolds et al. estimate that the average malpractice insurance premium rose by $1,300 annually.” Id. Concurrently, in response to a perceived increase in malpractice risks, the AMA surveyed physicians reported changes in their medical practices that were worth an additional $4600 per physician, per year. “The $4600 increase in defensive medicine costs was more than 3.5 times the concomitant $1800 increase in premiums.” Id. Thus, for each $1.00 of additional malpractice insurance risk (measured by premiums), an additional $3.50 in defensive medicine expenditures occurs. “Defensive medicine” means more time with patients, more use of routine tests and blood chemistries, more follow-up visits, and more time spent on record-keeping. Yet the frequency and severity of malpractice claims continues to rise. Harris concludes that “defensive medicine” is not effective risk-management. Id.

25. Americans spent almost $1,800 per person on health care in 1985. Califano, supra note 6, at 46. The Canadians, who ranked second, spent $1,300. Id. The Japanese spent $800 and the British spent $600. Id. Health care is sophisticated and modern in these countries; life expectancy is at least as high as in the United States, and infant mortality is lower. Id.

26. As of 1982, the last year when “reasonable cost” was the government’s reimbursement formula, 94% of all hospital bills were paid for by third-party payors or the government. See Ricardo-Campbell, The Economics and Politics of Health 187 (1982).

27. This process developed gradually. This author never heard the term “health care industry” until the mid- to late-1970s.

28. See Califano, supra note 6, at 44.

29. To the contrary, Congress reacted to the energetic lobbying of the American Association of Retired People (“AARP”), drug companies, and other health-care providers by expanding categories of people entitled to Medicaid benefits (now, poor people who
tried to aim its retrenching efforts at those who receive the government money: health care providers (primarily doctors and hospitals). As Congress gaveth, so it now must try to taketh away.

III. MONITORING OF PHYSICIANS BY THE STATE

Before discussing the steps the federal government has recently taken to try to retrench from its financial commitment to health care, it is helpful to clarify how those steps dovetail with the existing state physician regulatory schemes. Prior to the federal government's entrance into the health care arena (i.e., before 1965), the states were the sole governmental bodies charged with the responsibility of licensing and disciplining physicians. The state licensing boards were and still are the first "reviewers" of physicians; they administer the examinations which determine whether the physician will be issued a license. Licenses to practice generally must be renewed periodically, and it has customarily been the responsibility of the state licensing boards to discipline errant physicians who have violated any of the list of tenets of the profession.

own property and would have previously lost eligibility for Medicaid, can attain Medicaid eligibility), and by expanding payments to hospitals. Medicare was expanded in 1988 by the passage of the Medicare Catastrophic Coverage Act, 100 P.L. 360, 1988 H.R. 2470. This expansion, which had long been opposed by President Reagan, was finally approved by him, constituting the first substantial Medicare expansion since its inception. See Reagan OKs Expansion of Medicare Aid; Adds Warning About Necessity to Keep Costs Under Control, L.A. Times, July 1, 1988, at 2, col. 1. Political analysts felt that the Republicans were trying to counter Reagan's image as lacking compassion, as well as trying to garner some lost support among the elderly. Politics May Bring Vetoes; It Also Aids "Catastrophic Bill", Indus. Week, July 4, 1988, at 6.

30. See infra notes 44-88 and accompanying text for a discussion of PROs and DRGs, and notes 167-84 and accompanying text for a discussion of the Medicare fraud and abuse statutes.

31. See infra Section IV for discussion of federal legislation designed to reduce federal expenditures for health care.


34. In Illinois, for example, ILL. REV. STAT. ch. 111, para. 4400-22 (1989) lists 38 separate grounds on which the Illinois State Department of Registration and Education can base disciplinary actions against physicians. These grounds range from "gross negligence in practice," ILL. REV. STAT. ch. 111, para. 4400-22(4) (1989), to "fee-splitting or referral fees," ILL. REV. STAT. ch. 111, para. 4400-22(14) (1989), to "gross and wilful and continued overcharging for professional services," ILL. REV. STAT. ch. 111, para. 4400-22(25) (1989). Many of these grounds duplicate or are only slightly different from
The Office of the Inspector General ("OIG") of the Department of Health and Human Services ("DHHS") conducted a study of state medical licensing boards.\textsuperscript{35} This "review of the reviewers" concluded that in the two decades since the advent of the Medicare program, the state medical boards have become so overwhelmed with the increases in their workload that they have been unable to effectively "weed out" incompetent doctors.\textsuperscript{36} The OIG found physician incompetence to be a problem of major proportions, and yet also found that physician incompetence represented only a small number of disciplinary cases.\textsuperscript{37}

One of the main reasons cited for this discrepancy was the tremendous increase in work loads and responsibilities of the state boards (indicative of the "monitor mania" which also has afflicted the state boards), without a concomitant increase in staffing or funding.\textsuperscript{38} To adequately monitor physician incompetence, the state boards need the cooperation of both physicians and hospitals. This has been a major obstacle. Physicians and hospitals are reluctant to report incompetent doctors. Of course, there are great differences of opinion among physicians as to what exactly constitutes incompetence,\textsuperscript{39} which has resulted in a near paralysis of the ability of state boards to find a physician sufficiently "incompetent" to deny him licensure.

The OIG report found that in the instances when disciplinary proceedings have been held, they tend to be particularly complex, long, and costly. Generally, the state boards' burden of proof for disciplining physicians for medical incompetence is "clear and convincing evidence" — which is harder to prove than the civil law standard of "more probable than not" that is applicable in malpractice cases. Such a burden of proof is so time consuming and

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\item Gross negligence is also monitored by the courts and litigants in malpractice actions, as well as by the government via the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101 (Supp. 1986), and by the hospital reviewing committees. The state government's review of fee-splitting and referral fees is also reviewed by the federal government via the Medicare/Medicaid fraud and abuse statutes. The federal government also reviews Medicaid claims, which duplicates the state government's duty to review the practice of overcharging, or filing false reports to support claims against Medicaid, ILL. REV. STAT. ch. 111, para. 4400-22(21) (1989).
\item Office of the Inspector General, U.S. Dep't of Health and Human Services, Medical Licensure and Discipline: An Overview (1986).
\item For a discussion and summary of the OIG report, see Kusserow, Handley & Yes-\textsuperscript{sian, An Overview of State Medical Discipline, 257 J.A.M.A. 820 (1987).
\item Id. at 822-23.
\item Id. at 822.
\item Id. at 823.
\end{itemize}
\end{quote}
costly to meet that state boards ultimately do not commit their limited time and resources to attempt to meet this standard.\textsuperscript{40}

The list of other reasons suggested for the failure of the states to adequately "police" the competence of their physicians reflects the overwhelming number of aspects of monitoring physicians with which the state licensing bodies are charged. Consumer awareness on the part of patients has caused a tremendous increase in consumer complaints against physicians which must be investigated. The increase in litigiousness of patients has given rise to more malpractice suits, and the resulting malpractice insurance "crises" have put renewed pressure on state medical boards to "weed out" bad doctors. In some states, scandals involving fraudulent medical credentials consume time and resources. The state licensing boards also are responsible for monitoring and licensing foreign medical students, many of whom have been trained in new medical schools which are markedly inferior to United States and Canadian schools. Even when such foreign graduates manage to pass the equivalency tests in the United States, the state licensing boards still are concerned about the inadequate clinical training the graduates of those medical schools have received, as well as the minimal admission requirements needed to attend those schools.\textsuperscript{41}

It is no wonder that the federal government, charged with sanctioning physicians for Medicare and Medicaid abuses,\textsuperscript{42} would have liked to look to the states for assistance in doing their "spade-work." However, the conclusions of the OIG report, highlighting the inadequacy of the state licensing boards, led in part to the federal government's sense of urgency that it would have to enter the physician regulatory arena, an area that traditionally had been left to the states. The results of the OIG study played a large part in the development of the reporting requirements and data bank provisions of the Health Care Quality Improvement Act.\textsuperscript{43}

\begin{footnotes}
\textsuperscript{40} Id. In 1985, Wisconsin amended its medical practice act, allowing a court finding of physician negligence in patient care to be conclusive evidence that the physician was negligent, for purposes of the state board licensing hearing. Wis. Stat. Ann. § 448.02 (West 1988). Wisconsin also lessened its state board's burden of proof in disciplinary proceedings, calling for a "preponderance of evidence," rather than "clear and convincing evidence" of incompetence. Id.

\textsuperscript{41} For a discussion of this problem, see Kusserow, Handley & Yessian, supra note 36, at 821. The disciplinary actions which the state boards do successfully pursue are concerned mostly with excessive and unnecessary prescribing of drugs to patients, as well as unlawful distribution to drug addicts. Furthermore, the state disciplinary boards have been active in monitoring and disciplining physicians' self-abuse with drugs and/or alcohol. Felony and fraud are other case categories which the state investigators develop.

\textsuperscript{42} See infra Section IV(G) on Medicare fraud and abuse statutes.

\textsuperscript{43} See infra Section IV(E). See also Basanta, Quality Health Care and Physician
IV. MONITORING OF PHYSICIANS BY THE FEDERAL GOVERNMENT

A. Government Mandated Peer Review — Creation of PROs

In 1982, Congress enacted the first of a series of laws designed to cut back on its excessive financial commitments to health care providers. With the stated aim of promoting "efficient and high quality care," the Peer Review Improvement Act of 1982 established a peer review organization ("PRO") program.\(^{45}\)

The expressed purpose of this legislation is to enable the government to monitor the quality of health care, while recognizing that it could best be done by physicians, particularly through local community physician peer review.\(^{46}\) Of equal, if not greater importance to the government are cost containment objectives which the PROs are also charged with monitoring.\(^{47}\) The PRO seeks to ensure:

a) that medical services or items will be ordered or provided economically, and only when "reasonably and medically necessary," as determined by their review;\(^{48}\)

b) that the services will be of a quality which meets professionally recognized standards of health care;\(^{49}\)

c) that health care providers should support decisions with evidence of medical necessity and quality in a way that can be reviewed by a PRO.\(^{50}\) In other words, the hospitals are required to keep good records.\(^{51}\)

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45. A PRO is an entity which is either "composed of a substantial number of the licensed doctors of medicine and osteopathy engaged in the practice of medicine or surgery in the area" or "has available to it the services of a sufficient number of licensed doctors of medicine . . . or surgery in such area to assure that adequate peer review of the services provided by the various medical specialties and subspecialties can be assured." 42 U.S.C. § 1320c-1(1)(A),(B) (1982).

46. A PRO for a particular area has the responsibility of reviewing the professional activities of physicians and other health care practitioners relating to their provision of services to Medicare beneficiaries. 42 U.S.C. § 1320c-3(a)(1) (1982).


51. See 42 C.F.R. § 466.78(b)(2) (1985) (setting out the procedures for providing the
The PRO is also charged with the responsibility of deciding whether Medicare shall make payment for medical services.\textsuperscript{52} It was through this means that the government sought to gain some control over monitoring expenditures.

Under this legislation, if the PRO determines that a health care practitioner has violated his or her statutory obligations, the PRO must decide whether the violation was a "gross and flagrant" violation.\textsuperscript{53} If so, the PRO must give the practitioner written notice setting out this determination, the basis for it, and the sanction that will be recommended.\textsuperscript{54} The physician may then request a meeting with the PRO within thirty days, and is entitled to be provided by the PRO with a copy of the written material upon which the PRO's decision was based.\textsuperscript{55}

\textbf{B. Creation of DRGs}

Soon after the PROs were formed, Congress instituted changes in the reimbursement formula for hospitals that provide services covered by Medicare. Under the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"),\textsuperscript{56} Congress charged itself with the responsibility of formulating a prospective payment system ("PPS"). Congress created such a system in 1983,\textsuperscript{57} which abolished the open-ended "reasonable cost" basis of reimbursing hospitals, and substituted a fixed, predetermined amount of reimbursement for a particular service or procedure.\textsuperscript{58} These amendments to the Social Security Act provided fixed payments for Medicare inpatient hospital admissions\textsuperscript{59} which were classified upon discharge according to government-prescribed "Diagnostic Related Groups" ("DRGs"). The 468 DRGs defined fixed fee re-

\begin{itemize}
\item \textsuperscript{52} 42 U.S.C. § 1320c-3(a)(2) (1982).
\item \textsuperscript{53} 42 C.F.R. § 1004.40(a) (1986).
\item \textsuperscript{54} 42 C.F.R. §§ 1004.40(b), 1004.50 (1986).
\item \textsuperscript{55} \textit{See supra} note 51 and accompanying text.
\item \textsuperscript{58} \textit{See} Title VI of the Social Security Amendments of 1983, Pub. L. No. 98-21, 97 Stat. 65, 149 (amending § 601(a)(1) of the Social Security Act), which established Prospective Payments for Medicare Inpatient Hospital Services.
\item \textsuperscript{59} \textit{See} 1 Medicare & Medicaid Guide (CCH) ¶ 4204, at 1511-13 (July 1984).
\end{itemize}
imbursement rates to the hospital based on the diagnosis, regardless of the actual costs incurred in treating the patient. Congress' hope was that reimbursement of a fixed fee for each type of diagnosis would create incentives for hospitals to operate in a more cost-efficient manner.

Hospitals had based all their long-term planning on expectations of a continued "reasonable cost" based reimbursement rate. Thus, DRGs presented a drastic change in the payment formula for hospitals, which, in turn, had a drastic effect on the administration of the hospitals. The DRGs effect on the physicians' relationship with the hospital was nothing short of revolutionary. The use of DRGs prompted a 180-degree turn around in how physicians related to hospitals. Before September 1, 1983, hospitals stood to gain by having physicians on their staff who did a lot of procedures in the hospital and who were liberal in their utilization of hospital facilities. After September 1, 1983, hospitals stood to lose more money as the physician performed more procedures. Hospitals can only make a profit to the extent that they keep their costs below the fixed DRG rate. Suddenly and precipitously, less medical intervention meant more money to the hospital. While the government professed that nothing it was mandating should be construed as authorizing federal interference with the provision of medical treatment, overnight, the conservative method of treatment became the method most favored by the institutional health care facility. Procedure-oriented physicians felt the pressure to do an "about-face" in their practice patterns.

In a way, the new post-DRG health care order pushed in diametric opposition to the anti-malpractice hospital policies and procedures which had tended to encourage doctors to practice "defensive medicine," such as performing extensive diagnostic workups so as to be in the best position in a "failure to diagnose" medical malpractice situation. Because hospitals stood to lose money from doctors who freely utilize diagnostic and other procedures, new policies and procedures had to be put into effect which limited the appropriate diagnostic work-up and treatment for different diseases and injuries, depending on their DRG financial allotment.

Performing expensive and numerous tests to rule out differential diagnoses are no longer within the doctor's sole discretion. The hospital examines the need for those tests; it will, in effect, second guess the doctor's order based on cost considerations. If a hospital only stands to make a profit through under-utilization of procedures and treatment modalities, then it will encourage under-utilization.

How does this affect quality of care? Some would applaud Congress' cost-cutting goals, and point to the excessive overutilization of unnecessary tests and procedures which add their own level of risk. But it cannot be denied that the far more likely outcome will be that health care will be provided at a level below that which is technologically feasible. A few more needed days of hospitalization will be foregone, which will prolong patient recuperation

70. *See* Harris, supra note 24, for a discussion of the analytical techniques applied to data reflecting the increased medical costs generated by physicians practicing defensive medicine.

71. Hospitals make these evaluations through their Utilization Review and Quality Assurance programs. *See infra* Section VI for a discussion of utilization review and quality assurance.

72. *Note, Rethinking Medical Malpractice Law in Light of Medicare Cost-Cutting*, 98 HARV. L. REV. 1004, 1022 (1985) [hereinafter *Rethinking Medical Malpractice Law*]. That Note suggests that legislators have created a rebuttable presumption of joint hospital-physician liability in cases when the malpractice claim arises from a failure to order tests or procedures, or is otherwise due to cost-cutting concerns.

73. *See* Zaslow, supra note 65.


times. In addition, low-risk services (such as diagnostic tests), whose elimination might impair the quality of care, will be sacrificed.  

C. Analysis of PRO Review

The DRGs provided the PROs with a formidable tool for monitoring individual medical decisions. The law requires that, as a condition of Medicare participation and of receiving money under the PPS, the hospital must maintain an agreement with a PRO to monitor a variety of medical decisions. 78 "To admit or not to admit," is the threshold question that the PRO asks. Is the hospital admission "medically necessary"? "Could the patient be effectively treated more economically on an outpatient basis?" 79 If the PRO review determines that the treatment could possibly be done on an outpatient basis, then the patient should not be admitted. This decision, however, does not take into account the individual's personal circumstances and ability to recuperate as an outpatient, which doctors always used to take into consideration.

The PRO also reviews other core medical decisions. One such decision is the "invasive procedure review." 80 Is the doctor performing an invasive procedure which the PRO deems "medically necessary"? 81 Congress charged the PROs with identifying those invasive procedures which they felt were overused by physicians and for which payment was customarily too high. 82 Many procedures which were the "bread and butter" of some doctors were targeted as not being "medically justified." It is the contractual obligation of the PRO to either categorically deny coverage or to limit it to certain circumstances and certain rates of reimbursement. While this may limit the number of unnecessary surgeries and invasive diagnostic procedures which are being performed for financial gain, it also may have a chilling effect on the use of some procedures which might be legitimately helpful, but which the doctor does not want to order because neither he nor the hospital will receive reimbursement. 83

77. Compare Rethinking Medical Malpractice Law, supra note 72, at 1022, with Wong & Lincoln, supra note 75 (suggesting that fewer tests will reduce the incidence of false leads).
The PROs are also charged with monitoring quality of care. The statute calls it "Quality Review." The PRO reviews the "completeness, adequacy and quality of care" provided. To do this, the PRO reviews the medical records of sample patients and assesses their inpatient care by comparing it with pre-established criteria specific to the nature of services provided and the patient's condition.

The PROs also perform a "DRG Validation Review" which seeks to ascertain whether the principal diagnosis was in fact the diagnosis responsible for the admission, or whether the diagnosis has been made in a way to maximize reimbursement from the Medicare program. This provision is aimed at enabling those paid by the government to monitor the hospital employees charged with establishing which DRGs are appropriate for patients. The feared practice that this is designed to protect against is that hospital personnel might err or deliberately falsify the diagnosis so as to qualify for greater rates of reimbursement under the DRGs.

1. Expanding Areas of PRO Monitoring

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") expanded the areas that PROs were authorized to monitor. With the implementation of COBRA, Congress gave the PROs authority to monitor and review 100% of certain surgical procedures, as well as to review treatment plans and services rendered in HMOs and Competitive Medical Plans.

The Sixth Omnibus Budget Reconciliation Act of 1986 ("SOBRA") gives PROs even more power in reviewing quality of care. This legislation extends PRO review to home health agencies and skilled nursing facilities.

Thus, the PRO has become a major monitoring entity of physicians, with broad-ranging authority. The government is using PROs to determine if treatments are medically necessary, toward the end of protecting the integrity of the DRG system. While

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85. Id.
86. Id.
87. Id.
90. Id.
couched in language which makes quality of care appear to be a priority, there is little doubt that the PROs are the government's vehicle through which it hopes to gain some control over its self-imposed health care expenditures. The ongoing tension between the goals of cost-containment and high quality care pervades this legislation.

2. How a PRO Works

A nurse or other non-physician carries out the initial review process in most PROs. They decide whether the doctor's decision to treat a patient in a certain way was "medically necessary." If the physician wishes to justify his orders, he may do so. Does the nurse bear any responsibility if the doctor is sued for malpractice? No. Her concern is paring down costs to Medicare. She then brings the file to a reviewing physician, who examines the criticized treatment. Frequently, this physician is not board certified in the clinical area that he or she is reviewing. The reviewing physician makes a decision as to the medical necessity of the admission or the treatment and then makes a recommendation to the OIG.

The PRO is not authorized to impose sanctions, but the OIG does have such authority. The OIG publicizes its decision and notifies all medical societies, state licensing bodies, the Health Care Financing Administration ("HCFA"), PROs, hospitals, skilled nursing facilities ("SNFs"), and HMOs. The OIG is also entitled to notify insurance carriers and intermediaries. The only people who physicians are permitted to inform personally of any sanctions against them are their patients.

If a physician strongly objects to the PRO's recommendation, upon which the OIG's decision is based, he may appeal. Yet the decision stays in effect during the pendency of the appeal. Most cases which have been brought regarding the PRO process have sought temporary injunctions to stay publication of the OIG's de-

95. 42 C.F.R. § 1004.70 (1987). The sheer process of having a nurse institute such proceedings is inherently outrageous to most physicians. For lawyers, this process would be similar to having a paralegal going through a lawyer's files and questioning the validity of certain motions filed or depositions taken by that lawyer. Such a procedure surely would be strenuously opposed by the legal profession.
97. Id.
99. Id.
cision while the doctor’s appeal is pending. The majority of those cases, however, held that the doctor had received adequate due process and, therefore, permitted the injunctions to stay in effect.

3. Review of the Reviewers

If a PRO determines that a doctor erred in his decision to admit, to provide inpatient treatment, or to perform an invasive procedure, then the PRO must notify the doctor, the hospital, and the patient, and provide an opportunity for the case to be discussed. The PRO decision to deny payment is an “initial denial determination” which can be appealed.

If the error of the doctor is found to be severe enough, the PRO has the authority to recommend that the OIG impose harsh sanctions against the physician and/or the hospital. These sanctions take the form of fines, penalties, a refund of fees, temporary suspension from the program, or, in extreme cases, permanent banishment from the Medicare program. Still another level of review is authorized: any person entitled to Medicare benefits, or any doctor or hospital dissatisfied with the determination made by the PRO, is entitled to reconsideration, that is, another review by a qualified peer. Guidelines for this reconsideration are outlined in the regulations.

Further protection is offered a doctor pursuant to an agreement that was entered into between the HCFA, the AMA, the Association of Retired Persons, and the OIG, which entitles the physician to due process in all PRO review proceedings. When a decision which is adverse to the doctor receiving reimbursement is rendered, he is entitled to counsel, and he has the right to obtain ex-

100. See, e.g., Thorbus v. Bowen, 848 F.2d 901 (8th Cir. 1988); Doyle v. Secretary of Health & Human Servs., 848 F.2d 296 (1st Cir. 1988); Cassim v. Bowen, 824 F.2d 791 (9th Cir. 1987).
101. See supra note 100.
106. 42 C.F.R. §§ 1004.1 to 1004.130 (1986).
107. Id.
108. According to a HCFA press release dated May 13, 1987, this AARP-AMA-HCFA-OIG agreement is amendment § 602.5 to the PRO Manual.
pert witnesses, to review the records, and to have the reviewing physician present at the hearing. 109

4. Analysis of the Economic Consequences of Due Process Safeguards

Now that these safeguards have been placed into the system, it is likely that the HCFA will be expecting the PROs to bring more actions against physicians, followed by more due process hearings. 110 But what the government seeks to save with one hand, it will spend with the other. Although the government wants to increase lagging enforcement against physicians, towards the end of ensuring that the Medicare dollars are conservatively spent, the review process itself is exceedingly expensive. 111 From the government's point of view, it is questionable whether a cost-benefit analysis would show bottom line cost savings to the Medicare program from the use of PROs and their administrative appeal proceedings. It is more likely that the creation of an additional bureaucracy will tend to perpetuate and increase expenditures.

From a physician's point of view, availing himself of all the due process entitlements would pose a particularly burdensome expense. Given the many phases of the PRO review process, and given the physician's due process entitlements at each step, one can easily envision this process being too costly and time consuming for physicians to fully pursue. Unless lawyers are willing to represent physicians on a contingency fee basis, it is likely that they will

109. Id.

110. It is not only the HCFA which expects more sanctioning. On October 26, 1987, the Associated Press reported that a study conducted by the Public Citizen Research Group (a group associated with Ralph Nader and directed by Dr. Sidney Wolfe), revealed that PROs had not sanctioned any doctors in 23 states and the District of Columbia. According to Wolfe, those states "have more than one-fifth of the nation's Medicare doctors and serve more than six million Medicare beneficiaries." At a hearing in October 1987 before the House Energy and Commerce Health subcommittee, Wolfe stated: "The failure to use sanctions at all gives the signal that the peer review organization isn't very serious about doing disciplinary activity."

As of that time, as a result of recommendations made by PROs, the Department of Health and Human Services had fined 24 doctors and dropped another 53 from the Medicare system since late-1985, when the sanction program began. Another House panel had released PRO statistics suggesting that there may have been hundreds of thousands of instances of dangerous care given to Medicare patients since 1985, including up to 22,000 fatal cases.

111. Money for quality-of-care reviews by PROs was estimated at $468 million for 1986-88. Dr. Thomas Dehn, president of the American Medical Peer Review Association recommended that this amount be doubled, which would bring the PRO budget to .5% of Medicare spending, far short of the 5% most industries devote to quality control. Associated Press, Oct. 26, 1987.
not actively insist on enforcing their due process guarantees throughout the appeal process. If they did, then the government would be forced to defend its position, that is, the sides would polarize; lawyers would be hired and the expenses of such litigation would rapidly exceed whatever cost savings to the government the initial PRO sanction was supposed to engender.

Assuring doctors their due process rights makes it likely that they will need lawyers (guaranteed by the right to counsel) to represent them in the due process hearings on PRO recommendations. The adversarial legal process will be both an expense and a distasteful distraction to physicians. It is likely that physicians will accede to PRO recommendations more easily than they would if such legal expenses were not at stake. Physicians are not trained to have the same adversarial gusto as lawyers, and cannot be expected to welcome the opportunity to enter this fray when they are paying lawyers by the hour. Unless a physician feels that the PROs stance on a particular medical decision so threatens his future livelihood, or so increases his chances of being sued for malpractice, it is likely that the physician will accede to the PROs, if only to avoid the bureaucratic bother and expense of contesting its decision.112

Prior to the Peer Review Improvement Act of 1982, there had been virtually no restraints on government spending on Medicare/Medicaid since its inception in 1965.113 The Congressional acts discussed above, creating entities to monitor medical decisions, constitute one of the government’s desperate efforts to gain some measure of control over medical spending. In the process, a huge bureaucracy has arisen for the purpose of monitoring these excesses. That bureaucracy is itself an expense to the government and, like all bureaucracies, it tends to expand and perpetuate itself. The succession of acts and regulations augment the domain that the government will monitor, and thereby augment the bureaucracy performing the monitoring. Furthermore, the intricacies of the regulations promulgated under these laws require a whole new group of professionals to administer, decipher, and to assure compliance with or to contest them.

112. See McIlrath, All Sides Reporting Complaints About PRO Sanction Process, AM. MED. NEWS, Nov. 6, 1987, at 1; and Morford, PRO Program Must Continue to be True Peer Review, AM. MED. NEWS, Oct. 16, 1987, at 29, for a thorough discussion and analysis of peer review. See also Gosfield, PROs: A Case Study in Utilization Management and Quality Assurance, in 1989 HEALTH LAW HANDBOOK (1989), for additional discussion of PROs.

113. See generally Califano, supra note 6, at 44.
D. More Monitor Mania: Physicians Sanctioning the Physicians Who Sanction Physicians

If the sheer time and expense of participating in the peer review process were not sufficient discouragement to physicians, the prospect of the reviewing physician being sued by the reviewed physician for libel, slander, or conspiracy to restrain trade adds yet another disincentive for physicians to participation in peer review proceedings.

In the much-publicized case of Patrick v. Burget, the Supreme Court upheld a multi-million dollar jury verdict against a physician who had been involved in peer review activities. The defendant physician who revoked the surgical privileges of a local surgeon was found to have violated the antitrust laws, thereby incurring treble damages amounting to over two million dollars. The verdict generated a great deal of alarm and caused some physicians to decide that participating in hospital peer review was not worth the risk. It also gave physicians who suffered from adverse peer review actions the impetus to go to court to challenge those actions.

Whether or not the Patrick case does in fact pose an imminent risk of antitrust liability to physicians participating in peer review activities is questionable. Patrick is factually unusual and distinguishable from most cases on this issue because in the small town in Oregon where Dr. Patrick practiced, there were only two surgeons and one of them participated in the peer review that ultimately denied surgical privileges at the hospital to Dr. Patrick. The anti-competitive result of that peer review activity was clear: without surgical privileges, Dr. Patrick could not operate, leaving the other surgeon to monopolize the specialty in that town and surrounding area. Also, Dr. Patrick had refused to join the reviewing doctor's group practice. It was easy for the jury and the reviewing Court to find an anti-competitive motive of the doctor making the peer review decision.

However, neither physicians nor health-care legislators bothered to distinguish the Patrick case from the more usual situations. Across the country, repercussions from the Patrick decision led to

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115. Id. at 1666.
116. Id.
117. Id. at 1659.
118. Id. at 1661, 1666.
119. Id. at 1659.
fears that participation in good faith peer review could leave a physician open to multi-million dollar liability.\textsuperscript{120} The fear of treble damages would deter many physicians from participating in peer review activities.

\textbf{E. The Health Care Quality Improvement Act of 1986}

In another effort to give the peer review process a boost, and in order to counter the alarm generated by the treble damage verdict in the \textit{Patrick} case, Congress passed the Health Care Quality Improvement Act of 1986 ("HCQIA").\textsuperscript{121}

The HCQIA went into effect in November 1986 for the express purpose of encouraging doctors to participate in peer review activities.\textsuperscript{122} The idea behind it was that the government could improve the quality of care by encouraging physicians to identify and discipline other physicians who are incompetent or engage in unprofessional conduct.\textsuperscript{123}

One of the expressed assumptions of this law is that actual medical malpractice, not merely malpractice litigation, is increasing and that professional review can remedy that problem.\textsuperscript{124} Although the name of the statute emphasizes the "quality improvement" aspect

\textsuperscript{120} See Tambone v. Memorial Hosp. for McHenry County, Inc., 825 F.2d 1132 (7th Cir. 1987). The Tambone court stated that in the absence of "active state supervision" by Illinois in the peer review process, doctors participating in peer review were not immune from federal antitrust liability under the "state action doctrine" exemption from the Sherman Act. \textit{Id.} at 1135.

In spite of a state statute purporting to protect the participant in peer review from civil liability for damages arising out of the peer review process, ILL. REV. STAT. ch. 111, para. 4406, \textit{amended by} P.A. 85-661 (effective Sept. 20, 1987), the doctor could still be held liable in a federal antitrust action under the Tambone decision.

\textsuperscript{121} 42 U.S.C. §§ 11101-11152 (Supp. 1986).

\textsuperscript{122} 42 U.S.C. § 11101 (Supp. 1986).

\textsuperscript{123} 42 U.S.C. §§ 11101, 11151 (Supp. 1986).

\textsuperscript{124} Section 11101 provides as follows:

The Congress finds the following:

\begin{enumerate}
  \item The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrants greater efforts than those that can be undertaken by any individual State.
  \item There is a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance.
  \item This nationwide problem can be remedied through effective professional peer review.
  \item The threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional review.
  \item There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.
\end{enumerate}

of the legislation, it is clear that the act was also passed to help the government ease the way for physician input into the PROs which are monitoring the use of DRGs, the government's major cost-saving vehicle.

To that end, this act introduced a new body of legislation which sought to create immunities (primarily from antitrust liability, but also from libel or slander) for physicians who participated in peer review organizations and activities.\textsuperscript{125} The HCQIA provides immunity from damages under "any federal or state law" to two different categories of entities. One immunity is for those individual physicians who provide information to a "professional review body"\textsuperscript{126} regarding the competence or professional conduct of a physician.\textsuperscript{127} The other immunity is for the entities who take professional review actions against physicians.\textsuperscript{128}

A "professional review activity" is any activity of a health care entity which determines whether an individual physician may have a medical staff appointment or clinical privileges, and whether those privileges will be renewed, revoked, changed, or modified.\textsuperscript{129} In order for the immunities to be effective, the professional review actions must meet certain specified standards of reasonableness and due process.\textsuperscript{130} If an individual physician participates in a peer review activity, he will be protected from damage suits as long as the action taken by the reviewing body was taken in accordance with certain standards.\textsuperscript{131}

1. Impact of the Health Care Quality Improvement Act

The HCQIA is another body of legislation which seeks to protect and validate the already existing PRO legislation, which in turn, is responsible for monitoring the DRG system. That earlier legislative system would be worthless without the unfettered coop-

\begin{itemize}
  \item \textsuperscript{125} 42 U.S.C. §§ 11111, 11112 (Supp. 1986).
  \item \textsuperscript{126} A "professional review body" is defined as any health care entity, any governing body of the health care entity, or any committee of the health care entity which conducts professional review activity. 42 U.S.C. § 11151(11) (Supp. 1986).
  \item \textsuperscript{127} 42 U.S.C. § 11111(a)(2) (Supp. 1986).
  \item \textsuperscript{128} 42 U.S.C. § 11111(a)(1) (Supp. 1986).
  \item \textsuperscript{129} 42 U.S.C. § 11151(9) (Supp. 1986).
  \item \textsuperscript{130} 42 U.S.C. § 11112 (Supp. 1986).
  \item \textsuperscript{131} Those standards are that the action was taken: (1) in the reasonable belief that the action was in furtherance of quality health care; (2) after a reasonable effort to obtain the facts of the matter; (3) after adequate notice and hearing procedures are afforded to the physician involved; and (4) in the reasonable belief that the action was warranted by the facts known. 42 U.S.C. § 11112 (Supp. 1986).
\end{itemize}
eration of local physicians. Thus, the HCQIA attempts to support
the PROs.

A real question with regard to the HCQIA is whether the immu-
nities it provides will be sufficient to encourage physicians to ac-
tively participate in peer review functions, both in PROs and in
peer reviewing entities in their hospitals. Also, will that peer re-
view be used to further the government's purposes (i.e., no medi-
cally unnecessary admissions)? Soon after its passage, it appears
that this law may very well not have its intended effect.

Under the HCQIA, a physician who participates in peer review
activities cannot be held liable to the doctor who is the target of the
review on any grounds except those arising under the civil rights
statutes. 132 The law itself contains exceptions for civil rights based
actions, wherein the immunities it provides will not be in effect. 133
One possible conclusion of this is that any doctor participating in
peer review action which curtails the hospital privileges of a for-
egn-born, black, Hispanic, or female physician can be personally
liable to that physician for damages that arise from an abridgment
of that physician's civil rights. 134 If the targeted physician is a
white male, then his reviewer can commit libel, slander, and anti-
trust violations, and, under this legislation, will be immune from
damages.

The physician is left with a choice between participating in peer
review and risking personal liability, or not participating in peer
review and indirectly risking the hospital incurring liability for
negligent credentialing or respondeat superior. Why would any
sane physician participate in recommending summary action
against a doctor who falls into a class of people protected under
civil rights statutes? The HCQIA gives to any doctor whose privi-
leges are suspended or revoked a blueprint of just how his review-
ers can be personally liable to him. 135 In the broad exceptions that
it carves out, the HCQIA may very well defeat its own purpose by

133. Id. The immunities will not apply "under any law of the United States or any
State relating to the Civil Rights of any person or persons, including the Civil Rights Act
134. See Doe ex rel. Doe v. St. Joseph's Hospital, 788 F.2d 411 (7th Cir. 1986)
wherein a Korean-born female physician claimed that her hospital staff privileges had
been revoked because of her race, and sought damages from the hospital, the board of
directors, the president of the medical staff, and the members of the executive committee
of the medical staff. Id. at 413, 418. The Seventh Circuit Court of Appeals stated that she
could bring a claim under Title VII against her "peer reviewers." Id. at 425.
135. 42 U.S.C. § 11111(a), (b) (Supp. 1986).
ensuring a chilly response by physicians to peer review activities. Either a reviewing doctor would have to actually benefit by an adverse outcome against another doctor (e.g., financial, political, or administrative benefit), or the physician being reviewed would have to have committed indisputably egregious wrongs, for participation to be worth the aggravation and possible legal consequences. On the other hand, by immunizing certain participants in peer review from antitrust liability, the government may be paving the way for malicious, anti-competitive uses of the PRO process.

2. Creation of New Databank to Monitor Physicians

Perhaps even more significant from a “monitor mania” point of view is the provision of the HCQIA which provides for the creation of a national data bank for monitoring physicians. It establishes a national depository — a type of clearinghouse — of information regarding all physicians who have been subject to disciplinary or other actions for incompetence or professional misconduct. It requires that a “health care entity,” including medical malpractice insurers, hospitals, and state medical licensing boards, report all payments made in settlement or satisfaction of malpractice claims against physicians, in addition to reporting any corrective action which is taken against the physician (such as denial, revocation, suspension of staff privileges or any disciplinary or other action for incompetence or professional misconduct) to the state licensure boards. The state licensure boards, in turn, have to report these and any other actions they might take on a doctor’s license. Failure to make such a report to this national repository can cause the immunity created in the

136. The statute provides clearly delineated circumstances under which certain participants in the peer review actions will not be liable for damages under any law of the United States with respect to such peer review action. 42 U.S.C. § 11111(a)(1) (Supp. 1986). The statute specifically excludes certain types of actions from immunity: civil rights actions; actions initiated by governmental agencies; and actions by disciplined physicians for injunctive or declaratory relief for reinstatement of hospital privileges. Id.


138. Id.

139. A “health care entity” is defined broadly to include all licensed hospitals, HMOs, group medical practices, preferred provider organizations (“PPOs”), and any other entity which provides health care services and follows formal peer review for quality assurance. 42 U.S.C. § 11151(4)(A) (Supp. 1986).


other sections of the HCQIA to be lost.\textsuperscript{145}

The third part of the HCQIA gives particular legal importance to the data bank which will be generated by the reporting requirements. Pursuant to the HCQIA, hospitals are required to make an inquiry into the national depository for each new physician who applies for appointment to its medical staff or requests clinical privileges.\textsuperscript{146} Other doctors on the staff must be “checked out” every two years.\textsuperscript{147} The risk of not making this inquiry is that the hospital will be presumed to be on notice of any information contained in the data bank.\textsuperscript{148}

Although not specifically designed for this purpose, this section of the HCQIA creating the data bank will have a profound impact on medical malpractice cases. It will provide plaintiffs and their lawyers with a legal vehicle for bringing in the hospital in a malpractice action against a physician on the staff, on the grounds of “negligent credentialing.”\textsuperscript{149} If a hospital grants staff privileges to a physician who has been sanctioned in any way, who has settled a malpractice suit anywhere in the country (regardless of liability), who has had disciplinary proceedings instituted against him by any hospital or state board, who faces any adverse Medicare rulings, or who has been temporarily suspended for any reason, then that hospital might be guilty of negligent credentialing in any malpractice suit which might arise when that doctor is practicing at that hospital.\textsuperscript{150} “You [the hospital] were on notice that this physician might tend to be negligent, and you should have known better than to hire him,” the plaintiff will say; thereby implicating the hospital and gaining access to its “deep pocket.”\textsuperscript{151}

\textsuperscript{145} 42 U.S.C. § 11133(c) (Supp. 1986).

\textsuperscript{146} 42 U.S.C. § 11135 (Supp. 1986).


\textsuperscript{148} 42 U.S.C. § 11135(b) (Supp. 1986).

\textsuperscript{149} See infra notes 207-13 and accompanying text.

\textsuperscript{150} 42 U.S.C. § 11135(b) (Supp. 1986).

\textsuperscript{151} A letter in the \textit{New England Journal of Medicine} voiced another concern about other potential problems which such a “big brother” data bank will pose:

For example, a competent physician who has been sued, perhaps frivolously, and who settles the case out of court at the insistence of his insurance carrier would be noted as having been involved in a question of malpractice. If that physician decided to move to a more rural part of the country — where there was relatively little malpractice litigation and where competition for patients was keen — the local peer review board might decide to withhold hospital privileges under the guise of maintaining high standards of medical care in the community. This anticompetitive action is exempt from antitrust laws under the new statute.

The effect of this is that hospitals will be extremely reluctant to grant staff privileges to any physician whose staff privileges have been terminated anywhere. From the physician's perspective, this national data bank will facilitate "blackballing" of physicians. Once privileges have been terminated at one hospital, the physician will have an extremely difficult time relocating at any other hospital.

F. Government Monitoring of Physician Fees

Another area of monitoring physicians into which the government has inserted itself is physician's fees. The Deficit Reduction Act of 1984 created the "Medicare Participating Physician Program," which basically established a contract between the government and doctors who treat Medicare/Medicaid patients. In return for participating in the Medicare/Medicaid program (by receiving money from the government), the physician had to agree that he would accept assignment for goods and services reimbursed by Medicare/Medicaid, and that he would not charge more to Medicare/Medicaid patients than Medicare/Medicaid reimburses on those cases. The statutory reimbursement formulas are complex and vary from doctor to doctor, depending on what the doctor has charged historically and what Medicare has determined to be the "prevailing charge" for that treatment. The Act also created a fee freeze for a one-year period and provided disincentives to non-participating doctors, such as reduced coverage of their patients.

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153. Id.

154. Id. Incentives for physicians to join the participating physician program, and accept as payment in full what they receive from Medicare, include government publication of a list advertising physicians who participate. See Deficit Reduction Act of 1984, Pub. L No. 98-369, div. B, title III, § 2306(c), 98 Stat. 494, 1071. At the time this law was passed, it was estimated that 30-50% of all doctors charged their patients more than Medicare's reimbursement fee. See Bitter Pills for Medicare, TIME, July 9, 1984, at 21.

155. The operational rules regarding what services are covered by Medicare Part B, who may provide them, the formulas by which Medicare reimbursement amounts are to be determined, and how payment is made are found in the Regulations of the Health Care Financing Administration, 42 C.F.R. Chapter IV, and the Medicare Part B Carriers Manual, issued as the HCFA Publication 14-3. The Medicare Regulations have the force of law, but the Carriers Manual does not. Its instructions are, however, binding on carriers as part of their contract with HCFA.

For a thorough discussion of the intricacies of these regulatory provisions, see Weiland, Medicare Reimbursement of Physicians, in 1989 HEALTH LAW HANDBOOK (A. Gosfield ed. 1989).

156. This original fee freeze has been extended various times. They have always met
The Omnibus Budget Reconciliation Acts ("OBRA") of 1986\textsuperscript{157} and 1987\textsuperscript{158} brought further refinements to the participating physician program, making it more complicated to administer, and fostering more reimbursement disputes.\textsuperscript{159} Because approximately fifty million people are covered by Medicare/Medicaid,\textsuperscript{160} refusal to play by the government's rules puts a doctor at a significant disadvantage. Some doctors strive to maintain a practice purely comprised of privately insured or self-paying patients so as to not have to bother with the government monitoring. But it is difficult to exclude from one's practice all people over age sixty-five and all people on Medicaid. Such a practice is not only discriminatory and contrary to the Hippocratic oath, but it excludes a substantial percentage of the potential patient population.

The salient point of these acts is that they demonstrate more examples of the government flexing its monitoring muscle against doctors, toward the ostensible end of saving money. In so doing, the government has set up another bureaucracy and generated a whole category of litigation over reimbursement disputes which

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\textsuperscript{157} 42 U.S.C. § 1395u (Supp. 1986).

\textsuperscript{158} Pub. L. No. 100-203, 101 Stat. 1330.

\textsuperscript{159} For a thorough discussion of the myriad of reimbursement issues and disputes generated by this legislation, see AMA v. Bowen, 857 F.2d 267 (5th Cir. 1988). In Bowen, seven doctors and three medical societies representing physicians nationally challenged the provisions of section 9331 of OBRA of 1986 which changed the prior "reasonable charge" basis of reimbursement to substitute a new "maximum allowable actual charge" ("MAAC"). 42 U.S.C. § 1395u(j)(1)(B)(i) (Supp. 1986). Bowen, 857 F.2d at 268-69. The MAAC required an individual calculation by every physician for every medical service. Id. at 269. The court did acknowledge that "[t]o say that the calculation of individual MAACs by every physician for every medical service that may be performed (some 10,000 in all) is complex is to understate the matter ridiculously." Id. The court, however, declined to rule on the challenge, leaving the complex reimbursement formulas for physicians and their accountants to wrestle with. Id. at 272. For a discussion of legislation and how it affects physicians, see Wisconsin Department of Health and Social Services v. Bowen, 797 F.2d 391 (7th Cir. 1987); AMA v. Bowen, 659 F. Supp. 1143 (N.D. Tex. 1987). See also Deel v. Jackson, 862 F.2d 1079 (4th Cir. 1988); Burlington Memorial Hosp. v. Bowen, 644 F. Supp. 1020 (W.D. Wis. 1986).

For problems and disputes arising from calculating Medicaid rates of reimbursement, see Virginia Hospital Association v. Balles, 868 F.2d 653 (4th Cir. 1989). See also Bowen v. Michigan Academy of Family Physicians, 476 U.S. 667 (1986); Isaacs v. Bowen, 865 F.2d 468 (2d Cir. 1989) (challenging the Medicare reimbursement procedures from the claimant's perspective).

\textsuperscript{160} In 1986, 31,768,000 people enrolled in Medicare and 22,337,000 enrolled in Medicaid. \textit{Statistical Abstract of the United States}, supra note 6, at table 578.
arise out of the complex statutory provisions upon which payment and the differing rates of payment of physicians depend. 161 Certain-
ly, whatever money that might be saved by the provisions of the Deficit Reduction Act of 1984 and OBRA 162 is eaten up, if not exceeded by the sheer expense of administering the complex pro-
gram and defending the government's position in the disputes which arise under it.

1. Impact of the "Medicare Participating Physician Program"

For physicians, the Deficit Reduction Act of 1984 has imposed unfair, confusing, incomprehensible, and burdensome reimburse-
ment formulas, prompting one court to dismiss the reimbursement formulas as something that "only legislators and accountants can appreciate." 163 In its regulation of physician's fees, the govern-
ment has created a statutory morass. 164 The laws not only distract and outrage current medical practitioners, but they exert a far-
reaching impact on future generations of physicians. As one re-
porter noted: "Given the intricacy, intrusiveness and constant fluctuations of these price control measures, it is no wonder that top students are being deterred in droves from applying to medical schools." 165

The difficulties and inequities generated by these variable formu-
las prompted the federal government to suggest the instituting of DRG-type flat fees for physicians and the services they perform.


162. Because Medicare paid out $35,699,000 in 1980, and $75,997,000 in 1986, and Medicaid paid out $23,311,000 in 1980, and $40,805,000 in 1986, the Deficit Reduction Act of 1984 had a minimal impact, if any, on government expenditures.

163. Bowen, 857 F.2d at 269.

164. To get a sense of the mirky depths of this morass, note the following:

Each doctor's MAACs must be calculated for each procedure he performs for a Medicare patient. First, the doctor must determine whether he submitted charges to Medicare for the particular service (classified from among approxi-
mately 10,000 service codes) in the second quarter of 1984. If so, his MAAC for that base period on that service is computed by comparing his actual charge billed to Medicare patients during that base period with 115% of the current year's 'prevailing charge.' The 'prevailing charge,' in turn, depends on the 1973 rate for services updated by the Medicare Economic Index and adjusted locally by Medicare carriers on a procedure-by-procedure basis. The carriers normally maintain 'prevailing charge' information. If a doctor finds that his 1984 base period actual charge equals or exceeds 115% of the prevailing charge for non-participating physicians, the MAAC is 101% of the base period charge. 42 U.S.C. § 1395u (j)(1)(C). If his base period actual charge is less than 115% of the prevailing charge, a different formula applies.

165. Id. at 269 n.3. And the variations are endless.
However, the prospect of a prospective payment system for physicians was virtually abandoned because of the insurmountable difficulties in arriving at fair fees based on diagnoses. The AMA is currently working with the federal government in preparing a comprehensive fee schedule for physician procedures which takes into account factors such as the difficulty of the medical service, the cost to the physician, his/her expenses (i.e., rent), and his/her number of years of education and training.\footnote{AMA, Dep't of Federal Legislation.} It is hoped that such a fee schedule will be fair to physicians, and will enable the government to have a predictable, fixed rate of reimbursement for physician services.

\textbf{G. Government Monitoring of Physician Contracts: Medicare Fraud and Abuse Statutes}

The Medicare fraud and abuse statutes\footnote{42 U.S.C. § 1395nn(b) (1983).} constitute another large, complex body of legislation which attacks practices that tend to expand the costs to the government from the Medicare/Medicaid programs.\footnote{Many articles and periodicals thoroughly discuss the intricacies of these statutes. See, e.g., Anderson, \textit{Medical Profession Perspective}, in \textit{MEDICARE FRAUD \\ & ABUSE: UNDERSTANDING THE LAW}, 129-32 (1986); Teplitzky, Holden \\ & Sollins, \textit{Medicare and Medicaid Fraud and Abuse}, in 1989 \textit{HEALTH LAW HANDBOOK} (A. Gosfield ed. 1989); Hyman \\ & Williamson, \textit{Fraud and Abuse: Regulatory Alternatives in a "Competitive" Health Care Era}, 19 \textit{LOY. U. CHI. L.J.} 1133 (1988).} As noted previously, the PRO program seeks to monitor costs by standardizing them and ensuring that those standards, DRGs, are properly adhered to.\footnote{See supra notes 44-77 and accompanying text.} The reimbursement laws discussed in the above section seek to enable the government to get a handle on rates of physician reimbursement. The fraud and abuse statutes, on the other hand, seek to suppress referral fees or any other arrangements which tend to encourage the ordering of goods or services for which payment may be made under Medicaid or Medicare.\footnote{42 U.S.C. § 1320a-7b(b) (Supp. 1986). The basic principles embodied in the legislation are prohibitions against practices which tend to encourage the use of the Medicare/Medicaid program. Practices prohibited are those which:

\begin{enumerate}
\item Offer payment, solicitation, or receipt of any remuneration for:
\begin{enumerate}
\item Referral of patient for furnishing of items or services for which payment may be made under Medicare or Medicaid; and
\item Purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made under Medicare or Medicaid.
\end{enumerate}
\end{enumerate}
\textit{Id.}} The purpose behind the fraud and abuse statutes is to protect the Medicare/Medicaid program from overuse by health
care providers.\footnote{171} At a time when hospitals and HMOs are feeling a financial squeeze, there is real competition among hospitals to lure onto their staffs doctors who have large practices with patients who can pay privately or who present profiles of the kind of patient from which the hospital can make a profit from their DRG reimbursement.\footnote{172} Hospitals have devised infinitely variable incentive programs as a physician recruitment tool, and it is these programs — which contain little or no element of fraud or abuse — that are regulated by the fraud and abuse statutes\footnote{173} because they can be interpreted as arrangements which encourage utilization of the Medicare program.

Similarly, hospitals and doctors have entered into physician-hospital joint venture arrangements which have come under the purview of the fraud and abuse statutes inasmuch as they often encourage investor-physicians to refer patients to the hospital.\footnote{174} The government’s sense of urgency in examining these arrange-

\footnote{171. The protection afforded may be too little, too late, because billions have already been bilked from the system, with a variety of culprits. A recent task force including members of the Justice Department, the HCFA, and the OIG of the DHHS have recently uncovered what may be the largest financial scandal in the history of Medicare: “the misspending of as much as $10 billion in Medicare funds over the past six years.” Pound & Bogdanich, Has Medicare Paid Out Billions Actually Owed by Private Insurers, Wall St. J., Apr. 7, 1989, at 1, col. 6. That article points out that approximately one million people have this coverage: they are over the age of 65 and qualify for Medicare, and they remain on the job and are eligible for private health insurance. \textit{Id.} Although Medicare is supposed to only be a “secondary insurer,” and pay only for expenses not covered by private insurance, Medicare continues to pay many claims that should have been covered by private insurers, including workers’ compensation, accident insurance, and group health plans. The administration of Medicare, however, has often been turned over to the very insurance companies that stood to benefit from the erroneous overpayments (i.e., they pay less if Medicare overpays). Those companies have “overlooked” Medicare over-payments that benefit them. \textit{Id.}

\footnote{172. See Perry, \textit{U.S. Hospitals Wooing Superstar Physicians}, 18 \textit{Modern Health Care} 24 (Jan. 1988).}

\footnote{173. See \textit{GAO Rep. to the Chairman, Subcommittee on Health, Committee on Ways and Means, H.R., Medicare; Physician Incentive Payments by Hospitals Could Lead to Abuse}, GAO/HRD-86-103 (July 1986). \textit{See also Dechene, Hospital Programs to Attract and Retain Physicians, in 1989 Health Law Handbook,} for a thorough discussion of the statutory constraints on physician recruitment arrangements.

\footnote{174. Hyman & Williamson, \textit{supra} note 168, at 1149. \textit{See also Burda, Law Aimed at Curbing Medicare Fraud May Have Chilling Effect on Joint Ventures, 17 Modern Healthcare} 92 (Oct. 9, 1987). Another regulator, the Internal Revenue Service, also examines those joint venture contracts (primarily from the hospital’s perspective) to see if they are in furtherance of the hospital’s general, charitable purpose, or if they are primarily for the benefit of a private individual (profit for the health care provider), in which case the contract might threaten the hospital’s tax-exempt status as a charity. See I.R.C. § 501(c)(3) (1986); Treas. Reg. § 1.501(c)(3)-1(c)(2), 1.501(c)(3)-1(c)(1) (1986). \textit{See also Bromberg, Tax Exemption and Public Charity Status: An Update on Current Develop-
ments is supported by a recent study, conducted by the Department of Health and Human Services, which showed that physician-joint venturers and investors in laboratories order 45% more lab tests for their Medicare patients than do the rest of the physicians, who have no financial incentive to do so.175

Thus, the fraud and abuse laws provide the government with a vehicle to monitor the contractual relationships between doctors and institutions.176 The ingenuity of lawyers has been taxed, and numerous seminars are held on how to structure physician recruitment, incentive programs, and joint ventures between physicians and health care organizations so as to simultaneously skirt the constraints of the fraud and abuse laws and not jeopardize the hospital’s charitable tax status.177

In order to help interpret and construe the fraud and abuse statutes, various governmental agencies issue regulations, guidelines, and letters to give guidance to health care providers. There are Medicare manuals,178 and intermediary letters from HHS179 and HCFA.180 In addition, the passage of the Medicare and Medicaid


177. See Bromberg supra note 174. See also Dechene, supra note 173, at 467; Teplitzky, Fraud and Abuse in the Medical Staff Setting, Speech to ABA, Section on Tort and Insurance Practice, “Medical Staff Update” (Chicago, Ill. Nov. 11-12, 1989); National Health Lawyers Ass’n Convention, Tax Planning for Nonprofit Health Care Organizations (San Francisco, Cal. Oct. 12-13, 1989).

178. Medicare manuals are provided by HCFA to intermediaries and carriers who administer payments to hospitals and physicians. The manuals contain guidelines for all aspects of the Medicare program.

179. Intermediary letters are policy statements from HHS and HCFA to carriers and intermediaries intended to alert them as to activities, if discovered, which should be reported to HCFA.

180. The Medicare and Medicaid Guide (CCH) ¶ 13,170 (1988) states the mission of Health Care Financing Administration:

to administer the Medicare and Medicaid programs and related provisions of the Social Security Act in a manner which (1) promotes the timely and economic delivery of appropriate quality health care to eligible beneficiaries, (2) promotes beneficiary awareness of the services for which they are eligible and improves the accessibility of those services and (3) promotes efficiency and quality within the total health care delivery system.

Id.
Patient and Program Protection Act ("MMPPPA")\textsuperscript{181} created authority in the Secretary of HHS to issue regulations specifying legal payment arrangements.\textsuperscript{182}

From the physician's perspective, these agencies and their varying policies and interpretations of law present a convoluted, confusing and constantly fluctuating notion of which practices are legal and which are not. The physician's freedom to enter into contracts which might ordinarily appear to be a purely capitalistic response to a competitive squeeze is sharply curtailed by these extensive laws. Both hospitals and doctors are "hamstrung" from responding and adapting freely to difficult financial times.\textsuperscript{183}

This vast body of legislation, and the continuously-evolving regulations promulgated under it, constitute a maze-like body of regulations which intrude into the most private business affairs of physicians. The many entities involved in promulgating regulations and those which have arisen to assist in compliance with them make it doubtful whether these laws are accomplishing their purpose of saving the government money and sharply curtailing the overutilization and abuse of the Medicaid/Medicare entitlements.\textsuperscript{184}

V. PRIVATE ASSOCIATION MONITORING

A. The American Medical Association: Physicians Monitoring Physicians

The AMA tries to represent the best interests of the medical profession.\textsuperscript{185} Understandably, the AMA has been less than enthu-


\textsuperscript{182} Id.

\textsuperscript{183} See Burda, supra note 174; Teplitzky, Avoiding Fraud and Abuse Problems in Joint Ventures, \textit{4 Health Span} 17 (Jan. 1987); see also Schorr, Health Care Business Deals: Kickbacks or Capitalism? \textit{Health Pol'y Week Special Rep.} 3 (Apr. 11, 1988).

\textsuperscript{184} Hyman & Williamson, supra note 168, at 1195. Hyman and Williamson conclude that enforcement of all the regulations under the fraud and abuse statutes is "counterproductive and will impede the restructuring of the health care industry along more efficient and cost-effective lines." \textit{Id.}

For a practitioner's guide to the fraud and abuse statutes, see Teplitzky, Holden & Sollins, supra note 168.

\textsuperscript{185} Historically, the AMA was dedicated to the education of physicians and the improvement of the quality of medical practice in the United States. It was the AMA which originated the notion of accreditation of medical institutions, and it was one of the founding members of the Joint Commission on Accreditation of Hospitals (currently known as the Joint Commission of Accreditation of Health Care Organizations). AMA, Division of Quality Assurance.
tic about the federal government's aggressive entrance into the field of regulating physicians.\textsuperscript{186} That entrance bespeaks a criticism that not only have physicians failed to adequately police themselves, but the state government who is charged with policing them has not done so adequately. This federal governmental interference was precisely what the AMA feared when it originally opposed Medicare and Medicaid in the early 1960s.\textsuperscript{187}

One area of governmental regulation which is particularly objectionable to physicians is the government's assumption of a role in adjudging competence of physicians, and setting up bureaucratic systems which claim to monitor competence.\textsuperscript{188} In an effort to stave off further governmental intrusion into the problems of "weeding out" incompetent physicians, and also in response to accusations that doctors have not done enough to police their own ranks,\textsuperscript{189} the AMA has recently increased its involvement in physician monitoring.

In 1986, the AMA introduced a new, updated data file, known as the "Masterfile," which contains information about individual physicians, including hospital disciplinary proceedings as well as actions by state boards and DHHS.\textsuperscript{190} Plans for this data bank preceded the Health Care Quality Improvement Act data bank, which will contain much of the same information.\textsuperscript{191}

The AMA also took steps in 1986 to monitor so-called "impaired" physicians: those with alcohol and drug problems, as well as mental illness.\textsuperscript{192} It began a three-year program to develop a

\textsuperscript{186} See Federal Role in MD Licensure Chilling, \textit{AM. MED. NEWS}, Apr. 8, 1988, at 23.

\textsuperscript{187} See supra note 13 and accompanying text. Despite the AMA's original opposition to the federal government's interference with the practice of medicine, the AMA quite clearly wants the federal government to keep up its funding role — there can be no turning back to the days when doctors treated all indigents free of charge — but it bristles at the extent to which governmental bureaucracies seem to be invading medical domains.

\textsuperscript{188} See supra Section IV for a discussion of governmental regulations.

\textsuperscript{189} This is a frequent claim of plaintiff lawyers and consumer groups who argue that the rise in malpractice litigation in the last 15 years is attributable to an actual increase in medical malpractice, due to a failure of doctors to self-police. See supra note 22 and accompanying text. This claim was written into the introduction to the Health Care Quality Improvement Act, though no effort was made to substantiate it. See supra notes 121-25 and accompanying text for a discussion of the HCQIA.

\textsuperscript{190} See American Medical Association Board of Trustees, \textit{AMA Initiative on Quality of Medical Care and Professional Self-Regulation}, 256 J.A.M.A. 1036 (1986).

\textsuperscript{191} See supra notes 137-51 and accompanying text for a discussion of the data bank requirements of the HCQIA.

\textsuperscript{192} See \textit{A New Program to Assist Impaired Physicians}, \textit{AM. MED. NEWS}, Nov. 4, 1986, at 4.
data base on impaired physicians. The goal of the program is to better define what "impairment" actually is, and to foster research and control programs.

In addition, the AMA is working on quality of care guidelines; in effect, setting basic standards for medical care. To this end, a new department has been set up, whose goals are to specify what are appropriate standards of care (i.e., protocols). Currently, two bills relating to the development of such practice guidelines are before Congress. The AMA, which in this situation is probably representative of virtually all physicians in America, feels that the development of medical practice guidelines, if they must be standardized, should be done by physicians — not nurses or medical paraprofessionals, and certainly not government bureaucrats.

The AMA is also in the process of setting up uniform fee schedules for procedures. Whereas DRGs are prospective, based on the experiences of hundreds of hospitals around the country, what constitutes a fair fee for physicians must be evaluated in terms of the level of training and expertise necessary to perform it, the difficulty of the procedure, the rent, the office expenses, and a variety of other factors. The AMA, while protesting the application of DRGs by the federal government to physicians, has come up with an alternative fixed payment fee schedule that it hopes will more accurately represent a fair fee, for Medicare purposes, than the government would otherwise impose on them.

193. Id.
194. Id.
195. Dr. John Kelly at the AMA heads the Quality Assurance Department which is responsible for creating these protocols. According to Dr. Kelly, lawyers are afraid that these standards will create legal standards of care which can be used against physicians in malpractice litigation, but this is not their intended purpose. Their purpose is to enumerate specific steps that should be taken by medical practitioners in different specialties when faced with different medical problems. The AMA, in conjunction with specialist medical societies, is undertaking a vast, comprehensive development of practice guidelines which will set basic standards for medical care. Dr. Kelly stated that there is evidence that when such protocols exist, and physicians follow them, quality of care goes up and malpractice goes down.


According to Dr. John Kelly of the AMA, see supra note 195, the AMA supports the Mitchell Bill because it allows physician organizations to set their own practice guidelines.
Monitor Mania

While the AMA is trying on the one hand to prevent the government from deciding what are fair fees by forming its own fair fee formulas, on the other hand it wants the government to stay involved in "shelling out" money for doctors. In fact, the AMA consistently takes positions that require more government money: it asks for increases in physician reimbursement rates for Medicaid patients, as well as for funding for the creation of the medical practice guidelines.

B. Joint Commission on Accreditation of Health Care Organizations: Ensuring that Hospitals Monitor Physicians

The Joint Commission on the Accreditation of Health-Care Organizations ("Joint Commission") is a private, not-for-profit organization which traditionally has set standards for hospital management. It gives an official "stamp of approval" accreditation to hospitals which comply with its extensive guidelines on how hospitals and medical protocol in such hospitals should be managed. The Joint Commission publishes a manual that sets out guidelines that hospitals must follow in order to receive accreditation by that organization. These guidelines are primarily concerned with the policies and procedures which are followed in the structure and operations of hospitals and other health-care organizations. Their concern is efficiency of operation, quality of health care, and the creation of systems and procedures which will most likely foster those ends.

Almost every section of the manual directly impinges on some aspect of monitoring of physicians. The quality assurance obligations of a hospital constitute the most comprehensive monitoring mandates of the Joint Commission. As a prerequisite to accreditation, the Joint Commission requires that a hospital or health care organization have an "ongoing quality assurance program designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care, pursue opportunities to im-

197. See Expansion of Medicaid is Proposed, supra note 15.
198. See supra note 196.
200. JOINT COMMISSION ON THE ACCREDITATION OF HEALTH CARE ORGANIZATIONS, ACCREDITATION MANUAL (1988) [hereinafter ACCREDITATION MANUAL].
201. Id.
202. Id.
prove patient care, and resolve identified problems.  

In addition, the Joint Commission requires hospitals to have administrative mechanisms which monitor and evaluate virtually every aspect of all activities that take place in a hospital — from surgical case reviews, monitoring of radiological services, ambulatory care services, emergency room services, pathology and laboratory services, and medical record keeping, to monitoring and evaluating of staff appointments. Physicians and their medical performance are most directly monitored via the required quality assurance, utilization review, credentialing and staff reappointment, and reappraisal reviewing entities, which are usually medical staff committees. Thus, the Joint Commission is monitoring the hospital to ensure that the hospital has mechanisms in place for the adequate monitoring of physicians.

VI. PRIVATE INSTITUTIONAL MONITORING

Compliance with the Joint Commission standards brings a hospital accreditation, but in addition, a hospital must comply with local state licensing laws in order to receive a license. Virtually all states have hospital licensing acts which delineate the systems which must be in place in hospitals for the review and monitoring of physician decisions as a condition for licensure of hospitals. When put into practice, these systems constitute another host of entities in the private institution which have the same basic raison d'être as many of the above-discussed monitoring entities: to monitor physicians, their decisions, their treatment plans, and their practices.

A. Hospital/Health-Care Provider Institution
   as Reviewer of Physicians

In order to comply with state licensing laws, the Joint Commission and federally mandated DRGs (reviewed by PROs), hospitals and other health care providers have had to adapt and alter their administrative procedures to encourage doctors to do less, rather than more medical procedures. To do so, monitoring entities

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203. Id. at 235.
204. For the full gamut of monitoring and evaluating committees and mechanisms which are required within a hospital, see id.
205. The Accreditation Manual provides the most exhaustive and detailed guidelines for setting up hospitals. It is a Bible for any hospital administrator, hospital lawyer, or hospital management consultant.
which already existed for risk management objectives (and to comply with Joint Commission standards) began to assume the role of “in-house” monitoring of physicians’ practice patterns. The committees in hospitals — credentials committee, quality assurance committee, medical staff association, executive committee, utilization review committees — all conduct professional review activities. They were already in existence to help monitor quality of care to try to minimize risks of liability to hospitals in medical malpractice situations. Now, their orientation has been forced to have a decidedly financial objective as well.

1. Credentialing and Quality Assurance: Physicians and Nurses on Staff Reviewing Physicians on Staff

As a prerequisite to obtaining malpractice insurance, and in order to receive accreditation and comply with applicable state laws, health care provider organizations must maintain committees of their medical staff whose purpose is to review the credentials of physicians who are appointed to the staff or whose privileges are up for renewal.207 The details of the procedures necessary for being appointed on staff are usually set forth in the hospital by-laws.208 Within the hospital, there are at least two committees of physicians which review the applicant physician’s credentials prior to initial appointment.209 Prior to the renewal of medical staff privileges, more committees may be involved in the reappointment process because input on the physician’s behavior can come from the department chairman, the utilization review committee, or the sur-

207. See ACCREDITATION MANUAL, supra note 200, at 235-38.
208. Extensive questions are asked in the application process regarding the physicians complete chronology and medical training, his/her criminal and psychological record, and proof of malpractice insurance coverage. The applicant usually has a personal interview with a member of the credentials committee and the application, with letters of reference and verification of facts are reviewed by the credentials committee. The credentials committee issues a report, and the entire package of materials is reviewed by the medical executive committee, which then makes a recommendation to the governing board of the hospital. If the governing board is going to deny the application, it holds a hearing with the physician prior to doing so. See generally Shields & Turk, Credentialing and Utilization Review, in First Annual Health Care Law Conference presented by the INSTITUTE FOR HEALTH LAW of Loyola University of Chicago School of Law and the ILLINOIS INSTITUTE FOR CONTINUING LEGAL EDUCATION (1986).

For a credentialing decision, physicians are reviewed on such subjects as: blood use review; medical records review; surgical case review; drug usage review; monitoring and evaluation of emergency services; monitoring and evaluation of pathology and medical laboratory services; and monitoring and evaluation of radiology services. See ACCREDITATION MANUAL, supra note 200, at 235-38; see also Shields & Turk, supra.
209. The credentialing committee and the medical staff executive committee.
The hospital administration has a strong interest in having the physicians on staff performing their credentialing reviews conscientiously. One of the bases of expanding the liability of hospitals in medical malpractice suits has been the theory of "negligent credentialing" — that through a thorough investigation of the physician's background, the hospital knew or should have known that he was likely to be a "negligent" doctor. The failure to identify an incompetent physician through the credentialing process, when information was available that might have demonstrated some index of suspicion, and/or failure to act on that information by terminating, disallowing, or abridging the doctor's staff privileges, could render the hospital liable for any malpractice by that doctor.  

Trustees of hospitals may be found individually liable if the hospital is on notice of the doctor's negligent propensities and the hospital negligently renews his staff privileges. Therefore, hospitals have encouraged more assiduous efforts by the credentialing committees (composed usually of physicians already on staff) in reviewing other physicians on staff and those applying for staff membership.  

Between the AMA Masterfile and the national data bank es-
established by the passage of the HCQIA in 1986\textsuperscript{215} (but not yet operational), a credentials committee will have little excuse for not knowing about a physician's prior PRO or Medicare sanctions, license or privilege suspensions or terminations, or state and hospital disciplinary actions. Thus, all hospitals, HMOs, or private institutional health care providers which allow physicians on staff will be on notice of all the information contained in those data banks. The investigative, physician-monitoring responsibility of the credentials committee, set out in the hospital by-laws which must comply with the Joint Commission guidelines for credentials committees, has long existed. These data banks will merely facilitate the work of credentials committees, which will now be able to look in one place for evidence of any kind of sanction or judgment that has been placed against a physician in any state.\textsuperscript{216}

In addition, this data bank probably will provide a prima facie standard for hospital negligence in medical malpractice lawsuits. If incriminating data were in the data bank and the credentialing committee failed to discover it, a prima facie case for negligent credentialing could be made out.\textsuperscript{217} Conversely, if nothing were in the data bank, and the hospital had no other reason to be put on notice of a physician's likelihood to perform below the reasonable standard of care, then the hospital would have the defense that it did not know nor have reason to know of the physician's likelihood to commit malpractice.\textsuperscript{218}

By 1983, when the DRG and prospective payment system became the law, credential committees in hospitals throughout the nation took on a peer review type function which was apart from the original "risk management" function of the credentialing committee. Credential committees began to examine a doctor's credentials from a different point of view. The committees considered not only the competency or qualifications of the doctor, but they began to focus on how conservative the doctor's practice patterns are. The committees now also must address such questions as: Does

\textsuperscript{215} See supra note 138 and accompanying text.

\textsuperscript{216} This is in addition to the AMA's "Masterfile." See 42 U.S.C. §§ 11131-11137 (Supp. 1986); see infra note 190.

\textsuperscript{217} See Annotation, Hospital's Liability for Negligence in Selection or Appointment of Staff Physician or Surgeon, 51 A.L.R.3d 981 (1973).

\textsuperscript{218} See, e.g., Johnson v. Misericordia Community Hospital, 99 Wis. 2d 708, 301 N.W.2d 156 (1981) for a discussion of the standard for holding a hospital liable to an injured patient for the negligence of a doctor on the independent medical staff. In Johnson, the hospital failed to make reasonable efforts to investigate the doctor's qualifications before appointing him to the staff, and was charged with having such knowledge as it would have had if it had made such an investigation. Id. at 745, 301 N.W.2d at 175.
the doctor tend to admit patients who are so sick they need to overstay their DRGs? Has the doctor conformed to hospital policies that now reflect cost-containment priorities in medical practice? The physician reviewers on the credentialing committees must now help the hospital further its cost-containment mandate.\textsuperscript{219}

The case of \textit{Friedman v. Delaware County Memorial Hospital}\textsuperscript{220} is an example of a doctor who did not do the "about face" in practice patterns, which prompted the credentials committee to deny him renewal of staff privileges.\textsuperscript{221} Dr. Friedman, a pulmonologist, continued to do bronchoscopies for therapeutic as well as diagnostic purposes after the hospital policy had been changed to disallow therapeutic bronchoscopies.\textsuperscript{222} Because of repeated violations of hospital policy (i.e., repeated performances of therapeutic bronchoscopies), the credentialing committee refused to renew his staff privileges.\textsuperscript{223}

The express holding of the \textit{Friedman} case was that the antitrust laws could not protect the doctor from non-renewal.\textsuperscript{224} But this holding begs one very interesting issue in the case. When DRGs no longer covered bronchoscopies for therapeutic purpose,\textsuperscript{225} the appropriate policy committee had changed the hospital policies to limit bronchoscopies to almost purely diagnostic purposes.\textsuperscript{226} When the pulmonologist continued to use bronchoscopies for therapeutic reasons, he lost money for the hospital.\textsuperscript{227} His privileges were revoked and numerous instances of disobeying hospital policy were cited.\textsuperscript{228} There was no suggestion that the doctor performed

\textsuperscript{221} \textit{Id.} at 173.
\textsuperscript{222} \textit{Id.} at 178.
\textsuperscript{223} \textit{Id.} at 179.
\textsuperscript{224} The court refuted the argument that the hospital and the medical staff committee "conspired" to restrain trade. \textit{Id.} at 193. The court found that the medical staff committee was operating as an agent of the hospital, and that no conspiracy can exist between principal and agent. \textit{Id.} Also, there was no proven restraint of trade because the defendant had not been precluded from access to the rest of the hospitals in the area, nor was there any intent or effort on the part of the hospital to deny him such access. \textit{Id.} at 188-90.
\textsuperscript{225} In fact, bronchoscopies had been singled out as being a procedure which was overutilized, and the Omnibus Budget Reconciliation Act targeted bronchoscopies, among 11 other procedures, for special reductions in prevailing fees, citing them as particularly "overpriced."
\textsuperscript{226} \textit{Id.} at 184.
\textsuperscript{227} \textit{Id.} at 180.
\textsuperscript{228} \textit{Id.}
them in a negligent manner, only that he performed them too liberally.\textsuperscript{229}

It can be surmised that Dr. Friedman's liberal use of the procedure\textsuperscript{230} had been disliked but tolerated by the hospital for as long as the hospital had been reimbursed on a "reasonable cost" basis. This liberal practice pattern, however, was no longer compatible with DRGs and the prospective reimbursement system. Those same monitoring entities, which had previously tolerated Dr. Friedman's history of uncalled for bronchoscopies, were prompted to take action.\textsuperscript{231}

"Monitor mania" is reflected in the sheer number of monitoring entities needed to revoke Dr. Friedman's privileges for use of bronchoscopies for therapeutic purposes. This case provides a good example of the myriad of entities which exist within the hospital through which physicians and non-physicians monitor other physicians. At least twelve committees or entities in the hospital reviewed Dr. Friedman's practice patterns.\textsuperscript{232}

Dr. Friedman may have been excessively zealous in the use of bronchoscopies, but there still remain many instances where a bronchoscopy legitimately may be the preferred mode of treat-

\textsuperscript{229} Id. at 189. The bronchoscopies were performed so liberally, in fact, that an in-house and an outside blind audit of Dr. Friedman's files found that over one-half of his bronchoscopies were not indicated and had insufficient lab test results to justify their performance. \textit{Id.} at 186.

\textsuperscript{230} At one point, Dr. Friedman apparently performed a therapeutic bronchoscopy on a patient who had already died. \textit{Id.} at 183. Furthermore, it appears from the record that by all accounts, he overused the procedure and refused to justify his repeated violations of hospital policies regarding appropriate indications for the procedure. \textit{Id.} at 183-86.

\textsuperscript{231} \textit{Id.} The hospital's long-standing difficulties with Dr. Friedman had never led to suspension of privileges before. \textit{Id.}

\textsuperscript{232} \textit{Id.} at 177, 183-86. Those entities include:

1. The \textit{PROs} which are mandated to examine over-utilization of bronchoscopies;

2. The \textit{medical staff committees} involved in the review and monitoring of Dr. Friedman's medical practices included the \textit{quality assurance committee}, charged with "reviewing the professional activities as they pertain to the quality care of patients." \textit{Id.} at 177. The quality assurance committee felt that the violation of hospital policy against therapeutic bronchoscopies was not justified on quality of care grounds;

3. The \textit{admissions and utilization review committee}, which conducts studies designed to evaluate "the appropriateness of admissions to the hospital, lengths of stay, discharge practices, use of medical and hospital service and all related factors which may contribute to the effective utilization of hospital and physician services." \textit{Id.} at 178. It also analyzes how overutilization of hospital or medical services affects the quality of patient care. They felt his overutilization of bronchoscopies did not improve patient care and violated hospital policy;

4. The \textit{medical records committee}, which makes recommendations regard-
ment. Not permitting therapeutic use of bronchoscopies as a categorical policy would adversely affect quality of care in those cases where therapeutic bronchoscopy is the treatment of choice. Any doctor who knows about the Friedman case would certainly think twice before he pressed for a therapeutic use of a bronchoscopy on a patient.

The implications are clear: hospital policies are informing physicians of what procedures they may and may not perform and under what circumstances. What happens to “independent medical judgment”? Although in Friedman the end result seems to have been for the best (a physician who irresponsibly overused a procedure was denied staff reappointment), the underlying principle involved could easily defeat the quality of care purposes of hospital policies. A holding such as Friedman can serve as a powerful deterrent to doctors who might otherwise order tests or perform procedures which are now allowed only under limited circumstances. The fear of “monitor mania” will have a chilling effect on doctors who might object to hospital policies but who would not want to risk jeopardizing their privilege status by making waves with the hospital administration, including the physician participating.

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ing practices designed to improve the hospital’s medical record-keeping function;
5. The operating room committee;
6. The grievance committee, which reported complaints to the endoscopy committee;
7. The endoscopy committee — in this case, it was a joint committee of gastro-enterologists and pulmonary disease sections, which formulated guidelines for the hospital policy committee;
8. The hospital policy committee, which incorporated into hospital policy the acceptable circumstances for performing bronchoscopies and found those policies to be repeatedly violated by Dr. Friedman;
9. The utilization review committee saw that he was violating the policy with too much utilization. It made recommendations to the credentialing committee;
10. The credentialing committee, which recommended revoking his privileges, citing repeated examples of his violating hospital policy. The recommendations go to the board of directors;
11-12. The board of directors, who made the final decision to revoke his staff privileges. The board of directors had two committees, the board executive committee and the joint conference committee, which reviewed medical staff recommendations. The joint conference committee made decisions when the board did not agree with the medical staff’s recommendations.

For example, two recognized uses of therapeutic bronchoscopy are the removal of an aspirated foreign body from the lungs of a patient (the alternative treatment would be leaving the foreign body in the lung or doing open-chest surgery to remove it), and the suctioning out of fluids and secretions retained in the airways (the alternative would be to leave fluids accumulating in the lungs, thereby increasing intra-thoracic pressure and the likelihood of infection).
pants on the monitoring committees. On the other hand, if Dr. Friedman was such a gross over-user of bronchoscopies, then the prolonged and repetitive proceedings that had to be followed to deny him privileges reveal that even when prompt action is warranted, the "monitor mania" systems impede it by the sheer number of people and entities doing the monitoring and evaluating.

2. Judicial Review of the Physician Reviewers

When physicians have received adverse reviews from other physicians who have examined their credentials and either denied them appointment or reappointment to the medical staff, or suspended, curtailed, or terminated their staff privileges, the aggrieved physicians have often sought review of those decisions in the courts. The physician who has been victimized by "monitor mania" seeks judicial review of the hospital committee's decision.

Generally, courts have exercised considerable restraint in their willingness to overturn the decisions of private hospitals (via their medical staff credentialing and other committees) to curtail or deny staff privileges. The policy of non-judicial review dovetails


235. The Patrick v. Burget case, discussed supra at notes 114-20 and accompanying text, is a notable exception, and the apparent anti-competitive motive and consequences of the denial of staff privileges led the court to override its usual policy of judicial restraint to find an antitrust violation, and grant treble damages.

The Friedman v. Delaware County Memorial Hospital case, discussed supra at notes 220-34 and accompanying text, did grant judicial review and examined the same evidence that the hospital had examined, but ultimately refused to overturn the hospital's decision on the grounds that the antitrust claims had not been proven. Other cases that reveal the judiciary's extreme reluctance to second guess physicians on these kinds of decisions. See Mauer v. Highland Park Hosp. Found., 90 Ill. App. 2d 409, 232 N.E.2d 776 (2d Dist. 1967). In Mauer, the court held that: "It is a well-settled rule that a private hospital has the right to refuse to appoint a physician or surgeon to its medical staff, and this refusal is not subject to judicial review; the decision of the hospital authorities in such matters is final." Id. at 411, 232 N.E.2d at 778. In Barrows v. Northwestern Memorial Hospital, 123 Ill. 2d 49, 525 N.E.2d 50 (1988), the Illinois Supreme Court followed the majority rule, articulated in Mauer, of no judicial review of medical staff decisions to deny staff privileges. Barrows did recognize an exception when privileges already granted are taken away: courts then will examine the question as to whether the hospital's constitution and by-laws, in permitting termination of staff privileges, are not "unreasonable, arbitrary, capricious or discriminatory." Id. at 50, 525 N.E.2d at 51. See also Claydon v. Sisters of the Third Order of St. Francis, 180 Ill. App.3d 641, 536 N.E.2d 209 (4th Dist. 1989); Gates v. Holy Cross Hosp., 175 Ill. App. 3d 439, 529 N.E.2d 1014 (1st Dist. 1988); Jain v. Northwest Community Hosp., 67 Ill. App. 3d 420, 385 N.E.2d 108 (1st Dist. 1978).


For cases in the minority states which generally engage in judicial review of hospital
with the public policy of encouraging peer review among physicians by granting immunities to physicians who participate in the peer review function. The same sort of immunities granted in the HCQIA\textsuperscript{236} are contained in many state hospital licensing laws as well.\textsuperscript{237}

B. Utilization Review: Non-Physicians Reviewing Medical Decisions

As a prerequisite to obtaining medicare reimbursement for any of its patients, hospitals are required by the Medicare Act\textsuperscript{238} to maintain “utilization review committees” ("URCs") in order to assure that patients will receive neither a greater nor a lesser level of care than they need.\textsuperscript{239} The URC must include at least two physicians and may also include other professional personnel, such as registered nurses and social workers.\textsuperscript{240} An attending physician may not be a member of a URC that is conducting a review of that peer review decisions, see Bricker v. Sceva Speare Memorial Hosp., 111 N.H. 276, 281 A.2d 589, cert. denied, 404 U.S. 5 (1971); Greisman v. Newcomb Hosp., 40 N.J. 389, 192 A.2d 817 (1963); Sussman v. Overlook Hosp. Ass’n., 92 N.J. Super. 163, 222 A.2d 530 (Ch. Div.), aff’d, 95 N.J. Super. 418, 231 A.2d 389 (App. Div. 1967); Kelly v. St. Vincent Hosp., 102 N.M. 201, 692 P.2d 1350 (1984). Sussman also held that a physician was not entitled to counsel at hearing. This aspect was overruled by Garrow v. Elizabeth General Hospital and Dispensary, 155 N.J. Super. 78, 382 A.2d 78 (1977), modified, 79 N.J. 549, 401 A.2d 533 (1979); cf. Szczesniak v. Memorial Hosp. for McHenry County, 180 Ill. App. 3d 706, 536 N.E.2d 138 (2d Dist. 1989). In Szczesniak, the court refused to apply the immunities from the Illinois Hospital Licensing Act to the hospital’s CEO, who terminated privileges of a physician accused of sexual harassment. \textit{Id.} at 711, 536 N.E.2d at 141. In order for those immunities to apply, the statute required a showing that the hospital administrator’s decision was “a result of the acts, omissions, decisions, or any other conduct of a medical utilization committee, medical review committee, patient care audit committee, medical care evaluation committee, quality review committee, credential committee, peer review committee, or any other committee whose purpose . . . is internal quality control.” \textit{Id.} at 710, 536 N.E.2d at 140. The court agreed with the plaintiff that the termination of his privileges was not the result of an immunized committee decision, but rather of one man’s unilateral decision. \textit{Id.} at 711, 536 N.E.2d at 141. The appellate court did not feel that the policy of the Licensing Act, \textit{i.e.}, “to foster effective self-policing by members of the medical profession in matters unique to that profession and to thereby promote the legitimate State interest in improving the quality of health care in Illinois,” was furthered by the CEO’s unilateral decision. \textit{Id.} at 712, 536 N.E.2d at 142 (citing Knapp v. Palos Community Hosp., 176 Ill. App. 3d 1012, 1024, 531 N.E.2d 989, 997 (1st Dist. 1988)). Thus, his act of terminating the plaintiff’s privileges was not immune from civil liability. \textit{Id.} 

\textsuperscript{236} See supra notes 121-31 and accompanying text for a discussion of the HCQIA.


\textsuperscript{240} 42 U.S.C. § 1395x(k) (1982).
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physician's patient's care.\textsuperscript{241} The Joint Commission also requires hospitals and health care providers to maintain an effective utilization review program as a prerequisite to receiving accreditation.\textsuperscript{242}

The URC directly monitors and questions doctors' medical decisions. It is the utilization reviewer who asks whether a medical decision is medically necessary.\textsuperscript{243} Charged with the responsibility of keeping treatments to a minimum so as to enable the hospital to comply with DRGs (and to make a profit from them), the utilization reviewer is asking the same kinds of questions in the hospital that a PRO reviewer asks in its external review.\textsuperscript{244}

In both the in-hospital URC and the outside PRO, nurses and other non-physicians frequently initiate the questioning of the medical decisions.\textsuperscript{245} Before a URC can find that certain medical services were not necessary, it must give the patient's physician an opportunity to consult with the committee and to give his side of the story.\textsuperscript{246} According to the criteria set forth in the Joint Commission's manual: "Nonphysician health care professionals may participate in the development of review criteria."	extsuperscript{247} Utilization review programs allow non-professionals to question professional judgment, and require those professionals to defend and justify their medical decisions to these non-professionals.

This situation is inherently volatile because physicians cannot be expected to appreciate having nurses and other non-physicians stand in judgment and question their medical decisions. Outrage is

\textsuperscript{241} 42 C.F.R. § 405.1137(b)(3) (1987); see Kraemer v. Heckler, 737 F.2d 214, 216 (2d Cir. 1984).
\textsuperscript{242} See Accreditation Manual, supra note 200, at 300. The utilization review program must "assure appropriate allocation of the hospital's resources by striving to provide quality patient care in the most cost-effective manner." Id. Its concerns are "overutilization, underutilization, and inefficient scheduling of resources." Id. Utilization review includes "concurrent review" of patient charts focusing on "diagnoses, problems, procedures and/or practitioners with identified or suspected utilization-related problems." Id. at 299-300.
\textsuperscript{243} The Senate Report on the Medicare statute states that:
[H]ospitals and extended care facilities participating in the program would be required to have in effect a utilization review plan providing for a review of admissions to the institution, lengths of stays, and the medical necessity for services provided with the objective of promoting the efficient use of services and facilities.
\textsuperscript{245} See supra notes 48-52 and accompanying text for a discussion of "medically necessary."
\textsuperscript{247} See Accreditation Manual, supra note 200, at § 1.5.2.2.
the likely response of the physician, for medical decisions should be, by their very nature, precisely the sort of decisions which physicians make. If they are to be questioned, it ought only be by other physicians of comparable training. It is toward that end that the AMA has embarked on its exhaustive quality assurance program, defining what specific treatment steps are necessary in specific medical situations.

C. Judicial Review of Utilization Reviewers

In 1986, a California appellate court addressed the inevitable conflict between the doctor who wants to do more for the patient, and keep the patient in the hospital longer, and the utilization reviewer, who wants to adhere to DRGs, and discharge the patient at the time prescribed by the reimburser. The court in Wickline v. State was the first to acknowledge that the utilization reviewer influences treatment decisions, and should therefore share some of the liability when those decisions are held to be negligent.

In Wickline, a utilization reviewer influenced a rigid application of a DRG, which caused a patient to be discharged before the patient was truly medically ready for discharge. Foreseeable post-operative complications occurred, and it was found that they could have been either averted or, at least, minimized, had the patient stayed in the hospital longer, as the treating physician had suggested. The physician was found liable for the negligently premature discharge. His defense that the utilization review committee had refused coverage past a certain fixed time period was not valid against a negligence charge.

Wickline also illustrates the dilemma of doctors who do not wish to antagonize the hospital or its utilization review committees, and yet must act in accordance with the best interests of their patients. To what lengths should a doctor “go to bat” for additional services for his patient? It is not always clear — except in retrospect —

248. The AMA feels that what is medically necessary should be a question asked and answered by physicians.
250. Id. at —, 228 Cal. Rptr. at 671.
251. Id. at —, 228 Cal. Rptr. at 666.
252. Id. at —, 228 Cal. Rptr. at 667.
253. Id. at —, 228 Cal. Rptr. at 671.
254. Id. See also Furrow, Medical Malpractice and Cost Containment; Tightening the Screws, 36 CASE W. RES. L. REV. 985 (1986); Morreim, Cost Constraints as a Malpractice Defense, 18 HASTINGS CENTER REP. 5 (Feb./Mar. 1988).
what interests of the patient can be compromised without undue risk.

When the physician is certain that the decision of the utilization reviewers is wrong, and feels that medical necessity does exist and reimbursement should be allowed, the law will generally support his efforts in favor of the patient. Nevertheless, the acrimony and expense of the confrontation, as well as the sheer resentment of it, takes its toll on the defending physician.

VII. MONITORING OF MEDICAL DECISIONS BY THIRD-PARTY PAYORS

As the previously discussed entities force physicians to justify their treatment plans to non-physicians and colleagues alike, another interest group has recently become more involved in questioning and monitoring medical decisions: the third-party payors. The government is retrenching on payments, particularly with DRGs, and thus third-party payors are being looked to with greater frequency for coverage of medical expenses. After years of deferring to the judgment of physicians, insurance companies are instituting their own systems of monitoring physician treatment decisions. The days when insurance companies unquestioningly paid out on medical claims are gone.

The insurance companies, like hospitals and the government, have jumped onto the physician-monitoring “bandwagon.” The insurance companies perform their own independent inquiry by asking: “Is this medically necessary?” and “What is the appropriate length of stay?”

255. The question boils down to one of Medicare coverage. In assessing the patient’s condition for the purpose of judicial review of final determinations of the Secretary of Health and Human Services regarding entitlement to Medicare benefits, the court is required to use a common sense, non-technical approach. In determining the medical necessity for a specific service, the “proper legal standard . . . involves consideration of the patient’s condition as a whole, rather than an analysis of the specific services provided.” Gartmann v. Secretary of U.S. Dep’t of Health and Human Servs., 633 F. Supp. 671, 679 (E.D.N.Y. 1986).

256. For a thorough discussion of utilization review programs and the liabilities that arise from them, see Jespersen & Kendall, Utilization Review Programs: Avoiding Liability While Controlling Costs, NATIONAL HEALTH LAWYERS ASS’N, 1988 HEALTH LAW UPDATE PART V. See also Gosfield, supra note 112.

257. In April 1987, Blue Cross/Blue Shield, the nation’s largest private health insurer, issued the first guidelines aimed at getting doctors to eliminate unnecessary testing. See Findlay, Are We Hooked on Tests?, U.S. NEWS & WORLD REP., Nov. 23, 1987.

258. Many insurance companies have hired private “medical review companies,” which have sprung up for the express purpose of monitoring medical necessity and length of stay questions for insurance companies. An example is Private Health Care Systems,
Blue Cross/Blue Shield, the largest of the private third-party payors, has established two in-house programs which monitor and evaluate various medical technologies, towards the end of giving coverage guidelines to their member plans.\textsuperscript{259} The first, the “Technology Evaluation and Coverage Program,” is an in-house program which monitors and evaluates “technologies,” which are defined as “any drug, device or procedure.”\textsuperscript{260} Employed doctors, medical researchers, and other medical personnel thoroughly review the peer-reviewed medical literature to see how the scientific and medical communities have evaluated the particular procedure.\textsuperscript{261} The reviewers address questions such as: Is this procedure widely accepted by the medical community? Has the medical literature, that is, peer-reviewed medical journals and articles, demonstrated with consistency that the procedure or technology is tried and proven?\textsuperscript{262} If so, then the program establishes an explicit set of criteria for circumstances under which the examined technology should be used\textsuperscript{263} and, presumably, coverage permitted.

Blue Cross/Blue Shield also has instituted a “Medical Necessity Program,” which publishes “Medical Necessity Guidelines” for distribution to health care providers it insures.\textsuperscript{264} These guidelines establish the appropriate indications for such common diagnostic tests as chest X-rays and ECGs. The Medical Necessity Program evaluates technologies and procedures that are not particularly

\textsuperscript{259} There are 76 insurance programs across the country which are part of Blue Cross/Blue Shield.
\textsuperscript{260} Telephone interview with David Tannenbaum, head of the Technology Evaluation and Medical Necessity Programs, Blue Cross/Blue Shield (June 6, 1989).
\textsuperscript{261} Id.
\textsuperscript{262} Id.
\textsuperscript{263} The program evaluates 30 technologies per year, focusing on those which are likely to have a wide application, such as lithotripsy, magnetic resonance imaging (“MRI”), and angioplasty.
\textsuperscript{264} Id.
new, but which may have been overused or inappropriately used in the past. These insurance company reviewers, working with the American College of Physicians (Internists) and other medical specialty societies, look at routine clinical care to evaluate what is medically necessary. Blue Cross/Blue Shield also has put together its own data bank, including information regarding nationwide claims experience, so as to be able to show employers how their claims experiences compare with those of other employers in other regions. These data banks enable them to formulate their own rates of reimbursement.

Blue Cross/Blue Shield is at the vanguard of private insurers. Its efforts to establish its own reimbursement criteria by deciding what is appropriate and necessary medical care reflect an industry-wide trend. Whether the criteria are set up in-house, as at Blue Cross/Blue Shield, or whether the insurance company contracts to have an outside service review medical necessity, the end result is the same: non-physicians are establishing medical guidelines and making decisions which have a powerful impact on medical decisions and judgment. Yet another bureaucracy, apart from and different than the government and the hospital, is telling physicians which medical procedures are necessary and which are not.

VIII. PHYSICIANS MONITORED BY THE LAY PUBLIC: MEDICAL MALPRACTICE

While not constituting a monitoring entity per se, the physician’s patients and the patient’s lawyers pose a constant threat of painful scrutiny of the physician’s medical decisions. When every patient is a potential adversary in court, the traditional intimacy of the doctor-patient relationship is corroded. The threat of a medical malpractice suit has shaken the foundations of the traditional doctor-patient relationship based on mutual trust and honesty.

The medical malpractice trial presents the most stark example of

265. Id.
266. Id.
268. Previously a policy which covered surgery required only that the patient’s physician state that the surgery was necessary. Some policies required a second opinion regarding the necessity of the surgery. But this new insurance company trend of pegging insurance coverage to an in-house definition of which procedures are necessary, effective, and have positive outcomes, constitutes an even greater intrusion on the independent judgment of the physician.
untrained, non-professionals monitoring medical decisions. Lay jurors, with no medical training whatsoever, retrospectively pass judgment on medical decisions which were made years before. The medical training the juror gets prior to passing judgment on a physician's medical decisions is limited to that to which the juror is exposed in the courtroom. The lay juror only has the guidance of expert witnesses, who have the benefit of hindsight, and a leisurely perusal of the medical records and medical literature on the subject. Those witnesses can be misleading due to the way their testimony is elicited or cross-examined by attorneys.

It is not that medical malpractice does not occur, nor that physicians should not have to be accountable to patients who have been negligently treated, but to rest the ultimate decision of what medical judgments were negligent or in the realm of "reasonable care" in the hands of lay jurors who merely have a number of weeks of courtroom medical training, strikes physicians as being grossly unfair and inappropriate. In the long run, the spector of the patient as potential adversary in a jury trial may do more to erode the doctor-patient relationship, and ultimately the quality of care, than anything else discussed in this Article.272

Much effort and publicity has been given to the efforts of various states to reform the tort system.273 Reforms most urgently sought have included:

1.) limitations on the amount of money that can be recovered as damages in medical malpractice cases;274
2.) limiting non-economic damages;275
3.) limiting punitive damages,276 or only allowing a judge, in-

271. R. FISH, M. EHRHARDT & B. FISH, supra note 269, at 63.
272. Legislative efforts at tort reform have done little to stem the ever-rising costs of medical malpractice litigation. If a few fewer frivolous suits are brought as a result of tort reform measures, the cost savings are exceeded by higher and higher jury verdicts on cases which get tried. See Smith, Battling a Receding Tort Frontier: Constitutional Attacks on Medical Malpractice Laws, 38 OKLA. L. REV. 195, 196 n.2 (1985).
273. For a summary of the report from the director of the American Tort Reform Association on tort reform activities in state legislatures across the United States, see Shalowitz, Tort Reform; Outlook "Encouraging" in 8 States: ATRA, CRAIN COMMUNICATION, INC.; BUS. INS., Feb. 6, 1989, at 3.
274. See, e.g., IND. CODE ANN. §§ 16-9.5-2-2, 16-9.5-4-1 to 4-3 (West 1986); TEX. REV. CIV. STAT. ANN. art. 4590i, § 11.02 (Vernon 1987); VA. CODE ANN. § 8.01-581.15 (1984).
275. See, e.g., ALASKA STAT. § 09.17.010(b) (1986); CAL. CIV. CODE § 3333.2 (West 1987); FLA. STAT. ANN. § 768.80 (West 1987).
stead of a jury, to award punitive damages in a separate trial after
the defendant is found liable for actual damages;
4.) limiting attorney's fees;277
5.) amending or abolishing joint and several liability rules;278
6.) abolishing the "collateral source rule"279 under which a jury
is not informed about the other sources of compensation — such
as insurance or workers' compensation — to which a plaintiff is
entitled; and
7.) allowing damage awards to be paid to a plaintiff over a set
period of time, instead of in a lump sum.280

State legislatures have addressed different aspects of tort reform,
with varying provisions being adopted. Nonetheless, almost as
soon as tort reform legislation is passed, it is countered with legis-
lative and legal challenges, mostly from trial lawyers, which put
the long-term outcome of the reform legislation in doubt.281

The consensus of the studies by those involved in tort reform
seems to be that tort reform legislation has not resulted either in a
lowering of medical malpractice insurance premiums or in a dimi-
nution in the size of damage awards.282 Rather, costs are still ris-
ing. Putting it mildly, James Todd, M.D., a senior deputy
executive vice-president of the American Medical Association,
stated: "Tort reform has not been, in actuality, as successful as we
would have liked to have seen it." "It's been gutted by constitu-

277. See, e.g., ARIZ. REV. STAT. ANN. § 12-568 (1985); ILL. REV. STAT. ch. 110,
para. 2-1114(d) (1989); UTAH CODE ANN. § 78-14 7.5 (Supp. 1985).
278. Under this doctrine, any one of several defendants may be required to pay as
much as 100% of an award to a claimant, regardless of its degree of fault, if the other
defendants are unable to contribute to the award. See generally Note, Tort Equitable
Indemnity Under Comparative Negligence: Anomaly or Necessity?, 74 CAL. L. REV. 1057,
1076 (1986).
279. See, e.g., ARIZ. REV. STAT. ANN. § 12-565 (1986); DEL. CODE ANN. tit. 18,
280. See, e.g., CAL. CIV. PROC. CODE § 667.7 (West 1987); FLA. STAT. ANN.
§ 768.78 (West 1987); ILL. REV. STAT. ch. 110, para. 2-1705 (1989).
Supreme Court declared review panel unconstitutional); Note, Bernier v. Burris: The
Constitutional Implications of Abolishing Punitive Damages in Medical Malpractice Ac-
tions, 19 LOY. U. CHI. L.J. 1285 (1985)); see also Lopez v. Finnegan, No. CV-87-00232
(N.M. Dist. Ct. Mar. 31, 1989) (trial court declared the New Mexico Medical Malprac-
tice Act's damage cap of $500,000 unconstitutional); Condemarín v. University Hosp.,
No. 20602 (Utah May 1, 1989) (striking down $100,000 damage cap in suits against
government health facilities as violative of the equal protection clause).
48. In referring to a study completed, Holthus stated: "Patricia Danzon, a professor at
the University of Pennsylvania, Philadelphia, often considered the leading researcher on
tort reform, has found . . . that the number and size of claims against physicians contin-
ued to increase steadily, but not as fast as they would have increased without tort re-
forms." Id.
tional challenges and the further expansion of liability by the courts." 283

IX. CONCLUSION

The Bad News

There is no professional in the world whose decisions are more reviewed, monitored, and critiqued, both by peers and by lesser educated para-professionals and non-professionals, than the physician practicing in the United States. From the physician's point of view, this "monitor mania" poses a tremendous distraction from practicing medicine, which is, after all, what a physician is best trained to do. The additional time, paperwork, meetings, hearings, and psychic and emotional energy required of physicians to participate and comply with the various monitoring entities which impinge on the practice of medicine impose an enormous burden on the physician.

Physician's fees, which rose sharply to cover steep rises in malpractice insurance, will continue to go up to cover the additional expenses of hiring office personnel to handle the deluge of paperwork from the third-party and Medicare/Medicaid reimbursers. Physicians have had to pay out large sums for accountants, lawyers, practice management consultants, and a host of other business-type consultants who are needed to help the physician cope with the maze of laws, rules, and regulations to which his practice has become subject. The hospital committee work is non-delegable and non-billable, but its demands on a physician's time are great and constant.

Perhaps most galling to physicians is the indignity of having to explain and justify his/her medical decisions to non-professionals, or to physicians who are less trained, less experienced, and less involved in actual patient care. Ultimately, "monitor mania" compels the expenditure of time away from patients, from practicing medicine, from doing medical research, or from performing the professional tasks for which a physician is trained.

The Good News

Although the medical profession in America today is beleaguered, there are positive aspects of "monitor mania." Physicians do have to face the reality that theirs is not a profession as generously subsidized by the government as it has been. The reality of

283. Id.
huge population increases of public aid patients — be they Medi-caid, Medicare, or totally uninsured — means that cost-consciousness in the practice of medicine is an essential consideration to factor into medical decision-making. The carte blanche in medical treatment afforded by "reasonable cost" reimbursement under Medicare gave an unrealistic wealth to physicians and fostered excessive charges and rampant abuses. The government must get control of its expenditures, and the idea of monitoring fees, medical necessity, and fraud and abuse of the system is critical.

The problem, as this Article has hopefully revealed, is that the lack of coordination, the duplication and cross-purposes at which the myriad of monitoring entities exist generate more expenditures in bureaucratic waste — just when those dollars are tight and the need for them infinite — than they may save. Untold thousands are being spent in the formulating of medical practice guidelines and procedures by governmental entities, the AMA, insurance companies, and health care providers. Efforts are being duplicated and triplicated toward the end of ushering out independent medical judgment and imposing uniformity and standardization of medical treatment. "Cook-book medicine" appears to be the wave of the future — but too many cooks are writing the recipes.

In trying to enumerate the major medical monitoring entities, this Article has, per force, fallen short of enumerating them all. Nor has the author attempted to discuss any one of the reviewing entities or procedures from a detailed, practitioner's point of view. Hopefully, the discussions in this Article have demonstrated that if quality health care is to survive, we must not drive away the intellectual cream of our universities from studying medicine by placing the profession under siege.

Unfortunately, it appears that the dual goals of cost-containment and quality care are both suffering from our current piecemeal, quagmire of "monitor-maniacal" regulation.