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Malpractice Risks Rise With New Pressure on Doctors to Undertreat

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Introduction

Doctors are stuck between a rock and a hard place.

Overtreatment may be bad for healthcare costs, but doctors sometimes feel pressured to go too far in the other direction. Managed care organizations (MCOs), accountable care organizations (ACOs), and other new payment forms designed to lower costs often exert pressure on doctors to avoid various tests and procedures. The government, hospital, or insurance company may scrutinize the physician's records, and any of them may exert "pressure" to do less costly testing and fewer treatments and procedures.



However, the physician faces a liability risk if he misses a diagnosis.

The danger to the patient is in missing the diagnosis or in failing to offer the best treatment. The doctor can be sued for malpractice for failure to diagnose or treat properly. Doctors are held to the standard of care of the reasonable physician in his specialty at the time of the treatment regardless of financial demand by third party payers, MCOs, or the newly proposed ACOs.

ACOs: The Latest Pressure to Undertreat

An ACO is a network of doctors and hospitals sharing responsibility for providing care to patients. In the new federal healthcare law, an ACO would agree to manage all of the healthcare needs of a minimum of 5000 Medicare beneficiaries for at least 3 years.

ACOs may create additional administrative costs and possibly reduced reimbursement. But for doctors, there is the specter of increased malpractice liability when physicians are asked to limit expenditures for tests and treatments of ACO patients. How can doctors deliver the same standard of care under these pressures? And if they don't, how will they be protected? Regardless of any outside pressures, the physician remains responsible and liable for their patients' care.

Financial Incentives to Decrease Care

The proposed ACO model offers doctors and hospitals financial incentives to provide good quality care to Medicare beneficiaries while keeping down costs. What is new is the emphasis on cost reduction. Guidelines for this program, which starts in January 2012, are being proposed.

ACOs wouldn't completely do away with fee for service. But the idea is that providers would get paid more for keeping their patients healthy and out of the hospital.

Hospitals could be held accountable not only for the cost of the care they provide but also for the cost of services performed by doctors and other healthcare providers in the 90 days after discharge.

The Risks of Undertreatment Rise

The prime concern with undertreatment is that a diagnosis with its subsequent complications would be missed. Consider these examples:

1. Mrs. J is complaining of a headache. The emergency department physician or internist performs an exam. Nothing significant is found and Mrs. J is treated symptomatically with a mild analgesic.

She returns several days later still complaining of headache. Further testing reveals slight weakness of the right arm. Because of ACO involvement, it might be more difficult to order expensive CT scans or MRIs, causing a delay in care. Pressure by the insurance company or the ACO to minimize testing in order to keep expenses down may have caused a delay in referral to a neurologist or a delay in making the diagnosis, while medication or other intervention may have been successful in preventing further problems such as a completed stroke.

If Mrs. J does not receive a CT scan or an MRI, she could have a stroke, sue the doctor, and ask for payment for care for the rest of her life.

2. Mr. K presents for an evaluation of abdominal discomfort. Nothing specific is found but the physician has a gut feeling that something else may be occurring. Should the patient be referred to a gastroenterologist or get expensive x-rays that will increase the bill significantly or should symptomatic medications be ordered to see if the pain goes away? The ACO may recommend symptomatic medication. A rupturing aneurysm or malignancy may be missed.

3. Mr. L presents with chest pain. An expensive stress test or angiography is not ordered. Subsequently, Mr. L has a major heart attack, from which he doesn't recover. It is recognized that this type of testing might have major complications, but this must be balanced against the risk of not testing. Doctors may face such pressure to avoid testing in order to keep costs down.

4. Mrs. M hits her head and is treated symptomatically, only to have a subdural hematoma or subarachnoid hemorrhage show up a number of hours or days later. Recognizing the cost of the exam and the radiation exposure to the patient, the CT scan was not ordered. When there is a question of getting an exam, the medical indications and potential side effects are what should govern the decision for or against the testing, not the cost.

Reasons for Undertreatment Are Not All Financial

It's true that undertreatment may occur for reasons having nothing to do with cost. The physician may not ask the correct questions or the patient may not give the correct answers, resulting in the physician not making the diagnosis or correctly treating the problem.

One reason may be to avoid treatment risks. The patient could develop a reaction to an antibiotic ranging from a simple rash to a fatality. Ordering CT scans and other radiologic exams carries the real

risk of exposure to radiation, especially in younger children. Any invasive procedure such as a biopsy or surgical procedure may have complications including death.

Or the patient may decide not to purchase expensive medications required. The wrong treatment might modify the medical condition and mask symptoms that might have made the diagnosis clear. With a headache, the patient might quickly respond to an analgesic, causing the physician to stop the evaluation because he feels the condition was cured.

The ACO may feel that there has been too much testing and expenditure and encourage a decrease in the testing. Although the "pressure" may be subtle, it should be recognized and should not affect the physician's standard of care.

Valid Reasons for Overtreatment?

Certainly, reduction of much expensive and unnecessary treatment would be advantageous to Medicare and to our economy as a whole.

Defensive medicine is a reality to all doctors. There is the fear that if a test is not ordered or a treatment not offered there could be liability down the line if a patient gets sicker. The safer and more expensive course is to order all tests and treatment so that if a patient does get sick, the doctor will be able to show that he did everything possible.

In fields such as emergency or urgent care medicine, where the exam is usually limited to 1 visit, doctors may order many tests.

Also, patients often have expectations that include pressure to test, test, test. There is an expectation that patients will receive a prescription or a treatment for every complaint. Physicians must talk with patients and develop a good rapport so that the patients may accept less testing when it may not be indicated or if it is potentially dangerous.

Does the Standard of Care Help or Hinder Doctors?

The standard of care is a moving target. It is possible that new initiatives may influence the standard as it will be interpreted in the future. The doctor is held to the standard of a reasonable physician in his specialty at the time of the treatment. And the reasonable physician is usually deemed to be what other physicians in the locale or in the country are doing.

The standard changes through time. For example, with the HIV epidemic, the testing of blood became the standard of care. Today we have much more technology and a much greater availability of clinical information, which have raised the standard of care to new levels of testing and treatment.

If there are financial incentives or studies showing the limitations or harmfulness of some tests and treatments, it's possible that the standard may change. In the field of oncology, for example, studies have shown that certain tests do not reduce the mortality rates and others may have side effects that outweigh the benefits.

To determine whether the standard of care is met, judges and juries look to accepted practice standards of physicians in the relevant specialty. The law says you must meet a minimum standard of care regardless of the patient's coverage or ability to pay. If you undertake to treat someone, you must act with the same level of diligence as other physicians in similar situations. If you don't, you'll breach your duty to your patient and may be held liable for any injury resulting from your dereliction.

A legal and societal evaluation of the standard of care can be adjusted. It need not require every expensive test or treatment for every single diagnosis for each and every patient without careful consideration.

Informed Refusal

When there are financial incentives to keep costs down and to reduce unnecessary treatment, doctors should use the concept of informed refusal. If the doctor gives the patient a real option to refuse the proposed treatment, many patients will do just that. If the doctor is completely honest about the chances of success and the side effects/risks involved, the patient may forego the treatment of his own accord. Costs will have been cut and the physician would not have increased his liability exposure.

Mentally sound adults have the right to refuse any treatment as long as it's an "informed refusal." Make sure that you tell patients of the risks, benefits, and alternatives to a proposed treatment or procedure, including the option of no treatment. Document the conversation. If the patient still refuses the treatment or is otherwise noncompliant, ask her to sign a "refusal of consent" form.

MCOs and ACOs may make doctors feel they're no longer in charge of treatment decisions, but they are still accountable for errors, including over- or underutilization of diagnostic tests and procedures.