Patients with Psychogenic Pain

R. A. De Vaul, MD, Sidney Zisook, MD, and H. James Stuart, MD
Houston, Texas

This article describes characteristics of groups of patients with a high probability of having pain complaints on an emotional basis. An approach to patients with psychogenic pain, including management suggestions, is emphasized, with particular reference to the use of extensive history for their identification and the importance of minimizing unnecessary medical and surgical procedures.

Evaluating pain complaints is a large part of medical and surgical practice.[1] While pain is generally considered an indication of physical illness or distress by both the patient and physician, it is often emotional in origin and not due to organic pathology.[2-4] Pain of emotional origin or "psychogenic pain" is a real perception and is usually accompanied by all the physiologic concomitants of organic pain. In addition, neurologic findings such as paresthesias and functional motor weakness are common.[2] This similarity of organic and psychogenic pain frequently leads to unnecessary and inappropriate medical procedures or surgery to rule out any possibility of organic etiology. Pain medication or tranquilizers are frequently prescribed in lieu of management strategies appropriate to the emotional nature of the pain. Neither placebo trial nor psychological tests are reliable in differentiating the origin of pain.[5] However, a productive approach is the use of extensive medical history and the clinical presentation to identify patients with a high probability of psychogenic pain. These patients usually have characteristics of one or more relatively well-defined subgroups: (1) pain as a symptom of depression; (2) pain as a delusional symptom of psychosis; (3) pain as a conversion symptom of hysterical neurosis; (4) pain as a symptom of an unresolved grief reaction; and (5) pain as a symptom of a "need to suffer." The following are brief case illustrations and discussions of each of the subgroups of psychogenic pain patients with emphasis on identifying characteristics and management strategies.

From the Department of Psychiatry, The University of Texas Medical School, Houston, Texas. Requests for reprints should be addressed to Dr. R. A. DeVaul, Assistant Professor, Department of Psychiatry, Health Science Center at Houston, The University of Texas, P.O. Box 20708, Houston, Tex 77025.

Case Presentations

Depression

Mr. F. is a 56-year-old, white, married accountant, father of two, admitted to the surgery service with a chief complaint of severe, continuous, left upper quadrant abdominal pain of three weeks' duration. Medical evaluation, including complete laboratory and x-ray survey, was negative. Further history revealed three months of increasing depression. Symptoms included early morning awakening, loss of appetite, a 20 lb weight loss, loss of interest in sex, unprovoked crying spells, and occasional suicidal ideation. During the initial history, the patient had presented only his pain symptom. However, the symptoms of depression were obtained from the patient and his family upon direct questioning. The patient responded to tricyclic antidepressants with complete relief of his pain.

Pain is a well-documented symptom of depression.[6] Typically, a careful history will reveal the onset of depression preceding the pain complaint. However, the patient sometimes complains only of pain, and direct questioning of the patient and his family regarding other signs and symptoms of depression may be necessary. These often include feeling "down" or "blue," unprovoked crying spells, easy fatigability, inability to concentrate, loss of efficiency, a lack of interest and satisfaction in work, withdrawal from family and friends, sleep disturbance (particularly early morning awakening), loss of appetite, weight loss, loss of interest in sex, constipation, and suicidal ideation. Periodicity is also a characteristic of depressive pain.[7] In addition, a past history of depression, alcoholism, accident proneness, or manic episodes, as well as a family history of either depression, alcoholism, or sociopathy helps to corroborate the diagnosis.[8]

Once identified, depression (and accompanying pain) can often be relieved by a three-week trial of tricyclic antidepressants in the 100 and 200 mg per day range. It makes little difference which tricyclic antidepressant is used, so long as adequate doses are given over a long enough period of time. Should this fail to produce significant improvement, electroconvulsive therapy might well be considered.[9]

Psychosis

Mr. L. is a 21-year-old, white, single machinist, admitted to the psychiatric service complaining of persistent burning pain in his right shoulder from "cosmic rays being broadcast by the local radio station." The patient's presentation and history were consistent with the diagnosis of schizophrenic psychosis. He had received an electrical burn in his right shoulder at the age of six, working in his father's workshop. The patient's acute psychosis and his pain resolved with antipsychotic doses of phenothiazines.

Delusional pain may be seen in many types of psychiatric illness other than schizophrenia, including hysterical psychosis, mania, depression, toxic delirium, and other organic brain syndromes. Like other delusions, the pain is a fixed symptom, resistant to all reassurance or medical evidence to the contrary. The pain description is usually bizarre and is frequently presented in a very atypical, symbolic way.

The frankly psychotic patient is not difficult to recognize. However, a brief and structured interview may not reveal the extent to which a less disturbed patient has lost contact with

reality. A more extensive and nondirective history will usually demonstrate the patient's chaotic state and reality impairment. These patients are best referred for psychiatric treatment. Appropriate antipsychotic treatment generally leads to resolution of the delusional pain and other symptoms of psychosis.

Hysterical Neurosis

Miss D. is a 14-year-old, white, high school student, admitted to the surgery service with a chief complaint of crampy, lower abdominal pain. Medical evaluation was negative, including laboratory and x-ray evaluation. The patient seemed relatively unconcerned about the pain and was noted to be seductive and manipulative. The patient described her pain as "like being in labor." History revealed the patient wanted to have a baby, and was unable to deal with her sexual feelings. Despite a diagnosis of conversion pain, the patient was operated on with negative findings at laparotomy.

Pain as a conversion symptom is a neurotic solution to a personal conflict. Its characteristics often include: (1) a pain description that relates to the underlying personal conflict (this patient's pain was described as similar to someone in labor and prevented her from acting on her desire to become pregnant), (2) inappropriate indifference to the pain despite its continued presence, (3) sudden onset in an emotionally charged situation, (4) a pain description that defies neuroanatomical boundaries, (5) an associated gratification of dependency needs and relief of unpleasant responsibilities that the patient would find unacceptable in good health.[10]

Conversion pain is goal-directed. A situation or problem can be identified for which the patient's pain is an attempted solution. It is commonly seen in settings of marital discord, family problems, job difficulties, and non-recovery from traumatic injuries, particularly if they involved disability or compensation.

Psychiatric evaluation, hypnosis, or Amytal interview may help confirm the diagnosis. Placebo medications are frequently misused in the differential diagnosis of conversion pain because of a lack of understanding of the placebo effect. This effect is powerful, derives from the suggestions and expectations of the physician-patient relationship, and occurs as a significant part of any medical intervention. However, it is not useful in the differential diagnosis as it significantly relieves organic pain.[11] In addition "fooling" the patient jeopardizes the trust essential for a constructive medical intervention.

Effective management of this group of patients frequently requires a two-stage strategy. First, the physician should reassure the patient that there is no evidence of serious medical or surgical illness and suggest that he will feel better shortly. A minor analgesic may be prescribed with the strong suggestion of relief. This will be especially useful for acute symptoms that tend to begin and end suddenly. For patients who fail to respond to reassurance and suggestion, the next step is confrontation. The patient is told that there is no doubt about the validity of the pain and suffering but in all likelihood it is a manifestation of emotional stress. Following the usual mixed response of perplexity, anger, and disappointment, the patient may be willing to discuss personal problems and agree to appropriate counseling or social intervention. A genuine concern and willingness to continue to follow the patient medically is crucial to this approach.

Unresolved Grief Reaction

Mrs. L. is a 24-year-old, white, married mother of two, admitted to the medical service, with intermittent substernal chest pain of two months' duration. A diagnosis of angina was made on the basis of history. Further history revealed that the patient's mother had died quite suddenly of a heart attack approximately two weeks before the patient's symptoms began. The patient had been unable to attend the funeral, cry, or accept the fact that her mother was dead. Descriptions of her pains and those that her mother experienced were identical. With encouragement, the patient was able to grieve with disappearance of her chest pain.

The death of a close family member or friend is usually followed by a period of mourning or grief. Resolution of grief is a gradual process which leads to an acceptance of the loss and the ability to get on with one's life. Patients who are unable to grieve or who have unresolved grief reactions are a high-risk group to develop mental illness.[12] When questioned, these patients report an inability to cry sufficiently for the dead person, a need to cry in order to feel relieved, a lack of conviction that they have been able to grieve, and often a history that they have not attended the funeral.

One striking form of unresolved grief reaction is illustrated by the case example. The patient presented to the medical service with symptoms of her deceased mother's illness. Identification with the person who has died is a normal part of grief; in unresolved grief, it may take the pathologic form of enduring symptoms and signs of an illness of the person who died. The patient's description of the pain complaint is usually in the same terms as his description of a similar symptom of the deceased.

Patients with pain as a symptom of an unresolved grief reaction are important to identify to initiate proper treatment. Weekly counseling with the family physician, minister, priest, or social worker often mobilizes a grief reaction with complete relief of the symptoms. Counseling involves encouraging the patient to talk about the person who died and express the intense attendant emotions. Since grieving is painful, the patient needs support to proceed and frequently feels worse before beginning to recover.[13]

"A Need to Suffer"

Mrs. K. is a 45-year-old, white, married mother of two, admitted to the surgery service for persistent abdominal pain. She was dependent upon meperidine (Demerol) and had taken multiple analgesics and tranquilizers without relief in the past. The patient had had 35 abdominal operations for similar pain. Medical evaluation, including laboratory and x-ray screen, was negative with the exception of reported pain on palpation. Further history revealed the following: despite the description of pain as intolerable and unrelieved by analgesics, the patient appeared engaging, animated, and comfortable while discussing her problem. She appeared to relish talking about her many medical encounters and surgical procedures. Her review of the abdominal operations revealed a repetitive pattern. Each time, the patient was rejected by an initial surgeon, but then found a second surgeon who would operate for

her persistent pain. The patient's pain always returned in a few days after the operation. Past history was remarkable for descriptions of constant tragedy and suffering. She recalled always having to work very hard as a young girl, and her only reprieve was illness. Her mother had multiple illnesses and multiple surgery. It was noted that some of the patient's operations coincided in time to those that her mother had experienced. The patient denied any problems in her current living situation. She insisted that everything would be all right if she could just get some relief from her pain. It was also noted that any attempt to encourage or reassure the patient increased her complaints of pain.

This case illustrates many characteristics of a large group of psychogenic pain patients. Evidence that the patient requires pain and suffering dominates the clinical picture.[3] Their life histories are filled with personal tragedy and interminable suffering which is attributed by the patients to misfortune. However, careful scrutiny reveals that the patient has repeatedly placed himself in situations that were bound to fail. A striking feature is the onset of painful symptoms when things are going well for the patient, and their remission in times of external stress. One patient remarked, "My life reads like a bad novel," and "just when things seem to be going well for me, I end up sick again."

Past history usually includes deprivation, physical abuse, and hard work as a child. Illness is recalled as a respite and a time of special attention and concern from parents. Often a family member, especially the mother, has multiple illnesses and has been a model for pain behavior. Patients with multiple surgeries usually have their first operation as an adolescent, and many have succeeding surgeries at the same age that their parents underwent similar procedures.

Another characteristic is the frequent report that everything is fine in the patient's family relations, marriage, and work situation, despite all evidence to the contrary.

The way these patients relate to their physicians is of particular importance. There is a great intensity about the relationship and an urgency to be identified as a suffering patient. Their pain is intolerable and never significantly relieved by numerous analgesics or surgical interventions. Their pain complaints usually escalate if their physician is optimistic, encouraging, or reassuring.

Patients whose pain is a symptom of a "need to suffer" present two major management problems. First, the patient's life-long pattern of suffering in an attempt to satisfy an intense need for love and acceptance ("You must love me because I suffer") characterizes the doctor-patient relationship. To improve or recover during treatment would mean losing a major source of gratification. Therefore, the patient's suffering must be acknowledged and recommendations for recovery should be presented as an additional burden to the patient, especially for someone else's benefit.[14]

Second, these patients have often adopted the role of career patients, insisting that the doctor attempt to cure and relieve their suffering while they maintain their role of the intractable sufferer. It is extremely important that the physician refuse to attempt to cure the patient and is not manipulated by insistent demands for heroic attempts at diagnosis or pain relief.[4] The physician must insist that medical treatment be on his terms, and should include: (1) confronting the patient with the choice of continuing as a sick patient for whom there is no medical treatment or attempting the more difficult burden of learning to live with the pain and attempting to overcome the resultant disability; (2) withdrawal of all unnecessary medications; and (3) gradual return to work, family, and social responsibilities.[9]

Discussion

Patients with pain of emotional origin present special problems to busy physicians. Most will not be reassured by the negative medical examination and the physician's assurance that there is no evidence of serious disease. They insist on pain relief and pressure physicians to confirm the medical nature of their discomfort. At this point a more extensive history should be taken in lieu of the usual additional investigations or pain medications. This history is likely to provide evidence for the pain's emotional etiology which requires alternative management strategies. This is a critical decision; further investigative procedures or drug treatment will not be effective in treating pain of emotional origin, and more important, will collude with the patient in viewing his problem as a medical illness.[4]

Once identified, these patients are most effectively handled by a general approach that includes: (1) sympathetic and direct confrontation on the likely emotional origin of their symptoms, (2) specific recommendations for further evaluation or treatment of their emotional problems (social service, psychiatric evaluation, antidepressants), and (3) most important, the willingness to continue to see the patient as the primary physician. While not all patients will accept this approach, it has two very important advantages. It recognizes the real nature of the patient's problems and offers the patient an opportunity to use resources that may be helpful in resolving his emotional problems or problems in living. Most important, it minimizes the extremely high risk of these patients having unnecessary medical procedures, surgical operations, and iatrogenic drug dependence.[15]

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lic interest imposing a duty of care is the same public interest which makes the duty "nondelegable." In Tunkl v Regents of the University of California[118] the court's decision to invalidate the hospital's disclaimer clause was based on the hospital's performing a service of great public importance.[119] The duty of care in providing medical care that GPHPs and hospitals hold is too important to be avoided.[120]

Consumers' Limited Choice of Physicians. The GPHP contract severely limits the consumer's choice of physicians, while the plan is allowed to choose and limit the number of physicians. The rationale behind this "closed panel" is that the GPHP has knowledge enabling it to select higher quality physicians than the consumer could,[121] and that limiting the quantity and raising the quality of the physicians allows the GPHP to pay the doctors a fixed sum and reduce consumer costs.

Not only should this limited choice by the consumer and selection by the GPHP (two related but separately significant factors) cause a duty of care in selection to attach to GPHPs, but these factors argue as well for other GPHP liability theories. The consumer's limited choice and the GPHP's assumption of that function is a strong indicator of the GPHP's role as the medical care provider. Even the choice of physician has been institutionalized. The consumer is choosing an institution and not a physician to provide his care.

The patient's traditional freedom of choice of physician has long motivated courts to deny hospital liability.[122] But hospital emergency rooms are one area where the hospital often chooses the physician, and hospital liability for malpractice in the emergency room often results.

> The rule may fairly be deduced from the decisions of this court that when a person goes to a hospital for treatment for a particular malady, and expresses no preference as to the physician by whom he is to be treated, and is there directed to or assigned to a reputable physician, one who is not in that respect an employee of the hospital and who is apparently qualified to treat such malady, it is the duty of those in charge of the hospital to exercise reasonable care in the selection of the physician. . .[123]

Darling v Charleston Community Memorial Hospital, the landmark case in institutional medical care provision liability, seems to have partially relied on this factor. The Illinois Supreme Court held for the plaintiff, who had argued the hospital was negligent in not adequately controlling plaintiff's physician ". . . especially since Dr. Alexander had been placed on emergency duty by the hospital . . ."[124]

In another hospital liability case the court counted the plaintiff's inability to choose and the defendant hospital's sole ability to choose the malpracticing doctor as a reason for holding the hospital to be the employer/master of the physician.[125] Clearly, physician choice by the institution superseding choice by the patient is a strong indicator of institutional liability for lack of care in selection, and for other theories of institutional liability as well.

Contract Between Plan and Subprovider

Quality Control Regulations. The contract between the plan and the nonemployee subproviders may indicate plan control through the number and strength of care quality regulations the plan imposes upon the subprovider.[126] Through their indication of plan control of subproviders and the care provided, these quality regulations should indicate plan liability for malpractice by a subprovider.

Conversely, plan liability for subprovider malpractice may encourage the plan to insert quality control regulations into the plan/subprovider contract because such regulations are presumed to enhance the quality of medical care provision. Curran and Moseley advise that GPHPs incorporate some procedural devices to protect against actual malpractice occurrences. Among them are specific and rigorous criteria for granting and withdrawing hospital privileges or membership in the medical group, contractual provisions establishing an effective quality review committee, compulsory continuing education of medical professionals, and incentives and penalties for high and low quality medical care. Specific procedures requiring supervision of paramedical personnel by medical professionals are also recommended.[127]

These regulations are analogous to the hospital bylaws and accreditation

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standards in Darling, indicating the institution's duty of care.[128] So, GPHP contractual regulation of its subproviders may help define the scope of the plan's duty in addition to indicating the need for plan liability. First, the regulations indicate the plan's ability to control and its actual control of the subproviders' care. Second, because it is widely believed that these regulations do reduce malpractice, and therefore malpractice suits, plan liability will motivate plans to incorporate such regulations and other malpractice reducing procedures into their plan/subprovider contracts.

Capitation Contracts. Another substantial reason for encouraging plans to increase the quality of their subproviders' care arises from the capitation compensation clauses in GPHP contracts.[129] Because capitation clauses shift the risk of over-utilization to the subprovider, the plan is encouraging the subprovider to keep its costs down, which in theory should encourage health maintenance medicine, but which may encourage the subproviders to provide less or lower quality care.[130]

The answer to this problem is not eliminating capitation clauses. They are fundamental to the GPHP concept and serve a legitimate public policy: reducing medical care costs by eliminating excess usage and by emphasizing health maintenance medicine. Capitation clauses even counteract the motivation ordinary physician malpractice liability imposes on doctors to practice wasteful "preventive medicine."[131]

Yet, something more than faith in a physician's integrity must balance the negative motivation these clauses provide. Clearly, this balancing motivation should be applied at the plan level of the structure. It imposes the capitation clause, is the unit the consumer contracts with, and has the power to regulate the quality of the subprovider's care. Malpractice liability imposed upon the plan will also neutralize the plan's own motivation to encourage subprovider care skimping resulting from the plan's capitation contract with its consumers. Public policy therefore dictates plan liability.

Economic and Policy Factors

This section will focus on economic and policy factors that indicate GPHP liability when a physician-provider malpractices. The theories here are that certain effects of GPHP liability are desirable and should be encouraged, and that certain effects of GPHP nonliability are undersirable and should be discouraged.

Professors Harper and James postulate that tort law consists primarily of: (1) measures to reduce accidents and (2) measures which minimize the bad effects of accidents which do occur.[132] But these measures must not unduly inhibit valuable but dangerous activity and must on the whole satisfy the ethical or moral sense of the community: its feeling of what is fair and just. Therefore, among the possible objectives of tort law in accident cases are: (1) deterrence; (2) compensation; and (3) fairness. But in achieving these objectives courts must avoid discouraging desirable activity or imposing a disproportionate burden on any members or groups in society. It should, of course, be kept in mind that tort law is not the only device for social control of the accident problem. A rule of tort liability may not, therefore, be condemned, and may well be fully justified, if it promotes only one or two of these objectives, provided that the rule does no violence to the other objectives, and provided that these other objectives are being served as well by other devices of social control as they would by the tort rule which is the alternative to the one under consideration.

Many of these economic and policy theories have already been discussed in this paper.[134] Some will be touched on again, some will not. All of Harper and James' objectives will be discussed, if only briefly, in the context of GPHP liability when a physician-provider has malpracticed.

Liability as a Deterrent. The question of whether malpractice liability should be imposed upon a plan as a deterrent may be separated into three closely related inquiries: (1) are there reasonable foreseeable activities that *need* deterring (or encouraging); (2) is it *feasible* for liability to deter (or encourage) these activities; and (3) is it *appropriate* to place liability at the plan point of the medical care structure?

The first two questions have implicitly been answered affirmatively by the reasoning in previous cases applying liability to physicians and hospitals. Exceptional examples of the need and the feasibility of liability in the GPHP field will be brought out in the following discussion of the appropriateness of plan liability.

Three aspects of GPHP structure and function highlight the deterrent effect of imposing liability on the plan in addition to or instead of other entities: capitation contracts, quality control procedures, and physician selection by the plan.

The peculiar motivation to reduce the quality as well as the quantity of medical care that capitation clauses and other savings incentives inserts into the GPHP structure and the need to counterbalance it has been discussed previously.[135]

Plan liability will counteract the negative incentive because the plan writes the contracts, including the capitation clauses. It contracts with the consumer on a capitation basis, and therefore plan liability will neutralize its own incentive to cut corners. The plan imposes capitation compensation on its subproviders, and therefore plan liability will encourage the plan to neutralize its imposition of a negative incentive on subproviders by imposing counteracting measures in its plan/subprovider contract.[136] The appropriateness of plan liability to counterbalance capitation negative incentives is a fairly commonly accepted principle among those knowledgeable of the legal problems of GPHPs.[137]

The need and feasibility of internal quality control procedures has also already been established.[138] Plan liability is clearly the appropriate mechanism to encourage these procedures and therefore deter malpractice. Because plans presume that such procedures reduce malpractice, if they also know they will suffer financial loss as a result of each malpractice, they will impose such procedures through their contracts. Furthermore, it is known that large units (such as GPHPs) are in a strategic position to reduce accidents (such as malpractice). This is because liability creates more pressure to prevent accidents on large units than on individuals, and large units are in a far better position than individuals to reduce accidents.[139]

Because the plan, and not the consumer, always has the direct power to select its physicians, the appropriateness of imposing liability at the plan

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level is obvious;[140] the plan will be encouraged to select carefully. Additionally, the difficulty GPHPs are having in procuring physicians accentuates the need for and appropriateness of plan liability.

There are strong indications of a tight market for doctors willing to join HMOs. As a result, the HMOs probably are lowering their standards for hiring new doctors and are not being as strict in disciplining doctors already hired.[141]

GPHPs are having the most difficulty recruiting neurosurgeons, obstetrics-gynecologists, radiologists and other specialists. These are precisely the specialties that have the highest incidences of malpractice claims against them. Therefore, some GPHPs are lowering their physician quality standards for precisely those types of physicians who have the worst malpractice claim record.[142] It seems fair to conclude that imposing selection, control and contract liability upon the plan is not only appropriate, it is compelling.

Liability as Compensation. "The cardinal principle of damages in Anglo-American law is that of compensation for injury caused to the plaintiff by defendant's breach of duty."[143] Even under the newer, more equitable liability systems (no fault, strict liability), the major goal is victim compensation. Obviously, the public policy of compensation applies to GPHP liability as much as it does to any other situation. To assure proper allocation of limited resources in a free society, every enterprise must pay its own accident costs.[144]

GPHPs have the resources to compensate their injured consumers. "In anticipation of malpractice claims, all HMO's carry malpractice insurance coverage."[145] And plan liability will work to "make whole" the victim in more than a monetary sense. When a GPHP physician injures a consumer, the GPHP intensifies that consumer's care in an attempt to correct the consequences of the malpractice.[146]

Furthermore, any policy which would redistribute loss to one who can better afford it[147] would tend to force the GPHP to become responsible for its consumers' care. Even if it should be found true that a GPHP cannot yet realistically control the use of individual physicians, the plan liability becomes a legitimate business expense shared by all of the GPHP's consumers, not a penalty for "bad behavior."[148]

Finally, it has been argued that GPHPs should not be liable because an adequate remedy already exists – physician, hospital or medical group liability. While the entirety of this article has answered this largely irrelevant argument, some further comments are appropriate here. Making the GPHP liable increases the injured consumer's opportunity to recover, but not necessarily the amount of the award, for several reasons. The standard of care required of the GPHP may be that of the ordinarily reasonable person, rather than the professional standard applied to physicians, thus possibly avoiding the requirement of expert testimony and therefore avoiding any "conspiracy of silence." Additionally, a longer statute of limitations period may apply[149] and a res ipsa loquitur theory may be available against a GPHP because of its generalized duty and control and the complex integrated care it provides. The GPHP's greater financial resources[150] are, of course, also a factor.

Furthermore, the policy of liability as a deterrent argues for GPHP liability, without regard to hospital, medical group and physician liability. The plan itself should also be encouraged to reduce patient injuries.[151] Finally, no good reason appears for exempting GPHPs from liability.

Fairness. The principal philosophical justification for the fault liability system lies in morality. It does not ordinarily seek to punish wrong-doers, but to compensate victims. It is fair to make the actor/defendant compensate the victim/plaintiff if the actor is at fault. But if the actor is without fault or the victim is also at fault, there should be no compensation. Some sense of fairness is satisfied by the notion that the actor had a choice and of free will chose a culpable course of conduct and therefore is morally to blame.[152]

Unfortunately, the fault system largely lacks this moral justification.[153] But this does not mean accident law should abandon a moral objective, nor that the fault basis of liability should be perpetuated without regard to morals. Other and broader social moral considerations indicate the need for an entirely different system of liability that wisely distributes accident losses over society without regard to fault.[154]

There is evolving in tort law a shifting of emphasis from the fault principle based on *personal* moral objectives to a system closer to social insurance, based on *social* moral objectives; this process is occurring in health-care institutional liability law. To explain: the more objective (external, idealistic) the reasonable person standard (ie, less subjective: not taking into account the individual personal equation involved in the actions leading to the suit), the less personal fault is involved in determining liability. As pressure toward a social insurance theory of tort law becomes more dominant, the trend during the period of transition will be toward greater objectivity of the standard as applied to defendants.[155]

This is what the Darling[156] court did. In allowing the institution's staff regulations, accreditation standards, statutes, and the custom of other hospitals in the national community to define the hospital's standard of care, the court objectified the defendant's standard and moved a step closer to a social moral objective.

The Darling court's reliance on regulations, standards and health care quality statutes to fulfill the moral objective for liability should be duplicated for GPHPs. Society has begun to demand of GPHPs what it does from hospitals. GPHP statutes in at least three states require either that reasonable standards of quality of care be met or that internal procedures for quality control be established.[157] The Federal Health Maintenance Organization Act of 1973 specifically requires ongoing quality assurance programs and continuing education program for covered GPHP health professional staff.[158] Additionally, most GPHPs have quality control procedures similar to, or more extensive than, the defendant hospital in Darling had.[159]

Whether one espouses the personal moral objective and fault principle of liability or the social moral objective and social insurance principle of liability, the goal is the same – victim compensation. This objective will best be served by GPHP liability. Tort doctrine stressing personal moral objectives would suggest that the GPHP should be responsible for its institutional actions. If the moral objective is

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social, GPHP liability promotes equitable distribution of accident losses as a cost of health care provision. Each consumer, including the victim, shares equally through increased GPHP fees.

It would, of course, be folly to impose liability on GPHPs if that imposition substantially discouraged their desirable activities. But GPHP liability will not discourage the formation or full functioning of GPHPs. They can and do carry malpractice insurance. They can and do obtain indemnification from others. Extending malpractice liability from physicians, hospitals and medical groups to GPHPs will not necessarily increase the size of jury verdicts, but it will spread or shift the liability burden.[160]

GPHP liability will not disproportionately burden GPHPs, but will remove the undue burden from victims and spread it over all the GPHP's consumers. It bears repeating that, to assure proper allocation of limited resources in a free society, an enterprise must pay its own accident costs.

Finally, GPHP liability may take the pressure off individual physicians to practice "defensive medicine" and alleviate the growing medical malpractice crisis.

Conclusion

GPHPs were created to provide better health care at a lower cost. As GPHPs assume this role over time, they will move concurrently toward institutional liability. As health care is institutionalized, so liability is institutionalized. The GPHPs now in existence realize this fact, and many are beginning to deal with it. They are obtaining insurance or becoming self-insuring, providing voluntary or binding arbitration, or just settling with aggrieved consumers. Others are also attempting to provide for GPHP liability. New compensation and quality control systems are being discussed seriously. There are institutional no-fault liability systems, such as vicarious liability[161] and strict liability.[162] Variant arbitration systems are also being proposed and tested.[163]

Assuming that GPHPs will grow, GPHP liability will be expected by consumers and should be accepted by administrators and physicians. It should not be viewed as punishment, but as an equitable social tool. If liability is viewed this way, abuses may be corrected, and liability may become an integral and positive part of the health-care delivery system.

References

1. See eg, W. Curran & G. Moseley, The Medical Malpractice Experience of Health Maintenance Organizations and Foundations for Medical Care: Final Report (prepared for National Center for Health Services Research and Development, Dept. of H.E.W. 1973); summarized in Curran & Moseley, The Malpractice Experience of Health Maintenance Organizations, 70N.W.U.L. Rev. 69 (1975)

2. See eg, Darling v Charleston Community Memorial Hosp., 50 Ill. App.2d 253, 200 N.E.2d 149 (1964) aff'd, 33 Ill.2d 326, 211 N.E.2d 253 (1965), cert. denied, 383 U.S. 946 (1966)

3. Cases and commentary dealing with the problem discussed are scarce. Possible reasons for this are the relative newness of GPHPs and plaintiffs' usual success in collecting damages from alternative sources such as physicians, medical groups and hospitals

4. The term "group prepaid health plan" is used here instead of the more common term, "Health Maintenance Organization" (HMO), for several reasons. The federal Health Maintenance Organization Act of 1973 (42 U.S.C. § § 300e–300e-14a definition of HMOs now excludes most established GPHPs because they do not comply with the extensive requirements of the Act. Furthermore, the Act potentially includes Foundations for Medical Care, structures which this paper does not examine. Additionally, HMO in common usage has been generic and not a definitive term. A specific HMO may have relationships and contract obligations which result in questions of liability which are not of concern at all to other models of HMOs. See Aspen Systems Corp. Health Law Center, Digest of State Laws Affecting the Prepayment of Medical Care, Group Practice and HMOs, at 182-84 (App. F:1972)

5. See generally W. Curran & G. Moseley, supra note 1

6. See Beeck v Tucson General Hosp., 18 Ariz. App. 165,500 P.2d 1153 (1972); Wells v Southern California Permanente Medical Group, No. SEC6787 (Cal.Super.Ct., Los Angeles Co., Aug. 22, 1973); Larson v Kaiser Foundation Hosps., No. 43238 (Cal. Super. Ct., Santa Clara Co., April 9, 1973), as noted in 28 Citation 19 (Nov. 1, 1973); Bye v Group Health Plan, Inc., File No. 684091, Calendar No. 84165 (4th Div. Dist. Ct., Hennepin Co., Minn., March 12, 1974); Fiorentino v Wenger, 19 N.Y.2d 407, 227 N.E.2d 296 (1967); Bing v Thunig, 2 N.Y.2d 656, 163 N.Y.S.2d 3, 143 N.E.2d 3 (1957); Giuste v C. H. Weston Co., 165 Or. 525, 108 P.2d 1010 (1941); 18 Okla. L. Rey. 77 (1965); and see the cases cited in Annot., 69 A.L.R.2d 305 (1960)

7. See sections of this paper discussing structure and function of the GPHP, infra, at notes 71-160.

8. C. Steinwald, An Introduction to Foundations for Medical Care (Blue Cross Association, 1971)

9. Hereinafter, "GPHP" will refer only to this model

10. W. Curran & G. Moseley,[1] Study on Legal Issues in the Reorganization of Health-Care Institutions 30 (1974)

11. W. Curran & G. Moseley, supra note 1, at 10; O. Schroeder, Jr., The Law Medicine Letter, 51 Postgraduate Medicine, 53, (April 1972); Medical Group Management Ass'n Manual on Insurance, 65, 66, 83-91 (1974); see also Jordan v Group Health Ass'n, 107 F.2d 239 (D.C. Cir. 1939) in which the court held GHA not subject to Washington, D.C.'s insurance laws because the plan provided services and did not just indemnify and therefore is not an insuror

12. Bing v Thunig, 2 N.Y.2d 656, 163 N.Y.S.2d 3, 143 N.E.2d 3 (1957); Darling v Charleston Community Memorial Hosp., 50 Ill. App.2d 253, 200 N.E.2d 149 (1964), aff'd, 33 Ill.2d 326, 211 N.E.2d 253 (1965), cert. denied, 383 U.S. 946 (1966); Southwick, The Hospital as an Institution —

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13. W. Curran & G. Moseley, supra note 1, at iv

14. Id, at 6-9

15. See id. at 6, 7; Hansen, Group Health Plans: A Twenty-Year Legal Review 42 Minn. L. Rev. 527, 528 (1958)

16. W. Curran & G. Moseley, supra note 1, at 8, 156; Ellwood, Jr. Implications of Recent Health Legislation. Am. J. Pub. H. (Jan. 1972)

17. W. Curran & G. Moseley, supra note 1, at 156

18. Health Services and Mental Health Ad., U.S. Dep't of H.E.W., Health Maintenance Organizations — The Basic Facts (pre-1971)

19. Havighurst, Health Maintenance Organizations and the Market for Health Services. 35 Law & Contemp. Prob. 716, 794 (1971); Hansen, supra note 15

20. Health Services and Mental Health Ad., U.S. Dep't. of H.E.W., Health Maintenance Organizations, The Concept and Structure (1971); Health Services Mental Health Ad., supra note 18

21. See Tierney. Contractual Aspects of Malpractice. 19 Wayne L. Rev. 1457, 1459 (1973)

22. See eg, Calvin v Thayer, 150 Cal.2d 610, 310 P.2d 59 (1957); Mirach v Balsinger, 53 Cal. App.2d 103, 127, p.2d 639 (1942); Benson v Mays, 245 Md. 632, 227 A.2d 220 (1967); Roybal v White, 72 N.M. 285, 383 P.2d 250 (1963)

23. Wills v Regan, 58 Wisc.2d 328, 206 N.W.2d 398 (1973); see also Lane v Boicourt, 128 Ind. 420, 27 N.E. 1111 (1891)

24. For discussion of why a GPHP is a provider of actual health care and not just a financing and contracting agent, see text accompanying notes 10-20, supra

25. Another problem is that the courts convert breach of contract causes into tort actions, a problem common to cases against all types of medical care providers

26. See eg, Joiner v Mitchell County Hosp. Auth., 125 Ga. App. 1, 186 S.E.2d 307 (1971), aff'd. 229 Ga. 140, 189 S.E.2d 412; and see cases and discussion Annot., 51 A.L.R.3d 981 (1973)

27. Id.

28. Id. at 983-84, 989-90; Annot., 13 A.L.R.2d 11 (1950); See 40 U. Cin. L. Rev. 797 (1971); Southwick, supra note 12, at 461-65

29. See Annot., supra note 26, at 984, 987-89

30. See Holder, Negligent Selection of Hospital Staff, 223 J.A.M.A. 833 (1973)

31. See eg, Ozan Lumber Co. v McNeely, 214 Ark, 657, 217 S.W.2d 341 (1949); and see cases and discussion Annot., 8 A.L.R.2d 267 (1949)

32. In Glavin v Rhode Island Hosp., 12 R.I. 411 (1879), a negligent selection of physician case, the court required a corporation created for purposes which could not be accomplished without the exercise of special care and skill to exercise the requisite care and skill; Shapiro v Health Insurance Plan, 7 N.Y.2d 56, 194 N.Y.S.2d 509, 163 N.E.2d 333 (1959) held that a GPHP has the right to select and reject physicians employed by a medical group that is under contract with the GPHP to provide services

33. See W. Curran & G. Moseley, supra note 1, at 22

34. GPHP liability for physician selection would not preclude existing hospital liabilities; For cases and discussion of these points, see text at notes 91-125, infra

35. 125 Ga. App. 1, 186 S.E.2d 307 (1971), aff'd 229 Ga. 140, 189 S.E.2d 412 (1972)

36. See also text at notes 109-120

37. For discussion of the invalidity of this argument, see text at notes 10-25 and 71-132

38. Excepting perhaps vicarious liability, which is not discussed here because discussed at note 6

39. Darling v Charleston Community Memorial Hosp., 33 Ill.2d 326, 211 N.E.2d 253 (1965), cert. denied, 383 U.S. 946 (1966)

40. See text accompanying note 3, supra

41. Southwick, The Law of Hospital Liability, Legal Medicine Annual at 91 (1970)

42. 120 Mass. 432 (1876). See the discussion of McDonald's misconceived precedential underpinnings in Pierce v Yakima Val. Mem. Hosp. Ass'n., 43 Wash.2d 162, 167, 260 P.2d 765, 768 (1953); see also Bing v Thunig, 2 N.Y.2d 656, 163 N.Y.S.2d 3, 143 N.E.2d 3, 5 (1957)

43. Bing v Thunig, 2 N.Y.2d 656, 163 N.Y.S.2d, 3, 143 N.E.2d 3 (1957)

44. For cases distinguishing "medical" and "administrative" acts, see, Annot., 69 A.L.R.2d 305, 317-20 (1960); see eg, Schloendorff v Society of New York Hosp., 211 N.Y. 125, 105 N.E. 92 (1914), rev'd on other grounds; Bing v Thunig, 2 N.Y.2d 656, 163 N.Y.S.2d 3, 143 N.E.2d 3, 5 (1957)

45. Commonly, this involved breaching of a duty of care in the selection of employees, and more recently, nonemployee staff physicians; for cases and further discussion, see Southwick, The Hospital's New Responsibility. 17 Clev.-Mar. L. Rev. 146, 151 (1958); Annot., note 26, at 985-87; Annot. 25 A.L.R.2d 29, 112-125 (1952); and see text at notes 26-37 for cases and further discussion of a hospital's duty of care in the selection of physicians

46. See Annot. 25 A.L.R.2d 29 (1952), for cases and further discussion of these exceptions

47. Bing v Thunig, 2 N.Y.2d 656, 163 N.Y.S.2d 3, 143 N.E.2d 3 (1957)

48. Id. 143 N.E. 2d at 7

49. Id. 143 N.E.2d at 6

50. Southwick, supra note 12, at 465

51. Id. at 443; see also Darling v Charleston Community Memorial Hosp., 33 Ill.2d 326, 211 N.E.2d 253 (1965), cert. denied 383 U.S. 946 (1966); Gilstrap v Osteopathic Sanitorium Co., 224 Mo. App. 798, 24 S.W.2d 249 (1929); Feezer, The Tort Liability of Charities, 77 U. Pa. L. Rev. 191 (1928); for further discussion of hospital vicarious liability, see Southwick, Vicarious Liability of Hospitals. 44 Marq. L. Rev. 153 (1960)

52. See Pogue v Hospital Authority of DeKalb County, 120 Ga. App. 230, 170 S.E.2d 53, 54 (1969), where the court held, "A hospital is not liable for the negligence of a physician employed by it where the negligence relates to a matter of professional judgment on the part of the physician when the hospital does not exercise and has no right to exercise control in the diagnosis or treatment of illness or injury"

53. Galen (A.D. 130-200?) complained of the lack of quality control of Roman physicians during the Empire and the public's tolerance of the ignorance of lazy healers ". . . who flatter their whims." Quoted in Caldwell, Early Legislation Regulating the Practice of Medicine. 18 Ill. L. Rev. 225, 226 (1923). In the American colonies Virginia enacted a bitterly contested medical practice act to improve the quality of medical care in 1639; see generally R. Morris & A. Moritz, Doctor and Patient and the Law, (5th ed., 1971)

54. See Bergen, The Darling Case, 206 J.A.M.A. 1665 (1968)

55. Southwick, supra note 12, at 430-36, 466

56. Id

57. Id, at 431

58. Id, at 430; Southwick, supra note 45, at 146

59. Id

60. Id, at 155-56; Klema v St. Elizabeth's Hospital, 170 Ohio St. 519, 166 N.E.2d 765 (1960)

61. Darling v Charleston Community Memorial Hosp., 33 Ill.2d 326, 211 N.E.2d 253 (1965), cert. denied, 383 U.S. 946 (1966)

62. Walkup & Kelly, Hospital Liability: Changing Patterns of Responsibility, 8 U. San Fran. L. Rev. 247, 254-57 (1973); see also Annot., 14 A.I.R.3d 873 (1967)

63. Bing v Thunig, 2 N.Y.2d 656, 163

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