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Ginzberg recently described in the *Journal* the monetarization of medical care.[1] Law follows money, and along with monetarization have come new laws and legal regulations — constraints that cast a lengthening shadow over the clinical practice of medicine. PSRO (professional standards review organization), PRO (professional review organization), DRG (diagnosis-related group), and CON (certificate of need) are acronyms that have entered the physician's consciousness — along with malpractice liability, antitrust actions, and federal and state regulation. The health-insurance industry, increasingly the target of legal regulation by administrative agencies, legislatures, and courts, is itself a powerful regulatory influence and has acted in a quasi-governmental capacity, extending the lengthening shadow of legal constraints. Physicians have expressed growing concern about the impact of these legal constraints on their traditional professional standards and ethical responsibilities to patients.[2]

Critics of the medical profession tend to dismiss these concerns as the grumblings of a vested interest group opposing needed reforms of the health care "market" to protect its own substantial financial advantages. The American Medical Association's (AMA's) codified ethics have been repeatedly criticized over the years as "protectionist," serving the interests of doctors rather than patients or the larger society. The history of "ethical" opposition to Blue Cross, to Medicare, to Medicaid, and to health maintenance organizations (HMOs) is often cited as "protectionist" ethics deployed against necessary reforms of the health care market. Nonetheless, the purpose of this essay is to highlight the harmful and confusing effect of uncoordinated and contradictory legal regulations of health care. Despite the history, the current concern that professional standards and medical ethics are being swamped by the recent waves of administrative, legis-

lative, and judicial reform is not just the Medical Establishmen rying "wolf" again but an intelligible and realistic concern deserving pub- lic attention because there are important public consequences.

One should acknowledge at the outset that there is real c fusion and perplexity among physicians because the import of l l con- straints seems to be so contradictory. Much of the recent s e and federal regulation has been aimed at creating incentives to low aggre- gate health care costs.[3] On the other hand, the "judges at the dside" Saikewicz decision,[4] Baby Doe regulations, judical decisi s that expand the reach of hospital liability,[5] and the ever-present reat of malpractice litigation, which is time-consuming and thou to be professionally damaging, impel the physician to ignore cost l effec- tiveness considerations. The legal constraints aimed at c trolling expenditures suggest that the aggregate cost of health car s to be considered as an explicit factor in deciding what is ethicall nd clin- ically appropriate treatment in particular cases. The othe ypes of constraints suggest, explicitly in the case of the proposed by Doe regulations and implicitly in the threat of malpractice litig on, that cost cannot be either an ethically or clinically relevant con leration. How does the responsible physician respond to these mixed gal mes- sages?

Even when legal policy has been aimed solely at reduc g or con- taining aggregate health care costs, contradictory methods have been applied, with conflicting clinical and ethical implications. Basically, legal experts in health policy disagree about whether cost are better contained by command and control regulation or by deregulation and competition.[6] The former legal approach to health polic treats the health care system as an industry to be regulated, imposing five-year plans, hospital rate setting, price fixing, CON, and other controls on capital expansion. The latter approach favors an end to centralized control, believing that competition, entrepreneurial ingenuity, and a free market will lower costs and enhance efficiency.[7] These contradic- tory politicoeconomic philosophies translated into conflicting legal policies have attracted different political constituencies. As a result, legislation affecting health care is sometimes a strange compromise between contradictory legal approaches. Federal health-planning legis- lation exemplifies such provisions. Federal guidelines ask state plan- ning agencies to consolidate and regionalize health care services, but the agencies are also asked to promote competition and innovation among health care providers. How these contradictory goals of consol- idation and competition are to be reconciled is unclear.[7] Critical com- mentary on planning for obstetrical services offers a good example of the irreconcilable conflicts.[9]

Perhaps even more important in their clinical and ethical implica- tions are legal constraints acceptable to politicians on both sides of the struggle between regulation and competition. DRGs are the most recent example. They appeal to the supporters of regulation because they allow regulators to set the categories and fix the price tag of hospital treatment. The supporters of competition are appeased by the fact that at least DRGs provide an incentive for economic efficiency, and more efficient hospitals will benefit financially from the fixed price. But it is probably safe to say that one other good reason politi- cians endorse DRGs as they did HMOs and PSROs is that all the painful decisions inherent in balancing cost control and the quality of health care are passed on from government officials to health care providers. Even where such measures seem to be effective in contain- ing costs, these developments are changing the practice of medicine, diffusing ethical responsibility, challenging the physician's professional identity and autonomy, and affecting the doctor-patient relation- ship.[10] And if the time comes when patients are deprived of needed services or suffer some negative consequence, it will be the providers who will be held accountable for their decisions.

The standards of practice that may result from the response of physicians to these legally imposed economic constraints and to incen- tives intended to lower the aggregate cost of health care have yet to be reconciled with the body of law that pushes physicians to ignore cost. The most important practical consideration is malpractice litigation. How will a jury respond when economic rather than medical consider- ations are offered as the reason for a diagnostic or treatment decision that has led to a malpractice claim? The physician's alleged negligence is measured in court against the professional standard of care — an ambiguous concept based on expert medical testimony. But lawyers agree that the current professional standard is different and higher than a standard of care responsive to economic constraints.

It is clear that the physician is now at risk of being found liable for malpractice if any negative consequences occur as a result of devia- tions from the professional standard of care, undertaken to meet econ- omic constraints and incentives created by new cost-controlling legal policies. It is difficult to measure the actual importance of this new mal- practice liability, but there can be no question that the doctor's legal dilemma is real. And the legal dilemma mirrors in many ways the doctor's ethical dilemmas.

Ethical Implications

Although many physicians have welcomed the "committee approach" to ethical problems, some have become increasingly con- cerned about their personal ethical responsibilities to their patients. The ethical questions attendant on rationing health care to control cost touch directly on physicians' personal responsibilities, and such questions have frequently been discussed in this journal and else-

where.[11, 12] Many prominent physicians seem to feel that th e is a need to draw firm ethical lines against these threatening leg intrusions. Even highly interventionist courts have expressed a wil gness to consider medical ethics in their decision making.[13] But a there principles in medical ethics that are sufficiently clear to pern us or the lawmakers to draw sharp lines? Much has been written in e past three decades about medical ethics, but has this spate of sch larship produced any real or compelling consensus among practici physicians? It seems that although awareness of ethical issues s been increased and committees have proliferated, the lack of con nsus is now even more obvious. Perhaps the most important area ethical confusion is the care of the aged, in which DRG regulation h begun.

The author of a recent article in the *Journal* denounced d rimination against the elderly as an emerging and dubious resul f cost-benefit analysis for the control of health care costs.[14] T e views expressed were in sharp contrast to those in a paper publi ed only weeks before, in which the author argued that it is ethi , under appropriate circumstances, to provide resuscitation and int sive care "sparingly" to "pleasantly senile" patients. Although the th st of the latter article was patient autonomy and death with dignity, st saving and cost-benefit analysis hovered in the background as legit ate ethical considerations: "as society tries to contain the soar cost of health care, the physician is subject to insistent demands fo restraint, which cannot be ignored.[15] These contrasting papers are in icative of the medical profession's current confusion and uncerta ty about where we stand on our own ethical prinicples when confr nted with demands to reduce the aggregate cost of health care. The A MA's *Principles of Medical Ethics*, as currently formulated, certainly give few, if any, firm practical guidelines on this issue. They seem int nded more to pacify the Federal Trade Commission and others who ha e attacked our "protectionistic ethics" than to instruct the practit ner. Even "primum non nocere" is absent from the AMA's principles.

Is medical ethics a myth, is it a reflection of law and contemporary values pronounced in solemn tones, or does it have bite drawn from professional values and centuries of tradition? Consider this question in the light of the recent Baby Doe controversy. The Justice Department's legal theory of discrimination against the handicapped, whether right or wrong, was a principled position — that the quality of future life is not an appropriate consideration in withholding treatment from a newborn.[16] The American Academy of Pediatrics, speaking for a divided profession, did not offer a different principled ethical response in contesting the promulgated regulations. The alternative that the academy presented was decision making by local committee. It suggested no countervailing ethical guidelines with respect to the relevancy of the future quality of life. The only principle involved was local committee control rather than national legal control. And the proposed composition of the local committee seemed geared to the political accommodation of interest groups rather than to the facilitation of decisions made on the basis of ethical medical principles.

Nothing I have said is meant to suggest that particular medical ethicists or particular practitioners do not have principled responses to important ethical questions. The claim is rather that whether or not they do, there is no longer even the appearance of an effective consensus in the medical profession and, further, that our professional code of ethics lacks a coherent, stable, and principled foundation. Veatch has suggested that we "abandon the idea that an ethic for medicine can be based on a professionally articulated code."[17] Some medical ethicists have gone even further and have argued that the attempt to supplant a professional code and to apply other a priori ethical principles to particular cases has failed.[18, 19] The correct ethical conduct of the practitioner is too bound up, they suggest, with the particular context of the particular case. This argument appeals to many physicians, but it is an argument that cuts two ways. It does not suggest that the physician need not worry about governing ethical theories and that rigid legal or ethical rules must bend to particularistic clinical judgments. But it also makes the problem of relying on ethical principles in order to resist legal regulation all the more difficult. What is the ethical principle that will send physicians to the barricades to resist legal reform aimed at lowering the aggregate cost of health care?

Cost Saving and Practical Ethics

Even without a guiding set of professional ethical principles, most physicians are highly ethical in their practice. Their practical ethics are based on two familiar maxims: "do what you think will benefit the patient" and "primum non nocere," or first of all, do no harm. Veatch notes that the "conveyors of these traditions often do not realize that these traditional slogans are potentially in conflict."[20] Yet, every physician who has cared for a dying patient has faced both the question of how much more to do and the problem of determining when the benefit becomes the iatrogenic harm of prolonging futile suffering. These maxims may not constitute a theory of ethics, but they provide the dialectical framework within which the physician actually practices and judges the practice of other physicians.

Physicians learned how to proceed within this framework primarily by identifying at the start of their careers with role models. These role models were typically physicians who practiced in teaching hospitals. The best were conscientious and compassionate physicians who demonstrated a dedication to high-quality care, who in their quest for excellence practiced at the frontiers of medical knowledge, and who

pressed for certainty of diagnosis and every possible benefit of t eat-
ment even at what is now described as the flattening end of the c ve.
Their ethical practice and their quest for professional excellence ere
combined, not separate, virtues. If the art of practical medical et! s is
finding the proper balance between doing everything that may b efit
the patient and doing no harm, then it may well be true th we
identified with role models who erred on the side of doing too ich.

But the quest for excellence is a value that cannot easily dis-
missed in the education of future physicians — nor should it b The
wish to practice at the frontiers of medical knowledge and to e and
those frontiers is an equally important value in medical edu ion.
Those values may have skewed the balance of the art of pr tical
medical ethics, but they are values that have made American m icine
preeminent and have made American physicians deserving c their
patients' trust. It is those values that are threatened by both gula-
tory constraints and the emphasis on entrepreneurial ingenu and
competitive efficiency.

Havighurst, one of the leading legal proponents of market r m in
health care, has specifically attacked the "tyranny of prof ional
norms and standards" as the basic obstacle to such reform." Even
Fuchs, an economist sympathetic to the "caring physician," orries
that physicians are counterproductively "imprinted" with t "best
medical practice" in medical school.[22] But what these w -inten-
tioned critics who are concerned about the aggregate cost health
care fail to appreciate is the ethical void created when medical ractice
is viewed through the prism of cost-benefit analysis. For wher the law
attempts to control aggregate costs, either through regulati or by
promoting competition, it creates a potential conflict of interest
between patient and physician.

Critics of medical paternalism and the traditional maxims I have
described argue that physicians have ignored the importan e of the
patient's autonomy and rights. Informed consent is the focus of
attempts by ethical and legal reformers to remedy medical paternal-
ism. Certainly, the patient has a right to know not only the risks and
benefits of alternative treatments but also when cost-benefit analysis
plays a part in the doctor's recommendations. But why should a sick
and anxious patient accept the doctor's economic calculation? What is
the patient's interest in reducing the economic risk to the doctor or
the aggregate cost of health care by foregoing a bed in the coronary
care unit or a CAT scan? It is one thing to entrust your life and health
at times of crisis to a physician who is committed to the practical
ethics that involves a quest for excellence and who may err on the side
of doing too much. It is quite another to entrust your life and health
at times of crisis to a physician whose diagnostic and therapeutic
interventions are limited by new regulatory constraints or incentives
of competitive efficiency that "place the provider at economic risk."

If the "provider" does not make the patient aware of the implications of that economic risk, then medical paternalism will inevitably take on a different and even more damning kind of odium. And if it is ethically wrong to conceal these new economic incentives and the medical profession's responses to them, to reveal them may threaten the trust and confidence of patients even in "caring physicians." "Caveat emptor" will be more relevant than "primum non nocere" in doctor-patient relationships.

It is for these reasons that the current concern among practitioners is intelligible, realistic, and deserving of public attention. The traditional maxims and practical medical ethics have been undermined, the values that have made American medical education strong have been challenged, the legal liabilities of the physician have increased, and the doctor and patient now confront an economic conflict of interests that will not easily be resolved.

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