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Rationing Health Care: The Ethics of Medical Gatekeeping

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RATIONING HEALTH CARE: THE ETHICS OF MEDICAL GATEKEEPING

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I. INTRODUCTION

An ethically perilous line of reasoning is gaining wide currency in our country today. It starts with a legitimate concern for rising health care costs, finds them uncontrollable by any means except some form of rationing, and concludes that the physician must become the "gatekeeper," the designated guardian of society's resources. By negative and positive financial incentives it is reasoned, the physician can be forced to conserve tests, treatments, operations, hospitalization, and referrals for consultation. In this way, it is presumed, costs will be cut by the elimination of "unnecessary" medical care.

From an economic point of view this argument is attractive to those who must shoulder a good part of our "more-than-a-billion-dollar-a-day" health care bill. Policy makers, corporation executives, insurance carriers, affluent patients, and some physicians have already accepted the economic inevitability of rationing. The ethical implications are brushed aside as secondary given the size of the problem and the fact that it is indeed the physician who is responsible for seventy-five percent of all health care expenditures.

Before committing ourselves to a course of action that will drastically alter the already strained trust relationships between patients and physicians, some of the ethical questions in "gatekeeping" need closer examination. To what extent can, or should, the physician serve simultaneously the needs of his patients, his own interests, and those of society? To what extent should the physician be a double, triple, or even quadruple agent? Under what conditions would such divided advocacy be necessary, desirable, or morally licit? What are the implications for our traditional understandings of medical ethics? How is the physician to resolve the conflicts of obligations built into divided advocacies? What is society's responsibility for creating or ameliorating these conflicts? Are these legal issues as well?

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I will argue that the line of reasoning that leads to rationing and physician gatekeeping is morally unsound and factually suspect; that there are conditions under which rationing might be morally justifiable, but they are not met by current plans, and that, rather than enhance, we ought to minimize physician self-interest as a motive in medical and health care provision.

I will start with an examination of the conflict of interest that is a *de facto* aspect of physician-patient relationships, then define three kinds of "gatekeeper" roles, the moral issues inherent in each, and the conditions for a morally licit rationing system.

II. De Facto Conflict of Interest

When the first physician requested a fee for his services, economics and conflict of interest entered medicine.[1] Ever since, the physician's fee and the degree to which he could equate necessity for his services with maintaining his own income have been sources of suspicion and contention between physicians and patients. Socrates was forced in his dialogue with the cynical Thrasymachus to admit that the physician was engaged in two "arts"—the art of medicine, which had as its end the health of the patient, and the "art" of making money, which had the physician's self-interest as its end and which did not, in itself, contribute to the patient's welfare at all.

> Then isn't it the case that the doctor insofar as he is the doctor considers or commands not the doctor's advantage but that of the sick man? For the doctor in the precise sense was agreed to be a ruler of bodies and not a money maker.[2]
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> Do you call the medical art the wage earner's art even if a man practicing medicine should earn wages?[3]
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> * * *
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> The medical art produces health, the wage earner's art wages.[4]

Plato admitted, through Socrates, that these two arts could be in conflict, indeed had to be, given their disparate ends. For a more modern version of the fee dilemma, no one has more tellingly exposed the inevitability of a certain amount of conflict of interest in the physician's work than George Bernard Shaw.[5]

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1. Fees for service — in goods, preferments, or money — are as old as medicine. Fees, their level, problems in collection, and the like are found in many of the books of the Hippocratic Corpus.

2. Plato, Republic I342d.

3. *Id.* at 346b.

4. *Id.* at 346d.

5. G. Shaw, The Doctor's Dilemma. Note especially the acerbic but, sadly, too often accurate, "Preface on Doctors."

This *de facto* conflict of interest is difficult or impossible to eliminate given the fact that physicians must earn a living, support families, and have access to the same material goods as others. What mitigates the conflict is the ethical commitment of the physician to the patient's good, i.e., to the principle of beneficence. This has been the central principle of medical ethics. It is implicit in the Hippocratic Oath, the ancient codes of India and China, and in the ethics of Thomas Percival that inspired the AMA's first and subsequent codes.[6]

Beneficence means acting on behalf of, in the interest of, or as an advocate of the patient. It has always implied some degree of effacement of the physician's self-interest in favor of the interests of the patient. For centuries good physicians have treated patients who could not pay, have exposed themselves to contagion or physical harm in responding to the call of the sick, and have sacrificed their leisure and time with their own families—sometimes too liberally—all out of commitment to serve the good of the sick.

Indeed, it is the fact of this effacement of self-interest that distinguishes a true profession from a business or craft.[7] And it is the expectation that physicians will, by and large, practice some degree of self-effacement that warrants the trust that society and individual patients place in them. It is the physician's public commitment to service beyond self-interest that constitutes the real entry of the medical graduate into the profession. The awarding of a medical degree only signifies successful completion of a course of study; but the Oath is a public act of commitment to a special way of life demanded by the nature of medicine and the special obligations that bind those who enter it.[8]

Ethical commitments can, and do, mitigate the conflicts of interest inherent in medical practice, but they do not eliminate them—except perhaps in the heroic examples of self-sacrifice we expect only of saints and martyrs. Surely the salaried physician is not free of this impediment. If his financial incentives are reduced, other motives can conflict with the care owed the patient—i.e., prestige, power, professional advancement, self-indulgence,

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6. E.D. PELLIGRINO & D. THOMASMA, THE GOOD OF THE PATIENT, (forthcoming). In this book, Thomasma and I unpack the notion of patient good, to examine its components and the order of their moral importance.

7. H. CUSHING, CONSECRATIO MEDICI AND OTHER PAPERS 3-13 (1929). *See also*, Pellegrino, *What is a Profession*? 12 J. ALLIED HEALTH, 168-76 (1983).

8. The Hippocratic Oath is still the most common public declaration of voluntary assumption of ethical obligations inherent in medicine. Other oaths like the so-called Oath of Maimonides, the Oath of Geneva, World Health Organization, etc. all carry the same message of commitment to the good of others. This is true of the Oath of the Soviet Physicians as well, with one significant difference I shall comment upon later.

unionization, or family obligations. These can be just as detrimental to the patient's well-being as the physician's monetary interests.

While there has always been some irreducible quantum of self-interest in medicine, rarely, if ever, has self-interest been socially sanctioned, morally legitimated, or, encouraged as it is in the rationing approach to cost containment. Today, the physician's self-interest is deliberately used by policymakers to contain the availability, accessibility and quality of services to the patient. It is against this background of how they accentuate the *de facto* conflict of interest in medicine that the several forms of "gatekeeping," licit and illicit, must be examined.

III. Three Forms of "Gatekeeping"

a. De Facto "Gatekeeping": The Traditional Role

As with *de facto* conflict of interest, there is in the nature of the medical transaction, an unavoidable gatekeeping function which the physician has always exercised and, indeed, is under compulsion to exercise in a morally defensible way. The unavoidable fact is that the physician recommends what tests, treatments, medications, operations, consultations, periods of hospitalization, or nursing homes the patient needs. Currently, the fact is that the physician monitors the flow of seventy-five percent of today's health and medical care expenditures.

This fact imposes a serious positive moral obligation on the physician to use both the individual and society's resources optimally. In the case of the individual patient, the physician has the obligation, inherent in his promise to act for the patient's welfare, to use only those measures appropriate to the cure of his patient or alleviation of his suffering. What the physician recommends must be *effective*—that is, it must materially modify the natural history of the disease, and it must also be *beneficial*; that is, it must be to the patient's benefit. Some measures are highly effective—like treatments for pneumonia—but may not be always beneficial if they prolong unnecessarily the act of dying and thus impose the burden of futility and expense without benefit for the patient. There are also treatments that benefit the patient but are not effective in altering the course of the disease—pain relief, nursing or home care, for example.

The same applies to diagnostic procedures. The physician has a moral obligation to use laboratory tests, X-rays, and imaging procedures, only if they contribute materially to the certitude of the diagnosis or the nature of the clinical decision. Marginally helpful tests, especially if they are expensive, or tests that are simply for teaching purposes (if the patient is in a teaching hospital) are not justifiable.

The physician, therefore, has a legitimate, indeed, a morally binding responsibility to function as a "gatekeeper." He must use his knowledge to practice competent, scientifically rational medicine. His guidelines should be a *diagnostic elegance*—just the right degree of economy of means in diagnosis—and *therapeutic parsimony*—just those treatments that are demonstrably beneficial and effective. In this way, the physician automatically fulfills several moral obligations: he avoids unnecessary risk to the patient from dubious treatment and he conserves the patient's financial resources and society's as well.

The physician remains the patient's advocate. As the *de facto* gatekeeper, the physician is obliged to obtain tests and use treatments that are beneficial to his patient and not to restrict access purely for financial or economic reasons. The physician may withhold treatment if the patient decides that he does not wish to consume his family's resources. Thus, limiting access can be part of a legitimate gatekeeper role.

The role of *de facto* gatekeeper, when ethically performed, entails no conflict with the patient's good. Economics and ethics, individual and social good, and the doctor's and the patient's interests are all in congruence. In rational medicine, as I have defined it, the mode of the payment—whether by salary or fee—should make no difference. Properly conceived and practiced, rational medicine in a sense solves the dilemma posed in the First Book of the *Republic*. It subjects both the physician's art as physician and as wage earner to a higher standard—the standard of rational medicine, and that, in turn, derives its justification from the fact that it is in the patient's best interests. In the morally defensible gatekeeper role, the physician uses his *de facto* position to advance the good of his patient. In contrast, two new versions of gatekeeping have been introduced, each with serious moral objection because their primary intent is economic, not ethical obligation.

b. The Negative Gatekeeper Role

In the "negative" version of the gatekeeper role, the physician is placed under constraints of self-interest to restrict the use of medical services of all kinds but particularly those that are most expensive. A variety of measures is used, each of which interjects economic considerations into the physician's clinical decisions and limits his discretionary latitude in making decisions.

One way to do this is through the Diagnostic Related Group (DRG) program which assigns, in advance, to some 400 odd disease categories, a fixed sum or number of days of hospitalization. If the number of days (or tests, procedures, etc.) is exceeded, the institution, or the physician, "loses" the

difference; if the number of days of hospitalization (or procedures) is less than the allotted, then the institution or physician makes a "profit."

In other plans, the physician or institution contracts to provide care for some prescribed number of patients for a fixed annual sum. Again, if the total costs of care exceed the contracted amount, the provider bears the loss; if the costs are less, the provider makes a profit. Variations on these themes are several. They need not be detailed here. The essence of each is to motivate the provider to limit access to care by appealing to his self-interest.[9]

With all these plans, the physician becomes the focus of incentives and disincentives: in his role as a private practitioner when he hospitalizes a patient under the DRG system, and as the employee or partner in a prepayment insurance plan, like a Health Maintenance Organization (HMO), Independent Practice Association (IPA) or Primary Care Network (PCN). Increasingly, in each case the physician's economic efficiency is monitored and his deviations from the norm are rewarded or punished. The rewards may be in the form of profit-sharing, bonuses, promotion in the organization, or other perquisites and preferments. The disincentives are loss of profit, limits on admitting privileges, or non-renewal of co-employment contracts. In some instances, productivity and efficiency schedules, "pass through" criteria, and other quantitative measures, not only of cost-containment but of profit-making, are used to evaluate the physician's performance.

The major pressure in these plans at present is upon the primary care physician, the first contact member of the health care system who makes the majority of decisions about entry into the system. The primary care physician may be the family primary practitioner, general internist, or pediatrician. The primary physician as the "man in the trenches" has the greatest influence over access to expensive resources of hospitalization, testing and consulting. For this reason, many pre-payment plans insist that the patient must stay with one primary care physician within the system lest he or she shop around for one who might be more compliant. Gradually, as pressures for cost-containment increase, the consultant and tertiary care specialists will very likely also be included as gatekeepers with constraints and criteria suited to the nature of their specialties.

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9. Studies of the experiences with physician gatekeeping are beginning to appear. Samples of such studies are these: Eisenberg, *The Internist as Gatekeeper*, 102 ANNALS OF INTERNAL MED. 537-43 (1985); Somers, *And Who Shall be the Gatekeeper? The Role of the Physician in the Health Care Delivery System*, 20 INQUIRY 301-13 (1983); Inglehart, *Medicaid Turns to Prepaid Managed Care*, 308 NEW ENG. J. MED. 976-80 (1983); Moore, *Cost Containment Through Risk Sharing by Primary Care Physicians*, 300 NEW ENG. J. MED. 1359-62 (1979).

c. The Positive Gatekeeping Role

The "positive" version of gatekeeping is less well-defined and not usually explicitly formalized. In this version, the physician is constrained to increase rather than decrease access to services. The purpose here is not containing costs but enhancing profits. For those who can pay, the latest and most expensive diagnostic or therapeutic services are offered; services are provided based on market "demand" rather than medical need. The aim is to "penetrate" or "dominate" the market and to eliminate services that are not profitable. Increasing the demand for services is an implicit goal. Here the physician becomes virtually a salesman. We see this most blatantly already in the television and newspaper advertisements soliciting clients for elective surgery and all sorts of services, some authentic and some quite useless.

With the positive gatekeeper role, the physician uses his *de facto* position as gatekeeper to his own financial advantage or that of his employer. He shares in the profit directly if he is an owner of, or investor in, the service provided or he is rewarded by pay increases and advancement, if he is employed.

IV. The Moral Issues in Medical Gatekeeping

a. Moral Issues in Negative Gatekeeping

Both the positive and negative versions of gatekeeping exploit the *de facto* position of the physician as the filter through which patients gain access to services. The purposes to be served are, however, not primarily in the patient's interests. The moral issues arise in the degree to which these other interests dilute the trust the patient places in the physician as his primary agent, minister and advocate. The motives of self-interest upon which the newer gatekeeping roles depend complicate and accentuate the irreducible quanta of self-interest that have always existed in the patient-physician relationship.

Efforts at cost-containment are not, in themselves, immoral, and, as noted above, are morally mandatory when in the best interests of the patient. They violate those interests if, for whatever reason, they deny needed services or induce the patient to demand, or the physician to provide, unneeded services. The ethical dilemmas of gatekeeping therefore arise out of the way economic incentives and disincentives modify the physician's freedom to act in the patient's behalf. While in the past the physician was largely responsible for defining "necessary" and "unnecessary" care, those determinations are now formularized by policy. In applying the formulae, the physician

becomes the agent of the hospital or the system rather than the patient. And, his medical criteria of necessary treatment are subject to modification or veto by economic considerations.

Many of the ethical dilemmas are illustrated in the Medicare Prospective Payment System now in force in the majority of states. In this system, the cost-base per diem reimbursement system of the past is replaced by a Prospective Payment System (PPS) based in fixed prices for 471 Diagnostic Related Groups. The initial motivation behind this transition was to improve quality of care by linking quality of care directly to reimbursement. Thus it was reasoned that the DRG system would cut costs by closer scrutiny of care aimed especially at limiting "unnecessary" tests, drugs, procedures, and hospitalization. Besides being economically wasteful, unneeded care is also dangerous to patients.

These cost containment measures are not intrinsically immoral. Certainly we cannot consider them unethical simply because they limit the physician's latitude in decisionmaking. Rather it is the effect of this limitation on the patient that is ethically crucial as is the moral responsibility of the physician operating within such a system when he deems its impact to be harmful for his patient.

The difficulty in the application of present DRG policies arises in the determination of what is "necessary" for quality care for a particular patient. In a system based on "average" lengths of stay for each disease, individual patients may suffer since no two diseases manifest themselves in the same way in every patient. As a result, disease entities are treated, not individual patients, and the original aim of quality care is compromised, sometimes dangerously.

For example, the needs for hospitalization, tests, and medical care for a previously healthy, middle-aged head of household with a comfortable home and a good job with a diagnosis of pneumonia, are very different from the needs of the same disease in a chronically ill, elderly widow, living alone, with her family at a distance. Given the variable nature of patient responses to illness, a certain number of individual cases must fall outside the statistical projections. These are termed "outliers"—those who need lengthier stays, more procedures, and medications, than the DRG plan allows.

Two tendencies deleterious to patients are already manifest in the way the DRG system is being administered in many hospitals. One is the fact that patients are being discharged "quicker and sicker." The second is the failure to provide the extra funds needed by the "outlier." In both instances it is often the frail, elderly patient who is sent "home" with no adequate provision for post-hospital care such as nursing home care or home care. In fact,

the trend of public policy at the moment is to curtail payment for non-hospital and long-term care, further aggravating the harm done by premature discharge.

In Prospective Payment Systems, the physician is automatically a "negative" gatekeeper. To the extent that there is greater scrutiny of the quality of care rendered and unnecessary care avoided, the good of the patient is served. But when the system harms the patient then the question of the physician's primary agency arises. If he is primarily the patient's advocate, agent and minister, then he must protect the patient's interests against the system even at some risk and damage to his own self-interest.

In addition to the intrinsic difficulties of gatekeeping, the physician's judgments are beclouded by a variety of pressures and motives inimical to the patient's interests.[10] There is, first of all, the tendency toward underutilization since this rewards the physician or hospital. The temptation, therefore, is great to cut corners, to declare as "frills" what might otherwise be a necessity, or to be less sensitive to the more subtle but equally important needs of patients for psycho-social support. Further, the primary care physician is encouraged to temporize in his work-up and to delay expensive tests, treatments or consultations. He may even stretch his competence dangerously to do certain procedures himself in order to contain costs.

Another pressure in prospective payment plans is to disfavor or disenfranchise the sicker patients, those with chronic illness and those who need the more expensive kinds of care. Less admirable still is the way cost-containment can be used consciously or unconsciously to justify the exclusion or denial of services to difficult, troublesome, obnoxious or other categories of patients one prefers not to see—the neurotic, the "complainers," the "hypochondriacs"—or worst of all, the ethnic or social groups one dislikes personally.

Another deleterious effect of negative gatekeeping is to cultivate competition among providers on the wrong grounds. Instead of competition to provide the highest quality care, as judged by the standards of rational medicine, competition is for the best records of savings, productivity, efficiency, the shortest hospital stays or the least number of procedures done. Granted that excesses of care exist and are deleterious, it does not follow

10. Some of the tendencies, dangers and conflicts potentially harmful to patients and ethically suspect are discussed in the following: Rosenblatt & Moscovice, *The Physician as Gatekeeper*, 22 MED. CARE 150-59 (Feb. 1984); Relman, *The Allocation of Medical Resources by Physicians*, 55 J. MED. EDUC. 99-104 (1980); Moore, Martin & Richardson, *Does the Primary Gatekeeper Control the Costs of Health Care*, 309 NEW ENG. J. MED. 1400-04 (1983); Overholt, *The Socioeconomic and Political Future of Gastroenterology, Part II, Primary Care Network* 78 A. J. GASTROENTEROLOGY PART II, PRIMARY CARE NETWORK 457-60 (1983).

that underutilization is beneficial especially with certain very effective, though costly, kinds of high technology (e.g., renal dialysis, organ transplant, coronary angioplasty, CAT scanning, NMR examinations).

To be effective many prospective payment plans insist that patients must be locked into care by one primary care physician. The choice of physicians and the freedom to switch is severely limited. The most sensitive part of the healing relationship, the confidence one must have in one's personal physician, is thus ignored or compromised. Especially in chronic or recurrent illness this confidence is essential to effective care.

These factors converge to drive the physician's self-interest into conflict with the patient's. These conflicts are heightened by the rather drastic changes occurring in the economic status of the medical profession which make the physician more vulnerable to economic pressure. There is today an oversupply of physicians in urban areas and in many specialties.[11] Many physicians now graduate with debts for their education in the neighborhood of 100,000 dollars. The high cost of malpractice premiums must be laid out before anyone dares risk even a day of medical practice. Competition from corporately owned and operated clinics forces even conscientious physicians into "survival" tactics of questionable, moral defensibility.

The result of all of this is that many young and even older physicians are driven into salaried group practices and automatically become negative gatekeepers. The physician's independence, as Paul Starr has shown, is rapidly eroding, and with it, his ability to withstand the institutional and corporate strictures of his judgment about what is good for his patient.[12] It is becoming ever more costly personally and financially for even the most morally sensitive physician to practice the effacement of self-interest that medical ethics requires.

b. Moral Issues in Positive Gatekeeping

The moral conflicts in the positive version of gatekeeping are less subtle and more explicit. Here the profit motive is primary. The transaction between physician and patient becomes a commodity transaction. The physician becomes an independent entrepreneur or the hired agent of entrepreneurs and investors who themselves have no connection with the traditions of medical ethics. The physician begins to practice the ethics of the marketplace, to think of his relationship with the patient, not as a cove-

11. *Summary Report of the Graduate Medical Education National Advisory Committee to the Secretary*, Department of Health and Human Services, U.S. Government Printing Office, Washington, D.C., Sept. 30, 1980.

12. P. STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 514 (1982).

nant or trust, but as a business and a contract relationship. Ethics becomes not a matter of obligations or virtue, but of legality. The metaphors of business and law replace those of ethics. Medical knowledge becomes proprietary; the doctor's private property to be sold to whom he chooses at whatever price and conditions he chooses.

The dependence, anxiety, lack of knowledge and vulnerability of the sick person are exploited for personal profit. To encourage unnecessary cosmetic surgery, hysterectomy, CAT scans, or sonograms, even if the patient believes he ought to have "the latest and the best," is to defect from even the most primordial concept of stewardship of the patient's interests. Here the conflict of interest is more blatant than in the negative version of gatekeeping. The patient becomes primarily a source of income. The crasser financial motives that have motivated selfish physicians are legitimated and even given social sanction.

In the positive version of gatekeeping there is not, as there may be in the negative version, any defensible moral argument. Some defend the profit motive as necessary to medical progress, to maintain quality of service or even charitable care. It would be unrealistic to deny that for some physicians these are the only effective motives and that some good can come of them. But ultimately the profit motive erodes the moral sensitivities and standards of the profession. Ultimately when a conflict occurs between profit and patient welfare, patient welfare is sure to suffer. The unrestrained monetary instinct corrupts medicine as surely as the unrestrained instincts for power or prestige.

V. Some Social-Ethical Concomitants of Rationing

The negative and the positive gatekeeper roles both involve social consequences of dubious moral probity. Both tolerate and, indeed, foster two or more levels of quality, availability, and accessibility of health care. The affluent person can buy whatever he needs or wants; he can supplement what a DRG plan allows if he is an "outlier." The various prepayment plans and organizations seek eagerly to enroll him. The less affluent and the poor have no such access to care. They may or may not be assured of what is called an "adequate" level of care. Adequacy is vaguely defined, but on closer examination, it will be inevitable that the differences between what rich and poor can get will be significant. The poor and the lower economic strata of the middle class are relegated to public hospitals which will have to be re-established and, of course, financed.

The differences in the care provided in public and "private" hospitals extend beyond convenience, accomodations or "frills." Anyone whose experi-

ence, like this author's, goes back to the large municipal hospitals of several decades ago will recognize these differences. The efforts of the last two decades to undo the injustices of a multi-level system of health care are being reversed by the move to rationing, cost containment and gatekeeping.

A different kind of social-moral issue arises if we ask whether it is defensible for society to transpose its responsibility for rationing to the physician. Are not the criteria for these decisions the responsibility of all of us? In situations of extreme economic exigency, rationing could be justified. But the criteria for rationing and the principle of justice to be followed should rest with society, not the physician. There is no assurance that the physician is any fairer or juster than others in deciding who shall receive so crucially important a resource as health care. Do we as a society really want to give this kind of power to physicians?

A very careful balance between the relative place of societally-determined criteria for rationing and the latitude allowed physicians in making rationing decisions must be struck. Society may wish to use the DRG mechanism as a way of expressing its value choices, but should the physician accept such a charge in the face of his prime duty to be the patient's advocate?

On grounds, therefore, of the conflict it generates between the physician's and patient's interests and the social injustice it fosters, the role of gatekeeper entails an erosion and a violation of the commitment to the patient's welfare that must be the primary moral imperative in medical care. This commitment flows from the nature of illness and the promise of service made by individual physicians and the profession as a whole. That commitment has a basis in the empirical nature of the healing relationship in which a sick person—dependent, vulnerable, exploitable—must seek out the help of another who has the knowledge, skill, and facilities needed to effect cure. It is inevitably a relationship of inequality in freedom and power in which the stronger is obliged to protect the interest of the weaker.[13]

VI. Some Counter Arguments

Some would argue that the moral issues raised against gatekeeping, rationing and for-profit medicine on grounds of conflicts of interest and divided loyalties, are specious. The opposing viewpoints are several: medical care has always been rationed; differences in availability, accessibility and quality have always existed and always will; even the so-called not-for-profit hospitals make an "excess" of revenues over expenditures. Moreover, the doctor's fee is itself a "profit" and a source of conflict of interest. And even if this

13. Pellegrino, *Toward a Reconstruction of Medical Morality: The Primacy of the Act of Profession and the Fact of Illness*, 4 J. Med & Phil. 32-56 (1979).

were not true, rationing and fiscal motivations are essential to fiscal survival. Even religiously-sponsored institutions argue that they must make a profit and must ration care on the ability to pay. "No margin, no mission," they say. Survival, it is argued, demands practices that may be distasteful and unfair, but not unjust.

I would counter these arguments as follows: first of all the existence of inequity and injustice does not give them any necessary moral sanction, nor does the fact that all injustice cannot be eliminated in an imperfect world. If we cannot afford all the health care people want or need, there are alternative ways of rationing or allocating resources more morally valid than those now in use.

Second, there is a real difference between the way a for-profit and a not-for-profit institution handles the "excess" of revenue over expenditures. In a for-profit (or more decorously called "investor-owned") hospital, the primary aim is profit because the prime obligation is to protect and enlarge the investor's shares. This, it must be added, is a moral obligation since the for-profit hospital is steward of other people's money. The "profit," however, goes into the pockets of the investors, while in a non-profit hospital most of it must go into the improvement of patient care services or capital expansion. When the physician is gatekeeper in a for-profit hospital, he has conflicting obligations—to the investor and to the patient.

Proponents of rationing point to the over-utilization of services, inefficiency of management and operation and the lack of stimulus for innovative models of care that admittedly beset cost-reimbursement and government entitlement programs. One cannot defend these shortcomings, nor argue for a "blank check" approach to health care. Both must be eliminated in any defensible system of health care payment. But the fact is that the various cost-containment systems now being used have yet to achieve greater efficiency than not-for-profit systems.[14] Indeed, it appears that in the for-profit systems, gatekeeping has resulted in no cost advantage over not-for-profit systems while the charges are higher (sometimes by as much as twenty-five percent). Thus, successful cost containment, the major moral justification for gatekeeping, is questionable: prices are not appreciably lower. Yet, today, fewer people have adequate coverage and more are forced to deplete their financial reserves to pay for needed medical care.

Some would argue that we have in the PSRO mechanism all the controls we need to prevent abuses of the prepayment systems. Professional Standards Review Organizations [PSRO] were established in every state to moni-

14. Catlin, Bradbury, & Catlin, *Primary Care Gatekeepers in HMO's*, 17 J. FAM. PRAC. 673-78 (1983).

tor the quality and costs of services provided under Medicare. They are peer review organizations composed of physicians whose function is to assure quality of care and containment of costs by avoidance of unnecessary procedures. Because of concerns about the efficiency and assiduity of their policing of physician performance, they were re-organized last year by Congress. Since then the number of disciplinary actions has notably increased.

It is an essential moral duty of physicians as individuals and as members of these PSROs to monitor, correct, and discipline abuses by doctors and hospitals. PSROs should obviously be employed as effectively as possible. But PSROs do not solve the ethical dilemmas of gatekeeping. What they should assure is that the *de facto* gatekeeping functions are carried out and rational and honest medicine is practiced.[15] PSROs cannot eradicate the dilemmas created for the conscientious doctor by a national policy of rationing.

For the dishonest or incompetent physician, the ethical dilemmas outlined are inconsequential. It is the physician committed to the good of his patient, the one who practices rational medicine for whom divided loyalties are a genuine ethical problem. For such a physician, even the PSRO might pose an ethical dilemma, i.e., when peer reviewers censure him for failing to apply the cost containment measures if he sincerely believes doing so will serve his patient. Effective PSROs are essential to good care. It is the ethical implications of the health policies under which they operate that must be subjected to critical scrutiny.

VII. Is Rationing Inevitable?

The only argument with some moral substance for rationing is economic necessity. Some fear that rising health care costs will seriously compromise availability and accessibility of other good things our society needs to thrive—nutrition, housing, jobs, or national security. This is the justification for efforts to put some arbitrary ceiling on the percentage of Gross National Product dedicated to health care. Is the assumption of national bankruptcy by health care costs true? If it is, rationing might be justified. Then the moral question becomes, under what conditions? If it is not, then rationing has no moral sanction.

The question turns on the validity of the initial premise of the line of reasoning that leads to rationing as inevitable. This is a difficult question to answer because comparable figures on national expenditures for other things society wants are hard to come by. Moreover, whether there is a crisis or

15. Dans, Weiner & Otter, *Peer Review Organizations, Promises and Potential Pitfalls*, 313 New Eng. J. Med. 1131-37 (1985).

not depends very much on the value we place on other expenditures. Some of the data on health care costs that policymakers find distressing are these:

The nation's total health care bill has now exceeded one billion dollars per day in the United States. The percentage of our Gross National Product going into health care is higher than almost any other nation's and is going higher each year. Two and a half billion dollars is spent on keeping 70,000 patients with chronic renal disease alive; 4.4 billion is spent in heart and liver transplants; ten percent of all operating costs of a university hospital goes into the last three to six months of life; eighty percent of those who die do so in a hospital as compared with fifty percent in 1949 and much lower percentages at the turn of the century; 230,000 babies are born each year weighing less than 2,500 grams, half of them survive; fifteen percent of those who survive end up with some residual defect; two billion dollars per year are spent on neonatal intensive care units.

Each of these and other figures has been selected by some protagonist of rationing as the place to economize. Rationing for these groups is proposed on utilitarian, economic and humanitarian grounds, i.e., to reduce the number of dependent, non-productive members of society, or save money for other socially useful purposes or needs, or to prevent dooming the retarded and the disabled to lives of poor "quality." Some suggest that persons over a certain age should not be offered dialysis, that high technology procedures like liver and heart transplants or even coronary by-passes should not be performed, that research in high technology treatments like artificial hearts be halted, that babies under a certain cut-off weight should not be treated, that there should be a monetary limit on the expenditures for persons with terminal illnesses in the last few months of life, and that those above a certain age should not be treated vigorously.

These proposals deserve more critical examination than is possible here. They illustrate a range of policy options, all of which center on rationing of expensive forms of care. Against these expenditures we must consider expenditures for the following which, as a nation, we make willingly—indeed, sometimes avidly: Forty billion for alcohol, thirty billion for tobacco, sixty-five billion for cosmetics, sixty-five billion for advertising, unspecified billions for recreation hand guns, illicit drugs, gambling, or various types of luxuries.[16]

What decisions would we make if we consciously compared these expenditures against those for health care? Is 2.5 billion dollars too much to spend

16. Figures for national expenditures for goods, commodities and services are difficult to evaluate. For our purposes the important point is the relative order of magnitude of specific health and medical care expenditures as compared with other expenditures.

on keeping 70,000 people with renal disease alive—many of them in active lives—or four billion to return people to active life by means of cardiac, liver, or renal transplants which are becoming more effective each year? What about the fifty percent of underweight babies who *do* survive and the eighty-five percent who are not disabled or retarded? Can we decide what is "quality" life for another person and especially for an infant whose values cannot possibly be known? How do we distinguish between futile and burdensome treatment and effective, though expensive, life-saving treatments? How do we protect the vulnerable—the old, the very young, the poor, and the socially outcast—from being discriminated against in rationing decisions? How do we know when research into high technology may turn out to be beneficial for all, rather than a few?

How would we answer these questions if we considered health a higher value than some of the other things for which we make great expenditures without questioning them at all? Would we have to ask these questions at all if we could cut out truly unnecessary care, reduce inefficiencies of the care we now give, and establish some priority among the categories of care based on their need, benefit and effectiveness as seen from the patient's point of view.

If we address these questions in an orderly way, identifying the underlying values and making conscious choices, we might decide that rationing and life-boat ethics are not warranted in this country today. It would take more space than this essay permits to establish these contentions. The questions have yet to be examined carefully, particularly to expose their underlying value desiderata. This is a sensitive operation and one whose conclusions might prove embarrassing. How we make the choices rationing implies will reveal more about the kind of people we are, and want to be than it would about those we might wish to confront.

VIII. The Conditions for Morally Licit Rationing

Let us assume that there is a true economic crisis, that health care needs are, indeed, eroding society's capacity to obtain other needed goods—housing, jobs, food, security—and that we have consciously come to the conclusions that rationing and life-boat ethics are necessary on moral grounds. Under these conditions, we must face opposing moral obligations: to provide health care and at the same time to protect the fabric of society. Such conditions exist in times of natural disaster, war, epidemics and the like. Under those conditions, rationing of health and many other things is accepted. But even under less urgent conditions, morally valid criteria can be

established for both allocation and rationing of national resources dedicated to health and medical care. A tentative set of criteria might be the following:

First of all, all alternate measures to rationing should have been exhausted. We are far from such a goal. To attain it, we would have to assure the following at least:

a) The efficiency of management of personnel, facilities and fiscal resources are optimal. This is not the place to detail how the necessary measures are to be employed. Suffice it to say that economies have been and can still be made in this area. They must be made first if rationing is to be justified as a national policy.

b) Rational medicine, defined above as consisting of diagnostic elegance and therapeutic parsimony, would have to be practiced universally and optimally. The elimination of unnecessary tests would save in the range of fifteen to twenty billion dollars per year. An even larger sum could be saved by the elimination of truly unnecessary surgery, medications and other therapeutic procedures. An estimate of this figure is difficult to obtain since much depends on the definition of "unnecessary."[17]

c) Some hierarchy of services would have to be established to govern the priority assigned to various kinds of health care expenditures. To be morally valid this hierarchy must be ordered from the patient's point of view according to benefit, effectiveness, and need. One possible way to order such a hierarchy might be as follows:

1) Highly effective preventive measures for disease of wide distribution, e.g., immunization for small pox, tetanus, diptheria, pertosis, and polio might come first.

2) Then could follow beneficial and effective treatments for life-threatening disease: for example, emergency trauma care, renal dialysis, angioplasty in impending myocardial infarction, or radiation and chemotherapy for responsive neoplastic diseases.

3) Following this, the next category might be beneficial and effective treatment for less acute but serious diseases—coronary by-pass surgery for intractable angina pectoris, disabling hernia, drug treatment for gout, peptic ulcer, or hypertension.

4) Less urgent would be expenditures for expensive treatments with marginal benefit like coronary by-pass when medical treatment is equally effec-

17. *See* Rutkow, *Unnecessary Surgery: What is it?* 62 SURGICAL CLINICIAN N. AM. 613-25 (1982); Rutkow, *Rates of Surgery in the United States: the Decade of the 1970s*, 62 SURGICAL CLINICIAN N. AM. 781-91 (1982); *Study on Surgical Services for the United States*, AMERICAN COLLEGE OF SURGEONS, AMERICAN SURGICAL ASSOCIATION (1975).

tive, carotid endarterectomy of certain types, and preventive cholecystectomy for cholelithiasis.

5) Last would be effective treatment for non-disabling, non- life-threatening disorders—purely cosmetic surgery.

This is a list that is obviously a subject for vigorous debate as to content and priority. My point is not to make a brief for this particular list but only to suggest that establishing such a hierarchy is one precondition to morally licit rationing.

A similar hierarchical listing would have to be developed for diagnostic procedures as well. Many of these are expensive, and add only marginally to diagnostic accuracy. With diagnosis, as with treatment, the latest is not always the best. The additional benefit or effectiveness may not be sufficient to warrant the added expense.

We must be reminded that there are many acceptable ways to manage patients which do not necessarily involve the most sophisticated technologies. Some of these, indeed, may even be preferable since they may be less risky than the latest procedures. Tests done solely in the interests of "defensive medicine" to forestall litigation would have to be eliminated. Despite the physician's understandable fear of malpractice suits, he cannot morally justify the costs or risk of unnecessary procedures simply to protect himself.

Assuming that the above and other measures to contain costs have been utilized fully, the next condition for morally licit rationing is the open public disclosure of the categories of care that will be rationed together with the principles upon which they will be rationed. Selection of a morally defensible rationing principle is another difficult but unavoidable condition of a morally defensible rationing system.

Shall the principle be equity of access for all, or age, social worth, merit, ability to pay or lottery? Arguments have been marshalled to defend one or another principle of distributive justice. Again, we cannot examine each principle critically here.[18] I wish simply to establish the need for settling on some explicit principle. Once established, that principle must be made known to all. As it is, a variety of principles is in use and rarely is any explicitly stated. Again, the principle we select will tell much about our most cherished values and the kind of society we wish to be and whether we regard health as a human right, an obligation on society or simply as another commodity.

Especially crucial with respect to the gatekeeper role is that the hierarchy

18. Debates about the nature of justice and the principles of distributive justice that should obtain are particularly active today. *See* J. RAWLS, A THEORY OF JUSTICE (1971); R. NOZICK, STATE, ANARCHY AND UTOPIA (1974).

of services and the principle of rationing must be determined in public policy and made known to all who seek care. It is not left up to the physician to determine in individual cases who lives or dies, who gets care, and who does not. In this way, the physician can remain the primary advocate of the patient, albeit within constraints imposed by social or public policy.

The physician may disagree with those constraints when he feels they are injurious to patients—his own or others. When he does so, he has a moral obligation to use the means available in a democratic society to change policies, regulations, or procedures that violate his perception of what is good for patients. He can function with moral integrity in the "valid," *de facto* gatekeeping role described above. In that role, he serves his patient's interests, not his own, or those of the institution or corporation providing health care services.

But the invalid roles of negative and positive gatekeeper, as defined in this article, require the physician to dilute his primary advocacy of his patient's interest. Society should not force or encourage physicians to be double or triple agents. It is not morally defensible for society to "unload" its unpleasant rationing decisions on physicians. Nor can it run the risk of physician bias or prejudice in the way resources are rationed in individual cases. Patients who are denied some needed care must recognize that it is the whole of society that has denied them and under constraints that apply to everyone. Physicians are free to protest unjust measures and to educate public and policymakers to the dangers of their own rationing decisions. As a consequence, the covenant of beneficience between physician and patient is preserved. The one who is ill need not fear that his physician is acting as a hidden double or triple agent. The physician on his part is under serious obligation to protect his patient's interests within the constraints imposed by health policies, but also moally obliged to oppose and resist such policies when they prove injurious to his patients.

It is possible that our society will choose other things over health, that it will see health care as nothing more than a commodity or service like any other, and that it will impose the responsibility of specific rationing decisions on physicians. If this occurs, then it is a moral requirement that physicians publicly acknowledge the difference this will drastically make in the expectations the patient brings to his relationship with a doctor. The profession must signal the change the gatekeeper role entails for the transformation of medical ethics from primary concern for the individual patients to a competing conern for social or economic good. Were we to take this direction in medical ethics, we would be moving in the direction of the code of the Soviet physician which makes the good of the polity and society the prime principle

of medical ethics. Beneficence, patient autonomy, and justice—the cornerstones of professional medical ethics today—would have to yield to social good and economic need.

IX. Some Legal Questions

Neither the profession, nor the public, can have it both ways: either the physician serves primarily the interests of the patient or the physician becomes the instrument of social and fiscal policy as well as patient good.

We cannot predict how the American people will ultimately resolve the serious ethical dilemmas of gatekeeping and whether they are prepared to accept the ethical conflicts of divided loyalty. There is, however, some indication that the public may not be ready to abandon its moral expectation that the physician is the patient's primary agent. This is reflected in the potentials for litigation in which patients may hold physicians liable for harm done to them by premature discharge from the hospital, or the omission of tests, or treatment or failure to hospitalize under DRG and other cost containment prepayment plans.

One distressing legal development is the possibility that standards of care to which physicians are held will be downgraded to accommodate the kinds of decisions prospective payment will require. This possibility is already being discussed tentatively in the legal profession. The presumption is that standards can be lowered without loss of safety and that the public will accept "Chevrolet" in place of "Cadillac" care as long as it costs less.[19]

These assumptions are dangerous and invalid. They presume that lowering standards will mean simply eliminating "unnecessary" care or the "frills" and luxuries. Unfortunately, such distinctions are very hard to make since the differences between present and proposed standards are not all that trivial. It is very questionable whether such a move would decrease the possibility of suit or whether the doctor could be freed of his first duty to protect the patient. Moreover, there is very little likelihood that the American public would accept the implications of a lowered standard were it to be openly

19. Most of the litigation is still in the "possible" state being underlined by lawyers in informal opinions that are probably well grounded. *See, e.g.*, Chenen, *Prospective Payment: It Can Put You in Court*, MED. ECON. 3, 134ff (July 9, 1984); Ginsburg, *DRGs: Must Physicians and Hospitals be Adversaries?* 1985 PHYS. MED. 252; Gerber, *How DRG's Increase Your Malpractice Risk*, 1985 PHY. MED. (335). *See also* Curran, *Economic and Legal Considerations in Emergency Care for Analysis of the Case of Thompson v. Sun City Community Hospital*, 312 NEW ENG. J. MED. 374-75 (1985). In this case a young boy needing emergency surgery was transferred for financial reasons in a "stable" state. Suit was brought by patient's mother against the hospital and the emergency room physician for permanent impairment resulting from delay in surgery. The court found against the hospital but not the physician. More cases of this type surely can be anticipated and liability of physicians will be questioned in each.

announced. When it comes to health care, very few people are willing to compromise their own safety.

Already, in anticipation of suits, hospitals are seeking to avoid litigation. This is a legitimate move but it is more important still to act out of motives of ethical obligation than self-protection. Fear of litigation is not a self-justifying principle anymore than economic constraint.

Does the patient have a legal right to know in advance that a clinical decision has been made on economic rather than strictly medical grounds? Is the doctor to be held responsible for damage resulting from adherence to a national health care policy? Or is he liable if he does not violate such a policy when it has the potential to harm his patient? What penalty does he suffer for placing loyalty to patient above loyalty to public or fiscal policy? Is it morally defensible for society to put the physician in the midst of such ethical and legal dilemmas?

Must informed consent in the future include full disclosure of the fact that economic or social criteria will be used to modify judgments made on scientific criteria or patient need? Will living wills have to take account of that fact and direct physicians to use economic criteria in deciding on starting and stopping life support or other measures? These and other legal issues impinge upon and complicate the ethical dilemmas described in the various types of gatekeeper roles now being assigned to physicians. Intensive examination of the legal issues and the provision of appropriate legal safeguards for both the patient and the physician must be devised if we, as a nation, go the route of rationing *in toto*, or even in part, as prepayment plans already in existence require.

This examination has already been precipitated by litigation surrounding one of the most common practices associated with prepayment and for-profit plans and for institutions worried about deficits: the practice of "economic transfer."[20] When a patient presents himself for admission, his insurance coverage and ability to pay are assessed along with his medical condition. If the patient seems an economic risk, he is transferred to a public or religiously sponsored institution. These transfers are made when the patient is presumed to be in a "stable" condition. However, the definition of stability varies considerably from physician to physician and patients have suffered physical damage as a result, to say nothing of emotional trauma. It is a fact that the definition of stable state is altered by economic considerations when a physician is an employee of an institution or a member of the resident staff.

The conflict of interest here is obvious and explicit. The primary moral responsibility of the physician is clearly to the patient. He puts himself at

20. *See supra* note 19.

considerable risk when he approves an economic transfer, legal as well as moral. Once again we observe the paradox of an economic and market system exploiting the physician's self-interest and the public's expectation that the physician must act in the patient's best interests.

X. RECAPITULATION

The physician is responsible for seventy-five percent of the nation's expenditures for health care. He is the "gatekeeper" who can limit or facilitate access to tests, treatments, consultations, and admission to a variety of health care institutions.

There are three ways in which the physician can function as gatekeeper: one is morally mandatory, one is morally questionable, and one is morally indefensible. The first is the traditional, or *de facto* function, which imposes a responsibility to practice rational medicine, i.e., to use only those diagnostic and therapeutic modalities beneficial and effective for the patient. The proper exercise of traditional gatekeeping is not only morally imperative but economically sound.

The second form of gatekeeping is the negative gatekeeping role, usually within some form of prepayment system in which the physician strives to limit the use of health care services. This role is morally dubious because it generates a conflict between the responsibilities of the physician as a primary advocate of the patient and as guardian of society's resources. Under certain carefully defined conditions of economic necessity and moral monitoring, a negative gatekeeping role might be morally justifiable.

The third form of gatekeeping is positive gatekeeping in which the physician encourages the use of health care facilities and services for personal or corporate profit. This is an indefensible form of gatekeeping. No moral justification can be mustered in its favor.

Recognition of the ethical dilemmas created by the growing national belief that health care rationing is inevitable, their impact on the care of patients and the ethics of the physician-patient relationship are matters of wide public concern. There are also emerging legal issues of significance.

This article delineates the nature of the ethical dilemmas of gatekeeping from the viewpoint of the patient's interests. It concludes that the integrity of the physician's primary responsibility to his patient is something society must preserve, that rationing may not be as inevitable as generally supposed and that before we can impose rationing on morally valid grounds, all other means of cost containment must be exhausted.

No servant can serve two masters: for either he will hate the one,

and love the other, or else he will hold to the one and despise the other. You cannot serve God and mammon. Luke, 16:13.