Cost Containment Mechanisms in Health Care: A Review of Private Law Issues

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I. INTRODUCTION

THIS PAPER PROVIDES AN OVERVIEW of the private law issues relating to cost containment mechanisms in Canadian health care. It begins with a brief discussion of the general policy and ethical issues associated with health care reform that are relevant to the physician-patient relationship. While many of these issues are not strictly legal in nature, it is important to ground the paper in the context of the current health care environment. The remainder of the paper focuses on the specific private law issues associated with health reform initiatives. In particular, the following issues are addressed:

- *(i)* Informed Consent;
- *(ii)* Standard of Care;
- *(iii)* Fiduciary Law and Conflict of Interest; and
- *(iv)* Other Legal Issues including third party liability, application of the *Canadian Charter of Rights and Freedoms*[1], the legal definition of "medically necessary," and access to health care records.

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1 Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 [hereinafter *Charter*].

II. GENERAL BACKGROUND

IF ASKED, IT SEEMS CERTAIN THAT HEALTH CARE providers would view the increasing need to "do more with less" as one of the most pervasive themes of this era of health reform and cost containment. Indeed, a 1994 study found that 70 percent of Canadian physicians surveyed thought that government cuts have damaged the quality of care.[2] Whether the result of an explicit policy or a reaction to an implicit need, institutions have had to provide care in a climate of significantly reduced resources.[3] Further, as physicians control a large portion of the health care budget—through the direct utilisation of resources, referrals and admitting privileges—cost containment strategies have been, and will continue to be, aimed at micro-allocation decisions of physicians.[4]

As a result, a number of commentators have noted that this era of health care reform challenges the very nature of the duties owed by the physician to the patient.[5] Even asking physicians to consider the broader financial implications of their clinical decisions requires a shift in the focus of a physician's traditional legal and ethical duties. As noted by Marc Rodwin:[6]

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2 *Medical Post 1994* Physician Survey at 55.

3 See generally P. Armstrong & H. Armstrong, *Wasting Away: The Undermining of Canadian Health Care* (Toronto: Oxford University Press, 1996); D. Angus et al., *Sustainable Health Care for Canada: Synthesis Report* (Queen's University Ottawa Economic Project, 1995); M. Brown, "Changes in Alberta's Medicare Financing Arrangements: Features and Problems," in M. Stingl and D. Wilson, eds. *Efficiency v. Equality: Health Reform in Canada* (Halifax: Fernwood Publishing Co., 1996) at 148; and generally, M. Brown, "Rationing Health Care in Canada" (1993) 2 Ann. Health L. 101.

4 Indeed, the Medical Post survey found that 72.4% of physicians think government intervention has the potential to seriously impact the way they practice.

5 E.H. Morreim, *Balancing Act: The New Medical Ethics of Medicine's New Economics* (Washington D.C.: Georgetown University Press, 1995); J. Lairson, "Re-examining the Physician's Duty of Care in Response to Medicare's Prospective Payment System" (1998) 2 Wash. L. Rev. 791; and *Wickline* v. *State of California*, 228 Cal. Rptr. 661 (Ct. App. 1986).

6 M. Rodwin, "Strain in the Fiduciary Metaphors: Divided Physician Loyalties and Obligations in a Changing Health Care System" (1995) 11 Am. J. Law & Med. 241 at 254. See also R. Perkel, "Ethics and Managed Care" (1996) 80 Med. Clinics N. Am. 263 at 266; and C. Perry, "Conflicts of Interest and the Physician's Duty to Inform" (1994) 96 Am. J. Med. 375: "[T]he economic benefits and hazard of today's practice of medicine provide sundry and frequently subtle opportunities for fiduciary conflicts of interest." See also, Policy Perspective, "For Our Patients, Not for Profit" (1997) 278 J.A.M.A. 1733 at 1733:

> Patent financial incentives that reward overcare or undercare weaken patient-physician and patient-nurse bonds and should be prohibited. Similarly, business arrangements that allow corporations and employers to control the care of patients should be proscribed.

> [Health reform] trends and views encourage the idea that rather than strive to promote only the welfare of individual patients, doctors and medical organisations must also act in the interest of the population they serve.[7]

Cost containment strategies can take a variety of forms, ranging from simply restricting access to a particular a service, to informal policies that pressure physicians to "do less," to highly structured, explicit, strategies designed to encourage physicians to provide less expensive care. The growth of managed care initiatives throughout the United States is perhaps the most obvious example of the latter. While the term "managed care" is used to describe a wide variety of health care delivery systems,[8] it generally applies to the "controlled" delivery of health care services in a way that promotes efficiency and cost effectiveness.[9] Such programs often "place the primary physician as gatekeeper with an eye toward controlling utilization everywhere in the system."[10] One key feature of managed care programs is that they may provide incentives to actually provide *less* care, or a particular type of care.[11] Due to the structure of these delivery systems, which often include mechanisms such as capitalisation,[12] health are providers may earn more if they do less or if they provide a certain type of care . Such arrangements have obvious ethical and policy implications.[13]

In Canada, the spirit of financial and resource management—at the heart of managed care programs—has been embraced by numerous ministries, regional

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7 Rodwin, *ibid.* at 254.

8 See K. Christensen, "Ethically Important Distinctions Among Managed Care Organizations" (1995) 23 J. of L. Med. & Eth's 223, for a review of the key difference between various managed care organisations.

9 Of course, managed care initiatives have been criticised on numerous levels. One of the more interesting observations is that they may, in fact, encourage patients to exaggerate their problems in order to gain access to health care resources. See A. Barsky and J. Borus, "Somatization and Medicalization in the Era of Managed Care" (1996) 274 J.A.M.A. 1931.

10 Perkel, *supra* note 6 at 266. See also R.N. Butler et al., "Managed Care: What to Expect as Medicare-HMO Enrollment Grows" (1996) 51 Geriatrics 35.

11 Christensen, *supra* note 8 at 225.

12 For a brief general discussion of capitation see C. Donaldson & K. Gerard, *Economics of Health Care Financing: The Visible Hand* (London: MacMillan Press Ltd., 1992) at 110–12.

13 See *e.g.* E. Emanuel & N. Neveloff Dubler, "Preserving the Physician–Patient Relationship in the Era of Managed Care" (1995) 273 J.A.M.A. 323; and B. Culliton, "Managed Care and Conflict of Interest" (1996) 2 Nature Medicine 489 at 489:

> To the extent that the switch to managed care in the name of sound economy is ... undermining patients' legitimate need to be able to trust that their physicians are first and foremost on their side.

health authorities and health care institutions.[14] For example, it has been argued that the decrease in the average length of stay in some Ontario hospitals can be attributed, at least in part, to the financial incentives built into policies such "case costing."[15] Other examples include: various global caps placed on the provincial budgets for physician fee-for-service expenditures;[16] and fee adjustment mechanisms, such as "holdback" and "payback," that allow a reconciliation between the provincial government and the province's physicians at the close of the fiscal year.[17]

Though more formal allocation and physician incentive mechanisms are beginning to emerge throughout Canada, the most common form of cost containment pressure remains the informal, often unspoken, institutional policies

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14 See *e.g.* F. Caruth, "Redirecting Incentives in the British Columbia Health Care System: Creating A Consequence" in R. Deber & G. Thompson, eds., *Restructuring Canada's Health Services System: How Do We Get There From Here?* (Toronto: University of Toronto Press, 1992).

15 M. Waldman, "Conflicts of Interest, Physicians and Physiotherapy" (1996) 154 C.M.A.J. 1737 at 1737. This author argues that "case costing" drove down the "length of stay for a patient with a fractured hip ... from 56 days in 1992 to 24.2 days in 1995." Case costing is a funding mechanism that allots a fixed amount of money for a given diagnosis regardless of time spent in the hospital. Therefore, it is in the best interests of physicians and the institution to turn over beds quickly as this will allow more patients to be treated, thus generating more income for providers and saving money for the institution.

16 J. Hurley & R. Card, "Global Physcian Budgets as Common-Property Resources: Some Implications for Physicians and Medical Associations" (1996) 154 C.M.A.J. 1161 at 1162. For example, some provinces have caps on individual physician incomes (e.g., Ontario's upper range is $454,000 for all physicians, Newfoundland's is $350,000 for general practitioners and $450,000 for specialists). Other provinces use a formula to determine the income cap. Nova Scotia, for instance, sets the threshold at "1.8 standard deviations above the mean for the group."

17 See *ibid.* for a review of each province's global cap policy as of 1995. With holdback, a percentage of payments are held back during the year and then paid out after the reconciliation. In a payback scheme any excess expenditures are repaid at the year end. Again, these devises are broadly based incentives that aim to subtly compel physicians to consider the financial implications of their individual clinical decisions. For an example of a specific agreement see Alberta Medical Association and Alberta Health, *Letter of Understanding Between the Minister of Health of the Government of Alberta and the President of the Alberta Medical Association* (1 April 1995–March 1998) at 1. This agreement, which was designed to help to secure the funding envelope for Alberta physicians until spring of 1998, states that the "parties believe that change can best be brought about by the introduction of incentives at the provider level." The letter states:

> Savings achieved under $50 million will be shared one-third AMA and two thirds government. Savings achieved in excess of $50 million will be shared equal proportions of one-half AMA and one-half regions.

and allocation decisions.[18] Despite the fact that this is not a formally documented phenomenon,[19] it seems reasonable to conclude that health care institutions throughout Canada are increasingly asking front line workers to make tough allocation decisions.[20] As is discussed below, the few Canadian legal cases that have emerged in this area seem to be the result of such informal policies.

The bottom line is that at some level most cost containment mechanisms control expenditures by attempting to control physician practice.[21] While such policies may make sense from the perspective of distributive justice, they have the potential to severely compromise the classic physician-patient relationship—largely because they require or encourage physicians to integrate the needs of others into their clinical decision making process.[22] The private law principles relevant to health care—be they in relation to consent, the standard of care or fiduciary law—are built on the obligations that flow from the health care provider-patient relationship. These are legal duties owed by one individual to another.[23] As shall be seen in the following section, the law has already

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18 J. Williams & E. Beresford, "Physicians, Ethics and the Allocation of Health Care Resources" (1991) 24 Ann. R.C.P.S.C. 305 at 309.

19 There are, of course, many explicit institutional policies concerning the use of various procedures and pharmaceuticals (e.g., contrast media). See D. Roy, B. Dickens & McGregor, "The Choice of Contrast Media: Medical, Ethical and Legal Considerations" (1992) 147 C.M.A.J. 1321.

20 *On the Front Lines: Hard Choices: Resource Allocation at the Caregiver Level* (Red Deer: Provincial Health Ethics Network Annual General Meeting and Workshop, 1997). For a brief discussion of the role of physicians in the allocation of resources see D. Roy, J. Williams & B. Dickens, *Bioethics in Canada* (Scarborough: Prentice Hall Canada Inc., 1994) at 351–53.

21 J. Martin & L. Bjerknes, "The Legal and Ethical Implications of Gag Clauses in Physician Contracts" (1996) 22 Am. J. Law & Med. 433 at 438.

22 See Emanuel & Dubler, *supra* note 13 at 328:

> The physician patient relationship is the cornerstone for achieving, maintaining, and improving health. The structure of financing and regulation should be designed to foster and support an ideal relationship between the physician and the patient.

Of course, physicians have always been influenced by non-medical factors. See G.R. Langley et al., "Effects of Non-medical factors on Family Physicians' Decisions About Referral for Consultation" (1992) 147 C.M.A.J. 659; and M. Chren, "Physicians' Behaviour and Their Interactions With Drug Companies" (1994) 271 J.A.M.A. 684.

23 See J. Lomas & A. P. Contandriopoulos, "Regulating Limits to Medicine: Towards Harmony in Public and Self-Regulation" in R. Evans, M. Barer & T. Marmur, eds., *Why are Some People Health and Others Not?* (New York: Aldine De Gruyter, 1994) at 256, where the authors note that the system of professional regulation is similarly focussed on the relationship of physician/patient:

encountered some difficulty injecting the notions of "third party needs" into this historically exclusive relationship.

III. SPECIFIC LEGAL ISSUES

A NUMBER OF JURISDICTIONS THROUGHOUT THE WORLD have struggled with the legal issues and conflicts that seem endemic to cost containment in health care. In the United States and Britain, for example, there is a good deal of case law and legislation that flows directly from the pressure which cost containment places on the physician-patient relationship.[24] A number of jurisdictions have gone so far as to pass legislation that either prohibits physician financial incentives aimed at cost containment or requires the disclosure of the nature of such incentives.[25] Indeed, the concerns surrounding the impact of incentive mechanisms may be addressed by the US congress.[26] Moreover, there have also been a number of US and British cases, some of which will be reviewed below, that are relevant in this context.[27]

There have only been a handful of Canadian decisions that have directly considered the private law issues that have arisen as a result of health reform

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> The self-regulation process in medicine has focussed on the individual practitioner-patient encounter, a framework that both discourages resources consideration in making judgments of "good care" and makes it difficult to ascertain overall impacts on population health.

[24] For a review of a key case in Britain see M. Blake, "Battling the Budget: Judicial Review of National Health Resources" (1996) 6 Dispatches 1.

[25] See M. Anderlik, "Efforts to Regulate Physician Financial Incentive" in *Perspective in Health Law* (Houston: Health Law and Policy Institute, 1998) (www.law.uh.edu/LawCenter), where it is noted:

> [a]t least 20 states have legislation or administrative regulations that prohibit certain kinds of incentives, and at least 16 states require disclosure of incentive to enrollees under at least some circumstances.

For instance, an Idaho statute requires that no:

> MCO shall offer a provider any incentive plan that includes a specific payment made to a provider as an inducement to deny, reduce, or delay specific medically necessary, and appropriate services ... . (See *ibid.*)

[26] E. Dale Burrus, "Managed Care Will Receive an Overhaul with the 106th Congress" in *Perspective in Health Law* (Houston: Health Law and Policy Institute, 1998) (www.law.uh.edu/LawCenter).

[27] See generally L. Sederer, "Judicial and Legislative Responses to Cost Containment" (1992) 149 Am. J. Psychiatry 1157.

initiatives. Nevertheless, there are a number of legal trends and emerging principles that are highly relevant in this context.

A. Informed Consent

The doctrine of "informed consent" is now well established in Canadian law. It imposes a legal duty on physicians to provide patients with "material information" concerning a proposed treatment, including potential risks involved, so as to enable the patient to make an informed decision . "Material information" is defined in terms of what a reasonable person in the patient's position would want to know. Failure to provide this information constitutes negligence on the part of the physician.[28]

Over the years Canadian courts have had numerous opportunities to interpret the physician's duty of disclosure. Generally, this has resulted in a significant expansion of the duty. In particular, the duty now does not involve merely a disclosure of potential risks. The physician must also inform the patient of other material information, including the existence of any alternative treatment or procedures.[29] As was stated by the Alberta Court of Appeal in a 1998 decision:

> A patient should be advised of a known treatment which others in the same specialty consider superior, even if the doctor does not agree. It is the kind of information a patient fairly could expect to receive. [30]

A related issue is whether a physician is under a legal duty to inform patients of alternative treatment or procedures that are *not* available (for example, at the hospital where the physician practises) due to cost containment policies. Does the patient have the right to be informed that these alternatives may be available elsewhere? Although no Canadian court has yet addressed this important issue, some authors have argued that physicians may indeed have such a duty.[31] They take the position that not only would a reasonable patient want to have this type of information, hence the doctor disclose it, but also that disclosure is consistent with the fiduciary nature of the doctor-patient relationship. It has also been suggested that disclosure would enable patients to consider

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28 See *Reibl* v. *Hughes* (1980), 114 D.L.R. (3rd) 1 (S.C.C.) and E.I. Picard & G.B. Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 3rd ed. (Toronto: Carswell, 1996) at c. 3.

29 See Picard & Robertson, *ibid.* at 129–131.

30 *Seney* v. *Crooks* (1998), 166 D.L.R. (4th) 337 (Alta. C.A.).

31 T. Caulfield & D. Ginn, "The High Price of Full Disclosure: Informed Consent and Cost Containment in Health Care" (1994) 22 Man. L.J. 328. See also Miller, "Denial of Health Care and Informed Consent in English and American Law" (1992) 18 Am. J. Law & Med. 37; Fraser & Avery, "What You Don't Know Can Hurt You" (1994) 3 Health Law Rev. 3; Picard & Robertson, *supra* note 28 at 131–132.

"whether it is worthwhile pressuring decision-makers to change the policy in question."[32]

As discussed more fully below, it is well established in Canadian law that the doctor-patient relationship is a fiduciary one, thereby placing a legal obligation on doctors to act with utmost good faith and loyalty toward their patients and not to permit their own interests, or those of a third party, to conflict with the best interests of the patient.[33] One effect of characterising the doctor-patient relationship as fiduciary is that it likely expands the doctor's duty of disclosure. For example, it has been argued that the fiduciary obligation requires doctors to advise their patients of the existence of treatments or procedures that are being withheld, or are otherwise unavailable, because of cost containment policies.

Another example is conflict of interest. The Californian case—*Moore* v. *Regents of the University of California*[34] establishes that because doctors are fiduciaries they are legally required to inform their patients of any conflicts of interest. This includes disclosure of "personal interests unrelated to the patient's health, whether research or economic, that may affect [the doctor's] medical judgment."[35] In addition to the *Moore* case, there is Canadian case-law that supports the principle that fiduciary law requires doctors to inform their patients of any financial or other conflict of interest which they that may arise in treating the patient.[36]

The concept of a duty to disclose financial or other conflicts of interest may well apply to cost containment policies based on physician incentive mechanisms, whereby physicians receive financial incentives for *not* providing treatment. Are doctors under a legal obligation to disclose the existence of such incentives to their patients? This issue has not yet been considered by Canadian courts, but it may well be that fiduciary obligations extend to disclosure of this type.

B. Standard of Care

A doctor is required to exercise the same degree of skill and care that could reasonably be expected of a practitioner having the same experience and standing. The leading Canadian case states the principle as follows:

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32 Caulfield & Ginn, *supra* note 29 at 339.

33 See generally Picard & Robertson, *supra* note 28 at 4–6.

34 793 P. 2d 479 (Cal. 1990), cert. denied 111 S. Ct. 1388 (1991) [hereinafter *Moore*].

35 *Ibid.* at 485.

36 *Henderson* v. *Johnston* (1956), 5 D.L.R. (2d) 524 at 534 (Ont. H.C.), aff'd (1958), 11 D.L.R. (2d) 19 (C.A.), aff'd (1959), 19 D.L.R. (2d) 201 (S.C.C.).

37 *Crits* v. *Sylvester* (1956), 1 D.L.R. 502 at 508 (Ont. C.A.), aff'd [1956] S.C.R. 991. See also Picard & Robertson, *supra* note 28 at 132–134.

> Every medical practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. He is bound to exercise that degree of care and skill which could reasonably be expected of a normal, prudent practitioner of the same experience and standing, and if he holds himself out as a specialist, a higher degree of skill is required of him than of one who does not profess to be so qualified by special training and ability. [38]

In assessing whether a doctor has met the appropriate standard of care, a court will place particular importance on evidence of accepted practice. As a general rule, a doctor who is shown to have acted in accordance with the generally accepted practice will be found to have met the appropriate standard of care and will not be found negligent.[39] Conversely, if a doctor is shown to have departed from the accepted practice, this will provide strong evidence, though not necessarily conclusive , that the doctor was negligent. In light of these principles, the increasing reliance by the medical profession on the development of clinical practice guidelines is legally significant. These guidelines are likely to play a increasingly important role in malpractice litigation, as evidence of whether or not the doctor acted in accordance with the generally accepted practice.

In the context of standard of care, the main issue that arises from cost containment polices is whether a doctor can use these policies as an "excuse" in defending a malpractice claim by a patient. In other words, if a doctor decides, for reasons of cost containment, not to use a particular treatment or procedure, even though the treatment or procedure might be beneficial, does this provide a defence in an action for malpractice?[40]

The leading Canadian case on this issue is *Law Estate* v. *Simice*,[41] in which a widow sued several physicians as a result of the death of her husband due to a ruptured aneurysm. In defence, one of the reasons forwarded for not providing a CT scan[42] in a timely manner was that there were constraints imposed by the

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[38] *Crits* v. *Sylvester* (1956), 1 D.L.R. 502 at 508 (Ont. C.A.), aff'd [1956] S.C.R. 991. See also Picard & Robertson, *supra* at 132-134.

[39] *ter Neuzen* v. *Korn*, [1995] 10 W.W.R. 1 (S.C.C.).

[40] For a detailed discussion of the issue see T. Caulfield, "Health Care Reform: Can Tort Law Meet the Challenge?" (1994) 32 Alta. L. Rev. 685; J.C. Irvine, "The Physician's Duty in the Age of Cost Containment" (1994) 22 Man. L.J. 345; J.C. Irvine, "Case Comment: *Law Estate* v. *Simice*" (1994) 21 C.C.L.T. (2d) 259; Picard & Robertson, *supra* note 28 at 207–210.

[41] (1994), 21 C.C.L.T. (2d) 228 (B.C.S.C.), aff'd [1996] 4 W.W.R. 672 (C.A.) [hereinafter *Law Estate*].

[42] The ACT or CT (axial computerised tomography) scan is a radiological imaging technique.

provincial insurance scheme on the use of such diagnostic tools. The court did not accept this "economic defence" and went on to conclude that:

> [I]f it comes to a choice between a physician's responsibility to his or her individual patient and his or her responsibility to the medicare system overall, the former must take precedence in a case such as this. The severity of the harm that may occur to the patient who is permitted to go undiagnosed is far greater than the financial harm that will occur to the medicare system if one more CT scan procedures only shows the patient is not suffering from a serious medical condition. [44]

Similarly, in the malpractice case *Wickline* v. *State of California*, the Court concluded:

> While we recognize, realistically, that cost consciousness has become a permanent feature of the health care system, it is essential that cost limitation programs not be permitted to corrupt medical judgement.[45]

It is likely that this judicial trend will continue, making it clear that doctors who place cost containment ahead of the best interests of their patients run the very real risk of being held liable in a malpractice suit, should the patient be injured.

C. Fiduciary Law and Conflict of Interest

Because the principles that support fiduciary law flow from the unique nature of the physician-patient relationship, fiduciary obligations are particularly relevant in the context of cost containment initiatives and resource allocation policies.[46] In Canada, fiduciary law requires health care providers to "act with utmost good faith and loyalty"[47] in dealing with patients. Arguably, fiduciary law compels physicians to do that which is in the patient's best interests, even if it is at the expense of the physician's interest or that of any other person or entity.[48]

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43 *Law Estate, supra* note 41 at 240.

44 *Ibid.*

45 *Wickline* v. *State of California*, 228 Cal. Rptr 661 (Cal. App. 2 Dist. 1986) at 672.

46 M. Rodwin, "Strain in the Fiduciary Metaphors: Divided Physician Loyalties and Obligations in a Changing Health Care System" (1995) 11 Am. J. Law & Med. 241; See also B. Dickens, "Medical Records—Patient's Right to Receive Copies—Physician's Fiduciary Duty of Disclosure: *McInerney* v. *MacDonald*" (1994) 73 Can. Bar Rev. 234.

47 *McInerney* v. *MacDonald* (1992), 93 D.L.R. (4th) 415 (S.C.C.) at 423 [hereinafter *McInerney*]. See also *Norberg* v. *Wynrib* (1992), 92 D.L.R. (4th) 449 (S.C.C.); *Henderson* v. *Johnston* (1956), 5 D.L.R. (2d) 524 (Ont. High Ct.); and *Cox* v. *College of Optometrists of Ontario* (1988), 65 O.R. 461 (Ont. High Ct.).

48 For example, see generally, J. Erlen & M. Mellors, "Managed Care and the Nurse's Ethical Obligations to Patients" (1995) 14 Orthopedic Nursing 42 at 43, where the authors note that the nurses' "fiduciary relationship is grounded in the ethical principles of respect for persons and beneficence." "Patients expect that nurses will act in accord with their inter-

There have been a number of relevant US and Canadian cases that consider both specific health care reform conflicts and, more generally, the nature of the physician-patient relationship.[49] One of the most famous American decisions is *Moore* v. *Regents of the University of California*.[50] While Mr. Moore was receiving treatment for hairy-cell leukemia, his doctor discovered that Moore had unique cells that had the potential to be of both research and commercial value. Mr. Moore alleged that, without his knowledge or consent, his physician subsequently took cells from his spleen to develop a profitable cell line. Mr. Moore sued for damages and the defendant applied to the court to have the action summarily dismissed. The court held that Mr. Moore had a good cause of action and that his physician had a fiduciary duty to "disclose personal interests unrelated to the patient's health, whether research or economic, that may affect his medical judgment."[51]

There have also been a number of US fiduciary law decisions which flow directly from the operation of cost containment incentive mechanisms. For example, the recent case of *Herdrich* v. *Pegram*[52] held that "the use of a compensation arrangement in which physicians benefit financially from limiting care" constituted a breach of fiduciary law.[53]

While there have been no fiduciary cases in Canada that are specific to resource allocation policies, there have been a number of Supreme Court of Canada decisions that have re-emphasised the fiduciary obligations of physicians.[54]

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ests, and that nurses will not abandon them whenever they need help." See also C. McDaniel, "Ethics and Mental Health Service Delivery Under Managed Care" (1996) 17 Issues in Mental Health Nursing 11; and F. Chervenak, L. McCullough & R. Chez, "Responding to the Ethical Challenges Posed by the Business Tools of Managed Care in the Practice of Obstetrics and Gynaecology" (1996) 175 Am. J. Obstetrics and Gynaecology 523 at 523–24.

49 For a review of conflict of interest case law and legislation. See generally B. Dickens, "Conflicts of Interest in Canadian Health Care Law" (1995) 21 Am. J. Law & Med. 259.

50 793 P.2d 479 (Cal. 1990).

51 *Ibid.* at 485. See also Picard & Robertson, *supra* note 28 at 133.

52 *Herdrich* v. *Pegram*, 1998 LEXIS 20189 (7th Cir. 18 August 1998).

53 M. Anderlik, "A New Weapon Against Managed Care Organizations: ERISA" in *Perspective in Health Law* (Houston: Health Law and Policy Institute, 1998) (www.law.uh.edu/LawCenter). However, see *Ehlmann* v. *Kaiser Foundation Health Plan* 1998 US Dist. LEXIS 13326 (N.D. Tex. 24 August 1998). It is important that many of the US cost containment cases are complicated by the impact of the federal ERISA legislation. Among other things, this legislation limits the type of action one can bring against many MCOs.

54 See generally T. Caulfield, "Legal Aspects of the Physician-Patient Relationship" (1997) 43 Can. Fam. Phys. 2093.

In fact, Canada can be characterised as a country which places particularly onerous fiduciary obligations on healthcare professionals. In *McInerney* v. *MacDonald*, a patient's right of access to her healthcare record was debated. The court held that the physician-patient relationship is fiduciary in nature and that "[c]ertain duties do arise from the special relationship of trust and confidence between doctor and patient."[55] In the case of *Norberg* v. *Wynrib*, McLachlin, J. stated that the "the most fundamental characteristic of the doctor-patient relationship is its fiduciary nature."

What is the specific impact of fiduciary law in the context of cost containment policies? As fiduciary law is often implicated when a conflict of interest occurs, many commentators feel that the physician-patient issues that have arisen as a result of health care reform are best considered through the lens of fiduciary principles.[56] In particular, it has been noted that fiduciary law heightens the physician's obligations to disclose information regarding actual and potential conflicts of interest.[57] As such, it may compel physicians to disclose to patients the existence of incentives that may cause the physician to consider factors other than what is in the patient's best interests.[58]

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[55] *McInerney*, *supra* note 47 at 418.

[56] See *e.g.* Perry, *supra* note 6.

[57] See *e.g.* M. Gunderson, "Eliminating Conflicts of Interest in Managed Care Organizations Through Disclosure and Consent" (1997) 25 J. L. Med. & Eth's 192 at 197:

> Few would deny that physicians have a duty not to engage in conflicts of interest. As such, the duty can be eliminated by patients exercising autonomous choice to consent to the conflict after full disclosure.

See also Note, "The Patient as Not Been Informed: A Proposal for a Physician Conflict of Interest Disclosure Law" (1992) 27 Valparais University L. Rev. 495; and B. Culliton, "Managed Care and Conflict of Interest" (1996) 2 Nature Medicine 489 at 489:

> To the extent that the switch to managed care in the name of sound economy is undermining that trust [between physician and patient], the system is undermining patients' legitimate need to be able to trust that their physicians are fist and foremost on their side.

And later: "[F]ull disclosure should now become a basic element of all health insurance programs. Patients should know how their doctors are being paid."

[58] As noted by Martin & Bjerknes, *supra* note 21 at 457, in relation to a physician's obligation to disclose financial incentives in a managed care policy:

> Pursuing a claim for breach of fiduciary duty, particularly in conjunction with a claim for violation of informed consent, is likely to succeed based on the 'long history of judicial regulation of economic conflicts of interest in fiduciary relationships.'

In summary, Canadian fiduciary law has intensified the obligations owed by physicians to their patients. While it is difficult to predict how a court would apply the fiduciary principles in the context of a conflict created by a cost containment initiative (i.e., would a court find the mere existence of such an initiative to be a breach?), it is reasonable to conclude that, at a minimum, physicians may have an obligation to disclose to patients the existence of incentive mechanisms that may impinge upon their clinical judgement.[59]

D. Other Legal Issues

Cost containment initiatives give rise to a number of other important legal issues. The following is a brief description of some of these.

1. *Third Party Liability*

As physicians' clinical decisions become increasingly influenced by guidelines and incentives imposed by third parties—be they government, health authorities, or otherwise—the issue of whether third party decision-makers can be held liable will likely intensify. To date, there have been no Canadian decisions that clarify if and when a regional health authority, for example, can be held liable for forcing, or inducing, the provision of substandard care.[60] However, there have been a number of US and British decisions hint at the possibility of successfully suing a third party decision-maker for negligently allocating resources (i.e., refusals to provide certain care).[61]

2. *Application of the* Charter?

Could a government or health authority cost containment program be challenged under the *Charter*? For example, could s. 7 of the *Charter* be used to attack a law that limited a citizen's access to health care?[62] Martha Jackman has

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59 As noted above, a number of jurisdictions in the US have made such disclosure a statutory obligations.

60 See generally T. Caulfield, "Suing Hospitals, Health Authorities and the Government for Health Care Allocation Decisions" (1994) 3 Health L. Rev. 7.

61 For US cases, see *e.g. Wickline, supra* note 5 ; *Corcoran* v. *United Health Care Insurance*, 965 Fed. Rptr. (2d) 1321; *McEvoy* v. *Group Health Cooperation of Eau Claire*, 570 N. W. 2d 397 (Wis. 1997); and *Corporate Health Insurance Inc.* v. *Texas Department of Insurance*, 1998, where it was held that a patient retains the right to sue managed care organisations for substandard care. See also J. Orie, "HMO Liability for Medical Practice" (1997) 32 Scalpel and Quill 1; R. Scott, "Court Upholds Right to Sue MCOs, but Independent Review Process Limited" in *Perspective in Health Law* (Houston: Health Law and Policy Institute, 1998) (www.law.uh.edu/LawCenter). For a review of British cases see *Blake, supra* note 24; and C. Newdick, "Rights to NHS Resources After the 1990 Act" (1993) Med. L. Rev. 53.

62 See *e.g.* M. Jackman, "The Right to Participate in Health Care and Health Resource Allocation Decisions under Section 7 of the Canadian Charter" (1995) 4 Health L. Rev. No. 2,

claimed that "a right to life and to security of the person is meaningless without access to health care, both in a preventive sense, and in event of acute illness."[63] However, even if the *Charter* applies in this context,[64] the right to healthcare is "unlikely to entail more than an individual right to basic and medically necessary care."[65] This seems particularly true given that many of the relevant *Charter* cases have characterised a governmental denial of funding as a denial of an additional economic benefit.[66]

3. *The Legal Definition of "Medically Necessary"*

Related to the concept of a "right to health care" is the notion of "medically necessary."[67] As noted by one commentator, "[v]irtually all reform proposals

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3; M. Jackman, "The Regulation of Private Health Care Under the Canada Health Act and the Canadian Charter" (1994) 6 Constitutional Forum 54; and M. Jackman, "The Constitution and the Regulation of New Reproductive Technologies" in *Research Studies of the Royal Commission on New Reproductive Technologies Overview of Legal Issues in New Reproductive Technologies*, vol. 3 (Ottawa 1993) at 20–22.

63 "The Regulation of Private Health Care," *ibid.* at 56.

64 Indeed, a number of commentators have concluded that the chances of succeeding with a Charter challenge are slim. See B.F. Windwick, "Health-Care and Section 7 of the Canadian Charter of Rights and Freedoms" (1994) 3 Health L. Rev. 20, who concludes "the prognosis for s. 7 protection of health-care is not optimistic." See also Canadian Bar Association Task Force on Health Care, *What's Law Got To Do With It?: Health Care Reform in Canada* (Ottawa: Canadian Bar Association, 1994) at 26, who argue that "[t]here is no right to health care under the Charter of Rights and Freedoms)."

65 "The Regulation of Private Health Care," *supra* note 62 at 57.

66 See *e.g. Ontario Nursing Home Assn.* v. *Ontario* (1990), 74 O.R. (2d) (H.C.J.) 365 at 378. In this case it was held that the services demanded by the patient were essentially economic benefits. The court stated that "[t]he section does not deal with additional benefits which might enhance life, liberty or security of the person." See also *Brown* v. *British Columbia* (1990), 66 D.L.R. (4th) 444 (B.C. S.C.), where a government funded drug plan that only partially covered an expensive AIDS drug, AZT, but fully funded cancer and transplant drugs was challenged. The provisions of the plan were not held to violate section 7. See also *Re Fernandes and Director of Social Services (Winnipeg Central)* (1992), 93 D.L.R. (4th) (Man. C.A.) 402, where counsel argued that a denial of home-care services amounted to a violation of the rights of liberty and security of the person. The Court, however, held that "[t]he desire to live in a particular setting does not constitute a right protected under s. 7 of the *Charter*" (at 414). Finally, see also, *Lexogest Inc.* v. *Manitoba (Attorney General)* (1993), 16 Admin. L. R. (2d) (Man. C.A.) 144; and *Whitbread* v. *Walley* (1988) 51 D.L.R. (4th) 509 (B.C. C.A.). For an example of an Human Rights Commission case that is consistent with this line of cases see *Ontario (Human Rights Commission)* v. *Ontario* (18 December 1990), Toronto 92-02788 (Ont. Gen. Div.).

67 See generally T. Caulfield, "Wishful Thinking: Defining Medically Necessary in Canada" (1996) 4 Health L. J. 63.

contemplate limiting health insurance to medically necessary care."[68] The issue, however, is that there are "few legal standards by which to judge what is medically necessary."[69] As such, it is difficult to formulate concrete parameters for a government's moral or legal obligations to its citizens.[70] Given the complexity of the notion of human health and the vast differences between individual health care needs, an operational definition of medically necessary will likely remain elusive.[71]

4. *Access to Health Care Records*

As information technology progresses, it has become increasingly apparent that patients' health care information can be used in a more effective and efficient manner. For example, computer technology allows physicians to access comprehensive patient information whenever the need arises. Moreover, centralised data collection assists governments in ensuring that health care resources are being utilised efficiently.[72] However, the use of this technology has also raised profound concerns surrounding privacy, access and the use of confidential information for the purposes of research and quality control.

IV. CONCLUSION

THIS PAPER HAS HIGHLIGHTED AND DISCUSSED some of the main legal issues that arise from the use of cost containment mechanisms in health care. If one were to identify the most important underlying theme in this discussion it would likely be that cost containment mechanisms result in physicians suffering significantly increased exposure to legal liability. In summary, cost containment policies and mechanisms expand the duty of disclosure arising from the doctrine of informed consent, thus increasing the possibility that doctors will be held liable for failing to properly inform their patients. Furthermore, cost containment policies and mechanisms increase the potential for conflict of interest, therefore

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68 W. Mariner, "Patients' Rights After Health Care Reform: Who Decides What Is Medically Necessary?" (1994) 84 Am. J. Public Health 1515 at 1516.

69 *Ibid.*

70 E. Elhauge, "Allocating Health Care Morally" (1994) 82 Calif. L. Rev. 1449.

71 D. Callahan, *What Kind of Life: The Limits of Medical Progress* (Washington, D.C.: Georgetown University Press, 1990) at 46.

72 See *e.g.* Alberta Health, *Striking the Right Balance: A Discussion Paper* (5 December 1996) at 1, where it is argued that:

> [W]hen health information is not shared appropriately, it can have some negative effects ... [F]or the health system, incomplete information can result in costly duplication and waste of public funds ... .

increasing the possibility of doctors being held liable for breach of fiduciary duty. Finally, cost containment policies and mechanisms are unlikely to provide doctors with an "excuse" or "defence" when sued for malpractice for failing to provide a patient with a reasonable standard of care.