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THE LAW OF DOCTORING: A STUDY OF THE CODIFICATION OF MEDICAL PROFESSIONALISM

Andrew Fichter[†]

ABSTRACT

This essay argues that the concept of professionalism as it appears in health law is undergoing transformation as the applicable common law doctrines are increasingly being superseded by statutes and regulations. The doctor-patient relationship is being subjected to new rules of conduct intended to affirm the rights not only of patients but also of society at large. The bilateral relationship between doctor and patient has in many respects been transformed into a triadic one in which the concerns of public, as consumer and payor, are increasingly taken into account. In many respects this change has been necessary and inevitable as medicine has become a more commercial enterprise; but the change has also put traditional notions of professionalism at risk. Where professionalism is adversely affected by the process of its codification, it is incumbent upon law and policy makers to be aware of the fact. To this end, this essay first undertakes to define medical professionalism as a legal construct, and then formulates an analytic method with which to determine when professionalism is implicated and whether it is adequately accommodated by the law. The definition of professionalism the author advances is informed by concepts established in the literature of sociology, which identifies four core attributes—functional specificity, trust, disinterestedness and self-regulation. Each of these attributes is examined in turn with reference to case law selected to identify the value in question and to illustrate the nature of the change resulting from its codification.

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I. INTRODUCTION

For better or for worse, the body of law that shapes our idea of professionalism where health care providers are concerned has undergone a process of codification over the past several decades, and that process has accelerated recently. Much of the relevant doctrine that was historically left to common law is now located in statute, rule and regulation. In the process, our concept of medical professionalism is undergoing transformation. It is not just that the concept is now located in a different place than it was half a century ago, in the volumes of state and federal statutes and codes rather than in case reporters, but rather that the concept is being fundamentally changed through its codification. Society has deemed it necessary to articulate the rights and responsibilities of both sides of what has historically been an intensely personal and self-contained relationship between doctor and patient, and in so doing society has introduced itself into the relationship as a third party. Pressure for this change has steadily

mounted as the cost of health care has escalated, large segments of the population have chronically lacked adequate access, and quality concerns have persisted. But the potential costs of codification cannot be ignored. There is a price to pay in exchanging a culture in which professionals regulated their conduct principally with reference to their ethical canons and personal codes of conduct for one in which doctors and patients tend to refer to their respective legal rights obligations—trading a culture of responsibility for a culture of rights.¹ This essay urges that where law is a catalyst for producing fundamental changes in professional relationships, someone, whether legislatures or courts, should be taking a second look.

My thesis is built upon a premise that should be identified at the outset, namely that there is in fact a legal doctrine defining medical professionalism. To establish this I will look briefly at agency law, where the applicable doctrines have traditionally reposed, concluding, however, that this body of law is not adequate to explain the concept of professionalism as it is currently evolving. Then, in Section II below, I propose what may be termed an essentialist approach to defining professionalism as a legal construct.² Among other things, what is needed to understand medical professionalism as it currently makes its appearance in the law is a construct in which the interests of more than the doctor and patient alone are addressed. The significant body of literature on professionalism developed by sociologists is a valuable resource for this purpose. In Section III below I propose an analytic method by which we can determine when the core elements of the concept of medical professionalism are at issue in the law, and whether courts and policy makers may be justified in calling for a change in direction. Section IV applies the methodology to case law, most of which will be familiar to health law scholars as classics. I conclude, in Section V, that it remains important for the law to acknowledge the concept of professionalism in health care, and to understand its transformation, albeit the law may not in the last analy-

¹ See generally Wendy K. Mariner, *Informed Consent in the Post- Modern Era*, 13 LAW & SOC. INQUIRY 385 (1988). See also Carol A. Heimer, *Responsibility in Health Care: Spanning the Boundary between Law and Medicine*, 41 WAKE FOREST L. REV. 465 (2006); Lois Shepherd, *Assuming Responsibility*, 41 WAKE FOREST L. REV. 445, 445 (2006).

² See Mark A. Hall, *The History and Future of Health Care Law: An Essentialist View*, 41 WAKE FOREST L. REV. 347, 357-58 (2006) (using the term “essentialism” to describe an approach to defining health law generally as a body of substantive law with coherent features rather than an “assortment of rules that results from applying other bodies of substantive law to a particular economic sector or human activity”).

sis be entirely sufficient to the underlying concept. Professionalism cannot ultimately be confined to its legal parameters.

A. The Law of Medical Professionalism

The subject of this essay is the law of medical professionalism. I wish to emphasize from the outset that the subject is the *law* of medical professionalism, as opposed to medical ethics, and that it is the law of medical *professionalism*, as opposed to the variety of laws that may from time to time affect medical professionals—as tort law notably does—but without necessarily defining them as such. That is, I propose to deal with the concept of professionalism as it appears in the body of American law dealing with the aspect of the conduct of medical practitioners that distinguishes them from other service providers. I wish to stress that this perspective on professionalism differs from that typically encountered in the law school curriculum, where discussion of professionalism tends to focus on the ethical canons of professional associations. As a legal doctrine, professionalism has consequence in terms of enforceable rights and responsibilities, authority and duty. It is one thing, for example, for practitioners collectively to exhort themselves in their canons of professional conduct to keep patients informed;³ it is another thing for a court of law to provide a patient with recourse against a physician for a breach of his or her obligation under the legal doctrine of informed consent. It is the latter circumstance, and others like it, in which this essay seeks to locate the law of medical professionalism.

It must be conceded that the body of law to which I refer is not conspicuous, or at least it has not been so in the past. There is no Restatement of the Law Governing Medical Professionals.⁴ The jurisprudence of medical professionalism has relatively low visibility for reasons that have important implications for the subject. One reason is that the concept of professionalism is already at least partially accommodated within the larger doctrine of agency law, the patient being the principal and the physician being the agent in the

³ See, e.g., AM. ACAD. OF NEUROLOGY, AM. MED. ASS'N, CODE OF PROFESSIONAL CONDUCT § 1.4, at 2 (2008), available at <http://www.aan.com/globals/axon/assets/3968.pdf>.

⁴ See generally RESTATEMENT (THIRD): THE LAW GOVERNING LAWYERS at xvii-xviii (Proposed Final Draft No. 2, 1998) (according to Geoffrey C. Hazard Jr., Emeritus Director of the American Law Institute, there is unlikely to be a restatement governing medical professionals). See Carol A. Heimer, *Responsibility in Health Care: Spanning the Boundary between Law and Medicine*, 41 WAKE FOREST L. REV. 465, 466 (2006), for a discussion of the regulation of “law-like prescriptive statements” from “quasi-public regulatory bodies.”

case of medical professionalism; but even so, there are other reasons that tell us more about the nature of medical professionalism. Historically, the body of law addressing professionalism has had a low profile because courts and legislatures have given professions latitude to self-regulate. Self-regulation, as we shall see, is in fact one of the defining attributes of professionalism. Another closely related factor is that professional relationships have historically been viewed as fundamentally different from the commercial relationships for which the law of contract has developed. The law of contract has emerged to address transactions between self-interested parties; the relationship between a physician and his or her patient, by contrast, has traditionally been seen as a fiduciary one in which the interests of the physician are aligned with those of the patient in a way that largely obviates the need for marketplace law.⁵ Thus it has long been elementary in defining professionalism to begin by distinguishing it from commercial activity:

[T]he dominant keynote of the modern economic system is almost universally held to be the high degree of free play it gives to the pursuit of self-interest. It is the "acquisitive society," or the "profit system" as two of the most common formulas run. But by contrast with business in this interpretation the professions are marked by "disinterestedness." The professional man is not thought of as engaged in the pursuit of his personal profit, but in performing services to his patients or clients, or to impersonal values like the advancement of science. Hence the professions in this context appear to be atypical. . . .⁶

Whereas in the law of commercial contract courts have historically been ready and willing to apply certain warranties,⁷ they have typically been reluctant to do so in the case of medical professionalism.⁸ The classic argument against professional warranties, as stated

⁵ See the discussion of "disinterestedness" in Section II.C.

⁶ Talcott Parsons, *The Professions and Social Structure*, in *ESSAYS IN SOCIOLOGICAL THEORY* 34, 35 (rev. ed. 1954).

⁷ See *Williamson v. Amrani*, 152 P.3d 60 (Kan. 2007).

⁸ See, e.g., *Sullivan v. O'Connor*, 296 N.E.2d 183, 186 (Mass. 1973) (evaluating a patient's claim for damages when a surgeon failed to fulfill a promise to provide the patient with a nose similar to Hedy Lamarr's nose). For similar reasons, courts have declined to apply contract law in a variety of other physician-patient disputes, even where the parties have expressly agreed that a contract existed. See Maxwell J. Mehlman, *The Patient-Physician Relationship in an Era of Scarce Resources: Is There a Duty to Treat?*, 25 *CONN. L. REV.* 349, 356-57 [hereinafter *Is*

in *Sullivan v. O'Connor*, is that only doctors of substandard integrity would promise specific results, given the uncertainties of medicine.⁹ Similarly, whereas the law of agency involves subordination of the autonomy of the agent to the will of the principal in significant respects,¹⁰ courts have acknowledged the relationship between doctor and patient to be materially different. The reliance of patients upon their physicians is often what Judge Robinson described as “well-nigh abject” in *Canterbury v. Spence*, with the result that normal agency rules of control cannot obtain and must be modified accordingly.¹¹ The duties of our agents to act in accordance with our instructions, to keep us informed, to respect our privacy and even to act with undivided loyalty have in the past often been modified with respect to our physicians in a manner that confirms the doctor-patient relationship to be a special case within the law of agency, if not in some respects an exception to it.

The legal concept of medical professionalism, that is, has historically been expressed in terms of its divergence from commercial norms, which in turn has led to a sense that legal norms are not a good fit. That divergence was greatest by the middle of the last century, when the courts spoke of the “learned professions,” whose members were exempted from the application of antitrust laws¹² and not yet

There a Duty to Treat?] (“[C]ourts have struck down the following types of patient-physician agreements: a patient’s release of the physician from liability for negligence, a limitation of the patient to \$15,000 in damages, and an acceptance of binding arbitration by the patient.”) (citations omitted); see also Maxwell J. Mehlman, *Fiduciary Contracting: Limitations on Bargaining Between Patients and Health Care Providers*, 51 U. PITT. L. REV. 365, 401-04 (1990). See also *Tunkl v. Regents of Univ. of Cal.*, 383 P.2d 441, 448 (Cal. 1963) (to this list of unenforceable contracts we may add that courts have struck down disclaimers of liability and waivers of the right to sue as a condition to receiving charity care at a teaching hospital).

⁹ *Sullivan*, 296 N.E.2d at 185-86.

¹⁰ RESTATEMENT (THIRD) OF AGENCY § 8.01 (2006).

¹¹ *Canterbury v. Spence*, 464 F.2d 772, 782 (D.C. Cir. 1972). The court starts with the professional’s established duty to warn, for which the standard in a majority of jurisdictions before *Canterbury* was determined with reference to a prudent physician standard. The court then reasons that because the object of the physician’s disclosure is to permit the patient to exercise choice, and because the reliance of the patient upon the physician in this undertaking is “well-nigh abject”, the disclosure duty is augmented in the health care context. *Id.* at 782.

¹² With respect to medicine, the conviction that quality of patient care might suffer seems to have made courts initially reluctant to apply antitrust laws to the learned professions at all, until the clear language of the Sherman Act could no longer be denied. *Cf. Goldfarb v. Va. State Bar*, 421 U.S. 773 (1975) (overruling the “learned professions” exception with respect to the legal profession). *In re Mich. State Med. Soc’y*, 101 F.T.C. 191, 267 (1983) (holding that boycotts and “fee-tampering” by independent medical doctors violated the Sherman Act, but declining

permitted to organize their practices in corporate form.¹³ Medical professionalism then often made its appearance in legal doctrine in the negative, as a tissue of exceptions to normative commercial rules. Ironically, it was at that point that the law of medical professionalism was arguably most coherent. Courts could be relatively confident that they could identify medical professionalism when they encountered it, even if only by reference to what it was not. Law and society alike were comfortable in the conviction that the doctor's office was located at a safe distance from the marketplace, but in a place nonetheless easy to find.¹⁴

But the assumptions upon which the concept of professionalism has traditionally stood have been fundamentally altered in recent times. For one thing, the law of medical professionalism has increasingly been reduced to statute at both the state and federal levels. Matters that lawmakers and courts 50 years ago may have left for self-regulation by the medical profession—conflicts of interest, patient privacy issues, disclosure and consent norms with respect to diagnoses, skill levels and therapeutic objectives, interdisciplinary boundary disputes and the like—are now codified.¹⁵ At the same time, the distance between the doctor's office and the marketplace seems to have narrowed: exceptions to the rules of commercial conduct once

to apply *per se* analysis). The “learned professions” doctrine was gradually unwound with respect to the medical profession in a series of cases, including this one; *FTC v. Ind. Fed’n of Dentists*, 476 U.S. 447, 447-48 (1986) (notwithstanding their claim that quality of care concerns justified their conduct, dentists were held to have violated the Sherman Act by withholding x-rays in conjunction with demands for higher reimbursement rates from an insurer); *Wilk v. Am. Med. Ass’n*, 671 F. Supp. 1465, 1477-79 (N.D. Ill. 1987) (modifying rule of reason analysis to allow AMA to justify its boycott of chiropractors in the name of patient care). See also BARRY R. FURROW ET AL., *HEALTH LAW* § 14-6 (2nd ed. 2000). Even after *Goldfarb* had confirmed that antitrust laws applied to professions, courts were hesitant to apply *per se* rather than “rule of reason” analysis where quality of patient care was alleged to be at risk. See *id.* at § 14-9.

¹³ See generally, Andrew Fichter, *Owning a Piece of the Doc: State Law Restraints on Lay Ownership of Healthcare Enterprises*, 39 J. HEALTH L. 1 (2006) (discussing state law prohibitions on lay ownership of medical practices, historical restrictions on organization of physician practices in corporate form and related corporate practice of medicine prohibitions).

¹⁴ See, e.g., Einer R. Elhauge, *Can Health Law Become a Coherent Field of Law?*, 41 WAKE FOREST L. REV. 365, 371 (2006) (noting that “the best evidence that health law *can* be a coherent field of law is that it used to be one”).

¹⁵ For a comprehensive survey of statutes, rules and regulations governing American medical practice, see ROBERT I. FIELD, *HEALTH CARE REGULATION IN AMERICA* (Oxford 2006) and Timothy Stoltzfus Jost, *Health Law and Administrative Law: A Marriage Most Convenient*, 49 ST. LOUIS U. L.J. 1 (2004).

established for physicians have been eroded,¹⁶ as courts and legislators alike appear more willing to apply the law of commerce to the medical profession. Witness a recent decision of the Kansas Supreme Court to apply state consumer protection laws to assess the adequacy of disclosures made by a surgeon to his patient.¹⁷

It would be difficult to disentangle cause and effect where this change is concerned. Has medicine become more commercial in fact, as a result of which lawmakers have felt obligated to apply the rules of commerce? Or is the steady commercialization of medicine the result of what Guido Calabresi has called the "statutorification" of common law, in this case the law of doctoring.¹⁸ Both dynamics can be presumed, and it is not ultimately necessary to decide between them for purposes of this essay. What is important for present purposes, however, is to acknowledge the process and assess the effect of the (arguably excessive) reticulation of the concept of medical professionalism in statutes, rules and regulations. One ironic consequence may be that as the concept of medical professionalism is being articulated, rationalized and memorialized, it is also being effaced. If self-regulation is a defining attribute, as I shall argue it is, can professionalism survive legislative codification? If disinterestedness is a core principle, what is the consequence to the doctor-patient relationship of forcing it into a mold developed for commerce, where self-interest is assumed to be the prime mover? Now that a growing body of law exists that purports to regulate the relationship between medical professionals and patients, we are perhaps in a better position than ever to ascribe doctrinal definition to this relationship, but at what cost to the underlying construct? It is arguable that just as medical professionalism is becoming increasingly visible as a legal construct, its relevance is being diminished.

At the same time, the forces that have led to the increased codification of medical professionalism should be given their due. The felt need to write laws to shape professional conduct derives from (i) the sense that medicine has become much more commercial on its own accord in recent decades, (ii) the rise of the patient rights and patient autonomy movements, and (iii) the realization by policy makers that something has to be done to increase public access to affordable health care, to identify a few notable causes. To the extent that professionalism itself could not respond to these realities, policy makers

¹⁶ See Fichter, *supra* note 13, at 2-4.

¹⁷ *Williamson v. Amrani*, 152 P.3d 60, 72 (Kan. 2007); see also Elhauge, *supra* note 14, at 377-78 (ascribing causes for the disappearance of legal deference to professional self-regulation).

¹⁸ GUIDO CALABRESI, *A COMMON LAW FOR THE AGE OF STATUTES* 6-7 (1982).

have been forced to modify professional conduct accordingly. At this point in our history, few would deny that some transformation of the classical doctrine of medical professionalism has been justified.

This essay is written in the conviction that medical professionalism continues to play a critical role in society, notwithstanding its subjection to both internal and external transformative pressures, and that its chances of remaining vital improve if legislators and courts comprehend its nature and function. Specifically, if we recognize the core attributes of medical professionalism when we encounter them in legal contexts, acknowledge the respective interests of medical care providers, patients and society alike in professional relationships, and appreciate the effects of statutory and decisional law on these relationships, we are in a much better position than otherwise to assure the survival of medical professionalism. In service of this objective this essay proposes an analytic methodology that can be applied to identify professionalism's defining attributes and to assess the effect of both statutory and decisional law upon them.

B. Physician As Service Provider: The Statutory Context

The Kansas case referenced above brings the themes of this essay into focus. In *Williamson v. Amrani*,¹⁹ Tracy Williamson brought a claim against her surgeon, Dr. Amrani, under the Kansas Consumer Protection Act ("KCPA")²⁰ alleging that Dr. Amrani had misrepresented his rate of success with certain surgical procedures in question. Dr. Amrani protested that Williamson's claim improperly circumvented the body of Kansas law that had been developed to handle medical malpractice. The KCPA had advantages for plaintiffs generally in matters relating to negligence, although many of these were ultimately determined to be unavailable in Williamson's case. Whereas damages in medical malpractice cases had at least at one period in Kansas history been capped,²¹ the KCPA offered successful plaintiffs a choice between actual damages and a statutory penalty. Legislative changes to the collateral source rule favorable to health care providers would apply in the context of malpractice litigation, but not in a consumer transaction case.²² A plaintiff permitted to bring an action under the KCPA for conduct involving informed consent or some other more traditionally professional conduct might also have

¹⁹ *Williamson v. Amrani*, 152 P.3d 60 (Kan. 2007).

²⁰ Kansas Consumer Protection Act, KAN. STAT. ANN. §§ 50-623 (2005).

²¹ *Id.* § 60-3411 (2005) (repealed 1989).

²² *See, e.g., Williamson v. Amrani*, 152 P.3d at 71 ("[T]he KCPA is inapplicable to arrangements that fall within the provisions of the KRLTA.").

significant leverage for settlement if, as the dissent in *Williamson* intimates, malpractice insurers were to take the position that they are not obligated to cover consumer fraud claims.²³ Defending professionals in Dr. Amrani's position might find themselves having to settle or risk proceeding without defense coverage or under reservation of rights assertions, for different reasons, by both their malpractice and general liability insurers. Williamson, moreover, had hoped for another material advantage to a KCPA claim: she might have avoided the necessity of producing expert testimony to establish the standard by which Dr. Amrani's disclosures were to be measured, although Williamson ultimately proved unsuccessful in this regard.²⁴ She sought to characterize her transaction with Dr. Amrani as entirely a commercial transaction, in which case the requisite level of disclosure would have been determined from the perspective of a reasonable consumer (in this case, a patient), whereas Dr. Amrani argued that the doctor-patient relationship defined the interaction, and as a result the question of disclosure should be resolved by testimony from medical experts. And while the statute of limitations was not an issue in her case, Williamson could have had three years to bring her claim under the KCPA, whereas the limit for traditional medical malpractice claims in Kansas is two years.²⁵

For his part, Dr. Amrani argued that application of the KCPA to a doctor-patient transaction was improper because Kansas had developed a comprehensive statutory scheme under which doctor-patient transactions were intended to be exclusively handled. For one thing, a plaintiff was required to undergo the expense of producing expert witnesses in order to establish the applicable standard of care in a professional negligence action, and for another, a two-year statute of limitations applied. Moreover, the plaintiff would have been limited as to what information about insurance or other sources of funding available to the defendant physician could be presented to the jury. Such measures could be taken as evidence of a legislative policy of deterring malpractice litigation. By contrast, the policy behind the KCPA is calculated to favor the service consumer, and perhaps even to encourage litigation. The rationale for this would be to enable commerce to self-regulate by facilitating consumer litigation. The

²³ *Id.* at 71-72.

²⁴ The court ultimately determined that while the reasonable patient standard should apply to the extent that the question was purely Dr. Amrani's history of success with the surgical procedures at issue, the question was also necessarily whether full disclosure of risks was in the patient's best interest, and to this extent expert testimony was required. *Id.* at 72-73.

²⁵ KAN. STAT. ANN. § 60-513(a) (2005).

barriers to litigation evident in professional litigation are lowered, successful consumer litigants are rewarded and unsuccessful service providers punished with penalty damages.

The KCPA contained no carve-out for cases involving professional negligence. *Williamson* thus forced the Kansas Supreme Court to decide between applying the KCPA as written, thereby honoring the principle of legislative supremacy, or preserving a jurisprudential scheme that had been specially developed to handle professional negligence cases. Judge Davis articulated this position in his dissent, arguing that the majority ruling effectively gutted the body of law developed in Kansas for the purpose of controlling malpractice litigation. If a patient could bring a claim sounding in malpractice under consumer protection law, all the measures taken by the legislature on policy grounds to attract physicians, curb malpractice litigation and limit damages would be for naught.²⁶ Worse, the effect would be to aggravate the situation, as broad avenues for litigation would be opened, insurers would be panicked into raising premiums and limiting coverage, and the medical profession would experience a chilling effect.

The value of *Williamson* for purposes of this essay is that it forces us to consider how we can know when professionalism as such may be at issue so that, if so disposed, a court may consider treating that as a separate issue. Although it seems evident that a case in which a party seeks to apply a consumer protection statute to a doctor-patient relationship raises the issue of professionalism, it is not so clear which elements of the statute do so, or which aspects of professionalism are implicated. Some of the provisions of Kansas law developed to deter malpractice litigation can be said to benefit professionals, but not to define them as such. That a statute of limitation is shorter by a year in the case of medical negligence than in consumer suits may reflect a policy favoring professions, but not one that tells us anything fundamental about professionalism. Another aspect of the *Williamson* case does more in this regard, however, and that is the warranty issue that lies at the heart of the case. Implied warranties enforceable against commercial service providers are consistent with public policy as they offset the unfair advantage the provider may otherwise have against individual consumers. The policy proceeds from the presumption that consumers are competent to regulate markets where dispute resolution inequality is reduced. The jurisprudence of medical professionalism,

²⁶ See *Williamson*, 152 P.3d at 75 (Davis, J., dissenting) (“Consideration of the issue must also include an analysis of the legislature’s extensive treatment of the medical and health care professions found throughout Kansas’ statutory scheme.”).

on the other hand, has traditionally been wary of warranties, and suspicious of any presumption that patients may be competent to regulate their relationships with medical professionals.²⁷ Still, the observation that a professional relationship is different from a commercial one tells us more about what professionalism is not than what it is.

The *Williamson* court was nevertheless aware that unmitigated application of the KCPA to the issue at bar could have an adverse impact on professionalism, or at least on the statutory scheme Kansas has constructed to deal with professionals. Clearly there is a risk of damage to the doctor-patient relationship where it is suddenly recast as a commercial contract between presumptively equal bargainers. Both doctor and patient are potentially losers. The former must consider the implications of providing services under an implied warranty, which could precipitate the "race to the bottom" predicted in the *Sullivan* case, and the latter must consider exchanging the trust to which patients have traditionally been entitled for a *caveat emptor* stance with respect to their professionals. While it applied the KCPA as written to Dr. Amrani, the court also drew a map showing the legislature what needed to be changed. The problem arose from the fact that the KCPA was modeled upon the Uniform Consumer Sales Practices Act (the "UCSPA"), which defines the crucial phrase "trade or commerce" broadly enough to include the practice of medicine. The definition of a "consumer transaction" in the KCPA excluded insurance contracts, but not service arrangements between patients or clients and professionals.²⁸ The solution was thus for the Kansas legislature simply to follow Ohio (one of only two other states to have substantially adopted the UCSPA) in specifically excluding transactions between physicians and their patients from the law's application.²⁹ In the long run, if the Kansas legislature follows Ohio's example, *Williamson* may be remembered as little more than a message sent by the Kansas Supreme Court to the state's legislature to the effect that a statutory amendment is in order.³⁰ It will have served the purpose of this essay, however, by evidencing the willingness of at least one judge to recognize the impact of legislation on professionalism and then to urge necessary changes.

²⁷ *Is There a Duty to Treat?*, *supra* note 8, at 356-57.

²⁸ KAN. STAT. ANN. § 50-624(c) (2005).

²⁹ *Williamson*, 152 P.3d at 69 (referencing OHIO REV. CODE ANN. § 1345.01(A) (LexisNexis 2000)).

³⁰ A result which Dr. Amrani may contemplate with emotions unique to his circumstance, having been the vehicle for conveying the message.

C. Physician as Agent: The Common Law Context

Some of the discomfort we feel when professionals are forced into the mold of commercial service providers by statutes such as the KCPA is alleviated when we move to common law perspectives on professionalism. The common law understood a professional to be a special case of service provider, requiring more autonomy than would ordinarily be expected in a commercial relationship; and that the status of the recipient of professional services must be adjusted accordingly by the applicable rules of law. The common law therefore begins from the premise that the relationships between physician and patient or lawyer and client are agency relationships. A physician relates to his or her patient as an agent to its principal. Like other agency relationships, that existing between doctor and patient is created by reciprocal consent, often manifested in conduct rather than in writing, and apart from the understanding that the doctor is acting on behalf of the patient, any contract terms are typically implicit. Among the most important of the implied obligations of the physician-agent to the patient-principal are fiduciary duties of loyalty and care,³¹ including the duty to put the interest of the patient first,³² to avoid conflicts of interest,³³ to act within the scope of the grant of authority,³⁴ to keep the patient properly informed,³⁵ and to safeguard the patient's confidences.³⁶

So far, so good. But ultimately the doctor-patient relationship (at least as it was historically conceived) sits uncomfortably within the law of agency. The hallmark of an agency relationship is control by the principal over the agent,³⁷ and in this respect the medical professional historically fails to conform to agency norms. For its part, professionalism traditionally insists upon autonomy, and to a degree that denies any prospect of meaningful control by the patient. Witness the (somewhat colorful) description of the sociologist Burton Bledstein of the culture of professionalism in 19th century England and America:

³¹ RESTATEMENT (THIRD) OF AGENCY § 8.01, 8.08 (2006).

³² *Id.* at § 8.01 cmt. b.

³³ *Id.* at § 8.02 (prohibiting an agent from acquiring a material benefit from a third party "in connection with transactions conducted or . . . taken on behalf of the principal . . . through the agent's use of the agent's position").

³⁴ *Id.* at § 8.09(1).

³⁵ *Id.* at § 8.11.

³⁶ *Id.* at § 8.05(2).

³⁷ *Id.* at § 8.01 cmt. b.

The culture of professionalism released the creative energies of the free person who was usually accountable only to himself and his personal interpretation of the ethical standards of his profession. . . . The professional appeared in the role of a magician casting a spell over the client and requiring complete confidence. . . . The uncertainty and anxiety of a client heightened his receptivity to the commanding voice of professional authority. With such power over others, and with his judgment usually beyond both public and professional criticism, the ambitious practitioner often could not resist the opportunities for financial corruption. . . . Perhaps no Calvinist system of thought ever made use of the insecurities of people more effectively than did the culture of professionalism. The professional person extended the gift of his special powers to the client who was by definition unworthy of such attention. . . . The state of a client's dependence could become psychologically unbearable.³⁸

To be sure, agency law accommodates the notion that the agent may have more specialized knowledge than the principal, and thus the agent would not be expected to function under the absolute control of the principal,³⁹ but disequilibrium of the magnitude described by Bledstein strains the legal fiction of agency to the breaking point.⁴⁰ As between an ill-informed patient, often coming to the encounter in physical and mental distress, and a well-trained physician working within the scope of his or her specialty, any idea that the latter is operating under the authority and control of the former is likely to be the merest pretense.⁴¹

In the terms of agency law, the patient is the principal and the physician is the agent, consenting to carry out the patient's instructions. The applicability of this doctrine to the doctor-patient relationship, however, can almost immediately be called into question, since

³⁸ BURTON J. BLEDESTEN, *THE CULTURE OF PROFESSIONALISM* 92, 94, 97, 102, 103 (W. W. Norton & Company, Inc. 1976), excerpted from pages 92-102.

³⁹ See generally, RESTATEMENT (THIRD) OF AGENCY intro. (2006) ("The subject matter of this Restatement, the common law of agency, encompasses the legal consequences of consensual relationships in which one person (the "principal") manifests assent that another person (the "agent") shall, subject to the principal's right of control, have power to affect the principal's legal relations through the agent's acts and on the principal's behalf.")

⁴⁰ For an analysis of the informational problems of the health care consumer, see Frank A. Sloan & Mark A. Hall, *Market Failures and the Evolution of State Regulation of Managed Care*, LAW & CONTEMP. PROBS., Autumn 2002, at 169, 172-77.

⁴¹ *Supra* note 12.

the extent to which patients may be seen to instruct their physicians is extremely limited. The problem is not merely that patients generally do not know enough medical science to direct their physicians (this would be true in agencies of many kinds, such as where automotive mechanics or computer technology are involved), but that in addition to the obvious asymmetry of knowledge fraught with moral hazard, patients rely on their physicians to identify the problem as well as the solution, and then again to determine whether treatment is possible or appropriate, and finally to assess how successful any treatment may have been.⁴² As a consequence it becomes difficult to apply the rules of liability that normally attend agency law to doctors and patients. Whereas it may be reasonable to hold a principal legally responsible for the conduct of an agent acting within the scope of the agency, as in the case of employer and employee, it is less obvious where a patient could be held responsible for the conduct of his or her physician in delivering health care, or even accountable for consenting thereto.

Not surprisingly, then, medical professionalism appears in agency doctrine as a series of exceptions to rules. For instance, to the general agency rule that an employer may be held vicariously liable for the acts of an employee (the doctrine of *respondeat superior*), the law of medical professionalism contributes the "captain of the ship" or the "borrowed servant" doctrine, pursuant to which it is the physician rather than the employer to whom liability for the negligence of subordinate staff is vicariously transferred. Thus where the nursing staff employees of a hospital commit negligent error in an operating room, the surgeon in the theater and not the hospital can become vicariously liable.⁴³

But if it seems to require too much distortion to fit medical professionals into the typical principal-agent mold, perhaps we should look to another subcategory of agency law to accommodate the medical professional. Agency law, after all, contains several relationship models, including those in which the agent retains relatively more autonomy than is normally the case. Perhaps the nature of a doctor's agency relationship to his or her patient is more like that of a corporate director to the corporation or its shareholders.⁴⁴ Both physician

⁴² Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 951 (1963). See also ELIOT FREIDSON, PROFESSIONALISM REBORN: THEORY, PROPHECY, AND POLICY 191 (1994) (explaining that, because patients are not well-informed, well-equipped consumers, they are unable to make choices and bargain as autonomous individuals in the market-place of health care).

⁴³ *Synnott v. Midway Hosp.*, 178 N.W.2d 211, 213 (Minn. 1970).

⁴⁴ See generally MARC A. RODWIN, *MEDICINE, MONEY, AND MORALS*:

and corporate director, after all, are bound by a fiduciary duty to their respective principals, but in both cases the duty is based on a managerial rather than a stewardship model.⁴⁵ Corporate directors are invited to exercise their business judgment, even to the point of taking risks; and they are allowed the leeway to determine in any given circumstance not only the objectives of the enterprise but also whether the best interest of their charge aligns with that of shareholders or some other corporate constituent.⁴⁶ Similarly, the exercise of professional judgment by physicians is often tolerated, even encouraged in law.⁴⁷ The image of the physician as heroic risk-taker is well known. In recognition of the autonomy of this kind of agent, the legal rules that govern self-dealing are somewhat relaxed for medical professionals just as they often are for corporate officials. Corporate officers and medical professionals alike are permitted to make decisions that directly affect their compensation.⁴⁸ For their part, corporate directors are granted at least partial relief from the general rule that agents must fully inform their principals. Even majority shareholders do not have a right to all the information to which management may be privy. Similarly, in articulating the duty of physicians to inform their patients, courts have held that the standard is not absolute and complete disclosure (which could sometimes be therapeutically counterindicated), but disclosure to the degree that a similarly-situated physician would offer.⁴⁹

In the last analysis, however, the duties of health care professionals should be differentiated from those of other fiduciaries such as corporate directors. The analogy to the corporate fiduciary ultimately

PHYSICIANS' CONFLICTS OF INTEREST 192-96 (1993) (examining conflict-of-interest scenarios present in the "law of corporations, pensions, and securities").

⁴⁵ Neither physicians nor corporate fiduciaries, Rodwin observes, are held to the restrictive standard for self-interested conduct set for pension fund managers under the Employee Retirement Income Security Act ("ERISA") of 1974, P.L. 93-406 *et seq.* 129 U.S.C., § 1001 *et seq.* RODWIN, *supra* note 44, 192-96, *citing* ERISA §§ 406-07 (listing prohibited transactions).

⁴⁶ *Aronson v. Lewis*, 473 A.2d 805, 812 (Del. 1984) (noting that "[i]t is a presumption that in making a business decision the directors of a corporation acted on an informed basis, in good faith and in the honest belief that the action taken was in the best interests of the company"). *See also* *Sinclair Oil Corp. v. Levien*, 280 A.2d 717, 720 (Del. 1971) (affirming the business judgment rule, stating that "[a] board of directors enjoys a presumption of sound business judgment, and its decisions will not be disturbed if they can be attributed to any rational business purpose").

⁴⁷ *See, e.g., Jeffrey O'Connell & Andrew S. Boutros, Treating Medical Malpractice Claims Under a Variant of the Business Judgment Rule*, 77 NOTRE DAME L. REV. 373 *passim* (2002).

⁴⁸ RODWIN, *supra* note 44, at 193.

⁴⁹ FURROW *supra* note 12, at § 6-10(a).

breaks down because the needs of a patient are fundamentally different from the needs of a shareholder. The corporate system of delegated powers ultimately functions well because shareholders retain sufficient rights to information to protect their interests and sufficient authority over directors to enforce their rights. Patients, as I have observed, often lack not only the capacity to understand the decisions with which they are being presented but also to evaluate outcomes. As a result, health care is not an efficient market, capable of correcting itself. Because a patient often relies on his or her physician to a significantly greater extent than does a shareholder on a corporate manager,⁵⁰ self-dealing is generally even less tolerable when committed by medical professionals than by corporate fiduciaries.

Mark Hall aptly contrasts the nature of trust expected in health care from that expected in commercial settings:

Trust is also important in other arenas such as those involving commercial transactions, but trust plays a much greater role in medicine. Trusting a financial institution or account manager, even with one's life savings, is a much different proposition from trusting a doctor to perform open-heart surgery or correctly diagnose a disabling ailment. People have many options for organizing their financial affairs, and their decisions about how much authority to delegate and to whom are based to a great extent on their appraisal of the competing costs and benefits. Serious illness, in contrast, leaves one with little choice but to see a doctor, and the nature of medical practice permits some, but much less, control over what occurs during treatment. Added to this, the realization that one's life or physical and mental functioning is at risk creates much higher stakes than do financial transactions. These features create conditions of intense vulnerability, which magnify the role that trust plays in medical relationships and put trust on a much more emotional basis. This deeply personal type of trust is paralleled only in fraternal, family, or love relationships.⁵¹

Agency law fails fully to accommodate professional relationships for another reason that is important to appreciate for purposes of this essay. Agency law as traditionally applied to health care matters does not readily recognize all the interests involved in what we now

⁵⁰ RODWIN, *supra* note 44, at 194.

⁵¹ Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 471 (2002).

conceive to be medical professionalism. We are accustomed, that is, to applying agency law to deal with the bilateral relationship of doctor and patient, but not the triadic relationship that has come into being with the advent of managed care or the wide range of other rules imposed on health care transactions for the benefit of payors or of society at large.⁵² The modern law of health care has evolved to include the interest of a third party in many contexts—licensing authorities and other governmental and non-government authorities, insurance companies and other payors, the general public; but agency law, although theoretically capable of addressing third party interests, has for the most part lagged behind statutory law in adjusting to the changes. We have moved from a world in which the principle that a doctor's loyalty to patients was undivided and unrestrained to a world in which rationing is becoming conceivable and managed care legislation has made acceptable a certain degree of conflicted interest on the part of physicians. Indeed, in certain contexts scholars assessing the relevance of agency to health care have observed that if we are to use that concept, we must now wonder whose agent the physician is. It is now no longer clear for whom the physician is acting at any given moment, given the competing claims of the patient, the payor and the public at large.⁵³ Simply put, agency law has not given us the tools we now need to deal with matters involving more than two interests.

II. THE LAW OF PROFESSIONALISM: AN ESSENTIALIST APPROACH⁵⁴

Professionalism has been viewed as a special case within agency law or as a set of exceptions to other normative legal principles. For a more positive definition we need what Mark Hall has called an essentialist approach to the subject.⁵⁵ In addition, we need a definition that accommodates all the parties that now claim an interest in profes-

⁵² Among the many sociologists who have explored the triadic nature of the modern medical relationship are ERVING GOFFMAN, *The Medical Model and Mental Hospitalization: Some Notes on the Vicissitudes of the Tinkering Trades*, in *ASYLUMS*, 321, 333-44 (1961) (identifying "community" as the third party in interest in the triadic relationship in which the patient and psychologist are the other two); and FREIDSON, *PROFESSIONALISM REBORN*, *supra* note 42, at 187-88 (identifying professional, bureaucratic and commercial interests); *see generally* FREIDSON, *PROFESSIONALISM: THE THIRD LOGIC* (2001).

⁵³ GOFFMAN, *supra* note 52, at 333-44.

⁵⁴ I wish to acknowledge a general debt of gratitude to Professor Charles Bosk for guidance with this aspect of this essay.

⁵⁵ Hall, *supra* note 2, at 357.

sional transactions, not just the doctor and the patient. In this we can profit from the literature of social science.

In the Report of the American Bar Association Commission on Professionalism, Eliot Freidson observed that social science classifies an occupation as a profession when it is determined

1. That its practice requires substantial intellectual training and the use of complex judgments[,]
2. That since clients cannot adequately evaluate the quality of the service, they must trust those they consult[,]
3. That the client's trust presupposes that the practitioner's self-interest is overbalanced by devotion to serving both the client's interest and the public good, and
4. That the occupation is self-regulating—that is, organized in such a way as to assure the public and the courts that its members are competent, do not violate their client's trust, and transcend their own self-interest.⁵⁶

Freidson's formulation derives from a significant body of literature in sociology. Before him, Talcott Parsons had used the terms specificity of function, trust, disinterestedness and self-regulation to describe the parameters of professionalism identified above by Freidson. Specificity of function describes a profession's manner of dealing with a large and complex body of knowledge. It is reflected in the medical profession's organization according to training and specialties. Trust is a core value in most descriptions of professional relationships; it is evident in professional mandates to inform patients as to diagnosis, prognosis and other aspects of their condition, and to maintain confidentiality. Disinterestedness is the obligation of undivided loyalty or absence of conflicting self-interest clients and patients require of professionals. Self-regulation is apparent in the détente professionals have historically reached with government through which professionals are accorded deference in matters within the scope of their expertise.

⁵⁶ COMM'N ON PROFESSIONALISM, AM. BAR ASS'N, ...IN THE SPIRIT OF PUBLIC SERVICE: A BLUEPRINT FOR THE REKINDLING OF LAWYER PROFESSIONALISM 10 (1986), available at http://www.abanet.org/cpr/professionalism/Stanley_Commission_Report.pdf. Cf. Nancy J. Moore, *Professionalism Reconsidered*, 12 AM. B. FOUND. RES. J. 773, 778 (1987) (critiquing Freidson's definition of professionalism, stating "[i]f this is the appropriate definition [of professionalism], then the Commission is correct in concluding that a substantial decline in either the perception or the reality of lawyer altruism would be cause for serious concern. However, it is doubtful that there has been any such decline."); Ronald D. Rotunda, *Lawyers and Professionalism: A Commentary on the Report of the American Bar Association Commission on Professionalism*, 18 LOY. U. CHI. L.J. 1149 (1987).

Among the advantages of a formulation such as Freidson's is the fact that it not only informs our discussion of professionalism but also organizes it. Note that the second and third of the identified characteristics involve relations between professionals and their clients or patients, and that the first and last of the characteristics concern the internal operation of the profession. Note also that the attributes are sequenced: Because of the knowledge and skill barriers to entry into a profession (or, within the profession, into a specialty), patients must trust professionals; because patients must trust, professionals have an obligation to avoid self-interest; and because of all these things, it is both appropriate and necessary for the profession to regulate itself.

Looking ahead to this essay's enlistment of social science to frame a legal construct, the list of core principles of professionalism could be paired with legal issues as follows:

Core Value of Professions	Legal Issue
Functional specificity (issues dealing with training, credentials, specialization)	Licensure/ Antitrust laws (regulation of professional hegemony issues)
Trust	Fiduciary obligations of professionals (confidentiality, informed consent)
Disinterestedness	Divided loyalty and self-interest issues (human subject research; anti-kickback and self-referral prohibitions; managed care incentives)
Self-regulation	Governmental deference to a profession's establishment/ enforcement of standards (medical hearing boards; peer review organizations)

A. Functional Specificity

One critical function of a profession involves its organization and management of a specialized body of knowledge. The sociologist Burton Bledstein describes this attribute as follows:

The intellectual pretensions of [professionals] were specific in aim and definite in purpose. As professionals, they attempted to define a total coherent system of necessary knowledge within a precise territory, to control the intrinsic relationships of their subject by making it a scholarly as well as an applied

science, to root social existence in the inner needs and possibilities of documentable worldly processes.⁵⁷

Parsons used the phrase “specificity of function” to describe this aspect of professionalism.⁵⁸ It involves observing boundaries in several contexts. Where the professional’s technical competence is at issue, functional specificity means recognizing that a given professional’s knowledge and skill are limited to a particular “field.” Where contractual relationships are at issue, functional specificity means observing only the specific rights and obligations explicit or implicit in the agreement—what has been bargained for rather than what one party may need and what the other can afford to give.⁵⁹ Where a professional’s position in an administrative or bureaucratic hierarchy is at issue, functional specificity means recognizing and working within the limits of the authority of an “office.” At its core, functional specificity is about authority, and how it is acquired and maintained by operating within boundaries. In the vernacular, it is about “turf,” whether technological, administrative or occupational (and increasingly, economic).

As Freidson describes the attribute of professionalism he calls “specialization,” he strives to take technological, social and economic elements into account concurrently. Here is his catalog of the attributes of professionalism relating to specialization:

1. specialized work in the officially recognized economy that is believed to be grounded in a body of theoretically based, discretionary knowledge and skill and that is accordingly given special status in the labor force;
2. exclusive jurisdiction in a particular division of labor created and controlled by occupational negotiation;
3. a sheltered position in both external and internal labor markets that is based on qualifying credentials created by the occupation;

⁵⁷ BLEDSSTEIN, *supra* note 38, at 88.

⁵⁸ “Thus in an ordinary case of commercial indebtedness, a request for money on the part of one party will be met by the question, do I owe it? Whether the requester “needs” the money is relevant, as is whether the other can well afford to pay it. If, on the other hand, the two are brothers, any contractual agreements are at least of secondary importance. . . .” Parsons, *supra* note 6, at 39.

⁵⁹ In this respect, Parsons maintains, professional relationships, like commercial relationships, differ from kinship relationships, in which obligations and rights are “diffuse” rather than specific, and accordingly a professional responds to any request for assistance by asking why the assistance should be provided, rather than why not.

4. a formal training program lying outside the labor market that produces the qualifying credentials, which is controlled by the occupation and associated with higher education; and
5. an ideology that asserts greater commitment to doing good work than to economic gain and to the quality rather than the economic efficiency of work.⁶⁰

Functional specificity is evident in the fifth principle of medical ethics promulgated by the American Medical Association (“AMA”), viz., “A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.” The mandate includes homage to the importance of science, with a nod to the obligation to defer to other specialties where appropriate.

Transferring the idea of functional specificity into a legal context, we find ourselves dealing with areas in which the law supports or limits the medical professions in their efforts to create territorial boundaries. An important legal counterpart of functional specificity is the granting of monopolistic authority, such as through licensure. An important curb on this monopolistic authority is antitrust legislation.

B. Trust

Classical sociological theory identifies trust as one of the key elements of professionalism. The role it plays in medicine has been aptly described by Mark Hall:

Trust is the core, defining characteristic of the doctor-patient relationship—the “glue” that holds the relationship together and makes it possible. Preserving, justifying, and enhancing trust is a prominent objective in health care law and public policy and is the fundamental goal of much of medical ethics.⁶¹

Among sociologists like Freidson, trust has both positive and negative valences.⁶² It is not only the leap of faith taken by a patient by reason of the doctor’s merit, but reliance which the patient has no choice in placing, given his or her inability to evaluate the doctor’s performance. The condition of trust in a patient proceeds in part from the fact

⁶⁰ ELIOT FREIDSON, *PROFESSIONALISM: THE THIRD LOGIC* (2001) at 127.

⁶¹ Hall, *supra* note 51, at 470-71 (citations omitted).

⁶² FREIDSON, *supra* note 60, at 214.

that the gap in knowledge between the patient and the doctor is so great that the patient can neither fully appreciate his or her condition nor the success of its treatment by the doctor. From the vantage of the physician, it is both an entitlement and a responsibility.

In the ethical codes of the medical profession, the subjects of trust and loyalty are most readily evident in expressions of obligations of confidentiality and service, like these taken from the AMA's Principles of Medical Ethics:⁶³

IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

And more generally:

VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

Legal expressions of the essential principle of professionalism relating to trust can be found in laws establishing the fiduciary obligations of physicians. They are outgrowths of agency principles such as the duties of an agent to a principal with respect to information and authorization. In health law terms, these become the principles of confidentiality and informed consent. Statutory formulations of the concept of trust have been advanced in cases under the Employee Retirement Income Security Act ("ERISA") by plaintiffs arguing that health care providers assume the fiduciary obligations of plan administrators when they act in the context of health plans that are employee benefits.⁶⁴ Other statutory formulations of trust principles are more specifically related to health care professionals.

It will be important to this essay to grasp a structural difference between trust and functional specificity: the former involves the relationship between a doctor and patient while the latter involves conduct internal to the profession of which the patient is only an indirect beneficiary. The same distinction can be drawn between the remaining two core values, disinterestedness and self-regulation, the former being relational and the latter being organizational.

C. Disinterestedness

The third of the characteristics of professionalism listed above by Freidson involves the eradication of physician self-interest or divided loyalty. If trust forms the basis of the relationship between doctor and patient, disinterestedness is the justification for trust. The same qual-

⁶³ AMERICAN MEDICAL ASSOCIATION, *Principles of Medical Ethics*, available at <http://www.ama-assn.org/ama/pub/category/2512.html>.

⁶⁴ See, e.g., *Pegram v. Herdrich*, 530 U.S. 211, 277 (2000).

ity was earlier described simply as “disinterestedness” by Talcott Parsons.”⁶⁵ Parsons, a more unhesitating apologist for professionalism than Freidson, glossed the notion of disinterestedness with the observation that it evidences a crucial distinction between professional and commercial occupations.

For the dominant keynote of the modern economic system is almost universally held to be the high degree of free play it gives to the pursuit of self-interest. It is the “acquisitive society,” or the “profit system” as two of the most common formulas run. But by contrast with business in this interpretation the professions are marked by “disinterestedness.” The professional man is not thought of as engaged in the pursuit of his personal profit, but in performing services to his patients or clients, or to impersonal values like the advancement of science. Hence the professions in this context appear to be atypical, to some even a mere survival of the mediaeval guilds. Some think that these spheres are becoming progressively commercialized, so that as distinctive structures they will probably disappear.⁶⁶

And again:

The dominance of a business economy has seemed to justify the view that ours was an “acquisitive society” in which every one was an “economic man” who cared little for the interests of others. Professional men, on the other hand, have been thought of as standing above these sordid considerations, devoting their lives to “service” of their fellow men.⁶⁷

Although there is no explicit statement of subordination of self-interest in the Principles of Medical Ethics promulgated by the AMA, the idea is at least implied in the Seventh and Eighth Principles:

VII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

The professional’s obligation to remain disinterested is addressed by legal principles relating to conflicts of interest. The law tends to

⁶⁵ Parsons, *supra* note 6, at 35.

⁶⁶ *Id.*

⁶⁷ *Id.* at 43.

offer either management or structural solutions to professional conflict of interest issues. Management solutions are those in which professionals are given standards or guidelines for resolving conflicts, such as rules stating the occasions for and the effect of obtaining a patient's informed consent. Structural solutions are statutes, regulations and rules determining the degree of professional self-interest that may be permissible, as with managed care, or simply prohibiting professionals from putting themselves in a position where self-interest may arise in the first place, such as anti-kickback laws and prohibitions against fee-splitting and self-referrals.

D. Self-Regulation

In the eyes of the medical profession, its ability to self-regulate is justified by its other attributes, the facts that it requires extensive training and deals with highly scientific and technological information, that it warrants (and that its consumers rely upon) trust, and that its members avoid self-interest. Indeed, in Freidson's formulation of self-regulation as a characteristic of the legal profession, it is the culmination of the other attributes, all of which are related cumulatively:

[T]he occupation is self-regulating—that is, organized in such a way as to assure the public and the courts that its members are competent, do not violate their client's trust, and transcend their own self-interest.⁶⁸

Because the medical profession is functionally specific, and because its subject matter is abstruse and requires extensive training, the reasoning goes, consumers must trust; and because trust is essential, professionals must scrupulously avoid self-interest; and because it has all these attributes, the medical profession is entitled to, and in fact must regulate itself. Underlying all this reasoning is the assumption that professionalism is not fundamentally a commercial undertaking. Professionalism is the special province in which market rules are not needed, and where they fail in any event. Professions may self-regulate, it is argued, because the system of regulation forged in the commercial world is not apt and is not needed.

Our willingness to allow professionals to regulate themselves is evidence of our belief that professionals are essentially different from commercial actors. For Parsons, "professionalism" and "commercialism" were fundamentally antithetical, and it was the non-commercial

⁶⁸ COMM'N ON PROFESSIONALISM, AM. BAR ASS'N, *supra* note 56, at 10.

aspect of professions that qualified those occupations to make their most important contributions to society. As they “stand[] above [the] sordid considerations” of commerce, professionals are the trustees of their respective bodies of knowledge, preserving them for the general good.⁶⁹ Professionalism is more than a set of exceptions to norms, as common law seems to have it, but rather a separate and critically important estate within society. With his notion of the essentially altruistic motivation of professionals, Parsons is in line with the tradition of sociologists such as Carr-Saunders and Wilson, who argued that the role of professions, like that of other non-commercial institutions, is to stabilize democratic society: The professions

inherit, preserve and hand on a tradition. . . . Professional associations are stabilizing elements in society. They engender modes of life, habits of thought and standards of judgement which render them centres of resistance to crude forces which threaten steady and peaceful evolution. . . . It is largely due to them and to other similar centres of resistance that the older civilizations stand firm. . . . The family, the church and the universities, certain associations of intellectuals, and above all the great professions, stand like rocks against which the waves raised by these forces beat in vain.⁷⁰

In more recent times, to be sure, social science has questioned the non-commercial nature of professionalism, sometimes with disappointment and sometimes in the context of a search for other justifications for the institution of professionalism. Freidson seems to have espoused both viewpoints during his career, at one point acknowledging (with evident regret) the inevitability of self-interest on the part of the modern professional, but in the end elevating the professional to the status of a third ideal type needed to counterbalance the other two, free market and bureaucratic types, in order for society to function optimally.⁷¹

⁶⁹ Parsons, *supra* note 6, at 43.

⁷⁰ A. M. CARR-SAUNDERS AND P.A. WILSON, *THE PROFESSIONS* 497 (Frank Cass & Co. Ltd. 1964) (1933).

⁷¹ FREIDSON, *PROFESSIONALISM REBORN*, *supra* note 42, at 184. Freidson acknowledges the inadequacy of what he identifies as the free market (consumerism) to restrain the tendency of medical professionals to organize and operate for their exclusive advantage. He pictures the free market, the bureaucratic market (hierarchically organized), and the professional market in an uneasy stasis, each inclined to function in self-interest. *Id.* at 184-94. In his last book, *PROFESSIONALISM: THE THIRD LOGIC* (2001), professions become a transcendent ideal with a right to autonomy and an obligation to exercise their power benevolently (221), in service of a “larger good”

Recognition of the right of self-regulation is evident in Principles II, III and VI of the AMA's Principles of Medical Ethics:

- II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.
- III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.
- VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

The law acknowledges the right of a profession to regulate itself where its claims to do so are based on the profession's other inward-looking core value, functional specificity. Thus where the medical profession sets out to monitor its members' compliance with standards of care, for instance, the law defers to the profession. Where the rights of the public and other third parties are implicated, however, the law engages in careful line-drawing. Medical hearing boards and peer review organizations are witnesses to this.

III. A METHODOLOGY FOR ASSESSING THE EFFECT OF CODIFICATION ON MEDICAL PROFESSIONALISM

In the pages that follow I will examine selected cases in which courts are called upon to adjudicate issues arising where statutory law impinges upon the core values of medical professionalism outlined above. I propose here a uniform approach to these cases consisting of asking the following questions:

1. Is one of the core values of medical professionalism at issue?
2. What interests are implicated in this value? (i.e., is the value one that principally involves the profession's internal organization and management, affecting patients and others only indirectly, or is the value essentially relational, in which case, besides the practitioner, what second and third party interests are involved? Patients? Payors? The general public? The "greater good"?)
3. Has the law in question adequately identified and reasonably accommodated the interests that are implicated?

I suggest that these questions comprise the elements of a methodology with which lawmakers and decision makers can both identify circumstances in which professionalism may be at risk of unintended consequences and consider what, if anything, should then be done.

IV. THE CODIFICATION OF MEDICAL PROFESSIONALISM

In this essay I refer to the process by which common law doctrines that have shaped our concept of professionalism are being replaced by statutory formulations as codification. Codification affects the different core values, or defining attributes of professionalism identified above differently, as the next section of this essay will endeavor to demonstrate. But in certain important respects, codification affects all aspects of professionalism alike. For one thing, standards of conduct become more uniform across local and regional lines. There is no longer a need to refer to the conduct of similarly situated professionals of like kind within a given community, or to determine the applicable standard on a case-by-case basis, where a rule of law has interceded. Seen from the vantage of governmental (and particularly federal) purchasers of health care services, this uniformity is for obvious reasons a positive development. Local professionals, however, are apt to experience the change as an intrusion upon their autonomy. For another thing, codification inevitably changes professional conduct in more fundamental ways, accelerating the shift from a culture of responsibility to one of rights as mentioned above. Where a statute or regulation has established the limit of what is permissible in terms of, say, economic self-interest, that limit becomes extremely seductive, and often replaces community-based standards of conduct. Why ruminate about what colleagues would or should do when the law has drawn a bright line upon which all professionals within a group may be presumed to be walking? If a regulatory agency has established a safe harbor allowing an employer to compensate a professional employee in a manner that induces referrals, with the result that all other employers in the industry can be presumed to be conducting themselves accordingly, why should any individual employer or the professional employee pause to consider whether any such referral is defensible from a professional standpoint? The bright line established by the regulation tends to replace any sense of professional responsibility that may have pre-existed it, and it is thus that a culture of responsibility can by degrees be transformed into a culture of rights.

This is not to say that codification is in all cases a bad thing, an evolutionary force that it is the duty of decisional law to oppose.

Legislatures, after all, are in many respects better instruments of social policy than courts. A doctor and patient in a mutually satisfactory relationship are not concerned with the problem of providing others with access to care, nor, where insurance or some other third-party payor picks up the tab, are they likely to be sensitive to costs. These critical concerns are left to policy makers and legislators to address. Statutory law has led the way for beneficial health care policy change in recent decades, and it is to be hoped it will continue to do so.

A. Functional Specificity

I focus here on two areas in which codification has affected the core attribute of professionalism referred to above as functional specificity, namely, licensure and antitrust laws. These two areas of law are particularly useful for present purposes not only because in both instances the concept of medical professionalism has been palpably transformed by codification, but also because the statutes in question represent two very different approaches to professionalism and have produced two significantly different effects upon it. State licensure laws involve legislative grants of authority within a specific "field," either medicine in general or, as the case may be, a specific area within medicine. Such grants may either be exclusive and monopolistic, or non-exclusive. State and federal antitrust laws, on the other hand, involve limitations on monopoly.

Functional specificity is to a large extent an internal matter where the medical profession is concerned, as I have noted above. Any interest of patients in the outcome is derivative and arguably subordinate to the interest of professional groups themselves. The interest of payors, including patients to the extent that they are responsible for the cost of professional services, is nevertheless implicated. Licensure laws that allow professionals of lower skill levels to provide services that would otherwise cost more or be unavailable have an obvious effect on the public. Licensure laws involve primarily the intra-professional concern of hegemony and secondarily the societal concerns of cost and access to services. When statutory issues arising from licensure laws are brought before courts, they have understandably tended to act with deference to the professions with respect to the manner in which they organize themselves to manage the body of knowledge with which they are charged; but courts have tended to abate their deference and to credit legislatures with relatively more authority where the cost of services or public access to services are the issue and the claims of the profession are relatively weak. Antitrust laws, on the other hand, do not take professional values into account at all.

1. Licensure Laws

Licensure is the instrument with which government endorses a professional body's authority to establish its competency boundaries. The effect of a license may be to grant a certain professional group a monopoly in a given practice area, or merely to grant the group a non-exclusive right to it. The latter type of licensure statute is sometimes referred to as "open." Legal disputes sometimes arise when professional groups differ as to which of the foregoing types of law should apply. Viewed with the analytic tool this essay advocates, the interest of a professional disputant should be more compelling where issues of practitioner competency, the integrity of scientific field, and quality of care are at stake; and the interest of legislators should be more compelling where the objective is to delineate economic hegemony or to protect public and other third party interests.

One notable case in which a court was left to construe an "open" statutory definition of professional field was *Sermchief v. Gonzales*.⁷² Here the Missouri Board of Registration for the Healing Arts ("Board") argued that the medical licensure statute operated to prohibit certain conduct by nurses as the unlicensed practice of medicine.⁷³ The nurses were providing family planning, obstetrics and gynecology services directly to a low-income community through a nonprofit agency ("Agency") pursuant to standing orders issued by physicians in advance. The statute was drafted broadly to prohibit anyone not licensed as a physician to "practice medicine or surgery in any of its departments,"⁷⁴ with certain exceptions. Among the exceptions was one for nurses "licensed and lawfully practicing their profession within the provisions of [the nurse licensure statute]."⁷⁵

⁷² 660 S.W.2d 683 (Mo. 1983) (en banc).

⁷³ The legislation in question, the Nursing Practice Act of 1975, MO. ANN. STAT. § 335.011-257 (West 2008), was intended to expand nursing responsibilities pursuant to the recommendations of several national commissions during the early 1970's. See DEP'T. OF HEALTH, EDUC. AND WELFARE, PUBL'N NO. (HSM) 73-2037, EXTENDING THE SCOPE OF NURSING PRACTICE: A REPORT OF THE SECRETARY'S COMMITTEE TO STUDY EXTENDED ROLES FOR NURSES 8 (1971). See also NAT'L COMM'N FOR THE STUDY OF NURSING & NURSING EDUC., AN ABSTRACT FOR ACTION (1970); NAT'L COMM'N FOR THE STUDY OF NURSING & NURSING EDUC., FROM ABSTRACT INTO ACTION (1973). When the Missouri legislature enacted the Nursing Practice Act of 1975, thirty states had similarly amended their laws regulating the nursing profession. Audrey L. Ennen, Comment, *Interpreting Missouri's Nursing Practice Act*, 26 ST. LOUIS U. L.J. 931, 931 n.1 (1982). After 1975, at least forty states had broadened nursing practice statutes similar to the Missouri Nursing Practice Act. *Id.*

⁷⁴ MO. ANN. STAT. § 334.010 (West 2008).

⁷⁵ MO. ANN. STAT. § 334.155 (West 2008).

The nursing licensure statute in turn defined "professional nursing" non-exclusively as "the performance for compensation of any act which requires substantial specialized education, judgment and skill based on knowledge and application of principles derived from the biological, physical, social and nursing sciences. . . ." ⁷⁶ In other words, both the physicians' licensure law and that authorizing nursing were written in deliberately open language, so that nurses, physicians and courts were left to draw (and from time to time to redraw) the boundaries of their respective fields. ⁷⁷

Agency services provided by the nurses included the taking of patient histories; breast and pelvic examinations; laboratory testing of Papanicolaou (PAP) smears, gonorrhea cultures, and blood serology; the providing of and giving of information about oral contraceptives, condoms, and intrauterine devices (IUD); the dispensing of certain designated medications; and counseling services and community education. Pursuant to their standing orders, the nurses would refer patients to an Agency physician if they encountered certain specified conditions. ⁷⁸ At trial, no evidence of harm to patients was introduced; rather, the Board introduced expert witness testimony to the effect that the services provided by the Agency nurses consisted of services typically provided by licensed physicians, and the nurses in turn produced testimony to the effect that their conduct was within the scope of what was generally understood in that profession to be the practice of nursing. ⁷⁹

The threshold question explicitly at issue on appeal was whether Agency nurses could legally proceed under standing orders (rather than direct physician supervision) to dispense medications and contraceptive devices, provide counseling and otherwise react to specified conditions. ⁸⁰ The Missouri Supreme Court determined the conduct was permissible, based largely on its reading of legislative intent to broaden the scope of nursing practice. ⁸¹ It is clear from the firestorm of amici briefs filed, however, that the case provoked concern about a

⁷⁶ MO. ANN. STAT. § 335.016(11) (West 2008).

⁷⁷ See Barbara J. Safriet, *Health Care Dollars and Regulatory Sense: The Role of Advanced Practice Nursing*, 9 YALE J. ON REG. 417 (1992), for a review of the literature on the relative quality implications of practice by medical doctors and nurses.

⁷⁸ *Sermchief*, 660 S.W.2d at 684.

⁷⁹ *Id.* at 685.

⁸⁰ *Id.* at 686.

⁸¹ *Id.* at 689-90. The court succeeded in appearing to avoid making health policy, but in circumventing policy issues it may be accused of somewhat circular reasoning, viz., answering the question as to the scope of nursing practice with reference to the scope of nursing training, skill and, well, practice. *See id.*

number of substantive issues that were ultimately avoided by the court.⁸² With some speculation, a list of the motives driving public interest could have included concern for patient safety, for health economics (with physicians concerned to retain market share and payors and legislators urging for physician extenders), and for an articulation of public policy regarding family planning and birth control. The parties themselves wanted scope of practice line-drawing rules,⁸³ and they presumably hoped for principles broad enough for application for general organizational and operational purposes. What they got instead was statutory construction by a court wary of tripping an "avalanche of . . . malpractice suits" by declaring any given conduct to be unauthorized. In this respect the court seemed unwilling to go beyond holding, in effect, that nursing, like other departments of the health care profession, is what it is, and that if the conduct of one department happens to overlap with that of another, so be it.

Typical of such cases,⁸⁴ *Sermchief* must have been disappointing to those looking either to settle a wider range of professional border disputes or to see the court make substantive policy. The court's answer to the question, "What constitutes nursing and what the practice of medicine?" might loosely be characterized as follows: "Nursing is conduct not inconsistent with nursing training, skill and practice generally, and in any case includes reacting appropriately to conditions stipulated in advance by physicians under standing orders." It was left to each profession, or each department within it, to determine its boundaries in the legislative scheme then in place in Missouri. Indeed, the court acknowledged the occupational self-awareness of nurses as if it were an attribute of professionalism generally: "The hallmark of the professional is knowing the limits of one's professional knowledge."⁸⁵ And while each branch of the health care profession may regulate internally, it may not assume that statutory systems like Missouri's or the law of professions generally bestows any right to exclusivity.

Disappointing as *Sermchief* may have been for the litigants seeking positive determinations of their rights relative to each other, from the perspective of this essay the court's restraint may be justified.

⁸² See *id.* at 685-86.

⁸³ *Id.* at 688 ("The parties on both sides request that in construing these statutes we define and draw that thin and elusive line that separates the practice of medicine and the practice of professional nursing in modern day delivery of health services.").

⁸⁴ See also *State Bd. of Nursing v. Ruebke*, 913 P.2d 142 (Kan. 1996) (determining whether midwives were engaged in the practice of medicine).

⁸⁵ *Sermchief*, 660 S.W.2d at 690.

Applying the methodology described above, first, we can answer affirmatively that the case involves a core, defining attribute of professionalism, namely, functional specificity. In this terrain the court was obliged to defer to the arguments of the professions as to how they should best organize internally in order to cope with the vast body of scientific knowledge in their trust. The court's deference obligation to the Board would admittedly have been greater had it been supported by evidence of the scientific basis for such arguments, or evidence that an adverse holding would impair quality of care. At the same time, however, the court was justified in recognizing the secondary interests of the public in the cost and access. Refer to the second question in the methodology described above: what interests are implicated in the core attribute in dispute? In this case, the "field" authority of more than one branch of the medical profession is raised, and these interests are being weighed against the interests of society in controlling cost and increasing public access to professional services. Had the issue been strictly knowledge-based, the principle of deference may have carried the day, one way or the other. To the extent that the issue could also be framed in economic terms, however, the court does not appear to find it problematic to acknowledge the authority of the legislature and decide the case accordingly.

Referring to the third question in the methodology, did the *Sermchief* court, and did the Missouri legislature before it, reasonably accommodate the interests involved? History suggests they have. By an overwhelming majority, the states have adopted nursing statutes with broad language like that in *Sermchief* since the 1970s, ostensibly to allow that profession room to self-define and evolve, but also to create an environment in which more of the burden of health care can be shifted to lower cost providers. Cases upholding legislative authority to enact non-exclusive licensure laws establish that the law may take cost and access considerations into account in rule-making without undue harm to core principles of professionalism, at least until professional advocates convince courts that professional skills, quality of care or the integrity of medical knowledge will suffer.⁸⁶

To view the case in terms of what it tells us about transformative process, *Sermchief* stands for the principle that there is relatively more justification for legislative and judicial interference with professional self-regulation where the interests of third parties are at stake than where the issue is properly internal to the profession. By the same

⁸⁶ See Jerry Cromwell, *Barriers To Achieving A Cost-Effective Workforce Mix: Lessons From Anesthesiology*, 24 J. HEALTH POL., POL'Y AND L. 1331, 1345-51 (1999).

token, *Sermchief* evidences the law's growing cognizance of third party interests as its concept of professionalism evolves. The interests implicated in *Sermchief* are not just those of doctors, or of doctors and patients, but also those of society as a whole.

2. Antitrust Laws

Whereas licensure laws involve legislative grants of monopoly, antitrust laws involve the reverse. Both kinds of statutes, however, necessarily involve medical professionalism's defining attribute of functional specificity. The interest of the medical profession in this attribute is most compelling, we have noted, where medical knowledge is directly affected, and this has sometimes been the case in disputes revolving around antitrust laws. To this we may add that the interest of the medical profession in the quality of patient care must also add to the strength of the profession's claim, and again this issue has been implicated by antitrust laws. Professionalism stands on the firmest ground when it seeks to defend its particular body of knowledge or the quality of the care professionals deliver. The problem for decisional law in this area is that unlike licensure statutes, antitrust statutes leave no room for deference based on such concerns. Antitrust laws represent a purely economic agenda on the part of legislatures: there is no "quality of care" defense under the Sherman Act to a finding that a professional body has engaged in price fixing, boycott or the like.⁸⁷ As we might expect, then, courts have been more willing to challenge legislative supremacy where antitrust disputes involving professionals have been concerned.

The potentially detrimental effect of codification on medical professionalism is evident in the context of antitrust law. Antitrust legislation is at least in part predicated upon the assumption that free markets are in all significant respects superior to markets encumbered by special arrangements among suppliers or consumers. Antitrust laws seek to preserve commerce for fully-informed parties dealing at arms' length. Professionalism, on the other hand, has historically claimed for itself an exception to this rule on the grounds that marketplace principles do not apply in the relationship between doctor and patient. For one thing, the AMA has argued, there is too much "information asymmetry" to permit us to hope that consumers sifting through the ranks of professionals will ultimately be able to discover optimal combinations of price and quality.⁸⁸ And for many years,

⁸⁷ See, e.g., *FTC v. Ind. Fed'n of Dentists*, 476 U.S. 447, 462-63 (1986).

⁸⁸ *Am. Med. Ass'n v. Wilk* 895 F.2d 352, 361 (N.D. Ill. 1987), cert. denied, 498 U.S. 982 (1990).

courts acknowledged the validity of this claim on the part of professionals and carved a special place for them in antitrust jurisprudence. Eventually, however, the courts acceded to legislative supremacy with respect to antitrust issues, and in the process the traditional concept of professionalism was transformed.⁸⁹

There is virtually no room to accommodate the special attributes of professionalism within antitrust statutes, and little room in doctrinal professionalism for the logic of the market place. The Sherman Antitrust Act prohibits what it defines as anti-competitive conduct, without exception for conduct professionals have deemed essential for preserving the integrity of their body of knowledge or the quality of patient care. The Sherman Act and other antitrust statutes do so, as I have said, on the assumption that free markets will efficiently assess quality. Consumers of medical goods and services will eventually find the optimal value combination of quality and cost. Advocates of professionalism, however, argue that this market principle cannot work in a health care context, because patients, unlike typical consumers, are rarely in a good position to assess the quality of the care they are given. The informational asymmetry in health care is simply too severe for marketplace economics to work, and this fact, apologists for professionalism have argued, deserves to be recognized in the form of exceptions to the application of antitrust statutes. In the case of antitrust law, they have argued, the codification of professionalism has proceeded without due awareness of the damage done to professionalism itself.

*Wilk v. American Medical Association*⁹⁰ is seminal for this purpose, since it squarely raises the functional specificity justification for deference within the context of the economic program of the Sherman Act.⁹¹ *Wilk* was an appeal to the Seventh Circuit from a district court holding⁹² that the AMA violated § 1 of the Sherman Act by boycotting chiropractors with its promulgation and coercive enforcement of the following Principle of Medical Ethics as then formulated (hereinafter referred to as Principle 3): "A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily professionally associate with anyone who violates this princi-

⁸⁹ See Thomas L. Greaney, *Quality of Care and Market Failure Defenses in Antitrust Health Care Litigation*, 21 CONN. L. REV. 605 (1989), for a discussion of whether it may be possible to raise a quality of care defense based on a market failure argument.

⁹⁰ *Am. Med. Ass'n v. Wilk* 895 F.2d 352 (N.D. Ill. 1987), cert. denied, 498 U.S. 982 (1990).

⁹¹ 15 U.S.C. §§ 1-7 (2000).

⁹² *Wilk v. Am. Med. Ass'n*, 671 F. Supp. 1465 (N.D. Ill. 1987).

ple.”⁹³ The plaintiff chiropractors argued that the AMA enforced Principle 3 first by labeling chiropractics as “unscientific” and then advising AMA members and other professional associations that it was unethical to associate with chiropractors. Among the district court’s findings of fact were that the AMA’s purpose was the containment and elimination of the chiropractic profession and more particularly that the AMA sought to monopolize the hospital health care market.⁹⁴ The AMA had drafted an accrediting standard for the Joint Commission on Accreditation of Hospitals that would have excluded unscientific practitioners, and thus chiropractors from hospital staff, peer review committees and the like, and would have effectively denied chiropractors access to hospital clinical records, research results, and to hospital x-ray equipment and other facilities.

It is clear enough that the provenance of Principle 3 was at least nominally a professional concern for scientific method; the question raised in *Wilk* was whether that concern made any difference within the framework of antitrust law given the AMA’s manifestly anti-competitive conduct. Would antitrust law stand aside in the presence of one of the core parameters of professionalism? Two of the AMA’s responses warrant attention here. One argument was that its conduct did not in fact offend principles of competition because they do not apply in the medical services market. The second argument was that anticompetitive conduct could be justified in the name of quality of care.

The first of these two assertions was an argument to the effect that Principle 3 had pro-competitive implications that counterbalanced its anticompetitive conduct. The AMA argued that the market for medical services is one where there is “information asymmetry.”⁹⁵ Patients lack sufficient knowledge to evaluate the quality of medical services and therefore avoid necessary and accept unnecessary treatments. The medical market does not correct itself even after such mistakes are made because patients do not know what result they should have obtained. The result is “market failure,” an environment in which competition is at best inapposite and at worst damaging, as gullible patients lured by false promises flee from good medicine and its stability is jeopardized. Informational asymmetry is professionalism’s ultimate functional specificity rationale. It is the assertion that professionals are the guardians of a body of scientific knowledge and as such deserve deference. In the form presented in *Wilk*, however, the

⁹³ *Id.* at 1470.

⁹⁴ *Id.* at 1471.

⁹⁵ *Wilk v. Am. Med. Ass’n*, 895 F.2d 352, 361 (7th Cir. 1990).

argument was rejected as “speculative” by the district court and the Seventh Circuit agreed.⁹⁶ The AMA’s witness testified that an empirical study could not be performed to determine the pro-competitive effects of Principle 3. (Indeed the argument has Catch 22 features to the extent that it is incapable of proof independent of circular self-assertion. Its adherents seem to be saying, “Allowing the market to value medical services would be against the best interests of the market; take our word for it.”)

The “market failure” argument has the advantage of having a plausible place in Sherman Act analysis as a defense against claims of unreasonable restraint of trade. It is fundamentally an assertion of pro-competitive effect, and as such admissible as a defense.⁹⁷ The other AMA argument to be considered here, the so-called patient care defense, has less statutory legitimacy. Quality of care is not recognized by the Sherman Act as a justification for anti-competitive conduct. For decades, however, courts had held that “learned professions” were implicitly exempt from antitrust laws, and even after that doctrine was abandoned⁹⁸ courts continued to propound exemptions for the medical profession based on quality of care. The “patient care” defense formulated by the Seventh Circuit in *Wilk* provided that the AMA’s boycott would not be subjected to *per se* analysis and could be justified if the AMA established:

(1) that they genuinely entertained a concern for what they perceive as scientific method in the care of each person with whom they have entered into a doctor-patient relationship; (2) that this concern is objectively reasonable; (3) that this concern has been the dominant motivating factor in defendants’ promulgation of Principle 3 and in the conduct intended to implement it; and (4) that this concern for scientific method in patient care could not have been adequately satisfied in a manner less restrictive of competition.⁹⁹

On the facts in *Wilk*, however, the AMA failed to establish that its concern for scientific method rather than its desire to dominate its market for economic reasons was its principal motivation, and that it could not have advanced scientific methods in a manner less harmful to competition.

⁹⁶ *Id.*

⁹⁷ *Id.*

⁹⁸ See *Goldfarb v. Va. State Bar*, 421 U.S. 773 (1975).

⁹⁹ *Wilk v. Am. Med. Ass’n*, 719 F.2d 207, 227 (7th Cir. 1983); *Wilk*, 671 F. Supp. at 1470-71.

Could the AMA have succeeded in *Wilk* in establishing either that its conduct was pro-competitive or that it was justified in the name of patient care? If so, *Wilk* would have constituted an impressive vindication of the classic concept of professionalism. It is unlikely, however, that courts would confer legally-enforceable exclusivity upon the medical profession in the context of antitrust law any more than in matters of licensure. To prevail in an argument to the effect that refusal to deal is pro-competitive, were the AMA to continue to try, it would have had to establish objectively that it deserved to be the sole arbiter of truth and that consumers are not in a position to question its determinations. In an environment in which courts and legislatures are expanding patients' rights such as informed consent, it is unlikely that such a paternalistic premise could be accepted. For its part, the patient care defense hangs on a thread even in *Wilk*, and was arguably then already overruled by *Indiana Federation of Dentists*,¹⁰⁰ which rejected a quality of care defense by dentists who had withheld x-rays requested by insurers.¹⁰¹ In *Wilk* the Seventh Circuit followed the district court in rejecting the AMA's patient care defense on the grounds that (1) the AMA failed to establish that its singular adherence to scientific method was objectively reasonable (evidence had been admitted at trial to the effect that the AMA itself acknowledged that chiropractic was effective against certain musculoskeletal conditions) and (2) the AMA failed to show that it could not have achieved its goals using methods less injurious to competition (such as a public education campaign).¹⁰²

Viewed for its implications for the traditional concept that professionalism, the *Wilk* test for the patient care defense predetermines a somewhat adverse result. Professionalism in its traditional mode asserts that the professional is exclusive arbiter of issues relating to scientific method, whereas the *Wilk* test insists that the scientific method will prevail only where a court is convinced that it is objectively reasonable. *Wilk* establishes that the medical profession can be granted

¹⁰⁰ *FTC v. Ind. Fed'n of Dentists*, 476 U.S. 447, 462-64 (1986).

¹⁰¹ *Id.* But the court did decline to invoke *per se* analysis of the issue, as the Sherman Act would normally require in a boycott situation: "Although this Court has in the past stated that group boycotts are unlawful *per se*, . . . we decline to resolve this case by forcing the Federation's policy into the 'boycott' pigeon-hole and invoking the *per se* rule. . . . [W]e have been slow to condemn rules adopted by professional associations as unreasonable *per se* . . . and, in general, to extend *per se* analysis to restraints imposed in the context of business relationships where the economic impact of certain practices is not immediately obvious. . . ." *Id.* at 458-59. *Wilk*, 671 F. Supp. at 1481. (The *Wilk* court maintained that it was consistent with *Indiana Federation of Dentists* on the grounds that it too was decided on a rule of reason basis.)

¹⁰² *Wilk*, 895 F.2d at 362-64.

market dominance only when there is no pro-competitive alternative, and suggests an educational campaign on the failings of chiropractic as an alternative to boycott. But traditional professionalism is erected on an assumption of irremediable informational asymmetry, which seems an unlikely platform from which to launch an educational campaign. It is difficult to imagine a successful campaign to teach the public that it cannot reasonably expect to understand and evaluate the medical services being provided to it.

The extent to which the *Wilk* court credited the AMA's patient care defense evidences the reluctance of courts to apply normal antitrust analysis to the anti-competitive conduct of professionals. A strictly commercial defendant would likely have been found liable on a *per se* basis under the Sherman Act. The Seventh Circuit did ultimately reject the AMA's patient care defense, but maintained that it warranted rule of reason rather than *per se* analysis because the defense "involves a medical ethic which nonfrivolously addresses the importance of scientific method, a subject well within the natural ambit of a medical association."¹⁰³ Even this level of deference was, however, without basis in antitrust jurisprudence, and therefore ultimately fated to be discarded. Deference by the *Wilk* court and others that have similarly sought to mollify the effect of the Sherman Act on professions can probably best be viewed as judicial pleas against all hope of success for a second look at the consequences of antitrust legislation for professionalism. To a moderate degree administrative agencies such as the Federal Trade Commission have heeded the call, establishing specific "safety zones" in which professional conduct will not be prosecuted under antitrust laws.¹⁰⁴ But such measures do not alter the fact that a traditional attribute of professionalism—its autonomous control of certain "turf" issues—does not apply within the framework of antitrust law. If we can concur that a core value of professionalism is negatively impacted by antitrust legislation, continued pressure upon that legislation seems likely.

My purpose is not to side with the AMA in *Wilk*, but to underscore the evident frustration of the court, and other courts confronted with the same issue, when forced to apply rules designed for commercial application in the context of professionalism. In such circumstances, courts have repeatedly urged that more scope be allowed for consideration of quality of care or to question whether marketplace

¹⁰³ *Wilk*, 671 F. Supp. at 1480.

¹⁰⁴ See Press Release, Department of Justice, Antitrust Enforcement Policy Statements Issued for Health Care Industry (Sept. 15, 1993), available at http://www.usdoj.gov/atr/public/press_releases/1993/211661.pdf.

assumptions apply to professions. As a society we may ultimately wish to ignore such urgings and act instead to bring professions in line with commercial actors. My purpose is merely to identify the circumstances in which we should acknowledge the transformative effect of law upon professions, as courts have demonstrably already done from time to time.

B. Trust

Professionalism's defining attribute *trust* acquires legal implications where the law seeks to define fiduciary obligations. This can occur in the narrow context in which a professional may come within the scope of ERISA's definition of a fiduciary, or more generally in agency situations where the law seeks to redress harm arising from a failure of the professional to act within the bounds of his or her agency. Trust is specifically implicated where legal obligations of confidentiality arise. A duty of confidentiality can arise in common law as the obligation of the agent to safeguard information about the principal,¹⁰⁵ or under statutory law, such as the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").¹⁰⁶ The following sections of this essay will first develop the concept of confidentiality as it emerges from common law, then examine the effects of its "statutorification" in HIPAA.

Trust, as mentioned above, is a relational value, as distinguished from the values of functional specificity and self-regulation, which are predominantly internal concerns for professions. Functional specificity and self-regulation, that is, are aspects of the medical profession's dealings with itself, whereas trust is an aspect of the relationship between professionals and their patients. As an instance of the core value of trust, confidentiality should also be relational. Accordingly, for decisional or statutory law properly to address this value, the interests of both the patient and the professional must be taken into account.

1. Confidentiality

Claims that a professional has breached his or her fiduciary duty of confidentiality often arise in dispute situations along with claims involving breach of privacy; but as the court in *Humphers v. First Interstate Bank of Oregon*¹⁰⁷ observes, there is a difference. Briefly

¹⁰⁵ RESTATEMENT (THIRD) OF AGENCY § 8.05 (2006).

¹⁰⁶ 42 U.S.C. § 1320d-2 (2000); 45 C.F.R. § 160.101 et seq.

¹⁰⁷ *Humphers v. First Interstate Bank of Or.*, 696 P.2d 527 (Or. 1985).

stated, anyone can invade someone's privacy, but only a fiduciary can breach a fiduciary duty such as the duty of confidentiality owed a patient by a physician.¹⁰⁸ We may accordingly expect disputes about a physician's duty of confidentiality to bring us into contact with one of professionalism's core, defining attributes.

Humphers involved claims against a doctor's estate by a mother, Ramona Jean Peek, who had put her child up for adoption at birth and had sought thereafter to conceal her identity from the child. Upon reaching majority, the child, Dawn Kastning, had prevailed upon Ms. Peek's physician, Dr. Mackey, to assist in identifying and locating Ms. Peek. To this end Dr. Mackey gave Ms. Kastning a letter falsely stating that he had administered diethylstilbestrol (DES) to Ms. Peek and that possible consequences of this medication to Ms. Kastning made it important for her to find her biological mother. In reliance on this letter, the hospital records department produced copies of Ms. Peek's medical records for Dawn, who was then able to locate Ms. Peek. Ms. Peek sought damages from Dr. Mackey's estate for emotional distress.

By way of preface to the reading of *Humphers* that follows, my purpose is to show the emergence of the concept of confidentiality in a form uniquely relevant to professionalism. I believe the concept the court ultimately formulates reveals something of the essential difference between professionalism and commerce, a fact that is evidenced by the struggle of the court, first to forge a cause of action and a claim that fit squarely in neither traditional (marketplace) contract nor tort law, and then to find a basis for the concept among existing statutes and codes.

As the case came to the Oregon Supreme Court, the district court below had found for the defendant on the basis that the facts supported no theory of relief the plaintiff could advance. The plaintiff's tort-based claims would have had problems of proof, while claims sounding in contract would not have supported damages for emotional distress. Ms. Peek's claim that Dr. Mackey's conduct was tortious would have required expert testimony to the effect that such conduct fell below the level of care at which other physicians in the community practiced in order to establish that a standard of care had been

¹⁰⁸ *Id.* at 530 ("If an act qualifies as a tortious invasion of privacy, it theoretically could be committed by anyone. In the present case, Dr. Mackey's professional role is relevant to a claim that he breached a duty of confidentiality. . . ."). The court reasoned that the confidentiality obligation of a physician to his or her patient is unique: "If Dr. Mackey incurred liability . . . it must result from an obligation of confidentiality beyond any general duty of people at large not to invade one another's privacy." *Id.* at 533.

breached. Such evidence was not forthcoming. Moreover, her claim that Dr. Mackey had intentionally inflicted emotional distress failed upon findings of fact that Dr. Mackey had had no such intention, nor had he acted recklessly. Contract-based claims faced not only the difficulty of establishing any bargain for confidentiality (it would have had to be implicit), but also the remedy problem (contract damages would not have yielded adequate recompense). To the extent that any duty of confidentiality existed, the district court had reasoned, it must ultimately have been grounded in contract, which would not support damages for pain and suffering or emotional distress.

But Ms. Peek's needs could not be adequately addressed by contract theory. To find a legal theory that would help Ms. Peek, the Oregon Supreme Court had to deal with the decades-old problem of the misalignment of professionalism and the law of the marketplace. A cause of action and a remedy had to be found that in many respects were exceptions to the rules,¹⁰⁹ and in the process the legal parameters of professionalism were being established. The *Humphers* court thus defines a core attribute of professionalism by exploring the failure of legal norms to account for it. First, the court acknowledged that it was dealing with a uniquely professional issue, the alleged breach of a fiduciary duty of confidentiality, and not the lay issue of invasion of privacy. Then the court nodded to the contractual nature of the doctor-patient relationship, but would have to infer that confidentiality was a term of the contract. Confidentiality was implicit in the fact that Dr. Mackey had registered Ms. Peek under a false name when she gave birth to Dawn. Then the court wrestled with the tort nature of the problem in considering the applicable standard of care. Did a breach of the duty of confidentiality require expert testimony to establish the standard within the professional community, or could lay persons determine the level of confidentiality owed to a patient by a doctor? Simply to ask the question is to acknowledge something exceptional about this core value. To consider the possibility that the judgment of a lay person may be the measure of an aspect of a professional relationship is to recognize the bilateral (relational) nature of the element of trust.

¹⁰⁹ *Id.* at 529 ("A contract claim may be adequate where the breach of confidence causes financial loss, and it may gain a longer period of limitations; but contract law may deny damages for psychic or emotional injury not within the contemplation of the contracting parties. . . . A contract claim is unavailable if the defendant physician was engaged by someone other than the plaintiff[.]"). *But see* *Hammonds v. Aetna Cas. & Surety Co.*, 237 F. Supp. 96, 98-100 (N.D. Ohio 1965) (applying breach of contract theory).

Ultimately the *Humphers* court had to resort to a degree of “judicial innovation”¹¹⁰ to establish the theory upon which Ms. Peek could state a claim, and in doing so the court illuminated one of professionalism’s defining values. The plaintiff needed a tort-like remedy, but the claim of invasion of privacy was not available, nor was there a finding of intentional misconduct of a magnitude sufficient for a claim of emotional distress. The court needed to identify a confidential relationship that could give rise to tort damages. The court also need this relationship to be “nonconsensual”—a duty to keep a secret that was not based on contract, as it almost always is in the commercial world. Indeed, the court needed to establish that the doctor-patient relationship between Dr. Mackey and Ms. Peek was of a nature that gave rise to an obligation of confidentiality on the part of Dr. Mackey not to disclose confidential information to Dawn, as the duty of confidentiality had not previously been defined to cover that circumstance under Oregon law.¹¹¹ To this end the court searched for a statutory basis for Dr. Mackey’s obligation to Ms. Peek, because a statute could define the obligation and the remedies for its breach without having to fit within the norms of either tort or contract law. Without going into the particulars of the Oregon statutes from which the court sought to infer a nonconsensual, fiduciary duty of confidentiality owed by physicians, suffice it to note here that the *Humphers* court concluded that what it needed could be found in a combination of professional licensure statutes¹¹² (some of which established a physician’s compliance with the regulations of professional organizations as a condition to licensure),¹¹³ rules of evidence (the patient’s statutory privilege to exclude his or her physician’s testimony in litigation¹¹⁴) and adoption laws (sealing records). Having inferred from these statutes a basis for a fiduciary duty, the court could recognize a

¹¹⁰ *Humphers*, 696 P.2d at 532 (admitting implicitly that a degree of innovation is required, but less than the lower court had evidently believed necessary).

¹¹¹ *Id.* at 535.

¹¹² See also *Berry v. Moench*, 331 P.2d 814 (Utah 1958); *Felis v. Greenberg*, 273 N.Y.S.2d 288, 290 (1966); but see *Moses v. McWilliams*, 549 A.2d 950, 955 (Pa. Super. Ct. 1988) (determining that the right to confidentiality conveyed by the Pennsylvania physician-privilege statute is not absolute).

¹¹³ *Humphers*, 696 P.2 at 534, n.15 (citing cases in other jurisdictions sustaining professional constraints on disclosure if disclosure is incompatible with professional function).

¹¹⁴ OR. REV. STAT. § 40.235(2) (2007). It is important to note that this is only a testimonial privilege and not a true confidentiality obligation. See *id.* The patient may exclude confidential information from the evidence presented in court, but cannot use the same privilege to prevent a doctor from disclosing the information to other third parties. See *id.*

cause of action unique to a professional relationship.¹¹⁵ Dr. Mackey owed a duty of a nonconsensual and thus not entirely contractual nature, the remedy for which could, as in a tort action, be punitive, but whose parameters would ultimately be established by code rather than common law.

The *Humphers* court gives us no single, definitive standard against which to measure the duty of a physician to keep a patient's secrets, except to say that the duty "is determined by standards outside the tort claim for its breach," and accordingly "so are the defenses of privilege or justification."¹¹⁶ There is no catch-all standard for finding the level of confidentiality or identifying permissible disclosures, such as "what the reasonable, similarly-situated physician would do," or "what the reasonable patient would expect." Rather, defenses to the duty of confidence vary according to the particular statute or other source of that duty under the given circumstances. In the case of an infectious disease or child abuse, for instance, the applicable statute may require disclosure.¹¹⁷ In other civil actions the standard may be different.

Applying the methodology proposed in this essay, first, it seems clear that a core value of professionalism—trust—is at issue, not only because confidentiality is inherently a "trust" matter, a fiduciary obligation, but also because the court has taken pains to underscore the fact: "If an act qualifies as a tortious invasion of privacy, it theoretically could be committed by anyone. In the present case, Dr. Mackey's *professional* role is relevant to a claim that he breached a duty of confidentiality. . . ."¹¹⁸ Second, it is apparent that the court has identified the various interests implicated by this value, those of the physician and his patient(s), and third, the court has sought to take all these interests into account. Had Dr. Mackey's letter not been fraudulent and Ms. Kastning had been a DES baby, the court suggests that not only would Ms. Kastning have had a cognizable interest in finding Ms. Peek but Dr. Mackey might also have been privileged to assist her.¹¹⁹ When it comes to establishing a standard with which to

¹¹⁵ *Humphers*, 696 P.2d at 533 (stating that "The point of the claim against Dr. Mackey is not that he pried into a confidence but that he failed to keep one. If Dr. Mackey incurred liability for that, it must result from an obligation of confidentiality beyond any general duty of people at large not to invade one another's privacy.").

¹¹⁶ *Id.* at 535.

¹¹⁷ *Id.*

¹¹⁸ *Id.* at 530 (*emphasis added*).

¹¹⁹ *Id.* at 535 (mentioning other justifications and privileges, to include a physician's duty to report certain diseases in the interest of public health and a privilege found in some cases to report certain health information to a patient's spouse).

determine liability in future cases, however, *Humphers* can only take us so far without help from the Oregon legislature. Since the theory of confidentiality advanced by *Humphers* lies fully within neither tort nor contract, there is no common law standard; and since the duty depends on which of several possible statutory sources applies to the circumstances at hand, there is no uniform statutory standard either.¹²⁰

It will be noted that this is not a case where the court arrives at the sensitive juncture of law and professionalism and then seeks to induce a change in a legislative scheme that appears to impair professionalism. Rather, *Humphers* is a case where legislation has not yet defined the core value, and is needed for the purpose. A legislative pronouncement is needed not only because common law is evidently not up to the task, but also because standards need to be set so that the competing interests of the parties involved can be prioritized. If the *Humphers* court is calling out for anything from the Oregon legislature, it is for action rather than revision. The call would eventually be answered by HIPAA, among other privacy statutes.

2. HIPAA

HIPAA and regulations thereunder solve the problem confronted by the *Humphers* court by creating an explicit statute-based articulation of the physician's duty of confidentiality and the patient's right to privacy. Subpart E (Privacy of Individually Identifiable Health Information) establishes standards for the use and disclosure of protected health information, making it clear that patients have a privacy right to such information except as expressly permitted or required by the act.¹²¹ Permitted uses and disclosures include those for treatment and payment, among others, and those undertaken pursuant to valid authorization. Had HIPAA been available to Ms. Peek, her case would have been open and shut, and Dr. Mackey would arguably have been per se liable for violating her privacy right.

Measured by the objectives of the *Humphers* court, and viewed in the light of the methodology advocated in this essay, HIPAA is a

¹²⁰ *But see Doe v. Medlantic Health Care Group, Inc.*, 814 A.2d 939, 950-51 (D.C. 2003) (finding a “‘tort of breach of confidential relationship is generally described as consisting of the unconsented, unprivileged disclosure to a third party of nonpublic information that the defendant has learned within a confidential relationship’” that “‘arises from a duty . . . [that] imposes an obligation—stricter than the reasonable person test—to ‘scrupulously honor the trust and confidence reposed in them because of that special relationship. . . .’” (quoting *Vassiliades v. Garfinckel’s, Brooks Bros.*, 492 A.2d 580, 591 (D.C. 1985)).

¹²¹ 45 C.F.R. § 164.502 (2007) (referencing subpart C of § 160 of the subchapter).

reasonable solution to the problem raised in *Humphers*. It proceeds in evident awareness that a core value of professionalism is at stake, and that the nature of that value is relational. HIPAA, that is, accommodates the needs of patients for confidentiality and autonomy, but simultaneously accommodates the needs of professionals and those of certain third parties as well. In addition to uses and disclosures permitted by patient authorization, HIPAA recognizes that a variety of uses and disclosures are necessary even without consent, as when required by another law (e.g., a child abuse reporting law).¹²² Like the *Humphers* court, HIPAA strives for a balance between the privacy needs of the patient and the requirements of professional autonomy, including the need for certain uses and disclosures of confidential information where the interests of others may be impacted. HIPAA clearly establishes a standard for any permitted or required use or disclosure, however, and this is generally a requirement that the applicable party use or disclose protected information only to the minimum extent necessary for the use in question.

Where the legal construct of professionalism is concerned, HIPAA is ultimately both a blessing and a curse. It obviates the need of courts to navigate between tort and contract law to construct a concept of professional fiduciary duty, but its adequacy in this respect has the ironic effect of transforming professional conduct. Where the standards are established by law, they may no longer be established by the profession itself, or with reference to the objective standard of the similarly situated professional. HIPAA demonstrates an inescapable consequence of codification: once bright lines for permissible and impermissible conduct are drawn by statute, professional behavior invariably travels along those lines. The question ceases to be what brother and sister professionals would or should do in any given situation and becomes, what does the law permit or prohibit. This is the way a culture of responsibility is transformed into a culture of rights. Where there is gain in clarity of rules of conduct, there is a corresponding loss of professional self-awareness.

C. Disinterestedness

Disinterestedness is the third core attribute of professionalism, and the second of two that directly involve the provider-patient relationship. Professionalism requires that the physician not have a personal stake in the rendering of care. Law enforces this obligation by prohibiting kickbacks and by regulating human subject research,

¹²² § 164.512.

among other things. As with the core parameter *trust*, disinterestedness involves the relationship between medical professional and patient, and often that between the medical professional and society as well.

1. Human Subject Research

The core value disinterestedness prohibits physicians from being motivated by any interest other than the welfare of patients. But as one court has astutely observed, there is always conflicting professional self-interest where human subject research is concerned:

There is always a potential substantial conflict of interest on the part of researchers as between them and the human subjects used in their research. If participants in the study withdraw from the research study prior to its completion, then the results of the study could be rendered meaningless. There is thus an inherent reason for not conveying information to subjects as it arises, that might cause the subjects to leave the research project. That conflict dictates a stronger reason for full and continuous disclosure.¹²³

Self-interest on the part of the professional in the context of human subject research is sometimes disguised as altruism, as where the medical researcher defends a breach of a duty to a patient as something that advances the greater good. But it has been an established principle of both law and medical ethics since Nuremberg that advancement of the greater good does not justify subordination of a doctor's underlying duty to his or her patient.¹²⁴

The compatibility of our concept of professionalism and the regulatory framework established under the National Research Act of 1974 to govern human subject research can be assessed with this essay's methodology as follows: That the regulations acknowledge the presence of the core value of disinterestedness (whether explicitly or

¹²³ *Grimes v. Kennedy Krieger Inst.*, 782 A.2d 807, 850-51 (Md. 2001).

¹²⁴ In human subject research cases, courts tend to consider the claim of the "greater good" to be weak. In contrast, in situations where claims of society are made, public policy often provides for allocation of medical resources, such as managed care. Since the promulgation of the Nuremberg Code, courts have not given significant weight to arguments for advancing the greater good of society at the expense of individuals. See, e.g., *id.* at 850, 853 (stating it is not in any healthy child's best interest "to be intentionally put in a nontherapeutic situation where his or her health may be impaired, in order to test methods that may ultimately benefit all children"). Therefore, human subject research cases have the greatest impact where conflicts exist based on self-interest rather than divided loyalty.

not) is evident from their systematic attention to conflict of interest problems. The regulations deal with the problem structurally by establishing independent and multidisciplinary Institutional Review Boards ("IRBs") to oversee research projects. The objective of IRBs is to safeguard against both the abuse of researcher self-interest and that of exploitation of the research subject "for the greater good."¹²⁵ The regulations seek to assure IRB impartiality using both affirmative and negative mandates. Section 46.107 establishes diversity requirements for IRB composition, and section 46.107(e) expressly precludes anyone with a conflict of interest from serving. The regulations also deal with the problem of conflicts of interest substantively by establishing requirements for appropriate informed consent by patients (§46.111), and when necessary by appropriate representatives (§46.102(c)).

Further, the regulations acknowledge all the interests involved in the core value at issue and seek to accommodate their respective needs. The parties in interest are professional researchers, the research subjects and the public. The needs of professional researchers are accommodated by representation on IRBs of "at least one member whose primary concerns are in scientific areas" (§46.107(c)), for one thing. For another, the regulations are drafted so as not to intrude upon a purely therapeutic undertaking by a physician, even if it may be innovative in nature (§46.101(b)). Protecting the needs of the subject is the prime objective of the "Policy for the Protection of Human Research Subjects" that has guided development of the regulations. By way of illustration of this motive, the regulations provide that certain risks are not waivable, even by fully informed consent, if the risk is not reasonable in relation to anticipated benefits (§46.111(a)). But by definition human subject research is ultimately intended to benefit the public at large, and thus the regulations admit a risk-benefit calculation. The regulations are, however, particular as to the nature of the benefit that may be thrown into the balance against personal risk. Long-range "greater good" returns, or rewards in the form of measured effects on public policy, for instance, cannot be taken into consideration when determining whether to tolerate personal risk (§46.111(a)(2)).

All evidence of a well-balanced regulatory regime fully capable of accommodating the requirements of professionalism notwithstanding, a 2001 case in the Maryland Court of Appeals shows that a further look at the regulations can still be necessary. *Grimes v. Kennedy Krieger Institute, Inc.* involved a nontherapeutic research program

¹²⁵ 45 C.F.R. § 46.

conducted by the Kennedy Krieger Institute (“KKI”), a research entity associated with Johns Hopkins University, to assess the relative effectiveness on the health of children of various levels of lead paint abatement in their homes.¹²⁶ KKI arranged for lead paint abatement in differing degrees in several test homes.¹²⁷ Where the homes were not already inhabited by families with children, KKI induced landlords to rent to such families.¹²⁸ KKI encouraged the families to remain in these homes throughout the test period, during which KKI researchers regularly analyzed the blood of the subject children for the effects of lead contamination.¹²⁹ Participants in the program tended to be lower-income, and in at least one case minority families, possibly through self-selection.¹³⁰ KKI presented its research protocols for approval to the Johns Hopkins IRB, among other oversight bodies.¹³¹ The plaintiffs alleged not only that the protocol was inherently flawed in that it contemplated the exposure of otherwise healthy children to environmental contamination, but also that the study was not properly implemented in that subjects were not timely warned of health risks from lead dust during the course of the study.¹³²

In conducting its study, the *Grimes* court observed, KKI was necessarily subject to conflicting self-interest, even if not of a material economic nature.¹³³ There was not only the concern that subjects becoming aware of the existence of levels of lead dust in their homes might prematurely withdraw from the study, thereby diminishing its value, but also the inherent conflict in the competing “need to test hypotheses and the requirement to respect and protect individuals who participate in research.”¹³⁴

However noble the investigator’s intentions, when research involves human participants, the uncertainties inherent in any research study raise the prospect of unanticipated harm. In designing a research study an investigator must focus on finding or creating situations in which one can test important sci-

¹²⁶ *Grimes*, 782 A.2d at 811-13.

¹²⁷ *Id.*

¹²⁸ *Id.* at 812.

¹²⁹ *Id.*

¹³⁰ *Id.*

¹³¹ *Id.*

¹³² *Id.* at 841.

¹³³ KKI emphasized at trial that it was something of an “institutional volunteer,” lacking a profit motive. *See id.* at 832.

¹³⁴ *Id.* at 851 (citing 1 NAT’L BIOETHICS ADVISORY COMM’N, ETHICAL AND POLICY ISSUES IN RESEARCH INVOLVING HUMAN PARTICIPANTS 2-3 (2000)) (internal quotations omitted).

entific hypotheses. *At the same time, no matter how important the research questions, it is not ethical to use human participants without appropriate protections.*¹³⁵

Taking into account the vulnerability of the subject population,¹³⁶ and the fact that participants were provided with no therapeutic benefit under the study (indeed, the study anticipated lead accumulation in the blood of otherwise healthy children),¹³⁷ the Maryland Court of Appeals held that not even fully-consented disclosure could have satisfied the researchers' duty to the subjects:

[P]arents, whether improperly enticed by trinkets, food stamps, money or other items, have no more right to intentionally and unnecessarily place children in potentially hazardous nontherapeutic research surroundings, than do researchers. In such cases, parental consent, no matter how informed, is insufficient.¹³⁸

Grimes advances the principle that there are certain sorts of judgments for which professionals, as such, cannot transfer responsibility. This constraint effectively defines professionalism. Whether the relationship between researchers and their subjects is a professional relationship is perhaps open to discussion, and admittedly a related issue was decided in the negative in the court below. There, KKI successfully argued that the sole basis of any relationship between its researchers and their subjects was a signed consent, by which parents permitted researchers to conduct observations. There was no contract, KKI argued, no agreement to treat, no privity; nor was there any "special relationship" from which a duty sounding in tort might arise,¹³⁹ and thus no legal basis upon which to erect an obligation to warn or otherwise guard against risks inherent in living in possibly contaminated surroundings.¹⁴⁰ KKI successfully positioned itself during the trial as something of an observer.¹⁴¹ It was important for

¹³⁵ *Id.*

¹³⁶ *Id.* at 812, 852 (noting that the children and families involved in the study were from lower economic backgrounds and were sometimes minorities).

¹³⁷ *Id.* at 812-13, 852.

¹³⁸ *Id.* at 814.

¹³⁹ See, e.g., RESTATEMENT (THIRD) OF TORTS § 41 (Proposed Final Draft 1999).

¹⁴⁰ *Grimes*, 782 A.2d at 832 (noting this support as the trial court's basis for granting summary judgment in favor of KKI).

¹⁴¹ *Id.* ("KKI was not the owner of the property, not an agent for the owner, it didn't [accept] other properties from the landlord. It did not prefer the properties to the landlord. There is no basis to suggest that KKI was anything more than an

the Court of Appeals to establish both a bilateral agreement between KKI and its subjects and a special relationship upon which to base contract and tort duties, not only to advance the plaintiffs' case beyond summary judgment but also, for the purposes of the discussion at hand, to establish a cause of action based solely on consent and not fully dependent upon the traditional doctor-patient relationship.¹⁴² It is significant for purposes of our consideration of professionalism, as we shall see, that there exists a legal duty to avoid self-interest that does not readily merge into other contract and tort claims arising from the same underlying facts, and whose remedy is thus not likely to be subordinated to those otherwise available in medical malpractice cases.¹⁴³

In its analysis, the court takes notice of qualities that existed in the relationship between KKI researchers and their subjects (any by extension the relationships of professionals to their patients) that give rise to special and non-delegable duties. The court first notes the knowledge asymmetry that inevitably exists: "[G]iven the gap in knowledge between investigators and participants and the inherent conflict of interest faced by investigators, participants cannot and should not be solely responsible for their own protection."¹⁴⁴ The court further notes that KKI's reputation alone could justify certain assumptions of professional conduct: "Faced with seemingly knowledgeable and prestigious investigators engaged in a noble pursuit, participants may simply assume that research is socially important or of benefit to them individually; they may not be aware that participation could be harmful to their interests."¹⁴⁵ One could conclude that the status of professionals as such can be enough to create special expectations on the part of the patient and obligations on the part of the physician.

What could KKI have done, given the inadequacy of disclosure and parental consent to cure the conflict of interest problem inherent in its study? Presumably it could have designed the study in a manner that avoided any duty to the participants. This would mean taking no

institutional volunteer in that community.").

¹⁴² The Court of Appeals held that a contract existed between KKI and the appellants and that a special relationship could result from the relationship between the researcher and the subjects. *Id.* at 843-44, 846. In addition, the Court of Appeals held that duties arose under federal regulations and that such duties were consistent with medical ethics. *Id.* at 846, 849-50.

¹⁴³ See discussion of *Neade infra* pp. 44-48.

¹⁴⁴ *Grimes*, 782 A.2d at 851 (quoting 1 NAT'L BIOETHICS ADVISORY COMM'N, ETHICAL AND POLICY ISSUES IN RESEARCH INVOLVING HUMAN PARTICIPANTS 3-4 (2000)) (internal quotations omitted).

¹⁴⁵ *Id.* (internal quotations omitted).

steps to induce participation, discourage withdrawal, or even invest the project with the imprimatur of a reputable health and research institution. Additionally, the *Grimes* court's discussion of the doctrine of substituted judgment suggests that it would entertain the possibility of cure by means of a procedure involving independent representation of the competing interests in appropriate legal or administrative proceedings.¹⁴⁶ But the emphatic language of *Grimes* makes it difficult to see how a professional, acting as such and without a protocol satisfying minimal due process requirements, could ever remove the shadow created where self-interest can be alleged in nontherapeutic interactions with vulnerable populations.¹⁴⁷

To some extent, the *Grimes* court was concerned about the adequacy of disclosures to the parents participating in the lead abatement research program; and to some extent the court was concerned about break-downs in the implementation of IRB protocols intended to oversee the research. But to an important degree, *Grimes* is a statement to the effect that even if such protections had worked properly, they would not have been adequate: "Based on the record before us, no degree of parental consent, and no degree of furnished information to the parents could make the experiment at issue here, ethically or legally permissible. It was wrong in the first instance."¹⁴⁸ *Grimes* is perhaps an example of judicial paternalism in the ongoing struggle within decisional law to find the boundary between professionalism and the patient's right to self-determination. However one may feel about paternalism, it should be acknowledged that the stance taken by the court also had the effect of preserving a concept of professionalism as an institution in which certain forms of responsibility ultimately and inescapably reside.

A more complete statement of the obligations of professionalism with respect to conflicts of interest would require problems incurable by mere disclosure. We fully encounter the parameters of professionalism, that is, only when we find responsibilities that cannot be transferred to the patient, but which the professional alone must retain, by

¹⁴⁶ See 782 A.2d at 853-54. In its discussion of the doctrine of substituted judgment, the *Grimes* court references *Hart v. Brown*, 289 A.2d 386 (Conn. Super. Ct. 1972) (describing an action by parents on behalf of a recipient twin against the doctor and hospital that refused to transplant a kidney from a donor twin, then a minor) and *Strunk v. Strunk*, 445 S.W.2d 145 (Ky. 1969).

¹⁴⁷ See 782 A.2d at 855 ("When it comes to children involved in nontherapeutic research, with the potential for health risks to the subject children in Maryland, we will not defer to science to be the sole determinant of the ethicality or legality of such experiments.")

¹⁴⁸ *Id.* at 857-58.

virtue of his or her status as such. The concept of professionalism necessarily entails substituted judgment on a non-delegable basis. Otherwise, we are left with a definition of the health care professional as little more than an advisor to the patient, passing on the hard decisions. We encounter the limits of delegable responsibility in *Grimes*, where the Maryland Court of Appeals held that “[a] researcher’s duty is not created by, or extinguished by, the consent of a research subject or by IRB approval. The duty to a vulnerable research subject is independent of consent, although the obtaining of consent is one of the duties a researcher must perform.”¹⁴⁹

2. Referral and Managed Care Legislation

From professionalism’s point of view, federal anti-kickback and self-referral legislation on the one hand and managed care enabling legislation on the other proceed from irreconcilably opposite assumptions. The former seek to eradicate economic self-interest on the part of physician while the latter seeks to stimulate and exploit it. The Medicare and Medicaid anti-kickback statute (“AKS”)¹⁵⁰ prohibits, indeed criminalizes, any intentional solicitation or receipt of remuneration in return for a referral for goods or services reimbursable under a federal health care program, and the companion federal self-referral legislation (“Stark”)¹⁵¹ prohibits any physician Medicare and Medicaid referral for the provision of certain designated health services by persons or entities with which the referring physician has a financial relationship, without any need to establish intentionality. So much appears consistent with the core principles of professionalism, which also require the physician to deal with his or her patient without self-interest. The only conceptual difficulty with respect to professionalism is the problem noted above in the context of HIPAA, namely that codification of this core value tends to encourage the professional to “play up to the line,” as it were—go as far in the direction of self-interest as is legally permissible—rather than act out of an internal sense of responsibility to patients and colleagues.¹⁵² Codification tends to supplant the professional’s sense of responsibility.

¹⁴⁹ *Id.* at 850.

¹⁵⁰ 42 U.S.C. § 1320a-7b(b) (2000).

¹⁵¹ 42 U.S.C. § 1395nn (2000).

¹⁵² Shepherd, *supra* note 1, at 445. For a discussion of the effect of the complex array of fraud legislation on medical professionals, see Joan H. Krause, *Regulating, Guiding, and Enforcing Health Care Fraud*, 60 N.Y.U. ANN. SURV. AM. L. 241 (2004).

Managed care enabling legislation, on the other hand, does not seek to eradicate physician self-interest, but rather to cultivate and channel it (or at least to enable this to happen). In one managed care business model authorized by federal and state laws, a primary care physician in a position to refer patients to specialists and hospitals could receive remuneration for not doing so. The managed care plan provided incentives for physicians to help reduce the cost of patient care. From the viewpoint of the payor, whether Medicare or Medicaid in the case of the AKS and Stark or a managed care plan in the case of physician incentives not to refer, there is no contradiction: both arrangements seek to reduce cost and discourage overutilization of medical goods and services. Examined from the viewpoint of professionalism, however, the two statutory regimens appear ideologically irreconcilable, because while the AKS and Stark align with the professional mandate to avoid divided loyalty and self-interest, managed care laws sanction and even encourage self-interested conduct. It is not surprising, then, that the legal concept of professionalism encounters some of its most significant challenges in the context of managed care litigation.¹⁵³

3. Managed Care

As the Supreme Court has acknowledged in *Pegram v. Herdrich*,¹⁵⁴ there would be no managed care without mechanisms that rely on professional self-interest:

Like other risk bearing organizations, HMOs take steps to control costs. These [cost-controlling] measures are commonly complemented by specific financial incentives to physicians, rewarding them for decreasing utilization of health-care services, and penalizing them for excessive treatment.¹⁵⁵

In legislating to authorize managed care, Congress and state legislatures removed from judicial discussion any question of mandating professional disinterestedness in its purest form. Given legislation stating that recognizing and manipulating professional self-interest is

¹⁵³ Mark A. Hall & Robert A. Berenson, *The Ethics of Managed Care: A Dose of Realism*, 28 CUMB. L. REV. 287, 288-89 (1998) (questioning the possibility of sustaining medical ethics in a managed care environment: "We believe it is untenable for the medical profession to continue asserting an idealistic ethic that is contradicted so openly in daily practice.").

¹⁵⁴ 530 U.S. 211 (2000).

¹⁵⁵ *Id.* at 219.

permissible in the context of controlling utilization of medical services, courts have done little to shape public policy in this area. Where they are confronted with questions as to whether HMO's incentive plans corrupt medical judgment, the courts have for the most part acceded to legislative supremacy and merely acknowledged that pure professional disinterestedness is no longer public policy.¹⁵⁶ Perhaps as a result, courts have been slow in recent decades to develop a body of common law concerning physician conflicts of interest.¹⁵⁷ Once it is allowed that professional conduct may be economically coerced for purposes of allocating resources, the only questions remaining tend to be policy questions, which courts are ill-equipped to handle on their own: Should society risk harm to the individual in order to reserve resources for others, or for the possibility of rendering a greater good elsewhere? Does the economic harm of overutilization outweigh the risk to an individual patient of underutilization in a particular circumstance?

Since inducement to ration care goes to the very point of any HMO scheme, and rationing necessarily raises some risks while reducing others (ruptured appendixes are more likely; unnecessary appendectomies are less so), any legal principle purporting to draw a line between good and bad HMOs would embody, in effect, a judgment about socially acceptable medical risk.¹⁵⁸

And as between courts and legislatures, it is the latter to which the power to determine socially acceptable levels of risk is allocated.

The situation with managed care is in a sense the opposite of that we encountered in *Humphers*, where the court struggled to overcome the confinement of traditional tort and contract law theories in an effort to create a new, uniquely professional cause of action for patients aggrieved by a professional's perceived breach of fiduciary duty. The *Humphers* court needed legislation to act to help define the duty, and this need was ultimately met with HIPAA. In the case of managed care litigation in which patients seek to recover for breach of a fiduciary duty, courts now find that legislatures have already spoken on the subject with the clear intention of allowing the conflict upon

¹⁵⁶ *Bordlemay v. Keystone Health Plans, Inc.*, 2001 PA Super. 381; *Pulvers v. Kaiser Found. Health Plan, Inc.*, 160 Cal. Rptr. 392, 394 (Cal. Ct. App. 1979). Incentive plans are authorized under Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e (2000).

¹⁵⁷ *RODWIN*, *supra* note 44, at 168.

¹⁵⁸ *Pegram*, 530 U.S. at 221.

which patient-plaintiffs hope to build a claim. As a consequence, the courts tend to collapse what might in other contexts be an independent fiduciary claim into an existing tort or contract claim. Where plaintiffs bring claims against their physicians for failing to disclose the conflict of interest inherent in their receipt of economic incentives to delay or deny goods or services, courts have recently maintained that the parallel tort malpractice claim is sufficient. The law of professionalism as such is contracting rather than expanding in the managed care context.

Thus in *Pegram*, where the plaintiff alleged that economic incentives caused her physician to delay necessary testing, the Supreme Court stated that a claim for breach of fiduciary duty for failure to disclose could not exist in the same space as a claim for medical negligence.¹⁵⁹ The plaintiff, complaining of groin pain, visited her HMO-designated primary care physician, who required her to wait eight days to receive an ultrasound at a facility over 50 miles away, by which time the plaintiff's appendix had ruptured, causing peritonitis. The plaintiff sued for both medical malpractice by the physician and breach of fiduciary duty by the HMO. The Supreme Court reversed the Seventh Circuit's holding that the plaintiff had stated a cause of action for breach of fiduciary duty under ERISA, noting that the two claims would overlap:

[T]he defense of any HMO would be that its physician did not act out of financial interest but for good medical reasons, the plausibility of which would require reference to standards of reasonable and customary medical practice in like circumstances. That, of course, is the traditional standard of the common law. Thus, for all practical purposes, every claim of fiduciary breach by an HMO physician making a mixed decision [about a patient's eligibility for treatment under an HMO and the appropriate treatment for the patient] would boil down to a malpractice claim, and the fiduciary standard would be nothing but the malpractice standard traditionally applied in actions against physicians.¹⁶⁰

¹⁵⁹ *Id.* at 216, 235 (explaining that "for all practical purposes, every claim of fiduciary breach by an HMO physician making a mixed decision would boil down to a malpractice claim, and the fiduciary standard would be nothing but the malpractice standard traditionally applied in actions against physicians").

¹⁶⁰ *Id.* at 235 (citation omitted).

Where the same standards establish the duty in question, and the same harm establishes damages, allowing two claims appears unnecessary.

The argument against duplicative causes of action is easiest to make where the fiduciary claim is merely an effort to put a better face on a weak malpractice claim, as in *D.A.B. v. Brown*.¹⁶¹ Here, a plaintiff class alleged breach of fiduciary duty against a physician for failure to disclose that his involvement in a kickback scheme in an attempt to circumvent problems with the medical negligence claim relating to statutes of limitations and the requirement of proving actual injury.¹⁶² But *Pegram*'s progeny does not stop with such cases. Thus in *Neade v. Portes*,¹⁶³ the Illinois Supreme Court reviewed a suit brought on behalf of a patient who died of myocardial infarction against the treating physician. The plaintiff alleged both breach of fiduciary duty and professional negligence on allegations that the physician failed to disclose the incentives against referrals and medical tests on her husband created by their mutual managed care plan, Chicago HMO. Mr. Neade had complained of chest pain and shortness of breath, in response to which Dr. Portes had hospitalized Neade. While in the hospital, Neade received a thallium stress test and an electrocardiogram, which a hospital-based physician interpreted as normal. When Neade continued to complain of chest pain after discharge, on two separate occasions two different part-time physicians in the Portes group recommended angiograms; but Portes, relying on the hospital tests, declined to authorize the additional procedures. Neade died of a massive heart attack approximately a year after his initial hospitalization.

In an amicus brief,¹⁶⁴ the Illinois Trial Lawyers Association ("TLA") argued that an inherent conflict of interest was created when Dr. Portes, acting on behalf of his medical group, negotiated a contract with Chicago HMO in which a risk pool of \$75,000 was established for referrals and tests, with the stipulation that a portion of any balance remaining at the end of each contract year would be distributed to the physician group. In addition, the provider contract was a capitation rather than a fee-for-service arrangement, creating another incentive for the physicians in the provider group to underuti-

¹⁶¹ *D.A.B. v. Brown*, 570 N.W.2d 168 (Minn. Ct. App. 1997).

¹⁶² *Id.* at 171-72.

¹⁶³ 739 N.E.2d 496 (Ill. 2000).

¹⁶⁴ Brief Amicus Curiae of the Illinois Trial Lawyers Ass'n in Support of Plaintiff-Appellee, Theresa Neade, Administrator of the Estate of Anthony Robert Neade, Deceased, *Neade v. Portes*, 739 N.E.2d 496 (Ill. 2000) (No. 87445), 2000 WL 34213334.

lize medical services.¹⁶⁵ Neither the plaintiffs nor the TLA argued that the existence of incentives was per se a breach of fiduciary duty, but rather that the inherent conflict of interest should have been disclosed. Mrs. Neade urged in an affidavit that had she known of the incentive arrangement, she would have sought a second opinion as to the advisability of further tests.¹⁶⁶ The defense prevailed, however, by arguing that a claim of breach of fiduciary duty under these circumstances was duplicative of the underlying medical negligence claim, not only because the two claims have the same damages, but also because the fiduciary claim would have necessitated an exploration into the physician's motives.¹⁶⁷ The court accordingly dismissed the fiduciary claim, noting further that if there was a duty of disclosure, it would not properly fall upon the doctor, for whom the burden of keeping track of the various incentives in the several managed care arrangements existing in his office at any given moment would be unmanageable.¹⁶⁸

The rationale for cases like *Neade* is not principally that plaintiffs should not be permitted to circumvent procedural weaknesses in negligence actions, nor even simply that duplication of effort should be avoided, but rather that there is something fundamentally deficient in actions for breach of fiduciary duty based on conflict of interest, even where recovery for negligence is unavailable. The gravamen of Mrs. Neade's complaint was that had she known of the physician's economic incentive not to test, she would have sought a second opinion, and the outcome would have been different. Indeed, two other physicians had recommended angiograms, which would likely have saved Mr. Neade's life. Dr. Portes' diagnosis of hiatal hernia and/or esophagitis was wrong. The alleged breach of the fiduciary obligation to disclose a conflict of interest constituted separate cause of action, Neade maintained, distinct from the medical negligence, as it deprived Mr. and Mrs. Neade of their opportunity to find a physician who would have diagnosed correctly. Notwithstanding the misdiagnosis,

¹⁶⁵ *Id.* As the Trial Lawyers acknowledged, these financial arrangements could also be construed as incentives for the physicians to provide their patients with preventive care rather than to underutilize.

¹⁶⁶ *Neade*, 739 N.E.2d at 499.

¹⁶⁷ Reply Brief of Defendants-Appellants, Steven Portes, M.D. and Primary Care Family Center, S.C. at 1-5, *Neade v. Portes*, 739 N.E.2d 496 (Ill. 2000) (No. 87445), 2000 WL 34213331 at *1-5.

¹⁶⁸ *Neade*, 739 N.E.2d at 504 (citing Mark A. Hall, *A Theory of Economic Informed Consent*, 31 GA. L. REV. 511, 525-26 (1997)). The court took judicial notice of the fact that doctors cannot be expected to keep up with the number and variety of incentive arrangements to which they are subject. *Id.* So much for incentives.

however, Dr. Portes was determined to have acted within the standard of care in relying on the tests performed by the hospital-based physician and his diagnosis. He was therefore not liable in negligence, and this determination, the court held, obviated the need for a separate claim based on conflict of interest. The existence of the conflict was irrelevant, since the matter could be disposed of in a "medical negligence claim."¹⁶⁹

If we were to extrapolate from *Neade* and cases of which it is representative to a policy governing professional conflicts of interest in health care, it could contain the following precepts: Consent is only required for health care treatment decisions, not for matters which, however they may affect the provider's motives, are not directly related to the patient's health. There is no need for a separately actionable obligation of disinterestedness on the part of professionals, at least where the patient has another action in tort or contract based on standards of care; in fact, to give the patient the ability to attempt to evaluate the professionals' competing motives of self-interest and loyalty not only adds nothing, and arguably bestows a right impossible to exercise, but may also put the patient in a worse position than she would be in had she left it to the professional to sort out priorities. Imagine the patient, the reasoning goes, having learned that her physician has an economic motive to delay or deny treatment, attempting to sort out for herself the relevancy of various factors: "Is my doctor lying to me in order to benefit from the incentives created by my HMO, or would any doctor give the same advice? Would another doctor have other economic incentives? How strong are the incentives? Would my doctor yield to a relatively minor economic incentive if the health risk were major? If the risk were material, would my doctor not suggest a second opinion himself? May I infer from my

¹⁶⁹ *Id.* at 503. See also *Sweede v. CIGNA Healthplan of Delaware, Inc.*, 1989 WL 12608 (Del. Super. Ct. Feb. 2, 1989). Here, Kelly Sweede sued both her health plan and physician on allegations that the risk-sharing arrangement prevented her physicians from providing appropriate medical care on a timely basis. *Id.* at *1. The court tried the cases separately, and in the case against the physicians the court prohibited the plaintiff from introducing the financial incentive plan on the grounds that it would not be relevant. *Id.* Compare the *Sweede* decision with the dissent in *Neade* where the Chief Justice of the Illinois Supreme Court explained that: "[t]here is nothing in the [HMO] Act, however, which suggests that an HMO's duty of disclosure in any way supplants or supercedes the independent legal and ethical duty which a physician has to divulge his financial interests in withholding care to a patient. Indeed, to construe the Act as excusing physicians from their own disclosure obligations would actually diminish patients' access to information and thereby undermine the very purpose of the law." *Neade*, 739 N.E.2d at 507 (Harrison, C.J., dissenting).

doctor's conduct that a second opinion is not worth the cost to obtain? Should I put myself in a position to weigh risks, or leave it to the doctor, with his superior medical knowledge? What damage to the doctor-patient relationship will I cause by asking?" And so forth. A policy based on *Neade* could rationally hold that the patient is in no position to evaluate such risks, let alone the physician's motives, and that giving the patient a right to do so would at best amount to granting an illusory benefit and at worst shifting a burden unfairly on one ill-equipped to carry it. Under these circumstances the patient is arguably best served by relying on the deterrents existing under tort and contract law and allowing the physician to perform the relevant balancing acts. But as for the fiduciary obligation itself, the policy we have extrapolated from *Pegram* and *Neade* leaves it to the professional himself not only to arbitrate any conflicts internally, but also to determine whether they should be disclosed. Such a policy may fairly be characterized as paternalistic.

If *Neade* represents a reversion to paternalism, the alternative is equally fraught. The dissent in *Neade* objects, in effect, that claims for medical negligence and claims for breach of fiduciary duty based on failure to inform the patient of conflicts of interest do not align so perfectly as to permit one to be disregarded altogether. They are two distinct causes of action, both of which have a role to play in shaping professional conduct. On the facts in *Neade*, the doctor's conduct in refusing to authorize an angiogram was within the standard of care, but his separate conduct in concealing a motivating factor allegedly prevented *Neade* from pursuing an alternative course of action that would likely have saved his life. While it is easy to imagine circumstances in which this reasoning would prevail (as where the underlying conflict is not sanctioned by legislative acts authorizing managed care inducements to professional restraint), it is also foreseeable that there would be causation problems for plaintiffs. They must establish that but for the physician's failure to disclose, (1) the patient would have obtained a second opinion, (2) the second opinion would have been different, notwithstanding the fact that the opinion given was within standards of care, and (3) the patient would have obtained further testing. In addition, to establish proximate cause, the plaintiff would have to establish that he or she was not on notice of the conflict of interest from sources other than the physician. A rule permitting a plaintiff to state a cause of action if she can allege that she would have asked for a second opinion had she known of the conflict, moreover, could be discredited as an inducement to plaintiff fraud.

Both the paternalistic view of professionalism and that grounded in patient autonomy leave something to be desired when it comes to establishing standards for analyzing conflict issues. The paternalistic

approach assumes the physician will decide properly, given the deterrence of remedies in tort or contract, and the approach based on patient autonomy assumes the patient will make the right decision if fully informed. The principal shortcoming of informed consent cases for purposes of discovering neutral principles of decisional law relating to physicians' economic conflicts of interest is that such cases begin their analysis at a point where the existence of the conflict has already been acknowledged and deemed permissible, and where the only issue remaining is disclosure. There is no occasion in such cases for judicial consideration of whether the conflict should be permitted in the first place, and no answer to questions such as how the professional is to weigh his interests in the balance with those of the patient. We learn little of the substantive boundaries of professionalism where we are merely told that an affirmative or negative answer to the question of disclosure is sufficient, after which either the physician or the patient can decide the issue, but not how they should decide. What is needed for present purposes, then, is a body of decisional law in which the issue is whether the conflict is inherently so corruptive of medical judgment that mere disclosure would not provide a sufficient cure.

The principles we are given by the law of managed care with which to shape a new concept of professionalism would seem generally to be inadequate for the purpose. To restate the situation with a measure of cynicism, we are told by *Pegram* simply to accept the fact that our healthcare professionals may be exposed to conflicts of interest, even self-interest, and we are told by cases such as *Neade*, first, that the best we may expect in this situation is to be informed that we may not be able to trust our doctors in a given situation, and secondly, that the doctor may have no obligation so to inform us. At any moment, we may need a second doctor (if possible one who is not similarly conflicted); but even if we become aware of this need, there is no legal standard by which we or our physicians may navigate between the competing demands of patient loyalty and self-interest. *Pegram* assures us that our physicians may not simply subordinate patient loyalty to self-interest; but how the professional is to prioritize competing objectives, and whether in the end he or she has properly done so, are matters about which the law has little to offer. To be sure, the patient continues to have his or her remedy in breach of contract or tort; but having fundamentally altered the traditional concept of professionalism by admitting self-interest into the formula, it would seem incumbent upon the law to do more to rescue the concept itself from the resulting disorder.

D. Self-Regulation

In a sense, all encounters between the law and the concept of professionalism implicate professionalism's core value of self-regulation, and thus self-regulation has already been addressed in this essay. Self-regulation is what professionalism needs to preserve its integrity, and what law is willing to allow professions to the extent it can before having to intervene on behalf of the public. Self-regulation, as mentioned above, is a cumulative attribute, justified by the physician's disinterestedness, which is in turn required by the patient's trust, itself necessitated by the complex body of knowledge and the training and skill required to managed and implement medical science. The scope of legislative tolerance for professional self-regulation is evident in the deferential standard established under various statutory regimes¹⁷⁰ for judicial review of determinations of agencies such as medical hearing boards,¹⁷¹ and again under the provisions of the federal Peer Review Improvement Act¹⁷² (the "Peer Review Act"), authorizing government agencies to contract with independent peer review organizations ("PROs") comprised of medical professionals to review physician services.¹⁷³

One specific instance of deference to medical professionalism is the rule, known as the exhaustion rule, providing that judicial review of PRO determinations is not available until the physician has exhausted all administrative procedures and the PRO determination thus becomes final and appealable.¹⁷⁴

¹⁷⁰ See, e.g., Baldwin's Ohio Revised Code Annotated, establishing that in order to overturn an agency order a reviewing court must establish that the order "is not supported by any reliable, probative and substantial evidence in the entire record." R.C. 119.12.

¹⁷¹ In re Williams, 573 N.E.2d 638 (Oh. 1991), at 639 (citing R.C. 119.12, *supra* note 170).

¹⁷² 42 U.S.C. §§ 1320c(1)-(13) (2005).

¹⁷³ 42 U.S.C. § 1320c-1(1)(A) (defining a PRO as an entity composed of or having available "a substantial number of the licensed doctors of medicine and osteopathy engaged in the practice of medicine or surgery in the area and who are representative of the practicing physicians in the area. . .").

¹⁷⁴ As explained by then First Circuit Judge Stephen Breyer in *Doyle v. Secretary of HHS*, 848 F.2d 296 (1st Cir. 1988), the policy behind the exhaustion rule is that it "allows the agency to develop a factual record, to apply its expertise to a problem, to exercise its discretion, and to correct its own mistakes, all before a court will intervene. Insofar as specialized administrative understanding is important, the doctrine thereby promotes accurate results, not only at the agency level, but also by allowing more informed judicial review. By limiting judicial interruption of agency proceedings, the doctrine can encourage expeditious decision making. Insofar as Congress has provided that an agency will decide a matter in the first instance, to apply the doctrine normally furthers specific Congressional intent." *Id.* at 300.

Applying this essay's methodology to the Peer Review Act and regulations, the regulatory scheme appears to have identified the interests involved as (i) the professionals' interest in autonomy, (ii) the public's interest in health and safety, and (iii) the payor interest in economy and ease of administration. In the interest of the payor (in the case of the Peer Review Act, Medicare), the Act strives for interstate uniformity of standards and procedures to facilitate administration. Disputes implicating professionalism have arisen where this objective conflicts with the demand of the professional for deference, as in *Greene v. Bowen*.¹⁷⁵ The remaining question is whether the regulatory scheme properly balances these interests, or does it provoke courts to call for a second look. One area in which this question has arisen involves agency standard-setting, and in particular the extent to which PROs should take local practices and circumstances into account in assessing physician conduct.

Dr. Greene, a board-certified general surgeon practicing in sparsely-populated Tehama County, had been notified by California Medical Review, Inc., a PRO, of its preliminary finding based on a random search of medical records that Dr. Greene's performance had fallen below standards on at least three occasions. The violations alleged generally involved failure personally to administer post-operative care and premature discharge of a patient from acute care to a lower level of care. The applicable standard, established by regulation, required practice in accordance with "professionally recognized standards of health care," and the PRO making the determination was permitted, but not required by regulation to establish specific criteria applicable to particular localities if "(1) [t]he patterns of practice in those locations and facilities are substantially different from patterns in the remainder of the PRO area; and (2) [t]here is a reasonable basis for the difference which makes the variation appropriate."¹⁷⁶ Dr. Greene objected that the standard unfairly ignored local practice standards.

In essence, he argues that given the geographic relationship of Corning Hospital relative to his residence, and the fact that there are only two board-certified general surgeons in Tehama County, his practice of turning post-operative care over to the referring physician (ordinarily a general practitioner) was well

¹⁷⁵ *Greene v. Bowen*, 639 F. Supp. 554 (E.D. Cal. 1986).

¹⁷⁶ *Greene*, 639 F. Supp. at 562 (citing 42 C.F.R. § 466.100(c)-(d) (2007)). The applicable regulation has subsequently been amended to require consideration of the availability of other sources of services in the community. See 42 C.F.R. § 466.100(b)(3) (2007).

within the standard of care in Tehama County. He notes, however, that the PRO determination appears to have been made by the application of the standard of care in San Francisco, a compact geographic community where there are, if anything, a surfeit of physicians.¹⁷⁷

Supported only by precatory language of the regulation to the effect that a PRO *may* take practice locale into account, the court insinuated its way from the observations that the Peer Review Act “does not require a standard independent of local standards of practice,”¹⁷⁸ and that the “plaintiff’s argument that a PRO must consider the standard of care in a particular community is not without substance”¹⁷⁹ to the conclusion that “the statute and regulations may reasonably be read to *require* a consideration of the standard of care relevant to the community in which the doctor practices.”¹⁸⁰ Whether an interpretive *tour jeté* such as this was taken by regulators as a call for reconsideration of the rule is uncertain, but subsequent to (if not in consequence of) *Greene* and other similar cases,¹⁸¹ the rule was changed to mandate PRO consideration of the “availability of alternative sources of services in the community” when assessing physician conduct.¹⁸² Claims of cause and effect aside, cases such as *Greene* can be taken as judicial signaling for reconsideration of the original rule in the interest of professional autonomy.

Regulations under the Peer Review Act as revised now require the PRO to take the “availability of alternative sources of services in the community” into account in assessing practitioner conduct.¹⁸³ Considering that a primary objective of the Peer Review Act is to protect Medicare and its beneficiaries, it is perhaps understandable that this item has not always been included in the regulations, and that its presence or absence has from time to time been central to disputes arising under the Peer Review Act. The issue is whether the PRO is entitled to take into account facts such as the availability of qualified alternative post-operative care when determining whether a surgeon

¹⁷⁷ *Greene*, 639 F. Supp. at 560.

¹⁷⁸ *Id.* at 561.

¹⁷⁹ *Id.* at 562.

¹⁸⁰ *Id.* at 561 (emphasis added).

¹⁸¹ See, e.g., *Lavapies v. Bowen*, 687 F.Supp. 1193 (S.D. Ohio 1988).

¹⁸² The difference made by the regulatory change can be gauged with reference to *Doyle*, 848 F.2d 296 (1st Cir. 1988), sustaining application of the exhaustion rule where the PRO regulations had been amended to include the requirement that the availability of alternative sources of services in the community be taken into account. *Id.* at 299.

¹⁸³ 42 C.F.R. § 1004.80 (2006).

should have provided such care personally. Where more local circumstance of this kind may be brought to bear upon a decision the practitioner may be better served,¹⁸⁴ but Medicare may not, as such factors make it harder to attain uniformity of standards across the country.

Legislatures may have the last word when public policy is to be served, but courts should feel an obligation to assure that the last word is not uttered until the claims of professionalism have been heard. Self-regulation is not merely an expression of society's willingness to tolerate professions in their place, but rather an attribute the absence of which would be felt as a deep loss by professionals, patients and society collectively. We understand self-regulation, and in a sense the concept of professionalism itself, when we appreciate the extent to which it exists because we need it, not merely because we tolerate it, and that we need professionalism in a form not wholly comprehended within legal structures.

V. CONCLUSION

The objective of this essay has been to help us recognize the concept of medical professionalism when we encounter it in the law, and then to react accordingly. I have suggested that at times the codification of medical professionalism is potentially a threat to it. A taxonomy of the risks of codification with respect to medical professionalism would include the following: (i) Perhaps because they act principally in response to majoritarian social demands and not always with due consideration of core values of professionalism, legislators and agencies are capable of supporting two contradictory theories of professionalism at the same time. Thus licensure laws grant monopolies while antitrust laws prohibit them, and fraud and abuse laws assume that physician self-interest is innately corrupt while managed care laws seek to cultivate the same impulse. (ii) In other instances the risk to medical professionalism results from the excessive reticulation of conduct by code, effectively transforming a culture of responsibility with a culture of rights. Witness HIPAA privacy rules and fraud and abuse regulation under the AKS and Stark. (iii) In still other instances (the *Williamson* case discussed at the outset of this essay,

¹⁸⁴ *Lavapies*, 687 F.Supp. at 1205 ("Plaintiff argues that the PRO panel included five physicians from Columbus, Ohio and one from Toledo, Ohio, all affiliated with major urban hospitals. She further argues that her performance should have been evaluated in terms of reasonable and appropriate care in rural Martins Ferry, Ohio and that there is no indication in the PRS submittal to the OIG that she was so evaluated.").

or managed care legislation, for example), legislation fails adequately to separate professional and commercial motives, with the result that the latter eventually drive professional conduct.

I have also suggested, however, that at times codification is the instrument of necessary policy changes that would not otherwise occur. It is true that legislators are susceptible to the influence of the majoritarian will, but for this reason they are in many respects better equipped to advance public policy than are courts, which are inherently bound to follow precedent and rule. Thus it is often legislatures rather than courts that have driven the evolution of professionalism, forcing it to accommodate a wider range of social interests. The *Humphers* case discussed above, for instance, can be read as the struggle of a court to formulate a concept of confidentiality that did not exist in common law and for which legislation was needed. It has been through statutory law, moreover, that our notion of professionalism has evolved to include recognition of third party interests, whether those be payors, quality regulators or the public at large. The evidence is not only managed care but also licensure and human subject research legislation, among other statutory systems. It will be critical to acknowledge the triadic nature of medical professionalism as we begin to grapple with the idea of rationing medical goods and services. However one may feel about the effects of certain statutory regimes on the medical profession, few would now wish to construct a legal system around the principle that the relationship between doctors and patients is wholly and inviolably bilateral.

I have further suggested that decisional law has the capacity, and arguably a duty to induce reconsideration of laws that potentially impair medical professionalism. The cases I have referenced demonstrate the importance of judicial review to the survival of the concept of medical professionalism. At the same time, as in *Humphers*, I have suggested that decisional law from time to time needs codification to solve new problems. To a large extent, however, I have assumed the importance of the idea of medical professionalism itself, or allowed that fact to emerge on its own through the cases referenced. Why is it important to preserve the concept of medical professionalism against the risks presented by codification? I believe the reason is implicit in the moments in which law confesses its inadequacy to the circumstances at hand. Such a moment occurred in *Wickline v. State of California*,¹⁸⁵ which ended with a California Court of Appeal conceding that under applicable law the defendant physician had breached no

¹⁸⁵ *Wickline v. State of Cal.*, 192 Cal. App. 3d 1630 (Cal. App. 2 Dist., 1986).

legal duty, but simultaneously urging that professionalism required more.

Lois Wickline lost her leg due to medical complications occurring after she was discharged from Van Nuys Community Hospital, four days earlier than originally recommended by her surgeons and attending physician. These physicians had modified their original recommendation for a longer post-operative stay when the Medi-Cal payment authorization request was flagged by Medi-Cal's on-site nurse and then rejected by Medi-Cal's surgeon consultant.¹⁸⁶ Medi-Cal's professional representatives approved payment for only half the stay requested by the treating physicians without discussing the patient's condition with them, reviewing the medical records or examining the patient. The treating physicians revised their discharge orders accordingly, at least one testifying that he believed Medi-Cal had the power to compel the earlier discharge. All treating physicians were aware, however, that they could have appealed for more time, yet all acquiesced to the earlier discharge. The medical expert witnesses in the case subsequently testified that the conduct of the treating physicians, including the earlier discharge, was within the standard of practice. The treating physicians were not defendants in Lois Wickline's lawsuit, but had they been, they would not have been held liable for professional negligence. The Court of Appeal was to make it evident in its opinion, however, that this did not mean the treating physicians had not breached a duty of professionalism.

The plaintiff in *Wickline* alleged that Medi-Cal's cost containment program adversely affected her physician's judgment with the result that she was prematurely discharged from and lost her leg due to medical complications as a consequence.¹⁸⁷ The court held that Medi-Cal was not liable, in part because it had not led the treating physicians negligently to depart from their standard of care, and in part because

¹⁸⁶ Medi-Cal is California's Medicaid program.

¹⁸⁷ *Wickline* was a case of first impression in California for the question as to whether a prospective utilization review system could be causally linked to professional negligence. Medi-Cal's utilization review procedure constituted a departure from traditional practice not only because it was conducted prospectively, but also because it was not performed within the hospital setting and under the control of treating physicians. Prospective utilization review, though more effective than retrospective review in controlling costs, risked interference with the attending physician's professional judgment and thus not just the possibility of a wrongful withholding of payment but of preventing medically necessary services. This was Lois Wickline's fate. *Id.* at 1634.. See generally CAL. CODE REGS. tit. 22, § 70703 (2009) (noting that medical staff by-laws, rules, and regulations shall include, *inter alia*, utilization review); JOINT COMMISSION ON ACCREDITATION OF HOSPITALS 197-98 ACCREDITATION MANUAL FOR HOSPITALS (1985); 42 U.S.C. § 1395x(k); 42 C.F.R. § 405.1035.

the standard of care applicable to Medi-Cal was essentially the same as that for the treating physicians,¹⁸⁸ under which the earlier discharge was permissible. As the same court later explained in *Wilson v. Blue Cross of So. California*,¹⁸⁹ “*Wickline* was not a case where a cost limitation program such as the Medi-Cal review process was ‘permitted to corrupt medical judgment. . . .’” The *Wickline* court emphasized that a patient “who requires treatment and who is harmed when care which should have been provided is not provided should recover for the injuries suffered from all those responsible for the deprivation of such care, including, when appropriate, health care payors.”¹⁹⁰ There could be no liability for negligence, either by the professionals or the payor, where the standard of care had been met; but that fact did not prevent the court from uttering the following dicta:

[T]he physician who complies without protest with the limitations imposed by a third party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient’s care. He cannot point to the health care payor as the liability scapegoat when the consequences of his own determinative medical decisions go sour.¹⁹¹

The court evidently felt obligated to sound this warning, even though all the physicians involved had acted with applicable standards of care, because at least one of the treating physicians had been “intimidated” by the Medi-Cal program, and had mistakenly credited it with authority to countermand his own professional determinations.¹⁹² The *Wickline* dicta resonated widely. The court’s concern was later codified in section 2056 of California’s Business and Professions Code, which seeks to encourage treating physicians to advocate for medically appropriate health care by protecting them against retaliation by payors.¹⁹³ The *Wickline* court seems to have struck a

¹⁸⁸ *Wickline*, 192 Cal. App. 3d at 1646 (the court applied a standard of care derived from its analysis of various statutes and regulations, including provisions of former Welfare and Institutions Code § 14000 mandating the availability of Medi-Cal resources “whenever possible and feasible. . . , to the extent practical, . . . to secure healthcare in the same manner employed by the public generally. . .”).

¹⁸⁹ *Wilson v. Blue Cross of S. Cal.*, 222 Cal. App. 3d 660, 666 (Cal. App. 2 Dist., 1990).

¹⁹⁰ 192 Cal. App. 3d at 1645.

¹⁹¹ 222 Cal. App. 3d at 666.

¹⁹² *Wickline*, 192 Cal. App. 3d at 1645.

¹⁹³ CAL. BUS. & PROF. CODE § 2056 (West 2003) provides in pertinent part as follows: “(a) The purpose of this section is to provide protection against retaliation for physicians who advocate for medically appropriate health care for their patients pur-

chord as it speaks to a shared perception that professionalism is an obligation above and beyond conformance with standards of care. It is one thing to say Lois Wickline's physicians may not be held liable for professional negligence as long as experts testify that the conduct in question was within norms; but it is another to say that is how professionals, as such, should conduct themselves. The court's evident unwillingness to let legal liability be the last word on the matter can fairly be read as an assertion that society, having sanctioned the idea that a physician may respond to economic motivations, now more than ever needs professionals to assert moral authority, to act out of a sense of responsibility to safeguard quality of care.

It is in one sense admirable that the California legislature saw fit to codify an incentive for professionals to advocate for their patients, and it is a vindication of the thesis advanced by this essay. But in another sense this action is problematic because it should not be necessary. Codification of the parameters of professionalism seems to occur where both society and professionals themselves have lost faith in the capacity of a profession to regulate itself. Perhaps the most important lesson *Wickline* has to teach us is that professionals cannot ultimately rest upon their legal rights, or shape their conduct solely by the law, because ultimately the legal concept of professionalism does not yield all of what we need from our professionals.

suant to *Wickline v. State of California* 192 Cal.App.3d 1630[;] (b) It is the public policy of the State of California that a physician and surgeon be encouraged to advocate for medically appropriate health care for his or her patients. For purposes of this section, 'to advocate for medically appropriate health care' means to appeal a payor's decision to deny payment for a service pursuant to the reasonable grievance or appeal procedure established by a medical group, independent practice association, preferred provider organization, foundation, hospital medical staff and governing body, or payer, or to protest a decision, policy, or practice that the physician, consistent with that degree of learning and skill ordinarily possessed by reputable physicians practicing according to the applicable legal standard of care, reasonably believes impairs the physician's ability to provide medically appropriate health care to his or her patients[;] (c) The application and rendering by any person of a decision to terminate an employment or other contractual relationship with or otherwise penalize, a physician and surgeon principally for advocating for medically appropriate health care consistent with that degree of learning and skill ordinarily possessed by reputable physicians practicing according to the applicable legal standard of care violates the public policy of this state." *See also* *Khajavi v. Feather River Anesthesia Med. Group*, 100 Cal. Rptr. 2d 627, 632 (Cal. Ct. App. 2000) (stating that "the plain language of the statute demonstrates that it protects physicians and surgeons from termination or penalty for advocating for medically appropriate health care.") (citation omitted).

