HEALTHCARE LAW

By: Charles F. Redden
Pretzel & Stouffer, Chartered, Chicago

Duty to Advise Patients of Financial Incentives


In Neade v. Portes, M.D., the Second District of the Appellate Court held that a physician has a fiduciary duty to advise a patient of financial incentives in the physician’s contract with the patient’s managed care organization. This duty, the Court held, is separate from any duty of care owed to a patient to render adequate medical care and, if breached, the patient has a right of action against the physician even if the conduct of the practitioner met the applicable standard of care.

The medical facts of the case, as alleged, are tragic. Plaintiff’s decedent, Mr. Neade, had cardiac symptoms for which he sought medical treatment. The initial results of the cardiac work-up, a thallium stress test and EKG, were reported to plaintiff’s primary care physician (PCP), the defendant, Dr. Portes. Those test results indicated the symptoms were not cardiac related. The symptoms returned and Neade followed-up with Dr. Portes for continuing complaints suggestive of a cardiac etiology. The defendant sought the opinion of an associate primary care physician who recommended hospitalization and a referral to a cardiologist for an angiogram. Dr. Portes, relying on the results of the earlier tests, rejected the recommendation. Subsequently, cardiac symptoms brought the plaintiff back to his primary care physician and Dr. Portes asked yet another associate for an opinion on medical management. Dr. Portes received the same recommendation for hospitalization and an angiogram, but the defendant, again, rejected the suggestion, relying on the prior test results. Soon thereafter, Neade suffered a massive MI and died.

The allegations concerning the financial relationship between Dr. Portes and the patient’s managed care organization (MCO), as plead, are rather typical: Dr. Portes’ group’s contract with Neade’s managed care organization, Chicago HMO, included a “Medical Incentive Fund.” This fund was to be used for payment of certain tests and referrals by the PCPs to medical specialists. Monies remaining in the fund after a 12 month period would be divided between the MCO and Dr. Portes’ group of primary care physicians. The costs of the angiogram and the specialist to whom Neade would have been referred for that procedure, would have been paid out of that fund. Plaintiff sued, claiming that Dr. Portes should have revealed the financial incentive not to refer Neade for a cardiac consultation and angiogram.

On a motion to dismiss, the defendant successfully argued that the existence of a financial incentive or “motive” was irrelevant to the issue of whether Dr. Portes met the standard of care. Consistent with precedent, the trial court struck all allegations in the negligence count as to financial motive. In addition, the defendant argued that, in Illinois, there is no legally recognized fiduciary duty which would, under these circumstances, require a physician to divulge the existence of the incentive fund to his patient. The trial court agreed, dismissing the second count which sounded in breach of a fiduciary duty.

In a case of purported first impression in the Illinois State Court of Appeals, the Second District reversed the trial court with respect to the dismissal of count II. In reaching its conclusion, the Neade Court “distinguished” Illinois precedents which had refused a plaintiff the alternative pleading that a physician’s fiduciary duty allows for the admission of financial motive on a negligence claim (Bearden v. Hamby, 240 Ill. App. 3d 779 (1992)). The Neade Court also differentiated precedent which refused the argument that an allegation of a breach of fiduciary duty negated the need to prove that a physician’s conduct fell beneath the standard of care (Taber v. Riordon, 83 Ill. App. 3d 900 (1980)). As discussed below, the Neade Court effectively reversed those decisions rather than distinguish them.
Support cited in the Neade decision for the creation of a new cause of action was tortuous. First, the Neade Court cited the recent Federal decisions of Herdrich v. Pegram, 154 F.3d 362 (7th Cir. 1998), and Shea v. Esensten, 107 F.3d 625 (8th Cir. 1997). However, both cases concerned ERISA claims and statutory construction of the Federal Act. As discussed in an earlier column, the Herdrich Court found that the defendant-physicians managed the health care plan, including the doctor referral process, the nature and duration of patient treatment, and the extent to which participants were required to use plan-owned facilities. The Court noted that the board of directors consisted exclusively of the plan physicians who were in control of each and every aspect of the HMO’s governance, including year-end bonuses. From this, the Court in Herdrich inferred that the defendant-physicians were plan fiduciaries and individually liable for damages under ERISA.

Despite the distinction, the Neade Court found a basis in these federal precedents for requiring a physician to advise a patient of a financial incentive which might affect the physician’s judgment and, in a general sense, impact the patient’s health care choices.

The more particular question — whether there is a fiduciary duty that, if breached, may stand as an independent cause of action, required a referral to cases from other jurisdictions in order to avoid the decisions in Bearden and Taber. The Neade Court cited a California decision, Moore v. Regents of the University of California, 793 P.2d 479 (1980), as support for the proposition that an independent cause of action for breach of a fiduciary duty may stand. In truth, the Moore decision was a straight-forward case of lack of informed consent and should have been read as being consistent with Illinois law, not a basis for the creation of a new cause of action.

The defendants in Moore conducted tests on the patient’s cells as part of a research program without disclosing the physicians’ reasons, economic or otherwise, which were separate from the needs of the patient. Cases from Minnesota (D.A.B. v. Brown, 570 N.W.2d 168 (1997) and Colorado (Spoor v. Serota, 852 P.2d 1292 (1992), cited by the Neade Court, actually reached the conclusion opposite that for which they were cited; neither sustained an independent cause of action for a claim of a breach of a fiduciary duty.

Turning back to Illinois law, the Neade Court found support for the existence of a fiduciary duty between physician and patient in Petrillo v. Syntex Labs, Inc., 148 Ill. App. 3d 581 (1986), which concerned the physician’s statutory duty to maintain the physician-patient privilege.

Neade also referred to the Illinois Statute which prohibits self-referrals without disclosure of the financial interest (the Illinois Health Care Worker Self-Referral Act, 225 ILCS 47/1, et seq). This Act parallels a federal law and, together, they were enacted to eliminate potentially fraudulent referrals for medical services which were unnecessary. In any event, the issue was not whether a physician stands in a fiduciary relationship with a patient, but whether that relationship requires the disclosure of facts and circumstances that exist which may influence the physician’s medical judgment.

The only direct support for the existence of such a duty to disclose a “financial incentive” to a patient cited by the Neade Court came from an opinion on ethics published by the American Medical Association. That opinion states that physicians “must assure disclosure of any financial inducements that may tend to limit the diagnostic and therapeutic alternatives . . . .” (Current Opinions, section 8.132, 1996-1997 Ed.) The medical ethics opinion, the Neade Court correctly pointed out, was not a statement of the standard of care, but merely evidence of such.

Finally, the Neade Court bolstered its conclusion based upon the fact that one may sue an attorney for both negligence and breach of a fiduciary duty. The Neade Court did not distinguish between the unique nature of the fiduciary relationship between an attorney and client as compared to a physician-patient relationship. Certainly, both involve a degree of trust, with a level of confidence reposed on one side and domination and influence on the other.

But to compare the two professions and equate the relative fiduciary duties of both is improper. In the first instance, an attorney’s fiduciary responsibility to a client is far more expansive and limiting on the attorney’s conduct, mandating disclosure of information and withdrawal from representation despite the subjective belief that the attorney is able to remain an suitable advocate. In addition, a client cannot make legal decisions but must rely upon the judgment and good intentions of the attorney. Physicians, on the other hand, make medical
treatment decisions subject to the demands and approval of the patient. The patient, of course, needs to be properly informed by the physician regarding treatment plans and options. The recommendations of the practitioner must be judged by the medical standard of care regarding the extent of the disclosure of treatment alternatives, not the disclosure of potential financial benefit that may inure to the physician.

As one reads the Neade decision and the distinction between the claim of negligence (it was allegedly improper for Dr. Portes to continue to rely upon the prior test results in the face of persistent cardiac symptoms) and the breach of a fiduciary duty claim (had Neade known of the financial incentives involved, he would have sought a second opinion or sought the cardiology consultation at his own expense), the latter is in the form of a claim sounding in lack of informed consent. Under the traditional informed consent cause of action, one may assert that treatment given within the standard of care would have been rejected in the first instance had the patient been properly advised of all applicable treatment alternatives, potential risks and adverse consequences. This “right to know” is codified in the Illinois Medical Patient Rights Act, 410 ILCS §50/3. The Act provides that a patient has the right to receive information concerning his or her condition and proposed treatment in order to make an informed healthcare decision, including the refusal of any treatment or treatment plan. The claims against Dr. Portes fit well under this scheme, but they should not have included the issue of financial incentive.

“Informed consent” is a medical question subject to scrutiny under a medical standard of care review. The question is whether a patient has been provided with the appropriate information about his condition, prognosis and treatment options in order to make healthcare decisions. In Neade, it is far more egregious (and, perhaps, actionable) that Dr. Portes allegedly rejected the recommendations of two separate colleagues to have his patient admitted and worked-up by a cardiologist. Dr. Portes’ alleged failure to provide this information to his patient, at least in the form of an alternative treatment option, could form the basis for a negligence action based upon lack of informed consent. Consistent with Illinois precedent (which the Neade case followed, as noted below), the question of financial motive would have no place in the analysis of Dr. Portes’ judgment that the additional information did not need to be relayed to his patient.

But by accepting that a separate cause of action based upon a fiduciary duty, the Neade decision takes the informed consent issue out of the realm of medical judgment and, in fact, encourages further strain on the physician-patient relationship and confusion regarding the information a physician must disclose to a patient. Must a physician now disclose the fees he or she will earn from a recommended admission or surgical procedure, even though it will be paid by the patient’s insurer? Is a physician now obligated to reveal hospital utilization review studies, cesarean section rates or other data which, theoretically, influence the physician’s conduct and medical judgment? With medical resources limited in a variety of ways and for a number of reasons, when and to what extent must a physician involve a patient in these matters rather than merely practice within the standard of care?

Every recommendation and decision made by a physician has the potential to affect the physician monetarily, whether there is an incentive fund, the threat of non-renewal with the MCO, rejection of payments for subsequently-determined unnecessary medical care or even loss of hospital privileges. By creating a right of action for a failure to disclose a “financial incentive” under the physician’s fiduciary duty to his patient, informed consent takes on a new look. While the Neade Court stated it did not wish to “open the floodgates of litigation,” and cautioned that not every claim for medical negligence contains within it a claim for a breach of a fiduciary duty, it is hard to see where the line will be drawn. Worse, to the detriment of the physician-defendants, the “standard” applicable to a breach of fiduciary duty claim is substantially lower and, conceivably, one which will not necessarily require expert testimony.

Consistent with Illinois precedent, the Neade Court concluded that the financial incentive issue had no place in the negligence count – either the physician met or did not meet the standard of care. Whether Dr. Portes had an incentive to breach that standard, the Neade Court concluded, is irrelevant and, because the fiduciary cause of action was recognized, duplicative. The better decision, and one which may emanate from another District of the Appellate Court, or from our Supreme Court, would have been that a patient may have a right to
financial incentive information as a matter of medical ethics, such is irrelevant in a legal proceeding alleging medical malpractice.

ABOUT THE AUTHOR:

Charles F. Redden is an Equity Partner with the Law Offices of Pretzel & Stouffer, Chartered. His practice is focused on the representation of healthcare providers, including physicians, institutions, and managed care organizations. Mr. Redden received his undergraduate education at Boston University (B.A., 1980), and graduate education at Loyola University of Chicago, School of Law (J.D., 1984). Charlie is currently the Editor-in-Chief of the Illinois Association of Defense Trial Counsel’s Quarterly.