

Journal of Contemporary Health Law & Policy (1985-2015)

Volume 14 | Issue 2

Article 8

1998

Public Health Ethics and Clinical Freedom

Christopher Newdick

Follow this and additional works at: <https://scholarship.law.edu/jchlp>

Recommended Citation

Christopher Newdick, *Public Health Ethics and Clinical Freedom*, 14 J. Contemp. Health L. & Pol'y 335 (1998).

Available at: <https://scholarship.law.edu/jchlp/vol14/iss2/8>

This Article is brought to you for free and open access by CUA Law Scholarship Repository. It has been accepted for inclusion in Journal of Contemporary Health Law & Policy (1985-2015) by an authorized editor of CUA Law Scholarship Repository. For more information, please contact edinger@law.edu.

PUBLIC HEALTH ETHICS AND CLINICAL FREEDOM

*Christopher Newdick**

In the rationing debate, the language of rights has not served us well. We disagree as to what should count as "health;"¹ what care is "necessary;"² whether "need" should be measured according to individual or public considerations;³ whether ethics or economics should form the essential basis on which resources should be allocated;⁴ and whether democracy provides a fair and reasonable way of resolving these matters.⁵ As one commentator has put it, "[t]he debate about priorities will never be finally resolved. As medical technology, the economic and demographic environment, and social attitudes change, so almost certainly will our priorities."⁶ In this environment of uncertainty, how should the debate about justice in the allocation of health care resources proceed?

We are unlikely to discover a universal theory on which substantive

* Mr. Newdick is a Reader in Health Law at the University of Reading in the United Kingdom. This Article retains British spelling and citation form in many places.

1. See, e.g., K.W.M. FULFORD, *MORAL THEORY AND MEDICAL PRACTICE* (CUP, 1989); David Callahan, *The WHO Definition of "Health"*, in T. BEAUCHAMP & L. WALTERS, *CONTEMPORARY ISSUES IN BIOETHICS* 49 (1982); and E. Campbell, J. Scadding & R. Roberts, *The Concept of Disease*, 2 *BRITISH MEDICAL JOURNAL* 757 (1979).

2. See Mark A. Hall & Gerald F. Anderson, *Health Insurer's Assessment of Medical Necessity*, 140 *U. PA. L. REV.* 1637, 1640-41 (1992); and Wendy Mariner, *Patient's Rights After Health Care Reform: Who Decides What is Medically Necessary?* 84 *AM. J. OF PUB. HEALTH* 1515, 1516 (1994).

3. CHRISTOPHER NEWDICK, *WHO SHOULD WE TREAT? LAW, PATIENTS AND RESOURCES IN THE NHS* 19-36 (1995).

4. See, e.g., Norman Daniels, *Four Unsolved Rationing Problems*, 24 *HASTINGS CENTER REPORT* 27 (1994); G. MOONEY, *ECONOMICS, MEDICINE AND HEALTH CARE* (1992); A. MCGUIRE, P. FENN & K. MAYHEW EDS., *PROVIDING HEALTH CARE: THE ECONOMICS OF ALTERNATIVE SYSTEMS OF DELIVERY* (1991); and J. AVRON, *Benefit and Cost Analysis in Geriatric Care: Turning Age Discrimination into Health Policy*, 310 *NEW ENG. J. MED.* 1294 (1984).

5. See, e.g., W. John Thomas, *The Oregon Medicaid Proposal: Ethical Paralysis, and the Fate of a Utilitarian Health Care Program*, 72 *OR. L. REV.* 47 (1993); D. HUNTER, *RATIONING DILEMMAS IN HEALTH CARE* (National Association of Health Authorities and Trusts, 1993).

6. R. Klein, *Dimensions of Rationing: Who should do what?*, *RATIONING IN ACTION* 103 (1993).

rights to health care can be based. Instead, we need to improve our understanding of the systems in which health care is delivered in order to develop appropriate procedures for reassuring patients that those systems are serving their interests reasonably and responsibly. This Article discusses the future of clinical freedom and the Hippocratic oath; experiments with systems of management in the National Health Service ("NHS") in the United Kingdom; systems of accountability in health care; and the notions of solidarity, trust, and confidence amongst patients.

I. THE FUTURE OF CLINICAL FREEDOM AND THE HIPPOCRATIC OATH

Traditionally, the relationship between doctor and patient has been based on the Hippocratic ideal, which commits the doctor "[to] follow that system of regimen . . . I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous."⁷ The nature of this commitment has been described as follows:

In the course of treatment, the physician is obligated to the patient and to no one else. He is not the agent of society, nor of the interests of medical science, nor of the patient's family, nor of his co-sufferers, or future sufferers from the same disease. The patient alone counts when he is under the physician's care. By the simple law of bilateral contract . . . the physician is bound not to let any other interest interfere with that of the patient in being cured. But manifestly more sublime norms than contractual ones are involved. We may speak of a sacred trust; strictly by its terms, the doctor is, as it were, alone with his patient and God.⁸

From this, is it plausible to argue that doctors should consider themselves immune from the pressures imposed by scarce resources? Must they re-

7. See BRITISH MEDICAL ASSOCIATION, *MEDICAL ETHICS TODAY*, appdx. 1 (1993).

8. HANS JONAS, *Philosophical Reflections on Experimenting with Human Subjects*, *CONTEMPORARY ISSUES IN BIOETHICS* 417 (T. Beauchamp & L. Walters eds., Wadsworth Publishing Co., 1978). Quoted in T. BRENNAN, *JUST DOCTORING* 35 (Calif. Univ. Press, 1991). The American Medical Association considers that "[i]t is unethical to knowingly provide unnecessary care or be wasteful in providing needed care: [Nevertheless], [w]hile this responsibility to guard society's resources is an important one, physicians must remain primarily dedicated to the health care needs of their individual patients." Council on Ethical and Judicial Affairs, American Medical Association, *Ethical Issues in Managed Care*, 273 *JAMA* 330, 332 (1995). Similarly, the General Medical Council in the U.K. says that "a doctor should always seek to give priority to the investigation and treatment of patients solely on the basis of clinical need." GENERAL MEDICAL COUNCIL, *CONTRACTUAL ARRANGEMENTS IN HEALTH CARE: PROFESSIONAL RESPONSIBILITIES IN RELATION TO CLINICAL NEEDS* para.8 (1992).

gard their duty as absolute, imposing an ethical obligation to do only what they consider as best for the patient, regardless of the consequences to others of doing so? Or is the Oath no more than an ideal, or an "ideal type,"⁹ which we might recognise as a model for analysis, but not as the basis of a binding professional ethic? The following section suggests that the absolute view of the Hippocratic oath cannot be the salient ingredient of the doctor's duties in matters of resource allocation.¹⁰ It considers the decline of clinical freedom and the relevance of the claim that doctors owe fiduciary duties to patients.

A. *The Decline of Clinical Freedom*

Surprisingly, it is difficult to find in any of the medical literature a sustained examination of the nature of the liberty that resides in the notion of clinical freedom. Some have described its limitations, but not its central core.¹¹ Others, including doctors, have ridiculed the whole idea as an improper cloak behind which doctors have hidden decisions of questionable value, particularly in relation to resource allocation.¹² What is the nature of this "freedom" within the science and art of medicine, and what value ought we attach to it?

No one seriously contends that the notion of clinical freedom confers absolute liberty on doctors with respect to the treatment they offer, or fail to offer, to their patients. "Freedom" in this context may be understood by comparison to the discretion given to administrative officials. It is exercised within a framework of values created by statute and common

9. "Ideal types" seek to characterise ways of thinking as aids to analysis. They do not put any prescriptive value on "type" under consideration. See ANTHONY T. KRONMAN, *MAX WEBER*, ch.2 (1983); and H.H. GERTH & C. WRIGHT MILLS, *FROM MAX WEBER*, ch.8 (1970).

10. See Irvine Loudon, *The Hippocratic Oath*, 309 *BRITISH MEDICAL JOURNAL* 414 (1994). "I have searched for but failed to find even a shred of evidence that the oath was administered anywhere at any time." See also Eugene Robin & Robert McCauley, *Cultural Lag and the Hippocratic Oath*, 345 *THE LANCET* 1422 (1995); and Spyros Marketos et al., *The Hippocratic Oath*, 347 *THE LANCET* 101 (1996).

11. One extended consideration of the theme concentrates on the qualifications to the notion, for example confidentiality. R. HOFFENBURG, *CLINICAL FREEDOM* (1987).

12. M. COOPER, *RATIONING HEALTH CARE* 75 (1975). "The clinical freedom to differ widely as to their conception of need has led to inconsistencies of treatment between patients and to the allocation without challenge, of scarce resources to medical practices of no proven value. It is by no means clear that it is the patient who gains from clinical freedom." See also J. Hampton, *The End of Clinical Freedom*, 287 *BRITISH MEDICAL JOURNAL* 1237 (1983); and T. FOLMER ANDERSON & GAVIN MOONEY EDs., *THE CHALLENGE OF MEDICAL PRACTICE VARIATIONS* ch.2 (1990).

law.¹³ Thus, such discretion may be described as weak, or strong, depending on the latitude created by the enabling powers, and thereby accommodates the possibility of differences of opinion between decision makers.¹⁴ In this respect, doctors have traditionally been accorded a broad measure of discretion in the treatment of their patients. Naturally, the arguments surrounding the risks and benefits of particular courses of action, or inaction, were inconclusive and the courts were often ill-equipped to judge amongst them. Recent trends, however, suggest an increased degree of supervision of doctors. In England, a series of cases since 1992 have taken a more critical view of clinical discretion, not with a presumption for or against the doctor, but to test the decision in question against a logical framework of the risks and benefits of treatment. This "hard look"¹⁵ approach has introduced a closer degree of managerial and judicial supervision than hitherto.

In addition, developments in the field of information technology have enabled the different clinical practices of doctors to be evaluated according to their relative costs and efficacy. Some oppose the use of the word "science" to describe what has become known as "evidence-based medicine,"¹⁶ nevertheless the influence it gives to those whose job it is to manage groups of doctors is enormous.¹⁷ Increasingly, doctors will be expected to justify failures to adhere to the patterns of decision making adopted by their peers. Their peers will, correspondingly, be encouraged to follow those patterns that are perceived to generate the best value for

13. The most obvious common law restriction on administrative discretion is that demanded by the rules of natural justice, requiring impartiality on the part of the decision maker, and the right of those affected to a hearing. See, e.g., *Ridge v Baldwin* [1964] AC 40; *Schmidt v Secretary of State* [1969] 2 Ch 149; and *R v Kent Police Authority ex p Gooden* [1971] 2 QB 662.

14. See D.J. GALLIGAN, *DISCRETIONARY POWERS—A LEGAL STUDY OF OFFICIAL DISCRETION* 14-22 (1986).

15. Culminating in *Bolitho v City and Hackney HA* [1997] 4 All ER 771, 779, where Lord Browne-Wilkinson said "There are cases where, despite a body of professional opinion sanctioning the defendant's conduct, the defendant can properly be held liable for negligence . . . [I]f, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible."

16. See JOHN APPLEBY, KIERAN WALSH & CHRIS HAM, *ACTING ON THE EVIDENCE* (1996); and William Rosenberg & Anna Donald, *Evidence Based Medicine: An Approach to Clinical Problem Solving*, 310 *BRITISH MEDICAL JOURNAL* 1122 (1995). Doubts about the objectivity of the evidence at present are expressed by Wendy K. Mariner, *Outcomes Assessment in Health Care: Promise and Limitations*, 20 *AM. J.L. & MED.* 37 (1994).

17. See the assessment of Frances H. Miller, *Medical Discipline in the 21st Century: Are Purchasers the Answer?* (forthcoming, DUKE L.J.); C. VINCENT, M. ENNIS & R. AUDLEY EDS., *In Respect of Risk Reduction*, *MEDICAL ACCIDENTS* 80-115 (1993).

the money. Purchasers of health care (health authorities in the U.K., and insurers and large employers in the U.S.), rather than clinicians, will inevitably be the dominant influence in this process.

By analogy with the jurisprudence on administrative decision making, the discretion conferred on individual doctors in this environment is likely to become relatively weak. Lengths of stay for particular treatments, the procedures to be adopted, the medicines to be used (and not used), and the intensity of the care provided will be prescribed by guidelines and protocols. Information available to doctors and health service managers will quickly identify the "outliers," those doctors whose practice lies outside the normal distribution of the group. Of course, doctors will be reminded that they alone remain responsible for the care of their patients and that departures from established procedures will be possible whenever they are justified.¹⁸ On the other hand, departure from the standard accepted as normal by the group will increasingly require explanation and, perhaps, adjudication by others. Some doctors may well have the confidence in their practice and the self-assurance, energy, and time required to defend himself against a panel of review. In many cases, however, it would not be surprising if others took a less confrontational route¹⁹ and tended to practice in a manner that conformed with group expectation. In whatever form this new medical discipline occurs, the nature of clinical freedom in the future will increasingly refer to the freedom to comply with the standards and procedures of large bodies of other doctors. In this environment, the traditional conception of clinical "freedom" may appear misleading.

For those who believe that the past practices of doctors were frequently influenced by considerations of habit, rather than clinical reason,²⁰ and that the variations of practice between doctors have always been difficult to explain on any other basis, this change of culture will be welcome. Indeed, the overall standard of care available to patients in the aggregate may be expected to rise as a result. Whether or not this is true, there will

18. While accepting the need for guidelines and protocols devised by both doctors and managers, the American Medical Association says "it remains the physician's duty to . . . advocate for the patient's right to . . . treatment in any case in which material benefit to a particular patient would result." Council on Ethical and Judicial Affairs, *supra* note 8, at 332.

19. See J. Mehang, Letter to the Editor, re *The Hassle Factor*, 117 ANNALS OF INTERNAL MEDICINE 797 (1992).

20. See, e.g., J. Burnham, *Medical Practice a la Mode: How Medical Fashion Determines Medical Care*, 317 NEW ENG. J. MED. 1220 (1987); and T. FOLMER ANDERSON, *supra* note 12, at ch.2.

be a shift in emphasis in determining what is necessary for patients away from the judgments of individual doctors. In the future, the Hippocratic commitment to patients will be assessed by reference to the behaviour of groups.

B. Fiduciary Duties to Patients?

Will these pressures turn the doctor's attention away from patients as his primary focus of concern, and toward the management of resources in which his first duty will be to the health fund, or employer by whom he is engaged? Managers have a rather different complex of concerns than doctors.

In a management culture, individual interests are subordinated to the whole or collective. "The role is an essentially collectivist one, emphasizing strategic planning, establishing the corporate mission and goals of the organisation. . . . In contrast, medicine's values stress the individual, the assumption being that the doctor will work on behalf of the best interests of the individual patient."²¹

Intuitively, a doctor's commitment of loyalty and trust to the individual patient has great appeal. If this notion can be sustained, it offers an attractive response to the problem of the aggregation of the doctor's duties to his patients. The theory of fiduciary duty has been applied to the relationship based largely on the inequality of knowledge between doctor and patient and the degree to which the patient has to trust the doctor in weighing the risks and benefits of treatment; and additionally, the decision to recommend non-treatment and suggesting a sensible course of action.²² Indeed, the relationship between doctor and patient may be more

21. D. Hunter, *Doctors as Managers: Poachers Turned Gamekeepers*, 35 *SOCIAL SCIENCE AND MEDICINE* 557, 562 (1992). See also, E. Scrivens, *Doctors as Managers: Never the Twain Shall Meet*, 296 *BRITISH MEDICAL JOURNAL* 1754 (1988); Wendy K. Mariner, *Business vs. Medical Ethics: Conflicting Standards for Managed Care*, 23 *JOURNAL OF LAW, MEDICINE AND ETHICS* 236 (1995); and, for a more optimistic view of doctors in management, R. Smith, *Doctors Becoming Managers*, 289 *BRITISH MEDICAL JOURNAL* 311 (1989).

22. The theory of informed consent requires the doctor to disclose material facts that enable the patient to decide for himself how best to proceed. It would be wrong, however, to suppose that this removes the doctor from preeminence in the process. Patients may well want more information prior to treatment, but it would be an usually detached and impersonal doctor who refused to offer his own advice about the matter. Indeed, given the inequalities of information between them, the patient will often welcome advice of this nature. For a discussion of the different styles of "bed-side manner" doctors adopt, see ROBERT M. VEATCH, *THE PATIENT-PHYSICIAN RELATION: THE PATIENT AS PARTNER*, PART 2 11-15 (1991).

close, more dependent, and call for a greater sense of loyalty than many of the other legal relationships in which a fiduciary duty arises.

The patient seeks treatment or advice from the doctor and as part of the consultation will disclose intimate personal information. The doctor uses the information to advise and help the patient with his illness or complaint. The patient relies upon the doctor for help and places his trust in the doctor to act in his best interests. In doing so the patient exposes himself to the danger of exploitation and bad faith dealing. The patient is in a position of vulnerability: he is both trusting and in need of help. An asymmetry in the relationship exists which stems from the imbalance in knowledge and power vested in the doctor through his training and his position as the patient's doctor.²³

English law is ambivalent as to the existence of a fiduciary duty between doctor and patient. It accepts the doctrine of fiduciary duties in cases of undue influence, in which the doctor, or other trusted party, receives gifts of money or property made by the patient.²⁴ It also fully respects, subject to overriding public interests, the doctor's duty to respect information disclosed in confidence.²⁵ On the other hand, English law has rejected the application of a fiduciary duty in matters pertaining to the disclosure of information necessary to obtain the patient's consent to treatment and the treatment itself,²⁶ perhaps on the grounds that actions for negligent treatment generally involve no allegation of lack of good faith. Similarly, when doctors treat patients without obtaining their prior informed consent, the doctor's loyalty may not be in doubt, and the proper course of

23. A. Grubb, *The Doctor as Fiduciary*, CURRENT LEGAL PROBLEMS 311, 313-14 (1994). The author also discusses the Canadian cases of *Norberg v Wynrib* [1992] 92 DLR (4th) 449 (doctor made patient's access to medicines dependent on sex); and *McInerney v MacDonald* [1992] 93 DLR (4th) 415 (access to medical records at issue). See also Peter Bartlett, *Doctors as Fiduciaries: Equitable Regulation of the Doctor-Patient Relationship* 5 MEDICAL LAW REVIEW 193 (1997).

24. See by analogy *Barclays Bank v O'Brien* [1993] 4 All ER 417, 423; and *Williams v Johnson* [1937] 4 All ER 34 (PC).

25. *W v Egdell* [1990] 1 All ER 1089. Arguably, however, this duty arises independently of a fiduciary obligation from the related contexts of contract, equity, and property. See Ian Kennedy, *The Fiduciary Relationship and its Application to Doctors and Patients*, in PETER BIRKS ED., *WRONGS AND REMEDIES IN THE TWENTY FIRST CENTURY* 122-24 (1996).

26. See *Sidaway v Bethlem Royal Hospital Governors* [1985] 1 All ER 643, 650-51 per Lord Scarman, responding to the argument that the relationship between a doctor and patient is of a fiduciary character: "[t]here is no comparison to be made between the relationship of a doctor and patient and with that of a solicitor and client, trustee and *cestui qui* trust or other relationship in equity as of a fiduciary character."

action sounds in battery.²⁷ Nor can it discover any fiduciary duty on doctors to explain to the parents of a child who has died under their medical care the precise circumstances in which the accident occurred.²⁸ At best, then, the existence of a fiduciary relationship is heavily dependent on the facts of each case in which some aspects may, and others may not, be said to attract such a duty.

In none of these cases, however, has the claim of a fiduciary duty imposed the risk of a serious drain on resources. To what extent, if at all, can the theory be extended to choices about the nature and quality of the treatment the doctor should offer his patient? Take, for example, medicines that are capable of producing marginal benefits, meaning they may be effective for only a small proportion of those to whom they have been prescribed. Indeed, for this small group, the benefit may be slight and of short duration. Thus, the medicines are beneficial, but modestly so. In another example, consider the patient suffering from a terminal illness. One product alone presents the chance of improving the quality (but not the length) of his life; however, the likelihood of its doing so is around ten percent. In addition, its cost means that, within a fixed budget, treatments for other patients will have to be delayed or cancelled.²⁹ Were one to ask the doctor whether he would give himself, or a member of his family, the same treatment, he would probably answer in the affirmative. What fiduciary relationship, if any, exists in these circumstances? To what extent, if any, does the fiduciary duty oblige the doctor

27. See Grubb, *supra* note 23, at 323. Loyalty is in issue, however, when the doctor fails to tell the patient of his inexperience or poor success rate in relation to a particular procedure. The same is true when other doctors know of a colleague's poor record, but fail to take action to protect patients from harm. The duty to inform is recognised by the U.K.'s General Medical Council, which says "You must protect patients when you believe that a colleague's conduct, performance or health is a threat to them . . . if necessary, you must tell someone from the employing authority or from a regulatory body . . . The safety of patients must come first at all times." See DUTIES OF A DOCTOR: GOOD MEDICAL PRACTICE paras.18, 19 (1995); and *Consultant Found Guilty for Failing to Act on a Colleague*, 308 BRITISH MEDICAL JOURNAL 1 (1994).

28. See *Powell v Boldaz* (Court of Appeal, 1997. Unreported. Negligence was admitted and the parents received compensation for the psychiatric damage they suffered as a consequence of their son's death. However, they failed in their action to obtain a full account of the precise chain of events which led to his death.)

29. See in relation to the drug beta interferon, T. Walley & S. Barton, *A Purchaser Perspective of Managing New Drugs: Interferon Beta as a Case Study*, 311 BRITISH MEDICAL JOURNAL 796 (1995). See also P. Jacobsen & C. John Rosenquist, *The Introduction of Low-Osmolar Contrast Agents in Radiology: Medical, Economic, Legal and Public Policy Issues*, 260 JAMA 1586 (1988).

to offer his patient marginally beneficial treatment?³⁰

Doctors have to consider matters that lie uncomfortably within the traditional ideal of the Hippocratic oath because “the weighing of . . . benefits and risks with financial costs is not simply a medical decision but also a social judgment about the value of spending additional resources to lower health risks.”³¹ Nevertheless, we accept that it is proper to fund doctors in a manner that requires them to manage their resources prudently and to make hard choices amongst patients, based in part on considerations of social policy. It would be entirely inconsistent to demand at the same time a commitment to each patient of such a nature as would usually exhaust the funds made available before the end of the financial year. “Where limits are a fact of life, physician selflessness cannot directly translate into an institutional response.”³² After all, we are also patients when we are well. We trust doctors to treat us not only today, but to manage their resources in a way that will enable them to offer reasonable care tomorrow. Doctors, then, to some extent must become managers. But the purpose of their doing so is only to promote the clinical benefit of all of their patients. It is only within this framework, however, that the notion of fiduciary duty has significance.³³

Reasoning of this nature is common within a framework of fiduciary duty, the origin of which lies in equity. By analogy, the fiduciary duty of a trustee to beneficiaries is to be “impartial in the execution of his trust, and not exercise his powers so as to confer an advantage on one benefi-

30. See C. Newdick, *Resource Allocation in the NHS* 23 AM. J.L. & MED. 291, 310-16 (1997); Hall & Anderson, *supra* note 2, at 1640-41; and Mariner, *supra* note 2, at 1516. The American Medical Association considers that “allocation decisions should be determined not by physicians at the bedside but according to guidelines established at a higher policy making level.” Council on Ethical and Judicial Affairs, *supra* note 8, at 332.

31. Council on Ethical and Judicial Affairs, *supra* note 8, at 331. “The physician knows that there are other patients who have subscribed to the managed care plan and who are owed a certain level of health care.” *Id.* at 332.

32. Troyen A. Brennan, *An Ethical Perspective on Health Care Insurance Reform*, 19 AM. J.L. & MED. 37, 52 (1993). See also “the altruism of the physician’s concern for the individual patient must be extended to the class of potential patients. The good of the isolated doctor-patient relationship must be evaluated in the light of the good of all the patients.” *Id.* at 51.

33. To put the matter another way: “[f]or ethics or law to insist that all beneficial medical treatment must continue to be ordered regardless of the cost is to force patients to purchase a brand of insurance they may no longer be able to afford.” See Mark A. Hall, *A Theory of Economic Informed Consent*, 31 GA. L. REV. 511, 515 (1997). For a discussion of the role doctors already play in promoting public health, and an ethical case for their considering issues of cost, see MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS—THE LAW, ETHICS AND ECONOMICS OF RATIONING MECHANISMS 122-54 (1998).

ary or class of beneficiary at the expenses of another.”³⁴ To focus too closely on the minority’s interests within the group could be detrimental to the majority and result in a breach of the fiduciary duty owed to the latter. Undoubtedly, the nature of the personal relationship between doctor and patient is very different from the commercial environment that exists between, for example, company directors and shareholders. The point, however, is that the theory of fiduciary duty alone is insufficient to resolve the difficulties faced by doctors when demand for resources exceeds supply.

The essential principle of funding in the NHS, under the National Health Service Act of 1977,³⁵ is capitation.³⁶ We also accept, within the 1977 Act, the need for a substantial investment in preventive medicine, which obviously reduces the resources available for the treatment of disease.³⁷ It is improbable, therefore, that the Act was intended to give patients rights of access to every form of treatment no matter how expensive or marginal its benefits, irrespective of the impact such a decision would have on others. On the contrary, the Secretary of State for Health has a duty to take reasonable steps to ensure that resources are available to all patients throughout the year and that those who are well today have access to services when they need them tomorrow. This suggests that reasonable schemes designed to facilitate the equitable distribution of health care resources throughout the year are both a sensible and proper component of the powers available to the Secretary pursuant to his duty under the 1977 Act to provide a “comprehensive” service.³⁸ Increasingly, therefore, the question is not “whether” but “how” health care resources ought to be managed. The central issue is less about substantive rights of access, and more about the institutional and procedural settings in which decisions occur. This is the subject of the following section, with particular reference to the NHS.

34. UNDERHILL AND HAYTON’S LAW OF TRUSTS AND TRUSTEES 500 (1995). “[T]he obligation of a trustee is to administer the trust impartially or fairly, having regard to the different interests of the beneficiaries.” *Id.* at 502. See also *In re W. & M. Roith Ltd.* [1967] 1 WLR 432. By analogy, doctors may breach their duty of confidentiality to patients in order to protect others. See *Tarasoff v. Regents of the University of California*, 551 P.2d 334 (Cal. 1976); and *W v Egdell* [1990] 1 All ER 835.

35. NATIONAL HEALTH SERVICE ACT 1977 (Eng.).

36. See HCHS REVENUE RESOURCE ALLOCATION: WEIGHTED CAPITATION FORMULA (NHSE, 1994); and A FORMULA FOR DISTRIBUTING NHS REVENUES BASED ON SMALL AREA USE OF HOSPITAL BEDS (University of York, 1994).

37. See THE HEALTH OF THE NATION, *infra* note 56.

38. NATIONAL HEALTH SERVICE ACT 1977, § 3 (Eng.), discussed in NEWDICK, *supra* note 3, at ch.4.

II. THE ORGANISATION OF HEALTH CARE: EXPERIMENTS IN THE NHS

Over the past ten years, the NHS has undergone, and continues to undergo, significant change. This section discusses the relevant strengths and weaknesses of each stage of development in order to highlight both the systems that appear to be most attractive and the procedural safeguards that are necessary to preserve a proper balance between the “macro” and “micro” interests in the resources debate. The periods between 1948-91, 1991-97, and 1997 forward are discussed.

A. Top-Down Management: 1948-91

The salient feature of the organisation of the NHS that emerged in 1948 was its dual commitment to a “comprehensive” health service and the preservation of clinical freedom. The White Paper of 1944, on which the system was based, declared the Government’s intention that:

[E]very man and woman and child can rely on getting all the advice and treatment and care which they need in matters of personal health; that what they get shall be the best medical and other facilities available; that their getting these shall not depend on whether they can pay for them, or on any other factor irrelevant to the real need—the real need being to bring the country’s full resources to bear upon reducing ill-health and promoting good health in all its citizens.³⁹

In addition, “[o]rganisation is needed to ensure that the service is there, is there for all, and that it is a good service; but organisation must be seen as the means, and never for one moment as the end.”⁴⁰ Allocations were made, as they are today, on the basis of the profile of the relevant population, having regard to its number, average age, morbidity, and mortality.⁴¹ The system applied to health authorities responsible for providing

39. A NATIONAL HEALTH SERVICE, Cmd. 6502 (1944) at 5. The passage in the text suggests a hope that the incidence of ill-health in society would decrease, and so the commitment to NHS resources would be finite. The error of this expectation was exposed in THE REPORT OF THE COMMITTEE INTO THE COSTS OF THE NATIONAL HEALTH SERVICE 1956, Cmd. 9663, para.95:

The growth of medical knowledge adds continually to the number and expense of patients’ treatments and, by prolonging life, also increases the incidence of slow-killing diseases . . . There is no reason at present to suppose that the demands on the service will be reduced . . . so as to stabilise (still less reduce) [the] total cost in terms of finance and the absorption of resources.

40. *Id.* at 8.

41. *See supra* note 36.

hospitals and secondary care, and also primary care general practitioners (“GPs”) working in the community.⁴²

However, this theory of the “command economy” model of the NHS was entirely contradicted by the practice. The White Paper of 1944 also promised “[f]reedom for the doctor to pursue his professional methods in his own individual way, and not to be subject to outside clinical interference.”⁴³ Not surprisingly, given this commitment and the status and prestige of the medical profession, the culture of “professional perfectionism” dominated the health service, in which doctors were permitted to manage patients in the ways they considered most appropriate, without interference from others.⁴⁴ This position of preeminence did not stop at the bedside. In the absence of health economists to advise managers as to the most effective means of allocating resources between and within health authorities, this function also tended to be most heavily influenced by the medical profession.⁴⁵

Unsurprisingly, this system of allocation exerted considerable upward pressure on resources that managers found extremely difficult to influence. The dominance of the medical profession in decisions to purchase facilities, particularly in the absence of information as to the costs of doing so, was capable of leading to overcapacity in some areas and undercapacity in others. The manner in which lump sums were allocated to health authorities contained very little room for incentives that could act as inducements to achieve targets. Thus, notwithstanding the efforts of successive Secretaries of State for Health to adjust the ways in which resources were distributed, the system, together with the complaints that surrounded it, proved very resistant to change.⁴⁶

In 1985, this system of allocating resources was criticised by an American commentator with experience of the potential benefits offered by competition in health care.⁴⁷ He observed that, in the absence of incen-

42. GPs have worked almost exclusively as independent contractors and not as consultants. See NATIONAL HEALTH SERVICE ACT 1977, § 29(4) (Eng.). However, for the first time, under the NATIONAL HEALTH SERVICE (PRIMARY CARE) ACT 1997, §2, GPs may be engaged as employees. Whether this further compromises the independence of the GP has yet to be assessed.

43. A NATIONAL HEALTH SERVICE, *supra* note 39, at para.47.

44. RUDOLPH KLEIN, *THE NEW POLITICS OF THE N.H.S.* 33 (3rd ed. 1995).

45. *Id.* at 125. STEPHEN HARRISON ET AL., *JUST MANAGING: POWER AND CULTURE IN THE NATIONAL HEALTH SERVICE* 101-103 (1992); and BILL NEW & JULIAN LE GRAND, *RATIONING IN THE N.H.S.—PRINCIPLES AND PRAGMATISM* 5-10 (1996).

46. KLEIN, *supra* note 44, at 67. “The captain shouted his orders: the crew went on as before.”

47. ALAIN C. ENTHOVEN, *REFLECTIONS ON THE MANAGEMENT OF THE NATIONAL*

tives to improve standards, or introduce change, the formula for allocating resources was blind to those hospitals that were able to achieve the most with least. Equally, it continued to fund hospitals that made less productive use of the funds allocated to them without any means of encouraging an improvement in standards. He labelled this the "efficiency trap."⁴⁸ During this time there were a number of distressing stories in which needy patients could not be offered care, and in which the courts had found themselves unable to provide a remedy for the patients concerned.⁴⁹ In this environment, in which there was considerable criticism of failures of management in health authorities, the government announced its intention to reform the entire system of funding the NHS. It was persuaded by the argument favouring the introduction of managed competition into the NHS and committed itself to reforming the system accordingly, whilst retaining the fundamental principles of access and equality on which the system was founded.

B. Incentives in the Internal Market: 1991-97

The reforms to the NHS were introduced by the National Health Service and Community Care Act of 1990. It introduced an "internal market" into the NHS by separating the functions of purchasing and providing the health service bodies. Until 1999, the major purchasers of health care will be health authorities and GP fundholders⁵⁰—the major providers are, and will remain, NHS hospitals.⁵¹ Resources are allocated to purchasers who, in principle, are free to purchase from those hospitals that give the best value for the money; for example, by offering the most competitive prices, achieving the highest standards of patient care, and meeting the various targets agreed to with the other party. These agreements are contained in "NHS contracts"⁵² that do not have the force of contracts at common law, but are subject to internal regulations, which

HEALTH SERVICE—AN AMERICAN LOOKS AT INCENTIVES TO EFFICIENCY IN HEALTH SERVICES MANAGEMENT IN THE UK (1985).

48. *Id.* at 38-42.

49. NEWDICK, *supra* note 3, at ch.2.

50. GP fundholders are created by §§ 14-17, NATIONAL HEALTH SERVICE ACT 1990. About 50% of all general practitioners are fundholders. The remainder have their costs met directly by the health authority, but are subject to greater supervisory control. *See, e.g.*, § 18 of the NATIONAL HEALTH SERVICE ACT 1990. The system will be reformed in April 1999. *See* WHAT THE DOCTOR ORDERED, *infra* note 68, at ch.3.

51. *See* NATIONAL HEALTH SERVICE AND COMMUNITY CARE ACT 1990, § 4(1). *See generally* NEWDICK, *supra* note 3, at 63; and Newdick, *supra* note 30, at 295.

52. NATIONAL HEALTH SERVICE AND COMMUNITY CARE ACT 1990, § 4(1). "NHS contract" means an arrangement under which one health service body ('the acquirer') ar-

give them considerable influence when disputes arise between the parties.⁵³ The incentives on each of the purchasers are different.

1. Health Authorities

In the U.K., everyone has, and will continue to have, guaranteed access to health care. Health authorities are subject to a statutory duty "to arrange . . . with medical practitioners to provide personal medical services for all persons in the locality who wish to take advantage of the arrangements."⁵⁴ As purchasers, health authorities are funded on the basis of the capitation formula. They are subject to a number of policy directives from the NHS Executive. Thus, annual priorities and planning "guidance" set a general framework for health authorities to follow. This policy is notoriously imprecise, however,⁵⁵ and is usually more concerned with the manner in which the system functions than the achievement of particular goals. More specific are the targets established in *The Health of the Nation*,⁵⁶ in which distinct areas of accidents and illness are identified and for which precise percentage reductions in mortality and morbidity are established as goals. In addition, the *Patient's Charter*⁵⁷ gives specific undertakings as to, *inter alia*, the maximum waiting times for treatment, rights of confidentiality, access to records, and the right to be consulted in decisions as to suitable treatment. Again, however, the *Charter* has no legal force. Instead, it acts to encourage health service managers rather than provide a guarantee of standards.

Health authorities occupy an unenviable position in the NHS. They

ranges for the provision to it by another health service body ('the provider') of goods and services which it reasonably requires for the purposes of its functions."

53. *Id.* at § 4(3).

54. NATIONAL HEALTH SERVICE ACT 1977, § 29 (Eng.). See also the National Health Service (General Medical Services) Regulations 1992, S.I. 1992, No.635, for a more detailed account of the respective duties of health authorities and general practitioners.

55. In the form of annual priorities and planning guidance, see e.g. PRIORITIES AND PLANNING GUIDANCE FOR THE NHS: 1996/97 (NHS Executive, 1995), which introduces itself as follows: "The purpose of the NHS is to secure through the resources available the greatest possible improvement to the physical and mental health of the people . . . a service available to all on the basis of clinical need. In seeking to achieve this purpose the NHS, as a public service, aims to judge its results under three headings [1] equity . . . , efficiency . . . , responsiveness."

56. See THE HEALTH OF THE NATION (Department of Health, 1992). The specific areas of accidents and illness are coronary heart disease, cancer, mental illness, HIV/AIDS and sexual health, and accidents. Limited progress has been made toward some of the targets; others are resistant to change. See HEALTH OF THE NATION: A PROGRESS REPORT (House of Commons Paper 85, Session 1996/97, 1997).

57. PATIENT'S CHARTER, Department of Health, 1991.

must make hard decisions regarding resources by entering large-scale NHS contracts with NHS trust hospitals. The guidance, as we have seen, is largely unspecific as to the medicines, treatments, tests, and procedures that should be excluded from the framework of the NHS, so it is the executive officers of health authorities who carry the burden of balancing their budgets from year to year.⁵⁸ How can this duty be squared with the promise of the *Patient's Charter* that every citizen has the right "to receive health care on the basis of clinical need, regardless of ability to pay"?⁵⁹ The government refuses to recommend a list of treatments that should be excluded from this NHS provision. It believes that such a list could never be expressed in absolute terms and would have to allow clinical discretion to admit exceptional cases—in which case, the problem would not be resolved. Alternatively, the list would have to be so precise that "[t]here would be a real risk of taking decisions out of the hands of doctors."⁶⁰ In these circumstances, it is true that managers have acquired a much louder voice in the debate about the ways in which resources should be allocated. However, comparing the patterns of allocations before and after the introduction of the internal market, there has been no major change in purchasing behaviour.⁶¹

2. GP Fundholders

A more potent system of incentives exists for GP fundholders. Before discussing fundholding in particular, however, we should remind ourselves that around one-half of all GPs in England and Wales are not fundholding GPs and that all GPs, whether fundholders or not, remain subject to the statutory regulations by which they commit themselves to

58. As they are obliged to do under the NATIONAL HEALTH SERVICE ACT 1977, ch.30 (Eng.). Section 97A of the 1977 Act provides "[i]t is the duty of every . . . Health Authority, in respect of each financial year, so to perform their functions as to secure that the expenditure attributable to the performance by them of their functions in that year . . . does not exceed [its income]."

59. PATIENT'S CHARTER, *supra* note 57, at 8.

60. GOVERNMENT RESPONSE TO THE FIRST REPORT FROM THE HEALTH COMMITTEE, Cmnd.2826, para.7 (1995). For a similar view, see Rudolph Klein, *Can We Restrict the Health Care Menu*, 27 HEALTH POLICY 103, 112 (1994); and Rudolph Klein, *Defining a Package of Healthcare Services the NHS is Responsible for—The Case Against*, 314 BRITISH MEDICAL JOURNAL 506, 529 (1997). *But see also* Bill New, *Defining a Package of Healthcare Services the NHS is Responsible For—The Case For*, 314 BRITISH MEDICAL JOURNAL 503, 505 (1997).

61. See SHARON REDMAYNE, *SMALL STEPS, BIG GOALS—PURCHASING POLICIES IN THE N.H.S.* (1996), for an authoritative account of the evolution of policy since the introduction of the 1990 reforms to the NHS.

providing services with the NHS.⁶² These regulations, known as the "Terms of Service," impose many rights and duties on health authorities and doctors,⁶³ but they do not specifically address the question of scarce resources. In one sense, however, they confirm the government's commitment expressed in the *Patient's Charter* that patient care should depend on the criterion of need alone. Thus, paragraph 43 provides that "a doctor shall order any drugs or appliances which are needed for the treatment of any patient to whom he is providing treatment under these terms of service."⁶⁴ The precise nature of this statutory duty has never been tested in litigation. According to one view, it imposes an absolute obligation to respond to a patient's "need" without reference to other considerations, such as cost and the competing demands of others. According to another, the duty has to be considered to be relative to the resources made available to the NHS and, therefore, confers no absolute rights on doctors or their patients.⁶⁵

This is the background against which one must consider the particular position of GP fundholders. Statutory regulations permit fundholders to accumulate savings from their funds over a period of four years. These savings do not belong to the doctors themselves. They may only be used for purposes approved by the health authority and "for the benefit of the patients of the members of practice and . . . represent value for money,"⁶⁶

62. See NATIONAL HEALTH SERVICE ACT 1977, § 29, ch.30 (Eng.) as amended by the NATIONAL HEALTH SERVICE AND COMMUNITY CARE ACT 1990, § 2(1) and the National Health Service (General Medical Services) Regulations 1992, S.I. 1992, No.635, which imposes on health authorities a duty to arrange with GPs primary care medical services for all persons in their area.

63. The regulations are probably quasi-contractual in nature. See *Roy v Kensington and Chelsea FPC* [1992] 1 All ER 705, 709. Regulations of this nature were first introduced with the creation of the NHS in 1946. See generally, NEWDICK, *supra* note 3, at ch.4, 118.

64. National Health Service (General Medical Services) Regulations 1992, S.I. 1992, No.635, sched.2. para.43.

65. Precisely this difference of opinion was expressed in the analogous case of *R v Gloucestershire C.C., ex pa Barry* [1997] 1 All ER 1, which concerned the meaning of the word "need" in the context of a different social welfare statute. A majority of the House of Lords considered the local authority's duty to respond to a person's "need" to be variable, and relative to the resources made available. In doing so they differed from the judges of the Court of Appeal ([1996] 4 All ER 421, 422), who considered the word to impose an absolute duty, dependent only on the condition of the individual concerned. See also *R v Sefton BC, ex p Help the aged* [1997] 4 All ER 532.

66. National Health Service (Fund-holding Practices) Regulations 1996, S.I. 1996, No.706, reg.25(3); and *GP Fundholding—Use of Savings*, Health Service Guidelines (95)46 (NHS Executive, 1995). "Health Service Guidelines ("HSG")" are publications by which the NHS Executive communicates with health authorities and doctors who operate the system. Another method is by "Executive Letters ("EL")." Neither HSGs nor ELs consti-

and "unjustified" overspending in one financial year may result in the subtraction of sums from future year's allocations.⁶⁷ Clearly, this incentive may give rise to suspicion amongst patients that their clinical interests are in conflict with their doctor's financial interest. Equally, fundholders may not derive direct personal benefits from their savings, which must be used for the purpose of improving the services available for patients. The evidence as to the effects of these incentives on clinical practice is inconclusive.⁶⁸

C. Bottom-Up Management: 1997 On

The Labour Government doubts the benefits of the internal market for health, and has committed itself to reforming it.⁶⁹ In theory, when markets are in equilibrium, purchasers will be able to impose sufficient pressure on hospitals to guarantee a broad cross-section of services at reasonable prices so that patients can be assured of proper access to secondary care. But the market for health care is often characterised by ignorance on the part of both patients and doctors as to the standards of clinical outcomes achieved by hospitals.⁷⁰ Consequently, the forces that favour best value for money are less effective than elsewhere. In any case, the prospect, and the consequences, of an NHS hospital simply going out of business for failing to remain solvent has health and political implications vastly different from a commercial business facing the same prospect.⁷¹ In addition, markets are less effective in the service of those with uncommon illnesses for which extensive investment in manpower and other resources is unjustified. Here, cooperation, not competition, between providers is essential in order for single centres of excellence to

tute "law," but they have considerable impact on the manner in which the NHS organises and manages itself. NEWDICK, *supra* note 3, at 190-93.

67. See *Changing the Internal Market*, Executive Letter (97)33 (NHS Executive, annex B, 1997).

68. See H. Glennerster & M. Matsanganis et al., *GP Fundholding: Wild Card or Winning Hand?*, in R. ROBINSON & J. LE GRAND, *EVALUATING THE HEALTH SERVICE REFORMS* ch.4 (1994). One study found no evidence of fundholders making unwarranted savings in order to accumulate savings, see *Effect of the NHS Reforms on General Practitioner Referral Patterns* 306 *BRITISH MEDICAL JOURNAL* 433, 437 (1993). The Audit Commission is concerned that fundholders who invest savings in their premises improve its overall value. When they leave the practice, therefore, and extract their share in the equity, there are direct financial advantages to the doctor. See *WHAT THE DOCTOR ORDERED—A STUDY OF GP FUNDHOLDERS IN ENGLAND AND WALES* 78 (1996).

69. See *THE NEW NHS*, *infra* note 75, at ch.2.

70. See NEWDICK, *supra* note 3, at 43-59.

71. JOHN APPLEBY, *DEVELOPING CONTRACTS—A NATIONAL SURVEY* (1994).

become the focus of treatment of sufficient numbers of patients to remain effective.⁷² Also, the necessity for NHS trust hospitals to negotiate NHS contracts with local purchasers carries its own transaction costs of negotiation, drafting, supervision, invoicing, and dispute resolution, particularly when many GP fundholders are involved in the process. The new government considers that the costs of process are not justified by its benefits.⁷³

Perhaps most sensitive of all in the internal market of the NHS, however, is the entirely predictable feature that encouraged fundholding doctors to bargain more successfully with NHS trust hospitals and hence enable their patients to be seen and treated more quickly than those of non-fundholders. Their success arose from the fact that they could persuade NHS hospital trusts to create separate waiting lists for the patients of fundholders. The incentive for doing so was that the hospital needed the additional revenue, which fundholders could provide. Thus, the patients of non-fundholding GPs often found that they had to wait longer for treatment than those of fundholders. This led to the allegation that a "two-tier" system had developed, which undermined the promise that patients would be treated equally on the basis of need.⁷⁴ For this to be perceived as a disadvantage in the U.K. illuminates an underlying preference for overall equity in the system over piecemeal efficiency.

With these factors in mind, the Labour Party proposes to preserve the purchaser/provider split whilst abolishing the internal market⁷⁵ and the practice of fundholding. Beginning in 1999, health authorities will no

72. This was found to be the case, in particular, with respect to the treatment of cystic fibrosis and neonatal intensive care. See CLINICAL SERVICES ADVISORY GROUP, CYSTIC FIBROSIS (HMSO, 1993); and NEONATAL INTENSIVE CARE (HMSO, 1993).

73. See THE NEW NHS, *infra* note 75, at ch.2. Transaction costs are notoriously difficult to quantify. See WHAT THE DOCTOR ORDERED, *supra* note 68, at paras.69-75. See also in the United States, David Himmelstein & Steffie Woolhandler, *Cost Without Benefit—Administrative Waste in U.S. Health Care*, 314 NEW ENG. J. MED. 441, 442-44 (1986); David Himmelstein & Steffie Woolhandler, *The Deteriorating Administrative Efficiency of the U.S. Health Care System*, 324 NEW ENG. J. MED. 1253, 1256-57 (1991); and Donald Redelmeier & Victor Fuchs, *Hospital Expenditures in the United States and Canada*, 328 NEW ENG. J. MED. 772, 776-77 (1993).

74. See NEWDICK, *supra* note 3, at 56.

75. See THE NEW NHS—MODERN, DEPENDABLE ch.2 (1997). One explanation for the apparent contradiction in such an idea is as follows:

There is no inherent connection between a purchaser/provider system and the existence of competition . . . the main purpose of the purchaser/provider split . . . is to ensure accountability on the part of providers to purchasers and this does not in itself imply that there should be competition between providers for the resources controlled by purchasers. Put another way, the purchaser/provider system is justified not on the basis of economic theories which advocate the primacy of markets but in terms of the organisational politics of health care.

longer have to approve individual NHS contracts with NHS trusts. They will continue to be funded on the capitation basis from the NHS Executive. The health authorities' duty will be to assess the needs of their local populations and suggest longer-term strategic "health improvement plans" with "primary care groups" and NHS trusts. They will allocate resources to the former, and hold them accountable for their performance. Responsibility for purchasing health care will rest with each primary care group, which will represent around 100,000 patients. Representatives of the group will allocate resources to individual doctor's practices on behalf of patients in the area. Decisions as to the nature and quantity of services to be provided will be made by clinicians within the agreed strategy, so as to balance clinical and economic needs within the system.⁷⁶ A market of sorts will continue to operate, because primary care groups will preserve the freedom to choose between different hospital providers. The difference will be that the "service agreements" between primary care groups and NHS trusts will include more sophisticated mechanisms for resolving disputes, with the assistance of the NHS Executive if need be, so that cooperation is encouraged and the risk of destabilising movements of resources reduced.

Abandoning the transaction costs associated with NHS contracts may save a considerable sum of money. On the other hand, primary care doctors, rather than managers, will now be responsible for ensuring that targets are met and, for some, this will introduce a new dimension to their practice, more familiar to those practising in HMOs in the United States. In addition, the "two-tierism," which characterised fundholding, may now persist on a larger scale. The difference may now arise between different health authorities, some of which agree that health improvement plans should include certain benefits. Equally, local differences should reflect the differing priorities of different patient groups. It would clearly be erroneous to imagine that when the new system is introduced in 1999, the problems associated with scarce resources will disappear.

III. SYSTEMS OF ACCOUNTABILITY

The suggestion that the traditional Hippocratic commitment to individual patients has to be modified to embrace a more institutional approach

CHRIS HAM, PUBLIC, PRIVATE, OR COMMUNITY—WHAT NEXT FOR THE NHS? 27-28 (1996).

76. Services for specialist groups will be undertaken by larger commissioning groups. See THE NEW NHS, *supra* note 75, at para.7.23.

to the concept of "rights" is controversial. Once the notion of individual rights is diluted, what substantive entitlement to health care is left? Surely, if patients must accept that their claims may have to give way to public interests, we ought to be perfectly clear as to the principles on which such a decision is to be based. Otherwise, the position of the individual is entirely precarious, always subject to some higher, unspecific, but superior claim. History has taught us to be extremely wary of any such theory.⁷⁷ Nevertheless, that exactly represents our present predicament in health care, in which disagreement as to priorities persists. What arguments, therefore, are available as a foundation upon which further debate may take place? The following sections discuss procedural fairness, independent appeals procedures, and disclosure and regulation of incentives.

A. Procedural Fairness

One of the most unsatisfactory cases ever to have emanated from the Court of Appeal in England is that of *ex parte Collier*,⁷⁸ in which a four-year-old boy was denied surgery to repair a hole in his heart. His responsible doctor had placed him at the top of the list of clinical priorities, yet with the patient's condition steadily deteriorating, the operation he required was cancelled time and again because suitable facilities could not be provided. His father made an application to the court for a declaration that the operation should be performed, but the court refused to intervene. It said "[t]his court is in no position to judge the allocation of resources by this particular health authority."⁷⁹ The case is unsettling because neither the applicant nor the court appeared to know how, or why, facilities could not be made available for this undeniably urgent operation. On any Hippocratic assessment of the case, its merits could hardly have been greater: the case was urgent, surgery was life-saving and well-understood, and the prospects of success were good. How could any reasonable system of priorities sensibly have abandoned such a deserving case?

We should not be surprised that patients, particularly those in managed care systems, cannot be guaranteed all available care, irrespective of its

77. See, e.g., ISAIAH BERLIN, *FOUR ESSAYS ON LIBERTY* ch.2 (1980); and VEATCH, *supra* note 22, at 67. For a rather chilling example of where the debate may lead, see John Hardwig, *Is There a Duty to Die?*, 2 *HASTINGS CENTER REPORT*, 27, 34 (1997).

78. *R v Central Birmingham AHA, ex p Collier*, unreported, CA, 1988, available on LEXIS (ENGGEN file).

79. *Id.* at *2.

cost and likely benefit. Equally, however, if the system of allocation is forced to aggregate claims, patients require the reassurance that it operates in ways that are reasonable and defensible. There has been some indication of support for such a principle from a recent decision in the U.K. Significantly, in *ex parte Fisher*,⁸⁰ the High Court overturned the refusal of a health authority to make additional funding available for the new drug beta interferon, designed to benefit some patients with multiple sclerosis. The basis of the judgment was not that the refusal to fund the drug was unlawful, but that the reasons for its decision failed to give proper consideration to a relevant factor and was irrational. The relevant consideration was an executive letter⁸¹ published by the Medical Director of the NHS Executive recommending that “[p]urchasing authorities . . . develop and implement a prescribing approach for beta interferon.”⁸² Although the circular amounted to no more than guidance, and did not have the force of law, it nevertheless imposed a duty on the health authority to take it into consideration. “The respondents had to have regard to . . . national policy. They are not obliged to follow the policy, but if they decided to depart from it, they had to give clear reasons for doing so.”⁸³ The failure to give proper consideration to the policy recommended by the NHS Executive was held to be unreasonable and the decision was remanded to the health authority for reconsideration.⁸⁴

The issue of irrationality lay in the explanations offered by the health authority for its failure to make the drug available. One reason for the refusal was that the money could only be allocated on a “first come, first served basis” and many patients would find at the end of the financial year that the funds were exhausted and that this would be unfair. Of this reason the judge said:

When deciding whether to prescribe treatment to a patient a clinician has to have regard to many factors including the resources available for that treatment and the needs of and likely benefit to that patient as compared with other patients who are

80. *R v North Derbyshire HA, ex p Fisher* [1997] 8 Med.L.R. 327. See also Christopher A. Ludlum et al., *Treatment for Haemophilia by Postcode*, 314 BRITISH MEDICAL JOURNAL 749 (1997), criticising the unfairness of patients with identical needs being subject to differing decisions of access by health authorities responsible for their care, by reason of their place of residence.

81. See *New Drugs for Multiple Sclerosis*, Executive Letter (95)97 (NHS Executive, 1995).

82. *Id.* at para.2.

83. *R v North Derbyshire HA, ex p Fisher* [1997] 8 Med.L.R. 336.

84. After the decision, the health authority decided to make the drug available and reversed its previous policy.

likely to be suitable. It is absurd to suppose that before any patient is prescribed any expensive treatment a survey must be made of all patients who are, or might be, in need of the same treatment in the area. I do not accept that this was a rational justification for not releasing additional funds.⁸⁵

Ex parte Fisher clearly makes no contribution to the debate about substantive rights of access to NHS resources, or the problems presented by scarce resources. Its importance lies in its affirmation of rights to procedural fairness. Nevertheless, in the U.K. we are, as yet, very far from a general principle that obliges purchasers and providers of health care to explain to patients the reasons for the action, or inactions. On the other hand, once health authorities engage in a process of explanation, which they are increasingly pressed to do, their reasons must be candid, consistent, and cogent in order to withstand the court's review. The reassurance that the courts will scrutinize health authority decisions to exclude treatments from public provision is most valuable.

B. Independent Appeals Procedure

Ex parte Fisher concerned the effective denial of treatment to a group of patients suffering from multiple sclerosis. Should its reasoning be applied to individual patients in the same way? Short of formal judicial review, should health "insurers" (including health authorities within the NHS) provide an internal, informal mechanism by which individuals may challenge decisions to deny them certain medical treatment? This recommendation has been made for members of health maintenance organizations in the United States.⁸⁶ Such a system, it is said, should be quick, easy to use, and fair. Patients should be able to obtain a second opinion within hours, and in cases of denial of urgent treatment, an independent internal appeals process within forty-eight hours. Representation for the patient will be required, paid for by the health insurer, perhaps funded by an increase in the licensing fees imposed on those engaged in the business of health care. Such a procedure applied to a case such as *ex parte Collier*

85. *R v North Derbyshire HA, ex p Fisher* [1997] 8 Med.L.R. 337.

86. George J. Annas, *Patient's Rights in Managed Care—Exit, Voice, and Loyalty*, 37 *NEW ENG. J. MED.* 210, 214 (1997), discussing the case of *Grijalva v. Shalala* 946 F.Supp 747 (D. Ariz. 1996). See also E.D. Kinney, *Procedural Protections for Patients in Capitated Health Plans*, 22 *AM. J.L. & MED.* 301 (1996); and Council on Ethical and Judicial Affairs, American Medical Association, *Ethical Issues in Managed Care*, 273 *JAMA* 330, 332 (1995). "It is also critical for managed care plans to have a well-structured appeals process through which physicians and patients can challenge the denial of a particular diagnostic test or therapeutic procedure."

offers an attractive solution; indeed, the very existence of the procedure, together with its need for cogent reasons, would probably have prevented such a denial of care from ever having occurred in this case.

Equally, there is a difficulty with the extent of this proposal. It seeks to utilise procedures that are natural in the courtroom where, to a greater or lesser extent, the court endeavours to discover established principles of law suitable for the resolution of disputes. In health care, however, we have no comparable system of accepted principles on which issues of resource allocation can be resolved. In the absence of agreement, on what basis could such a tribunal conduct its enquiry?⁸⁷ If the proposal is made less a search for right answers, and more for public reassurance, this is certainly desirable. But it may be less satisfactory for those who feel that the allocation process would be distorted by tending to favour those who complain. And if it encourages complaints from every dissatisfied patient, we ought to be sensitive to the cost of the exercise and the extent to which it would divert resources away from caring for others. In one sense, an internal review mechanism introduces precisely the problem of resource allocation that managed care and the aggregation of "rights" seeks to avoid. In an environment, such as the United States, in which health care is provided under numerous contracts, which are far from similar, and in which the market encourages both doctors and patients to review their entitlements regularly with a view to change, the predominance of the notion of private rights and disputes clearly has great significance. By contrast, in the U.K., the law of contract plays no part in decisions as to one's right of access to care within the NHS. Thus, subtle matters as to the proper interpretation to be given to contractual phrases such as "necessary," "appropriate," and "not experimental" care⁸⁸ do not arise. Instead, the NHS has introduced uniform internal complaint procedures intended to improve accountability to patients, both at the primary and secondary care level.⁸⁹ On the other hand, exceptional cases

87. See generally David Hadorn, *Emerging Parallels in the American Health Care and Legal-Judicial Systems* 18 AM. J.L. & MED. 73 (1992); and Marc A. Rodwin, *Consumer Protection and Managed Care: Issues, Reform Proposals, and the Trade-offs* 32 Hous. L. REV. 1319 (1996).

88. See Hall & Anderson, *supra* note 2, at 1640-41; and Mariner, *supra* note 2, at 1516.

89. The system is governed by a number of statutory and non-statutory measures. For complaints against GPs, see the National Health Service (General Medical Services) Amendment Regulations 1996, S.I. 1996, No.702. For hospital complaints, see the HOSPITAL COMPLAINTS PROCEDURE ACT 1985; and DEPARTMENT OF HEALTH, GUIDANCE ON IMPLEMENTATION OF THE NHS COMPLAINTS PROCEDURE (1996). See generally J. MONTGOMERY, HEALTH SERVICES LAW ch.5 (1997).

ought to have access to judicial review in the anticipation that, with the more critical approach expressed in *ex parte Fisher*, a body of principles will develop to guide sufficiently those whose task it is to make hard choices of this nature.

C. Disclosure and Regulation of Incentives

In principle, we may agree that the various financial incentives offered to doctors to treat, or not to treat, their patients are undesirable. They may distort an impartial assessment of the patient's case and undermine the special relationship between the parties.⁹⁰ In practice, however, it is extremely difficult to devise systems of remunerating doctors that exert no influence on clinical decision making because "financial neutrality is an ideal. No payment mechanism completely eliminates the influence of payment on treatment."⁹¹ The payment of fees for each episode of care may encourage overtreatment, particularly if doctors are rewarded for referring patients to particular hospitals for care. By contrast, the imposition of penalties for exceeding capitation limits may incline doctors to undertreat, particularly if the service as a whole is underfunded. Remember too, the irony that systems which encourage excess capacity may also tend to undertreat patients.

For example, because [in the U.S.] we have too many mammography machines, each is underutilized. This doubles the cost of each test. As a result, many women cannot afford screening. Thus, because we have too many mammography machines, we have too little breast cancer screening.⁹²

To some extent, therefore, we may have to live with incentives. How should they be regulated? In the U.S., the case of *Shea v. Esenstein* suggests that details of financial pressures, which inhibit treatment, should be disclosed to patients.⁹³ The patient was a member of a health maintenance organisation ("HMO"), which undertook to provide all medically

90. See generally MARC A. RODWIN, *MEDICINE, MONEY AND MORALS—PHYSICIANS CONFLICTS OF INTEREST*, chs.3-4 (1993); and Steffie Woolhandler & David Himmelstein, *Extreme Risk—The New Corporate Proposition for Physicians*, 133 *NEW ENG. J. MED.* 1706 (1995).

91. Gordon D. Schiff et al., *A Better-Quality Alternative—Single-Payer National Health System Reform*, 272 *JAMA* 803, 806 (1994).

92. *Id.* at 806. The authors note too that, as a result, surgeons may have insufficient exposure to surgery to retain a desired level of expertise in their specialty, thus increasing the risk of error.

93. *Shea v Esenstein*, 107 F.3d 625 (8th Cir, 1997). A similar point is made by the Supreme Court of California in *Moore v. Regents of the University of California*, 793 P.2d 479, 483 (Cal. 1990), when the court says "a physician must disclose personal interests

necessary care. Unknown to the patient, the contract between the doctor and the HMO “created financial incentives that were designed to minimize referrals. Specifically, the primary care doctors were rewarded for not making covered referrals to specialists, and were docked a portion of their fees if they made too many.”⁹⁴ The patient’s family had a history of heart disease. The patient visited his doctor on a number of occasions with chest pains, but the doctor advised the patient that consulting a cardiologist was unnecessary. The pains continued, the patient offered to pay for the consultation himself, but the doctor offered the same reassurance. A few months later the patient died of heart failure. The plaintiff’s widow alleged that, had her husband known of these incentives, he would have disregarded the doctor’s advice and sought the advice of a specialist at his own expense and would have avoided his heart attack. The court reasoned as follows:

[A] financial incentive scheme put in place to influence a treating doctors’ referral practices when the patient needs specialized care is certainly a material piece of information. This kind of patient necessarily relies on the doctor’s advice about treatment options, and the patient must know whether the advice is influenced by self-serving financial considerations created by the health insurance provider. We conclude Mr. Shea had the right to know [the HMO] was offering financial incentives that could have colored his doctor’s medical judgment about the urgency for a cardiac referral . . . [then] he could have made a fully informed decision about whether to trust his doctor’s recommendation that a cardiologist examination was unnecessary.⁹⁵

How extensive ought to be this duty of disclosure?⁹⁶ A difficulty, which has at least some judicial sympathy, is that the requirements of the language of “rights” in this context serves to increase the time doctors and patients spend simply talking. Obviously, talking is often essential to the

unrelated to the patient’s health, whether research or economic, that may affect the physician’s professional judgment.”

94. *Shea*, 107 F.3d at 626-27.

95. *Id.* at 628-29. See also by analogy the insurer’s duty to an insured under a policy of health insurance. In *Eddy v. Colonial Life Insurance Company*, 919 F.2d 747, 750 (D.C. Cir. 1990), the Court of Appeals said “A fiduciary has a duty not only to inform a beneficiary of new and relevant information as it arises, but also to advise him of circumstances that threaten interests relevant to the relationship,” citing in support para.173 of the RESTATEMENT (SECOND) OF TRUSTS, comment d (1959).

96. The American Medical Association recommends that “physicians should disclose all available treatment alternatives, regardless of cost, including those potentially beneficial treatments that are not offered under the terms of the plan.” Council on Ethical and Judicial Affairs, *supra* note 8, at 332.

creation of a meaningful and trusting relationship between them, but the time spent doing so also impinges on the time available to treat others.⁹⁷ Thus, in *Truman v. Thomas*,⁹⁸ a very extensive duty was imposed on the doctor to disclose to the patient information concerning the dangers of her refusal to have a cervical smear. The dissenting judgment, however, pointed to the danger of assessing the merits of the case according to an unqualified focus on the rights and duties of the parties before the court, at the cost of those who are not litigants. It was argued that an overly generous duty “will result in reduced care for others. Requiring physicians to spend a large portion of their time teaching medical science before practising it will increase the cost of medical diagnosis—a cost ultimately paid for by an unwanting public.”⁹⁹ To this duty of disclosure of information about the risks of non-treatment, must we also include the duty to disclose the existence of incentives?

A duty to explain to every patient the nature and degree of the incentives surrounding a particular clinical decision appears extreme. Certainly, incentives tend to diminish the trust and confidence that should form the basis of the doctor-patient relationship. But an overemphasis on regular and detailed disclosure of the details of such payments and deductions would not necessarily enhance trust between them, indeed it might have entirely the contrary effect. If we have to learn to live with incentives, it is their capacity to distort clinical judgment that must be addressed. A preferable solution is to introduce consistent and visible systems that both regulate incentives and inform patients of their likely impact on treatment decisions.¹⁰⁰ In the NHS, this objective is achievable under the regulations governing the ways in which fundholding GPs (and

97. See Hall, *supra* note 33, at 511, advocating a system of “prior informed consent to rationing” in which explanations of the principles on which resources are allocated should be given by the insurer prior to patient enrolment. The duty to disclose information to patients is more extensive in Canada (*Reibl v Hughes* [1980] 114 DLR (3d) 1), Australia (*Rogers v Whitaker* [1992] 175 C.L.R. 479) and many of the state jurisdictions of America, than in England and Wales (*Sidaway v Royal Bethlem Hospital* [1985] 1 AC 871). Recent English authority, however, favours more extensive disclosure. See *Smith v Tunbridge Wells HA* [1994] 5 Med LR 33.

98. *Truman v. Thomas*, 611 P.2d 902, 910 (Cal. 1980).

99. *Id.* (dissenting opinion). Precisely this point has been made by the Court of Appeal in England in a case concerning access to health resources. See *Re J (a minor)* [1992] 4 All ER 614, 625. However, more recently in the House of Lords, Lord Browne-Wilkinson has said “it is not legitimate for a judge in reaching a view as to what is for the benefit of the individual whose life is in issue to take into account the wider practical issues as to allocation of limited financial resources.” See *Airedale NHS Trust v Bland* [1993] 1 All ER 821, 879.

100. See Hall, *supra* note 33, at 516-25.

primary care groups after 1999) may use their savings,¹⁰¹ and specific restrictions on incentives have recently been introduced with respect to U.S. doctors who treat Medicare or Medicaid¹⁰² patients. Open and consistent regulations of this nature would be a more understandable and cost-effective means of reassuring patients that incentives are not imposing unacceptable distortions on clinical judgment. Such systems should be designed to reassure patients that standards of care will be maintained¹⁰³ and that incentives will be responsive to issues relating to quality and cost of care.¹⁰⁴

IV. SOLIDARITY, TRUST, AND CONFIDENCE

Trust and confidence in health care systems are crucial. One of the advantages of systems that promote unity of purpose and a sense of solidarity is the confidence they inspire, notwithstanding the difficult decisions that have to be made between competing demands for care. This is impossible to quantify but is immensely important. It explains why, in the U.K., the bargaining pressure available to fundholding GPs, which enabled them to gain advantages for their own patients at the expense of others, was unacceptable. The inevitable inequalities that arise from market competition, in which some providers perform better than others,

101. See generally, AN ACCOUNTABILITY FRAMEWORK FOR GP FUNDHOLDING (NHS Executive, 1995), which introduces principles of openness and candour in the way in which fundholders plan and provide services. Patients and health authorities should have access to such plans. Principles of this nature could form the basis of more sophisticated regulation of incentives.

102. See David Orentlicher, *Paying Physicians More to do Less: Financial Incentives to Limit Care*, 30 U. RICH. L. REV. 155, 162-64 (1996), favouring the use of modest incentives for doctors. Massachusetts is considering a bill to establish an Office of Managed Care Oversight and a principle that "[n]o provider contract . . . shall the risk threshold of any individual provider exceed 5% of the provider's annual payment from the health plan." Bill 6/97 Re-draft, *To Protect Consumers in Managed Care Plans in the Commonwealth*, title IV (1997). The American Medical Association considers that "[r]easonable limits should be placed on the extent to which a physician's ordering of services can effect his or her income. For example, quantitative financial incentives should be calculated on groups of physicians rather than individual physicians." Council on Ethical and Judicial Affairs, *supra* note 8, at 334.

103. For a more flexible view of standards, see John A. Siliciano, *Wealth, Equity and the Unitary Malpractice Standard*, 77 VA. L. REV. 439 (1991).

104. The U.K. Government proposes to introduce a number of new statutory institutions to improve health care quality, including a National Institute for Clinical Excellence and a Commission for Health Improvement. See THE NEW NHS, *supra* note 75, at para 7.6. On the need for patient involvement in the process, see Marc A. Rodwin, *Consumer Protection and Managed Care: The Need for Organised Consumers*, 15 HEALTH AFFAIRS 110 (1996).

seems to be less desirable than the sense of fairness that a "level playing field"¹⁰⁵ promotes.

Clearly, this concern for equality is ethical rather than economic. "What unites it with ethical considerations is its focus on integrative systems: on processes, transactions and institutions which promote an individual's sense of identity, participation and community and allow him more freedom of choice for the expression of altruism and which, simultaneously, discourage a sense of individual alienation."¹⁰⁶ Many European systems of health care endeavour to embrace this "sense," which for convenience, is described as corresponding to the "Beveridge" or the "Bismarck" models.¹⁰⁷ Under the Beveridge model, countries such as the U.K., Sweden, Norway, Italy, and Spain commit themselves to a system under which health care is financed by the treasury from general taxation. In Bismarck systems, adopted in countries like Germany, Holland, France, and Belgium, health care is financed through compulsory social insurance in which entitlements to care are based on standards and criteria agreed between the insurance providers and the government. In the Netherlands, for example, a government report designed to assist the debate as to priorities in health care described the basis of this public "ethic" as follows:

Solidarity is the awareness of a unity and a willingness to bear the consequences of it. Unity indicates the presence of a group of people with a common history and common convictions and ideals. Group solidarity has played a prominent role in the history of health insurance. Solidarity can be voluntary, as when people behave out of humanistic motives, or compulsory, as when the government taxes the population to provide services to all. Compulsory solidarity is a central theme in social insurance.¹⁰⁸

105. *Id.* at annex B.

106. RICHARD TITMUSS, *THE GIFT RELATIONSHIP—FROM HUMAN BLOOD TO SOCIAL POLICY* 224 (1971). The NHS is "[t]he most unsordid act of British social policy in the twentieth century [which] has allowed sentiments of altruism and reciprocity to express themselves; to be made explicit and identifiable in measurable patterns of behaviour by all social groups and classes." *Id.* at 225.

107. See CHRIS HAM ED., *HEALTH CARE REFORM—LEARNING FROM INTERNATIONAL EXPERIENCE* ch.1 (1997); JO LENEGHAN ED., *HARD CHOICES IN HEALTH CARE: RIGHTS AND RATIONING IN EUROPE* (1997); and Brian Abel-Smith & Elias Mossialos, *Cost Containment and Health Care Reform: A Study of the European Union*, 28 *HEALTH POLICY* 89 (1994).

108. *CHOICES IN HEALTH CARE* 15 (Government Committee on Choices in Health Care, Zoetermeer, The Netherlands, 1992). Social solidarity is also described as a "value, whereby the costs of care are intentionally cross-subsidised from young to old, from rich to

On this basis, the report found no difficulty in recommending, as a principle, that some types of care should not be provided within the Dutch system of social insurance. Similarly, the final report of the Swedish Parliamentary Priorities Commission identifies the notions of human dignity, need, and solidarity as principles on which questions of allocation should be founded.¹⁰⁹ Both reports, therefore, commit themselves to excluding some categories of care in order to provide a minimum guarantee to everyone. This reappraisal of the idea of rights and the recommendation that they should be modified according to communitarian ethics is also gaining favour amongst social scientists elsewhere.¹¹⁰ The serious difficulty faced by these proposals, however, is their absence of precision as to entitlements. Notably, neither the Dutch nor the Swedish report was able to say what type of care should be excluded from a comprehensive package of benefits.¹¹¹ Does this make them worthless?

According to one view, the Dutch and Swedish packages serve no purpose and naively imagine that patients will agree to forego specific treatment in the interest of some higher good.¹¹² Unless systems of health care and insurance can identify the categories of treatment to be excluded, then it is for each patient to look out for himself and to claim, as of right, as much as possible.¹¹³ On the other hand, in an environment in

poor and from the healthy to the sick, to ensure that all members of society receive the care that they need." See R. B. SALTMAN & J. FIGUERAS, *EUROPEAN HEALTH CARE REFORM—ANALYSIS OF CURRENT STRATEGIES* 6 (1997).

109. *PRIORITIES IN HEALTH CARE 20* (Final Report of the Swedish Parliamentary Priorities Commission, 1995).

110. See, e.g., AMITAI ETZIONI, *THE NEW GOLDEN RULE—COMMUNITY AND MORALITY IN A DEMOCRATIC SOCIETY* (1997). Similar ideas have also been expressed in the health care context in MICHAEL GRODIN ED., *META MEDICAL ETHICS: THE PHILOSOPHICAL FOUNDATION OF BIOETHICS* 61-76 (1995).

111. The Dutch report recommended that *in vitro* fertilisation, homeopathic medicine, and dental care for adults could be excluded, but that sports injuries and homes for elderly people should be included. See *CHOICES IN HEALTH CARE*, *supra* note 108, at 87-92. The Swedish report recommended inclusion of *in vitro* fertilisation, but excluded growth hormone deficiency (shortness of stature). It also recommended the avoidance of waste by the more efficient use of resources, a theme advocated by some as the most important element in extending health coverage. See *PRIORITIES IN HEALTH CARE*, *supra* note 109, at 121-130. See, e.g., Robert M. Veatch, *The Oregon Experiment: Needless and Real Worries*, in M.A. STROSBERG ET AL., *RATIONING AMERICA'S MEDICAL CARE: THE OREGON PLAN AND BEYOND* (1992).

112. The number of complaints from NHS patients continues to rise each year. See DEPARTMENT OF HEALTH, *BEING HEARD: THE REPORT OF A REVIEW COMMITTEE ON NHS COMPLAINTS PROCEDURES 101-05* (1994).

113. Reasons for the dominance of the concept of "rights" in the United States are considered by George Annas, *The Dominance of American Law (and Market Values) Over*

which there is a collective commitment to public health, there may be a greater willingness to compromise demands that impose a disproportionate strain on resources. The nature and extent of the compromise will be impossible to define and may change from time to time.

If we accept, as we must, that there is no such thing as a perfect system of health care, that there is no "holy grail" of health care priorities, and that clinical freedom does not exist in a vacuum, then we have to modify our conception of the duties owed by doctors to patients. We should seek to achieve an acceptable balance, between competing demands within systems of care, that has the respect and trust of those it serves. No system of health care will inspire this sense of confidence if managerial priorities become the dominant factor in matters of resource allocation, in which precisely those who need care the most find it the most difficult to obtain insurance.¹¹⁴ Thus, doctors must be at the centre of the debate about priorities, sensitive to their duties to patients. Such a modification of the Hippocratic commitment to individuals requires, at a minimum, that the entire community has adequate access to care, that differentials between different categories of patients are acceptable, and that the system of making choices is visible and accountable.¹¹⁵ These elements are essential to any community interested in creating a system of public health ethics.

American Bioethics, in MICHAEL GRODIN ED., *META MEDICAL ETHICS: THE PHILOSOPHICAL FOUNDATIONS OF BIOETHICS* 83-84 (1995).

114. See Robert Morgan & Beth Virnig et al., *The Medicare-HMO Revolving Door—The Healthy Go In and the Sick Go Out* 337 *NEW ENG. J. MED.* 169, 174 (1997).

115. See generally, Brennan, *supra* note 32, at 55-64. The NHS is beginning to grapple with these issues. See, e.g., *CODE OF CONDUCT AND ACCOUNTABILITY* (Department of Health, 1994); *CODE OF PRACTICE AND OPENNESS* (NHS Executive, 1995); and *ACCOUNTABILITY IN THE NHS* (British Medical Association, 1994).