Caution! HMOs may be dangerous to your health

by Linda Everett

In the first lawsuit of its kind in the United States, a Michigan woman has charged that the structure of her Health Maintenance Organization (HMO), and the financial criteria used to govern medical decisions, were inherently "responsible for the failure of its physicians to deliver medical care."

In an HMO, a patient pays a monthly fee in advance for services from an HMO-salaried physician, rather than paying a private physician directly for services delivered. In HMO-Individual Practice Associations (IPAs), the patient pays a set HMO fee, but sees a private physician who participates in the HMO plan. The IPA physician sees his regular fee-for-service patients, along with the HMO enrollees in his own office. But in some HMOs, especially those proliferating most recently, a difference in care is likely to obtain, thanks to the profit incentive. If the fund containing the monthly HMO fees to pay for care has money left over in it at the end of the accounting period, the doctor keeps a portion of it—and if it doesn't, he may even have to make up the difference—hence, a motive to *minimize* care.

The Michigan case involves a 34-year-old Saginaw woman, Mrs. Sharon Bush, who sued her HMO for damaging the quality of her medical care through its "capitated gatekeeper" arrangement, which put her primary care physician at financial risk. In such an arrangement, the primary physician acts as a "gatekeeper" for the HMO patients, controlling whether a patient receives a referral to see specialists. He "manages" the patient's care, weighing it, not necessarily on needed medical care alone, but against his profits or losses as well. Should the physician spend less than the set amount of HMO money allotted per patient (called capitation), the doctor makes a profit. Should he exceed the budget, with lab tests, x-rays, referrals, or extended hospitalization, the doctor goes into the red.

The Bush case is unusual for several reasons. It strikes at the heart of the latest profit-making mechanism in this country's tidal wave of new HMO programs. Experts say that the case may point to a legal trend against such operations. And, a full 10 months after Mrs. Bush's lawsuit was filed, after the case gained national notoriety through articles in the *American Medical News* and the *Chicago Tribune*, the attorney for one of the physicians named in the suit successfully requested that the court, without notice, suppress the file on the case and order the parties involved not to discuss the case in public.

The *American Medical News* (*AMN*) covered the story in its Sept. 4, 1987 issue, based on a copy of the original complaint obtained prior to the gag order.

In August 1985, Mrs. Bush, the mother of two, complained to her longtime physician, Dr. Paul Dake, of vaginal bleeding unrelated to her menstrual cycle. The suit alleges that Dr. Dake did not order a Pap test, nor did he refer her to a specialist until the following February, even though the antibiotics he had prescribed did nothing to stop the problem.

The obstetrician-gynecologist she was referred to merely changed Mrs. Bush's antibiotic, but she still experienced bleeding. Dr. Frederick Foltz also failed to take a Pap test or ascertain if one had been taken. A full eight months later, in April 1986, Mrs. Bush, now in unbearable pain, again went to her family physician and demanded another visit with the specialist. Although the bleeding persisted, Dake, as her "gatekeeper," refused to authorize a second visit, claiming that she was not sick enough for the referral.

By May, Bush, desperate, finally went to a hospital outside the HMO, the Saginaw General Hospital emergency room, where she was admitted and diagnosed as having cervical cancer that had spread through her body. She required a series of operations.

In a suit filed in the Saginaw County Circuit Court on Sept. 26, 1986, Bush names both Dake and Foltz for malpractice, but it also names Group Health Services of Michigan (GHS) and Valley OB-GYN Clinic as liable for the physicians' alleged negligence.

Dr. Dake is a member of an individual practice with GHS, a Blue Cross health maintenance organization. GHS, in turn, sends some of its referrals to Valley OB-GYN. Mrs. Bush's complaint alleges that the HMO's "capitated gatekeeper" arrangement with Dr. Dake was a "significant causative factor" in Dr. Dake's failure to order tests, and to make referrals in a timely way, and in Dr. Foltz's failure to order a Pap test, which would have indicated cancer very early on.

Capitation 'inhibits, chills, and thwarts'

According to *AMN*, Group Health Services paid Dr. Dake a capitation fee per patient and also placed funds in two IPA

accounts for consultant, lab, and hospitalization costs. If the money remained in the pools at the end of the accounting period, Dr. Dake and other IPA physicians would split it with GHS. It is this arrangement which Bush alleges violated medical ethics and state law.

It "inhibits, chills, and thwarts the accepted standard of referring for consultation and procurement of indicated laboratory procedures and is legally an impermissible interference in the relationship" between patient and physician, the complaint declares. This conflict of interest, the brief asserts, creates the financial incentive not to refer cases to specialists.

Not mentioned, but equally important, is the fact that Dr. Dake referred his patient to Dr. Foltz for treatment of vaginitis only. Dr. Foltz was authorized to treat *only* that condition and was *not* permitted to undertake a Pap test—a ludicrous policy that discounts the specialist's expertise and independent diagnosis.

Dr. Arthur Efros, an officer of Physicians Who Care, a national group of 2,000 physicians who oppose any health plan offering financial incentives to doctors and who want to preserve private, fee-for-service medical care, told *AMN* that an aggravating factor in the Sharon Bush case was the fact that she was not aware of the capitation arrangement. "All the time the lady is thinking the problem is not that serious or the doctor would be doing something. If she was told about the financial agreement, she would have thought, 'What's going on here?' " Dr. Ronald Bronow, a Los Angeles physician and vice president of Physicians Who Care, called the concept of a doctor restricting services to make more money, "outrageous."

As one Harvard Business School professor told a *Chicago Tribune* reporter: When you walk into an HMO doctor's office, the doctor sees you, the patient, with a big price-tag on your forehead. The more frequently you show up, the more tests you need, the more you cost that doctor. The doctor pockets what he does not spend on your care. Some HMO-salaried physicians have 15% of their fees withheld until the HMO meets its financial goal. Thus, doctors must give careful scrutiny to exactly how much they spend on each HMO patient, and how expenditures compare with those of fellow physicians. Thus, the patient becomes a profit-making asset, or a financial risk.

Traditional non-profit HMOs allegedly offered unlimited care for a flat monthly fee from its enrollees. They claimed a cheaper delivery of health care services than fee-for-service physicians and hospitals, and boasted cost-cutting mechanisms that had patients spending 40% less time in hospitals than traditional plans. They thrived by cutting (debatable) "non-essentials," by signing up relatively healthy young people who required less medical care than, say, the elderly, and by placing fierce treatment restraints on their staff. More recently, for-profit corporations and insurance companies have created an explosion of new HMO plans, each with an enormous and expensive bureaucracy and each competing for the same client base.

No longer is the issue one of delivery of cheaper medical care by cutting "unnecessary" services. The aim, here, like most business ventures, is to maximize profits for stockholders. And, those profits are not generally reinvested into new technologies, experimental research, or advanced patient care. Financial incentives reward physicians for providing less services, fewer tests, and shorter hospital stays. Last year, the federal government banned similar incentives that endangered the lives of thousands of elderly enrollees because their Medicare-contracted HMO firms refused to deliver critically needed medical care.

Third party payers legally accountable

In just 10 years, from 1976 to 1986, the number of Americans enrolled in HMOs quadrupled to about 25 million participants. An HMO research group called InterStudy says that the number of HMOs starting operation in those 10 years skyrocketed from 150 to over 600. But with this frenetic HMO expansion, there is a steady rumble of dissatisfaction and despair growing. Thus the national interest in the Sharon Bush suit.

In a similar case last year, a California judge warned doctors and third-party payers they were playing a dangerous game. In that case, *Wickline* v. *California,* Lois Wickline claimed that Medi-Cal, that state's version of Medicaid, was responsible for the loss of her leg. Wickline underwent surgery for a blocked artery in a Los Angeles hospital. Her Medi-Cal physician-reviewer told Wickline she was ready to go home. Although she protested, her family physician and surgeons did not. Wickline was discharged from the hospital. Within nine days, Wickline returned to the hospital in pain. Her leg had to be amputated due to complications from surgery.

Contending that the state was at fault, she sued the state and won. A higher court judge overturned the ruling, but added a vigorous admonition. District Court Judge Barnet Cooperman wrote: "Third-party payers of health-care services can be held legally accountable when medically inappropriate decisions result from defects in . . . cost-containment mechanisms as, for example, when appeals made on a patient's behalf for medical or hospital care are arbitrarily ignored or unreasonably disregarded or overridden. However, the physician who complies without protest . . . cannot avoid his ultimate responsibility for his patient's care. He cannot point to the health-care payer as the liability scapegoat."

HMOs are not alone in gouging the guts out of American medical care. Insurance companies, like Blue Cross and Blue Shield or Metropolitan, are consciously wrenching the medical system into health-care reductions, and have the clear intent of forcing programs like Medicare and Medicaid into line. Thus, health care could cease to be that happy but scientific combination of the physician's personal commitment and inspiration, the nation's challenge and mobilization, and the citizen's hope and trust.