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ETHICAL ISSUES IN MANAGED CARE: CAN THE TRADITIONAL PHYSICIAN-PATIENT RELATIONSHIP BE PRESERVED IN THE ERA OF MANAGED CARE OR SHOULD IT BE REPLACED BY A GROUP ETHIC?

Eugene C. Grochowski*

Over the last decade managed care has become the dominant form of health care delivery, because it has reduced the cost of health care; however, it has also created serious conflicts of interest for physicians and has threatened the integrity of the traditional physician-patient relationship. In this Article, Dr. Grochowski argues that the efficiencies created by managed care are one time savings and will not in the long run reduce the rate of rise of health care expenditures without a concomitant plan to ration health care. He explores the traditional physician-patient relationship and concludes:

a) that while rationing of health care is inevitable, physicians must not ration care at the bedside;
b) that physicians must be advocates for their patients;
c) that physicians must avoid conflicts of interest whenever possible;
d) that physicians must put the needs of the patient before their own self-interests; and
e) that physicians must act in ways to promote trust in their relationship with patients.

INTRODUCTION

Managed care[1] creates a tension between the treatment physicians believe is medically indicated and the costs the managed care

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1. *See* John K. Iglehart, *Physicians and the Growth of Managed Care*, 331 NEW ENG. J. MED. 1167, 1167 (1994). In his article, Iglehart states:

> Managed care is a system that, in varying degrees, integrates the financing and delivery of medical care through contracts with selected physicians and hospitals that provide comprehensive health care services to enrolled members for a predetermined monthly premium. All forms of managed care represent attempts to control costs by modifying the behavior of doctors, although they do so in different ways.

Id.

organization (MCO)[2] is willing to pay.[3] MCOs increase this tension by creating incentives for physicians to spend less, which in turn create a conflict of interest. MCOs, physicians, and others have tried to reduce this tension by a variety of methods:

1) Changing what is medically indicated by requiring the use of practice plans, by defining certain procedures or therapies as experimental, and by simply declaring that some procedures or therapies are not medically indicated. These attempts at changing what is medically indicated have paradoxically sometimes increased the tension between physicians and MCOs.
2) Writing contracts that exclude certain benefits. This straightforward method has met resistance in practice. First, insurance laws limit what MCOs can exclude.[4] Second, items that are excluded can be challenged in court.[5]

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2. Managed care organizations vary greatly. The adage that when you have seen one managed care organization, you have seen one managed care organization is true. *See generally* Carolyn Clancy & Howard Brody, *Managed Care: Jekyll or Hyde?*, 273 JAMA 338 (1995) (pointing out that there are both good and bad managed care plans).

While I have tried to use the term MCO (managed care organization) instead of HMO (health maintenance organization), the terms are often used interchangeably. Peter Kongstvedt defines the terms as follows:

> HMO—Health maintenance organization. The definition of an HMO has changed substantially. Originally, an HMO was defined as a prepaid organization that provided health care to voluntarily enrolled members in return for a pre-set amount of money on a [per member per month] basis. With the increase in self-insured business, or with financial arrangements that do not rely on prepayment, that definition is no longer accurate. Now the definition needs to encompass two possibilities: a health plan that places at least some of the providers at risk for medical expenses, and a health plan that utilizes primary care physicians as gatekeepers (although there are some HMOs that do not).
>
> ....
>
> MCO—Managed care organization. A generic term applied to a managed care plan. Some people prefer it to the term *HMO* because it encompasses plans that do not conform exactly to the strict definition of an HMO (although that definition has itself loosened considerably).

PETER R. KONGSTVEDT, THE MANAGED HEALTH CARE HANDBOOK 504–05 (1993).

3. *See* JOHN LA PUMA & DAVID SCHIEDERMAYER, THE MCGRAW-HILL POCKET GUIDE TO MANAGED CARE 135 (1996) ("The central ethical conflict in managed care is the tension between what is medically indicated . . . and what is financially available.").

4. *See* Vickie Yates Brown & Barbara Reid Hartung, *Managed Care at the Crossroads: Can Managed Care Survive Government Regulation?*, 7 ANNALS HEALTH L. 25, 33 (1998).

5. *See* Norman Daniels & James E. Sabin, *Last Chance Therapies and Managed Care: Pluralism, Fair Procedures, and Legitimacy*, 28 HASTINGS CENTER REP. 27, 27–28 (1998) ("[D]enials of coverage for seriously ill people are highly visible. Even health plans that use impeccable science and patient-centered deliberation while trying to hold the traditional,

Third, a plan that is too restrictive will not be very popular with employers who purchase these plans for their employees.

3) Shifting the physician's duty from the patient to the group of patients within the managed care organization. This is a repudiation of the traditional ethic of patients first.

The last method, which has the greatest potential to reduce this tension, is the focus of this Article. The traditional physician-patient relationship ought to be preserved.[6] Other commentators, however, have made the following arguments for shifting the physician's duty from the traditional patient centered ethic to a group ethic:[7]

1) Most physicians have already shifted their duty from the individual patient to society, so why continue to assert the traditional ethic?[8]
2) When physicians accept a panel of patients in an MCO, they assume responsibility for all of these patients, even the patients they never see.[9]
3) Given the need for rationing, making individual spending decisions at the bedside (bedside rationing) is more efficient than trying to make global spending decisions that would apply to all patients (macro-level rationing). Furthermore, because bedside rationing is

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contractually specified line against unproven therapies risk horrendous publicity, expensive litigation, and legislative mandates requiring coverage.").

6. *See, e.g.*, Amber Barnato et al., *Does Managed Care Require a "New" Medical Ethics?*, ETHICAL ISSUES MANAGED CARE Q., Spec. Ed. 1998, at 1 (discussing the work of a group of physicians convened by the Integrated Healthcare Association to re-examine the principles underlying the Hippocratic Oath from a managed care perspective); Jerome P. Kassirer, *Managing Care—Should We Adopt a New Ethic?*, 339 NEW ENG. J MED. 397, 397 (1998).

7. *See generally* MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS, & ECONOMICS OF RATIONING MECHANISMS (1997) [hereinafter HALL, MEDICAL SPENDING DECISIONS] (arguing that medical spending decisions are inevitable and examining three alternative medical spending decision-makers: (i) patients paying for treatment out of their own pocket; (ii) doctors making cost/benefit trade-offs at the bedside, (iii) third parties imposing spending limits from outside the treatment relationship).

8. *See* Steven H. Miles & Robert Koepp, *Comments on the AMA Report: "Ethical Issues in Managed Care,"* 6 J. CLINICAL ETHICS 306, 308–09 (1995); Peter A. Ubel & Robert M. Arnold, *The Unbearable Rightness of Bedside Rationing: Physician Duties in a Climate of Cost Containment*, 155 ARCHIVES INTERNAL MED. 1837, 1840–42 (1995). This argument ignores the fact that ethics are normative, not descriptive.

9. *See* Mark A. Hall & Robert A. Berenson, *Ethical Practice in Managed Care: A Dose of Realism*, 128 ANNALS INTERNAL MED. 395, 398–99 (1998).

not compatible with patient centered duties, the traditional physician-patient relationship must change.[10]

Shifting from the traditional ethic to a group ethic will also make physicians more comfortable and compliant with MCOs. They will be able to justify their failure to put patients first. They can be agents of the MCO, and at the same time assert their allegiance to the new medical ethics. Thus, some physicians will be strongly motivated to adopt such an ethic. Eliminating the traditional ethic will also blunt their concern over the conflicts of interest that exist in managed care.

Despite the motives of MCOs for desiring this change in ethics, a larger issue is at stake: the undeniable need to ration medical care. So, in addition to the title question, *Can the traditional physician-patient relationship be preserved in the era of managed care or should it be replaced by a group ethic?*, there are two related questions: (1) How ought physicians be involved in rationing medical care, if it all? (2) Do traditional ethics allow bedside rationing?

This Article attempts to answer these questions. Part I lists a series of foundational assumptions. Because it is central to the problem, Part II makes a case for rationing, one of the foundational assumptions. Part III of the Article explores the traditional physician-patient relationship, attempting to explicate what is demanded of the traditional ethic, including advocacy, trust, and avoidance of conflicts of interest.[11] In this context it will demonstrate how conflicts of interest erode trust. Part III further argues that the traditional physician-patient relationship allows withholding of marginally beneficial treatment, and concludes that the ethics of the traditional physician-patient relationship ought to be enforced and that conflicts of interest created by the practice of giving physicians money to spend less on the care of their patients ought to be abandoned. Part IV briefly describes how the traditional ethos in medicine is changing, and how those very changes support the need to preserve the traditional physician-patient relationship. Part V discusses the problem of balancing patients' interests with societal interests and concludes that bedside rationing is incompatible with the traditional physician-

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10. *See* Mark A. Hall, *Rationing Health Care at the Bedside*, 69 N.Y.U. L. REV. 693, 711–27 (1994) [hereinafter Hall, *Rationing Health Care*]; David Orentlicher, *Paying Physicians More to Do Less: Financial Incentives to Limit Care*, 30 U. RICH. L. REV. 155, 167–73 (1996).

11. Conflicts of interest will always be present in the physician-patient relationship, but one can still strive to create an environment that avoids as many as possible and that minimizes the impact of unavoidable conflicts of interest.

patient relationship; and that because this is so valuable to patients, bedside rationing must not be allowed.

I. FOUNDATIONAL ASSUMPTIONS

The following assumptions lay the foundation for this Article:

- Patients ought to be respected because they are persons.
- The physician-patient relationship is a fiduciary relationship.
- Whenever possible, conflicts of interest ought to be avoided.
- Traditional ethics requires patient advocacy.
- Trust is important in the therapeutic relationship.
- There are other social goods equally as important as health care.
- Rationing ought to be logical and made explicit.
- Because monetary resources are limited, and physicians ought to be good stewards of scarce resources, physicians should use the least expensive effective alternative.
- Rationing is necessary.
- All Americans have a basic right to available adequate health care.

Except for the last two, these assumptions enjoy widespread agreement. It is therefore necessary to say more about these last two assumptions.

The last assumption creates a paradox. Although few people publicly state that they disagree with this statement, at any one time there are tens of millions of U.S. residents who are uninsured[12] and taxpayers seem unwilling to pay even a little more in taxes to solve this problem.[13] Furthermore, a right to health care

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12. *See* CHARLES J. DOUGHERTY, BACK TO REFORM: VALUES, MARKETS AND THE HEALTH CARE SYSTEM 6 (1996) ("[I]n 1995, approximately forty million Americans had no health insurance coverage. These people are not eligible for Medicare or Medicaid and do not have any private insurance coverage. They are literally uncovered and would have to pay out of pocket in the event health care were needed.").

13. Again, as Dougherty notes:

> Polls since 1938 have shown a very high level of support for universal coverage, support that drops precipitously as the readiness to pay for it by increased taxation is

depends upon a corresponding duty to provide health care. In the U.S., there does not appear to be a duty incumbent upon anyone to provide basic health care to all Americans. We have laws that provide emergency care for anyone, but extend to neither preventive care nor routine care.[14] Further discussion of this important item is beyond the scope of this Article.

II. RATIONING[15]

The penultimate assumption, *rationing is necessary*, is central to this Article and requires further discussion. Regrettably, our society has always rationed health care based on one's ability to pay; however, this form of rationing is neither necessary nor logical. It is unnecessary because the health care system could be restructured (for example, the government could pay for the health insurance of all U.S. citizens instead of having employers pay just for their employees). It is not logical because it arbitrarily binds insurance to employment.

Nevertheless, rationing is necessary. First, if health care rationing is defined broadly as limiting health care that patients want and that may benefit them no matter how small the expected benefit, no health care system can afford not to ration.[16]

Second, physicians must ration the amount of time spent with patients based on whether there are sicker patients who need at-

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> assessed. At the height of the debate over the Clinton plan, polls showed that an increase of only thirty dollars a month (or $360 annually) could not get majority support.

Id. at 10.

14. *See* Leigh M. Chiles, Note, Summers v. Baptist Medical Center Arkadelphia: *A "Disparate" Application of EMTALA's Terms*, 50 ARK. L. REV. 559, 559 (1997) (discussing how the Emergency Medical Treatment and Active Labor Act (EMTALA), part of the Consolidated Omnibus Budget Reconciliation Act (COBRA), is also known as the federal "anti-dumping" statute and seeks "not only to prevent hospitals from refusing to treat patients based on their inability to pay but also to stop the increasing practice of transferring patients to nonprofit hospitals before stabilizing life-threatening conditions"). EMTALA is codified at 42 U.S.C. § 1395dd (1994).

15. I will use the straightforward term "rationing" despite its negative connotations. For example: "And, whereas during World War II rationing was common and meant simply a 'fair allocation of scarce resources,' rationing now has an exclusively negative connotation and is a code word for denial of care." GEORGE J. ANNAS, STANDARD OF CARE: THE LAW OF AMERICAN BIOETHICS 212 (1993).

16. *See generally* Richard D. Lamm, *Marginal Medicine*, 280 JAMA 931 (1998) (discussing the inevitability of rationing and the conflict created by a narrow interpretation of traditional medical ethics).

tention. Moreover, unless physicians are willing to see only a few patients each day, they must also ration their time based on whether their waiting rooms are full.

Third, any attempt to cut costs while preserving quality must logically lead to rationing. It is wishful thinking to believe that simply cutting administrative costs and improving efficiency will keep the lid on rising health care costs, because cutting the fat out of health care creates only a one-time savings. It fails to change the slope of rising health care costs that, prior to the emergence of managed care, were unsustainable. Thus, to flatten the slope, the amount of care delivered must be decreased. In order to maintain quality of care while decreasing the amount of care delivered, a sensible plan for limiting care—rationing is needed.[17]

Fourth, benefits from newly emerging half-way technologies cost more per benefit received.[18] Half-way technologies are sophisticated ways to cope with medical problems instead of curing them. For example, polio vaccine is an efficient, economical way to prevent polio, but a fancy new expensive iron lung would be a half-way technology. Consider hemodialysis, which keeps patients with kidney failure alive, albeit at enormous costs each year.[19] This is a half-way technology that cannot be eliminated because an effective way to prevent most cases of renal failure does not yet exist. Each year, the techniques of dialysis are slowly refined (erythropoietin for anemia, calcitriol for bone disease, and biocompatible membranes), but at ever increasing expense. It is true that some half-way technologies are cost effective, but few are cost saving (for example, use of inhaled corticosteroids to treat asthma leads to a net savings because this form of asthma treatment reduces

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17. *See* William B. Schwartz, *The Inevitable Failure of Current Cost-Containment Strategies: Why They Can Provide Only Temporary Relief*, 257 JAMA 220, 220–21 (1987).

18. Consider the charges for imaging the lumbosacral spine with plain X-ray (two views, $60.83) versus CT scan (non-contrast, $347.13) versus MRI (non-contrast, $506.64); and consider the charges for a course of antibiotics with aminoglycosides (gentamicin $.75 per day) versus third generation cephalosporins (Cefotaxime $21.00) versus Quinolones (Levofolxacin $24.70 per day). These were the charges at a local academic institution in July 1999.

Alternatively, one can look at the cost of an X-ray machine: $100,000; a computerized automated tomography (CAT) scanner: $1 million; a magnetic resonance imaging (MRI) machine $3 million, and a positive emission tomography (PET) scanner: $10 million. *See* HALL, MEDICAL SPENDING DECISIONS, *supra* note 7, at 4.

19. *See* UNITED STATES RENAL DATA SYSTEM, 1998 ANNUAL DATA REPORT xviii (1998) (stating that the total spending for ESRD in 1996 was $14.6 billion and that Medicare Dollar per patient spending in 1996 for hemodialysis was $55,000.00; for peritoneal dialysis was $48,000; and for transplant recipients was $18,000 (excluding the cost of organ procurement)).

hospitalizations).[20] Therefore, to achieve more than a one-time savings—to decrease the steep slope of rising health care costs—these new technologies will have to be rationed.

One can look at rationing from several points of view:

- Inevitability: accept or deny
- Acknowledgment: overt or covert
- Mechanism: rational or default
- Process: by gate-keepers, by inconvenience, or by policy
- Level: mega, macro, or micro.

We must accept the fact that rationing is necessary, and overtly acknowledge that we ration care and that we need to develop a coherent plan for rationing. After all, the Latin root of rationing is *ratio* or reason.[21] The U.S. had a plan for rationing during World War II, but rationing of health care today is not planned. It occurs by default; it is unacknowledged, and as a consequence, it is often unfair to the disadvantaged. Failure to acknowledge rationing is deceptive and in the end will erode patient trust. Furthermore, making rationing decisions explicit and publicly accountable is an important first step in creating a just health care plan.

The process of rationing is related not only to mechanism (rational plan or by default), but also to whether it is overt or covert. Currently, gatekeepers ration care by deciding whether to refer patients to specialists, by limiting access to expensive procedures (CT scans, MRI, or bone marrow transplants), and even to procedures which are not so expensive (chest X-rays, back X-rays, or throat cultures). Some HMOs ration by inconvenience, requiring excess paperwork or a laborious process of pre-approval as a way to discourage physicians from ordering certain tests or therapies.[22] Alternatively, patients may be made to wait an exceptionally long time for an appointment as a way to discourage use of certain services. For example, a patient may want to see a dermatologist, but the next available appointment for the approved dermatologist

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20. *See* Harold C. Sox, *The Dilemma of Internists: Caught in a Box with Technology*, ACP OBSERVER, May 1998, at 11 (giving coronary bypass surgery for left main coronary artery stenosis as an example: the cost per year of quality life is reasonable, but the cost of surgery exceeds the cost of treating angina).

21. *See* Martin Benjamin et al., *What Transplantation Can Teach Us About Health Care Reform*, 330 NEW ENG. J. MED. 858, 858 (1994).

22. *See* Gerald W. Grumet, *Health Care Rationing Through Inconvenience: The Third Party's Secret Weapon*, 321 NEW ENG. J. MED. 607, 608 (1989).

may be months away. HMOs ration by policy when they declare in their contracts that a service is not covered. For example, most HMO contracts state that experimental care is not a covered service. This form of rationing at least has the advantage of being overt, and sometimes even rational; however, it is not without controversy because whether a treatment is experimental or not is open to argument.

The level at which rationing occurs also has important implications. The mega-level has to do with allocation of funds to major social and governmental programs like health care, education, transportation, or defense. The macro-level describes the budget of a health care plan. Will the plan (indemnity insurance, an HMO, Medicare, or Medicaid), for example, pay for heart transplants, or for artificial hearts, or for dialysis for all patients over 90 years of age? If the plan decides that these are not covered services, then the plan will not pay for anyone to get these services no matter how beneficial the services may be. In contrast, micro-level rationing involves decisions about individuals. For example, should we give a heart transplant to this fifty year old diabetic man with severe peripheral vascular disease, or should we offer dialysis to this eighty-year-old woman with metastatic breast cancer?

III. TRADITIONAL PHYSICIAN-PATIENT RELATIONSHIP

Accepting that rationing is inevitable, that it ought to be overtly acknowledged, and that it ought to be logical, I will now explore the demands of the traditional physician-patient relationship with respect to rationing medical care and to practicing in a managed care environment.[23] The physician-patient relationship has been described in a variety of ways, but a common theme of many of these descriptions is the requirement that physicians subordinate their own interests to the interests of their patients. Pellegrino describes this as a requirement that physicians be self-effacing;[24]

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23. *See* M. Gregg Bloche, *Clinical Loyalties and the Social Purposes of Medicine*, 281 JAMA 268, 268 (1999) (arguing that the conflict between "loyalty to patients" and physicians' social responsibilities has not been managed adequately, "because they either deny or unsuccessfully finesse the reality of contradiction between fidelity to patients and society's other expectations of medicine" and concluding that the "reality needs to be more squarely acknowledged").

24. *See* EDWARD D. PELLEGRINO & DAVID C. THOMASMA, FOR THE PATIENT'S GOOD: THE RESTORATION OF BENEFICENCE IN HEALTH CARE 174 (1988) ("Indeed, it is this effacement of self-interest that distinguishes a true profession from a business or craft. And it is

others describe this as a fiduciary relationship.[25] A fiduciary relationship means that patients have a right to expect that physicians will not only look after the interests of patients, but also will work positively for the good of patients.[26]

Integral to the concept of a fiduciary relationship are the positive duties that physicians owe their patients. Among these are a duty to respect the autonomy of patients, a duty to advocate for their patients, and a duty to create an atmosphere that will foster trusting relationships.

A. Duty to Respect Autonomy

Physicians have a positive duty to respect the autonomy of their patients.[27] This duty derives from the duty to respect patients as persons of unconditional worth who have the capacity to determine their own goals. The duty reflects that patients are ends in

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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.").

25. *See* MARC A. RODWIN, MEDICINE, MONEY & MORALS: PHYSICIANS' CONFLICTS OF INTEREST 210, 211 (1993) [hereinafter RODWIN, MEDICINE] ("Physicians often act as traditional fiduciaries and espouse a fiduciary ethic. In a few situations, courts apply fiduciary law principles to doctors. But aside from these limited circumstances, physicians—as clinicians—are not held to fiduciary standards, especially with respect to financial conflicts of interest."). However, Rodwin believes that it is "important to develop financial practice standards that will preserve physicians' fidelity to patients." *Id.*

26. Marc Rodwin describes fiduciaries as follows:

> A fiduciary is a person who has power over the affairs of another party and who is required by law to act on that person's behalf. The law holds fiduciaries to the highest standards of conduct. Fiduciaries are expected to be loyal to those for whom they act and, in exercising discretion and independent judgment, to act for their exclusive benefit. The law explicitly defines some relations as fiduciary, including the trustee—beneficiary relation, the lawyer—client relation, the corporate officer—shareholder relation, relations among partners, and the public servant in relation to the public. The law has held that physicians, nurses, and medical care institutions are fiduciaries for patients, but only in limited contexts. Still, it is generally believed that medical personnel should act as fiduciaries for patients.

Marc A. Rodwin, *Conflicts in Managed Care*, 332 NEW ENG. J. MED. 604, 604 (1995); *see also* TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 430 (4th ed. 1994) (arguing that "[t]he patient-physician relationship is a fiduciary relationship—that is, founded on trust or confidence; and the physician is therefore necessarily a trustee for the patient's medical welfare.").

27. *See* BEAUCHAMP & CHILDRESS, *supra* note 26, at 126 (stating the negative proposition that "[a]utonomous actions should not be subjected to controlling constraints by others").

themselves and must not be used as means to someone else's end.[28] The duty to respect autonomy spawns several correlative duties: veracity, confidentiality, and informed consent. It even extends to the idea that patients should be treated as partners and that physicians and patients ought to share medical decision making. However, there is no duty to do everything that the patient wants. Physicians are moral agents, not syringes for hire, and as such, must make moral judgments about whether to agree to a patient's request.

B. Duty of Advocacy

Few would argue against the notion that traditional ethics requires physicians to advocate for their patients;[29] however, just what this duty of advocacy requires remains unclear. Advocacy may be viewed as a manifestation of the more general concept of fidelity to patients. The AMA Code 8.13 Managed Care[30] states: "The duty of patient advocacy is a fundamental element of the physician-patient relationship that should not be altered by the system of health care delivery in which physicians practice. Physicians must continue to place the interests of their patients first."[31]

In order to answer the question of what the duty of advocacy requires, I will first explore the traditional limits of advocacy and then the limits of advocacy within managed care.

1. Traditional Limits of Advocacy—Even though traditional ethics require physicians to advocate for their patients, the requirements of advocacy have always had limits.[32] These limits place the good of society above the good of the patient in certain circumstances. First, advocacy is limited by law. Regardless of patients' wishes, the law requires physicians to report certain communicable diseases,

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28. This is a rephrasing of Immanuel Kant as referenced in Beauchamp & Childress, *see id.* at 125.

29. The duty of advocacy can also be derived from the principle of beneficence, a commitment to the patient's good. "Beneficence means acting on behalf of, in the interest of, or as an advocate of the patient." Edmund D. Pellegrino, *Rationing Health Care: The Ethics of Medical Gatekeeping*, 2 J. CONTEMP. HEALTH L. & POL'Y 23, 25 (1986).

30. COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AMERICAN MEDICAL ASSOCIATION, CODE OF MEDICAL ETHICS: CURRENT OPINIONS WITH ANNOTATIONS 126 (1996–97 ed.) [hereinafter COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS].

31. *Id.*

32. *See* American College of Physicians, *Ethics Manual, Fourth Edition*, 128 ANNALS INTERNAL MED. 576, 588 (1998) [hereinafter *Ethics Manual, 4th ed.*].

many of which are sexually transmitted, to public health authorities. Physicians also have a duty to warn identifiable third parties.[33]

Second, physicians themselves have limited advocacy based on medical standards of care. For example, frequency of screening tests such as pap smears and mammograms are based on national recommendations which take into account the cost of finding a disease and saving a life. Pap smears are recommended only every three years for low risk patients and yearly for higher risk patients. But why not every year for everyone, or every six months? If the cytology lab misses the diagnosis, a repeat test in six months, instead of three years, may have profoundly different consequences. Also, consider the recommendation that yearly mammography be offered only to women over forty. Breast cancer occurs in women under forty years of age.

Medical standards of care also dictate how complete an exam a physician is likely to perform. For example, patients who see their ophthalmologist for frequent contact lens checks do not get a funduscopic exam at each visit, even though such an exam might uncover a serious retinal problem that might have a better prognosis if treated early. Medical standards of care also dictate the routine for vaccination practices that may put the individual patient at risk, more for the benefit of the population than for their own benefit.[34] For example, when a large portion of the population has been vaccinated, the prevalence of the disease decreases to such low levels that the risk of an unvaccinated patient contracting the disease may be lower than the risk of a side effect of the vaccination. Yet, until the disease is completely eradicated from the world (like small pox), physicians continue to recommend vaccinations so that the rate of immunity remains high in the population. They are not recommending the vaccination to protect the individual patient from the disease. Of course, if all physicians stopped vaccinating their patients whenever the rate of immunity was high and the risk of disease low, the number of immune patients would fall and the population, including their individual patients, would be put at risk.

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33. *See* Tarasoff v. Regents of the Univ. of Cal., 17 Cal. 3d 425, 463 (1976) (holding that once psychotherapist discovered that patient posed a risk of danger to others, psychotherapist had a duty to warn intended victims). This case is often cited in the bioethics literature as the source of the legal duty to warn identifiable third parties at risk.

34. *See* Bloche, *supra* note 23, at 268. In addition to immunization practices, Bloche provides another example: "choosing antibiotics with an eye toward slowing the evolution of resistant bacterial strains" rather than choosing the most effective antibiotic for the patient. *Id.*

Third, advocacy has often been limited by physicians' sense of good stewardship.[35] Even in a fee-for-service environment, physicians resist patients who insist on, for example, an MRI for an obvious tension headache.[36] Furthermore, physicians generally refuse to certify as disabled a patient they feel is malingering. In the transplant arena, physicians often refuse to give scarce organs to patients who are not likely to live very long even with the transplant.[37] Thus, even within the traditional physician-patient relationship, physicians in certain circumstances place the good of society before the good of the patient.

2. Advocacy in Managed Care[38]—Given these traditional limits on advocacy within the general fee-for-service environment, how far should physicians go within a managed care environment to advocate for their patients? Should physicians game the system? Should they help patients get care to which they are not entitled? Should they exaggerate symptoms so that their patients will meet a threshold necessary for reimbursement? For example, a forty-year-old man wants an exercise stress electrocardiogram because his older brother recently had a heart attack. His HMO will not pay for exercise stress tests unless the patient has angina or has recently had an infarct. The patient's only symptom is dyspepsia (acid indigestion) that has improved markedly after taking medication that

35. *See Ethics Manual, 4th ed., supra* note 32, at 586 ("Physicians should also contribute to the responsible stewardship of health care resources .... Parsimonious care that utilizes the most efficient means to diagnose a condition and treat a patient respects the need to use resources wisely and to help ensure that resources are equitably available.").

36. There is another reason for refusing to order tests on very low risk patients: a positive finding may be more likely due to a false positive test result than to the discovery of real disease. False positive findings may lead to more invasive testing or even to treatment, both of which may carry substantial risk.

37. *See generally* Benjamin et al., *supra* note 21 (examining the fair and efficient principles developed by the transplantation system to rationally allocate the limited supply of organs).

38. Advocacy has been described as follows: "[t]he physician has a moral and ethical duty to act as an advocate for the patient when needed care is denied." James T.C. Li, *The Physician as Advocate*, 73 MAYO CLINIC PROC. 1022, 1022 (1998).

But physicians who advocate for their patients within managed care may lose their jobs. *See* Brian McCormick, *What Price Patient Advocacy?*, AM. MED. NEWS, Mar. 28, 1994, at 1 (reporting allegations of such conduct). In addition, the Ethics Manual of the American College of Physicians states:

> The physician's first and primary duty is to the patient .... Whether financial incentives in the fee-for-service system prompt physicians to do more rather than less or managed care arrangements encourage the physician to do less rather than more, physicians must not allow such considerations to affect their clinical judgment or counseling on treatment options, including referrals, for the patient.

Ethics Manual, 4th ed., supra note 32, at 586.

inhibits acid production in the stomach. The physician, sympathetic regarding the patient's anxiety, orders the stress test, indicating: "chest pain, rule out angina."

This patient's request is reasonable. He is understandably anxious due to his brother's acute illness, and he worries that the same fate will befall him. Nevertheless, physicians ought to work within the system by requesting an exception to the rules and perhaps even appealing the decision if the exception is denied. Physicians who agree to work in MCOs should agree to follow the rules. If they believe that the organization acts unfairly, they can work to change it or they can leave, but they ought not deceive. Patients may be pleased if their physicians game the system, but in the process patients learn that their physicians are dishonest and perhaps should not be trusted.

Within the rules of the system, how far should physicians go to advocate for their patients? Should physicians fight for everything that may be of benefit and that the patient wants, regardless of how small the benefit or how large the cost? If every physician successfully did this for every patient, the cost of health care would become so enormous that other important social goods would have to be forgone. Consequently, provision of such services would place physicians in direct conflict with their social obligations.

Some of the social obligations of physicians were discussed above:[39] reporting duties imposed by law (usually regarding issues of public health), a duty to warn identifiable third parties, and less well defined notions of good stewardship. Without making a formal argument, I believe that physicians have a responsibility to be good stewards of our resources. Physicians regularly assume this responsibility during situations of scarcity or limited supply. For example, when physicians allocate solid organs for transplantation, they consider how long a patient is likely to survive with the transplanted organ. Also, when blood supply is low or when intensive care unit beds are in short supply, physicians consider the needs of other patients, not just their own patients. Finally, physicians advance several arguments for limiting treatment on the basis of futility. Ultimately, this position has a social basis. When the likelihood of achieving a particular outcome becomes too remote, physicians argue that expensive societal resources should not be spent trying to achieve this unlikely outcome. Physicians have an implicit obligation to society to provide medical care without bankrupting society.

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39. *See supra* Part III.B.1.

In practice, likely because of a sense of good stewardship, most physicians do not provide their patients with everything that may be of benefit and that the patient wants, regardless of how small the benefit or how large the cost. I will now attempt to better define a sub-group of these services that I will call marginally beneficial services. They are characterized by the following: The maximum likely benefit that these services can achieve and the probability of achieving this maximal benefit are not balanced by the burden (expense, pain, suffering or risk of further harm).

Thus, marginally beneficial services represent a problem of proportionality. Whenever we make a decision, medical or not, we balance the benefits and burdens of our choice. If we are considering buying a new car, we balance what benefits us (appearance, comfort, reliability, safety, or handling) against what burdens us (higher monthly payments, higher insurance premiums, or higher personal property taxes). Other burdens might include what we would have to give up (a vacation, dinners out) in order to pay for the new car. We may make bad decisions, but no rational person deliberately chooses greater burdens than benefits.

In health care, patients likewise make choices based on net benefit, but they sometimes choose marginally beneficial services, because the patients do not have to bear the expense (burden)[40] of these services, so they only see the benefit. The burden is out of sight and out of mind. Of course, the burden still exists. It is borne by the payers, the insurance company or the MCO. They in turn pass this expense (burden) on to their subscribers. Viewed from the narrow perspective of the patient, marginally beneficial services may be proportionate (they provide net benefit to the patient), but when viewed from the larger societal perspective, they are disproportionate, that is, they are expensive, and they provide only marginal benefit (considering all the burdens, including cost, they do not provide a net benefit). Choices may be socially disproportionate, even if they are not expensive, where the cost combined with other burdens far exceeds the limited benefit combined with the small likelihood of achieving that benefit.

For example, consider a patient with signs and symptoms of a tension headache who insists on an MRI. The benefits to the patient are anxiety reduction (likely) and discovery of a brain tumor or other serious brain pathology that can be more easily treated if discovered early (unlikely). The burdens are the cost (very expensive), and the risk of finding an artifact that will increase anxiety

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40. There may be other burdens beside cost, such as pain, risk of harm, or even risk of death.

and lead to further testing (more likely than finding a treatable brain tumor). The test itself is non-invasive and thus causes minimal patient discomfort.[41] If the patient had to pay for this test out of pocket, then his desire to relieve his anxiety would be balanced against the cost of the test. If most patients of modest means would find the cost too high relative to the benefit of anxiety relief, then provision of this care would be socially disproportionate, and by my definition would be a marginally beneficial service.

The following are some other examples of marginally beneficial services:[42]

- Weekly office visits for a patient with stable chronic renal failure.
- Referral of a thirty year old man with panic attacks to a cardiologist.
- Referral of an asymptomatic young woman to an Ob/Gyn specialist for routine pap and pelvic exam when her primary care physician could easily perform the exam.[43]
- A chest x-ray for a patient with bronchitis who is otherwise healthy.

I can now restate the question about how far physicians should go to advocate for their patients. Should physicians provide services that are marginally beneficial/socially disproportionate (services that do not provide net benefit when all the burdens—including cost that is not borne by the patient—are considered), or does their duty within the physician-patient relationship prohibit even this limited social view? To answer this question, I need to ask yet another question: Is it fair for patients to demand socially disproportionate care? The proportionality argument implies that patients would not choose socially disproportionate care if they had to endure the burden themselves. If this is so, and if the patient were of average means, then it would be unfair to insist that

41. Some patients who are claustrophobic find the procedure intolerable.

42. Physicians viewing this list can always envision some exception to the examples, but that should not detract from their overall usefulness to illustrate what I mean by marginally beneficial services.

43. I realize that this is a sensitive issue with many female patients. In fact, their demand to have routine gynecologic care performed by their Ob/Gyn physician has forced the inclusion of Ob/Gyn physicians into the category of primary care physician, a role for which they have no special training. Nevertheless, these referrals are properly labeled marginally beneficial services unless the patients are willing to spend out of pocket the increased cost incurred to the plan.

society pay for these services.[44] This conclusion is rooted in formal theories of justice that are beyond the scope of this paper. I argue here only that it is a reasonable conclusion based on the straightforward notion of justice as fairness.

Another way of trying to answer the question about whether it is fair for patients to demand marginally effective/socially disproportionate care would be to look at stewardship. Patients as well as physicians have a responsibility as members of a larger society to practice good stewardship, to make the best use of the available resources. This is analogous to our responsibility to protect our environment. It is an ecological argument.[45] No one should be permitted to disproportionately use (abuse) our environment or to disproportionately use our social resources. Therefore, from a stewardship perspective as well as a rational choice perspective, it is unfair for patients to insist on socially disproportionate care. If it is unfair for patients to insist on socially disproportionate care, then it is hard to imagine how the ethics of the physician-patient relationship would compel physicians to advocate for this care. Thus another limit on patient advocacy is the provision of marginally effective/socially disproportionate care. Put another way, rationing marginally effective care does not violate traditional ethics.[46] There is a positive duty, based on fairness and stewardship, for physicians to avoid providing marginally beneficial services.

C. Duty to Foster Trust

This Article has reviewed two positive duties that physicians owe their patients: the duty to respect the autonomy of patients and the duty to advocate for patients. The Article will now review the third

44. This analysis works only if the patient can afford the services and would purchase them if they provided more benefit. If the cost is so high or if the patient is so poor that the patient simply cannot afford the service no matter how great the benefit, then the proportionality and fairness analysis breaks down.

45. For a discussion of the ecological metaphor, see George J. Annas, *Reframing the Debate on Health Care Reform by Replacing Our Metaphors*, 332 NEW. ENG. J. MED. 744, 746–47 (1995); *see generally* Special Supplement, *Nature, Polis, Ethics*, 28 HASTINGS CENTER REP., Nov.–Dec. 1998, at S1.

46. While not addressing the specific issue of marginally effective care, the AMA Council on Ethical and Judicial Affairs did stipulate the following: "[r]egardless of any allocation guidelines or gatekeeper directives, physicians must advocate for any care they believe will materially benefit their patients." Council on Ethical and Judicial Affairs, American Medical Association, *Ethical Issues in Managed Care*, 273 JAMA 330, 334 (1995). Unfortunately, the Council did not define "materially benefit," so it is not clear to me whether this includes marginally effective care.

and final duty, the duty to create an atmosphere that will foster a trusting relationship.

Despite the desire for shared decision-making and the need to respect patient autonomy, the physician-patient relationship is unbalanced: physicians have knowledge while patients are ignorant; physicians have power and strength while patients are in need and are often ill.[47] Consequently, patients must trust their physicians. Patients trust that physicians have the knowledge and the necessary skills (competency), and they trust that physicians will apply that knowledge and those skills to benefit patients (patients' interests first). Furthermore, patients trust that what they tell their physicians will be kept confidential, and that physicians will be there when needed. Unfortunately, however, patients' trust of their physicians is being eroded by financial conflicts of interest,[48] and by patients' perception of the increasing powerlessness of physicians. This Part will first discuss the problem of conflicts of interest and then discuss the problem of physician powerlessness.

1. Conflicts of Interest: Trust—Trust is important in the physician-patient relationship.[49] It is therapeutic (perhaps through a placebo effect) and it relieves anxiety. Reassurance that the patient's symptoms are minor and do not portend serious disease is a common goal of many physician-patient encounters. For example, let us return to the earlier example of the forty-year-old man whose brother recently had a myocardial infarct and who is anxious about the possibility that he too has coronary artery disease. He comes to the office demanding an exercise stress test, but what he really wants is to be reassured that he is healthy. After a careful history, physical examination, routine laboratory tests, and a successful trial of medication that inhibits acid production, the physician concludes that the patient does not have symptoms of coronary

47. *See Ethics Manual, 4th ed.*, *supra* note 32, at 577 ("The patient-physician relationship entails special obligations for the physician to serve the patient's interest because of the specialized knowledge that physicians hold and the imbalance of power between physicians and patients. The physician's primary commitment must always be to the patient's welfare and best interests . . . .").

48. For an in-depth survey of the prevalence and effects of financial incentives on primary care physicians, see generally Kevin Grumbach et al., *Primary Care Physicians' Experience of Financial Incentives in Managed-Care Systems*, 339 NEW ENG. J. MED. 1516 (1998).

49. *See* Audiey C. Kao et al., *The Relationship Between Method of Physician Payment and Patient Trust*, 280 JAMA 1708, 1708 (1998) ("More fee-for-service (FFS) indemnity patients (94%) completely or mostly trust their physicians to 'put their health and well-being above keeping down the health plan's costs' than salary (77%), capitated (83%), or FFS managed care patients (85%) . . . ."). *But see* Alan L. Hillman, *Mediators of Patient Trust*, 280 JAMA 1703, 1704 (1998) (suggesting FFS patients' ability to choose may result in selection bias as they "likely shop until they find a physician they trust; that is, they self-select into a system and chose a 'trustworthy' physician . . . .").

artery disease, and despite the strong family history is at low risk for asymptomatic coronary artery disease. If the physician and patient have a trusting relationship, then the patient will likely accept the reassurance from his physician and drop his request for an exercise stress test. However, if the patient perceives that the physician is a gatekeeper who achieves a secondary financial gain through not recommending the expensive exercise stress test, the patient may not be convinced that the exercise stress test is unnecessary. This illustrates one of the problems of conflicts of interests: they erode trust.

2. *Conflicts of Interest: Judgment*—Conflicts of interest not only erode trust, they also impair physician judgment. Physicians and other professionals often believe that they are immune to the pernicious effects of conflicts of interest, and so speak of "potential" conflicts of interest.[50] This is a redundant phrase because conflicts of interest are themselves potentially pernicious behavior: breaches of obligation.[51] Thus, conflicts of interest ought to be avoided, whenever possible, because they have the potential to lead to a breach of obligation, and they ought to be avoided for another reason: they subtly influence judgment.[52]

To illustrate this, let us return once again to the anxious forty year old who wants an exercise stress test. The physician made a judgment about the patient's risk for asymptomatic coronary artery disease and about the value of getting the desired exercise stress test. In her evaluation of this patient, there was no single test and no single physical finding that conclusively excluded the presence of asymptomatic coronary artery disease. All the data taken together allowed the physician to make the judgment. The decision-making process was judgmental; it was not a process of assigning numbers to each piece of data and then adding them all up to see if they exceeded some threshold that would make the exercise stress test necessary. Very little decision-making in medicine works that objectively. Most decisions are judgment calls involving the physician's experience, the data, and often a gestalt as to what is the best course to follow. Most decisions are made in the gray area, few are black or white. Physicians, like all professionals, are human beings, well trained but still prone to outside influences. Very few physicians would deliberately withhold treatment in a clear black and white situation, but most physicians, despite their claims to the contrary, are influenced in subtle ways as they make countless

50. *See* RODWIN, MEDICINE, *supra* note 25, at 9.
51. *See id.*
52. *See id.*

medical decisions in the gray area. If this patient presented with symptoms more suggestive of angina and if his laboratory data showed a high cholesterol level and if he were a heavy smoker, then few physicians would say no to his request, despite conflicting financial interests. However, if the situation were less clear, if the patient had no chest pain, if his cholesterol were only slightly elevated, and if he smoked only a half pack of cigarettes per day, then the physician would have a difficult decision to make. If on top of all that, the physician's contract with the HMO was such that she would have to pay for the test out of her own pocket, then her judgment might be influenced to deny the patient's request even if during the entire decision making process the physician never consciously thought about the fact that she would lose income by ordering this test. Conflicts of interest insidiously influence decision-making. In fact, that is why MCOs create financial conflicts of interest (financial incentives). They want to influence physicians to spend less money on health care.[53]

3. Conflicts of Interest: Differences in Fee-for-Service—Proponents of financial incentives in managed care try to counter these objections by pointing out that conflicts of interest also exist in fee-for-service arrangements in which physicians get paid more for doing more. This is certainly true, but there are important differences. First, patients can always say no or they can get a second opinion if they are unsure whether to follow the advice given. However, if patients are not offered a certain treatment that they otherwise would not have known existed, they would have no recourse.[54]

Second, in a fee-for-service or indemnity insurance environment, conflicts of interest are not encouraged as they are in managed care.[55] In fact, they are discouraged. For example, there

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53. *See* Alan L. Hillman, *Financial Incentives for Physicians in HMOs: Is There a Conflict?*, 317 NEW ENG. J. MED. 1743, 1743 (1987) [hereinafter Hillman, *Financial Incentives*] ("Certain financial incentives, especially when used in combination, suggest conflicts of interest that may influence physicians' behavior and adversely affect the quality of care.").

54. Beauchamp and Childress emphasize this distinction:

> The patient is in a very different position when the physician has incentives to *restrict* needed treatment than when the physician has incentives to provide *unnecessary* treatment. In the latter situation, patients can obtain another opinion. In the former situation, patients may never be aware of a needed treatment because no one has recommended it.

BEAUCHAMP & CHILDRESS, *supra* note 26, at 439.

55. *See* RODWIN, MEDICINE, *supra* note 25, at 153 (arguing that "[b]y using financial incentives to change the clinical practice of physicians, society calls forth self-interested behavior. In asking physicians to consider their own interest in deciding how to act, we alter the attitude we want physicians ideally to have"). The American College of Physicians, *Ethics*

are peer review panels that reprimand physicians who are suspected of performing unnecessary surgery.[56] Also, the AMA Code 8.03 Conflicts of Interest Guidelines[57] state:

> Under no circumstances may physicians place their own financial interests above the welfare of their patients. The primary objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. For a physician unnecessarily to hospitalize a patient, prescribe a drug, or conduct diagnostic tests for the physician's financial benefit is unethical. If a conflict develops between the physician's financial interest and the physician's responsibilities to the patient, the conflict must be resolved to the patient's benefit.[58]

Unfortunately, organized medicine, specifically the AMA, has in the past not done enough to discourage entrepreneurship among its members.[59] It took legislation sponsored by Representative Pete

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Manual—Third Edition, 117 ANNALS INTERNAL MED. 947, 951–52 (1992), makes a series of comments with respect to conflicts of interest which may be summarized as follows:

> A. The welfare of the patient must at all times be paramount.
> B. Trust in the profession is undermined when there is even the appearance of impropriety.
> C. Physicians must be conscious of all potential influences.
> D. Physicians should avoid any business arrangement that might lead to personal gain which in turn might influence their decisions in the care of the patient.
> E. In general, physicians should not refer patients to an outside facility in which they have invested and at which they do not directly provide care or services.

See id.; *see also* PELLEGRINO & THOMASMA, *supra* note 24, at 174 ("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.").

56. Also, in a medical malpractice suit in which there is an adverse event, a physician would not want to be additionally accused of performing an unnecessary procedure.

57. COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AMERICAN MEDICAL ASSOCIATION, CODE OF MEDICAL ETHICS: CURRENT OPINIONS WITH ANNOTATIONS 105 (1996–97 ed.).

58. *Id.*

59. *See* Arnold S. Relman, *Dealing with Conflicts of Interest*, 313 NEW ENG. J. MED. 749, 751 (1985). Relman notes:

> The AMA's present position has an even more troublesome aspect. In admitting that business deals create conflicts of interest for physicians, but arguing that we need be concerned only about arrangements that demonstrably lead to bad practice, the AMA's statements ignore the damage done to the public trust in the medical profession by even the *appearance* of conflicts of interest.

Stark (D-California) to call attention to the fact that physicians who have ownership in a health care facility tend to over-utilize that facility, and that referral of patients to these facilities represents an unacceptable conflict of interest.[60]

A dramatic example of how physicians over-utilize expensive equipment that they own comes from a study by Hillman and colleagues.[61] They found that physicians who used imaging equipment in their offices obtained imaging examinations four to four and a half times more often than physicians who always referred patients to radiologists.[62] Also, for some of the studies, the physicians who used imaging equipment in their offices charged significantly more than the radiologists.[63]

Fee-splitting is another example of a conflict of interest that is deemed unethical.[64] Fee-splitting creates a conflict of interest be-

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Id.; *see also* Arnold S. Relman, *Editor's Reply*, 314 NEW ENG. J. MED. 252, 252 (1986). Relman further notes:

> I agree with Dr. Todd and the AMA leadership that an ethical canon against conflicts of interest would not of itself make ethical physicians more ethical, nor would it deter the unethical. It would, however, be a beacon to guide the many physicians who are confused and uncertain about this question, and it would have a powerfully salutary effect on the public's esteem for our profession.

Id. But see Ethics Manual, 4th ed., *supra* note 32, at 587 ("Physicians should not refer patients to an outside facility in which they have invested and at which they do not directly provide care.").

60. Stark proposed legislation to eliminate virtually all physician self-referral of Medicare patients, but his legislation was opposed by the AMA and many other medical societies. *See* RODWIN, MEDICINE, *supra* note 25, at 127. The compromise law was limited to prohibiting physicians from referring Medicare patients to clinical laboratories in which physicians had a financial interest. *See* Omnibus Reconciliation Act of 1989, Pub. L. No. 101-239, § 6204, 103 Stat. 2136 (adding section 1877 to Title 18 of the Social Security Act).

61. *See* Bruce J. Hillman et al., *Frequency and Costs of Diagnostic Imaging in Office Practice—A Comparison of Self-Referring and Radiologist-Referring Physicians*, 323 NEW ENG. J. MED. 1604, 1606–08 (1990) [hereinafter Hillman, *Frequency and Costs*]; *see also* John K. Iglehart, *Health Policy Report: The Debate over Physician Ownership of Health Care Facilities*, 321 NEW ENG. J. MED. 198, 201–02 (1989); Jean M. Mitchell & Jonathan H. Sunshine, *Consequences of Physicians' Ownership of Health Care Facilities—Joint Ventures in Radiation Therapy*, 327 NEW ENG. J. MED. 1497, 1497 (1992). Mitchell and Sunshine found:

> The frequency and costs of radiation-therapy treatments at free-standing centers were 40 to 60 percent higher in Florida than in the rest of the United States; there was no below-average use of radiation therapy at hospitals or higher cancer rates that explained the higher rates of use or higher costs in Florida.

Id.

62. *See* Hillman, *Frequency and Costs*, *supra* note 61, at 1606.

63. *See id.*

64. *See Ethics Manual, 4th ed.*, *supra* note 32, at 587. The American College of Physicians advocates this position:

cause physicians may refer patients to the physicians who give the biggest kickback, instead of to the physicians who are most capable. Some commentators claim that giving physicians money to spend less on their patient's health care is analogous to giving kickbacks to the referring physicians.[65]

Third, in fee-for-service, the incentive to do more is limited by the physician's available time. There is little incentive to do an unnecessary procedure if a busy physician would have difficulty finding the time to do it. On the other hand, in a managed care environment there is no limit to the gain physicians may receive by doing less, because the less they do the more money they get, and because doing less is not limited by the length of the day.[66] Couple this with the fact that physician's salaries have been squeezed and that many physicians are struggling to stay even by increasing their work load,[67] and one has a situation ripe for serious conflicts of interest. Of course, this argument does not hold up for physicians who are having trouble getting their practice going. As a former editor of the New England Journal of Medicine points out, traditionally, "[p]hysicians were not impervious to economic pressures, but the pressures were relatively weak and the tradition of professionalism was relatively strong."[68] Unfortunately, the traditional ethos is changing[69] and at the same time the economic pressures are increasing.[70]

Fourth, there is a difference in the degree of incentives. A common practice in MCOs is to withhold a percentage of the physician's gross income for a period of time (quarterly or yearly) and then distribute that income based on whether spending targets have been met. A twenty percent withhold is not uncommon

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> A fee paid to one physician by another for the referral of a patient, historically known as fee-splitting, is unethical. It is also unethical for a physician to receive a commission or a kickback from anyone, including a company that manufactures or sells medical instruments or medications that are used in the care of the physician's patients.

Id.

65. *See* Steffie Woolhandler & David Himmelstein, *Extreme Risk—The New Corporate Proposition for Physicians*, 333 NEW ENG. J. MED. 1706, 1706 (1995).

66. In managed care, the financial incentive is to spend less, not just to do less. Actually, in some circumstances, a gatekeeper may have to do more in order to avoid costly referrals or costly diagnostic procedures. This fact, however, does not negate the overall argument.

67. *See* Sox, *supra* note 20, at 11.

68. Arnold Relman, *What Market Values Are Doing to Medicine*, ATLANTIC MONTHLY, Mar. 1992, at 99, 101.

69. *See id.*

70. *See id.*

and this amounts to $60,000 to $70,000 for most gatekeepers.[71] It is hard to imagine any physician doing so much unnecessary care that he could generate an additional $60,000 of gross income, and yet this is not the biggest incentive in managed care. The biggest incentive, or more correctly, the biggest "stick" in managed care is job security. Because physicians typically sign one year contracts, physicians can be deselected, a euphemism for being fired by non-renewal of contract without cause.[72] Once a physician is deselected from one HMO, he will find it very difficult to be accepted by another HMO. This is especially problematic in areas in which there is high managed care penetration. The threat of deselection hangs over every physician in managed care, and it effectively serves to keep physicians in line. This form of control not only keeps physician spending down, but it also has a chilling effect on a physician's willingness to advocate for his patient by appealing adverse decisions. There is no analogy to this in the fee-for-service environment. Attempts to mandate due process when deselecting physicians have been met with stiff opposition by the managed care industry.

4. *Conflicts of Interest: Disclosure*—Some commentators have proposed that disclosure of these conflicts of interest will be sufficient to protect patients and preserve or restore their trust.[73] Unfortunately, disclosure is an insufficient remedy.[74] First, patients may not

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71. *See, e.g.*, Letter from Steffie Woolhandler and David Himmelstein, 340 NEW ENG. J. MED. 321, 322 (1999) (pointing out that, "[f]or the average internist in 1995, a 'withhold' of 20 percent of gross practice income would have amounted to $77,200—41.6 percent of net income (after practice expenses)").

In Hillman's survey of HMOs, he found that the most frequent withholding rate was 11% to 20%, and that 30% of HMOs place primary care physicians at financial risk beyond the withhold rate. *See* Hillman, *Financial Incentives, supra* note 53, at 1745; *see also* Grumbach et al., *supra* note 48, at 1520 (reporting on a survey of nearly 1,000 physicians that states "[o]f physicians whose managed-care program include bonuses and who reported both the amount of the bonus they earned and the additional amount that was at risk but not earned, 13 percent reported that the total amount of income at risk was more than $40,000"); Hall, *Rationing Health Care, supra* note 10, at 773–74; Woolhandler & Himmelstein, *supra* note 65, at 1706 ("One secret to this success is a payment formula that binds primary care physicians' interest to the firm's. The base capitation payment barely covers office overhead. An internist with 1500 of the plan's patients might take home more than $150,000 from bonuses and incentives, or nearly nothing.").

72. *See generally* Ken Terry, *When Health Plans Don't Want You Anymore*, MED. ECON., May 23, 1994, at 138.

73. *See* RODWIN, MEDICINE, *supra* note 25, at 213; Douglas F. Levinson, *Toward Full Disclosure of Referral Restrictions and Financial Incentives by Prepaid Health Plans*, 317 NEW ENG. J. MED. 1729 (1987); E. Haavi Morreim, *Conflicts of Interest: Profits and Problems in Physician Referrals*, 262 JAMA 390 (1989); The Royal College of Physicians, *The Relationship Between Physicians and the Pharmaceutical Industry*, 20 J. ROYAL C. PHYSICIANS LONDON 235 (1986); Brian McCormick, *Referral Ban Softened*, AM. MED. NEWS, July 6, 1992, at 1.

74. *See* RODWIN, MEDICINE, *supra* note 25, at 213.

understand or may be too dependent on the good will of their physicians to act on the information, or their judgments may be clouded because of the emotional and physical effects of their illness.[75] Second, patients may not have meaningful options. Many patients in MCOs have no alternatives because their employers offer only one plan.[76] Even if patients fully understand the financial incentives of their physician, their only choice is no insurance at all. Third, disclosure alerts the patient to the risk of physician disloyalty.[77] Imagine a sign in your physician's waiting room that reads:

> Warning: While I will strive to provide you with optimal care, you need to understand that a significant amount of my income is dependent on saving money for your health insurance company.

Fourth, disclosure does not alter the influence that a conflict of interest can have on decision making in the gray area.[78] Because of this, the Stark Amendments prohibit referrals of Medicare patients to health care facilities in which physicians have a financial interest.[79]

Although disclosure is an insufficient remedy, conflicts of interest must be disclosed.[80] The duty to respect patient autonomy and the correlative duty of informed consent demand disclosure. HMOs make these disclosures to patients in the written material distributed to patients at the time of enrollment, but they usually bury this information within a stack of information, and it is usually vague enough that patients fail to understand its importance. If the demand for disclosure comes from the need for obtaining informed consent, then the responsibility for disclosure, like the responsibility for obtaining informed consent, rests with the physician.[81] E. Haavi Morreim reaches the same conclusion using a slightly different argument:

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75. *See id.* at 214.
76. *See id.* at 215.
77. *See id.* at 216.
78. *See id.* at 215.
79. *See id.* at 127.
80. *See generally* Levinson, *supra* note 73. *See also* RODWIN, MEDICINE, *supra* note 25, at 214–15; *Ethics Manual, 4th ed.*, *supra* note 32, at 579; Tracy E. Miller & William M. Sage, *Disclosing Physician Financial Incentives*, 281 JAMA 1424, 1427 (1999) (pointing out that nearly 20 states have created legal mandates requiring MCOs to disclose physician compensation methods to enrollees).
81. The following outlines a more formal argument for requiring physicians to take responsibility for informing patients about the financial conflicts of interests:

A) Premises:

1. Conflicts of interest ought to be avoided whenever possible.
2. When unavoidable, conflicts of interest must be revealed.
3. Conflicts of interest are especially problematic when they are not expected.
   - Patients who visit surgeons in a fee for service setting understand that the surgeon recommending the procedure will be paid for her effort.
   - However, patients who are referred to a particular surgeon by their primary care physician would not expect their physician to be paid by the surgeon for each referral.
4. Patients generally believe that physicians act in the best interest of their patients.
5. The moral requirement for disclosing conflicts of interests comes from the concept of respect for persons and the principle of truth telling.
6. The moral requirement for obtaining informed consent comes from the concept of respect for persons and the principle of autonomy.
7. Informed consent contains two elements:
   - Information: Patients must be informed about the proposed treatment or procedure in such a way that they can understand the risks and benefits and the alternatives to treatment.
   - Consent: Patients must be capable of making the decision. They must have the capacity to make the decision that confronts them, and they must be able to make a free choice.
8. Physicians are responsible for making certain that patients have been properly informed, are capable of deciding, and have given consent. Physician responsibility in this regard is not mitigated by forms that patients may be required to sign.
9. Disclosure of conflicts of interest are part of the informed consent process.
10. In the managed care setting, primary care physicians may literally have to pay out of their own pocket for any referrals that they make to specialists or for special procedures. This is problematic for two reasons:
    - The patient is often unaware of this conflict, because it is contrary to the fee-for-service plan that most patients are accustomed to.
    - If the potential benefit of a referral does not come up in conversation between the patient and his physician, then the patient may not know enough to even question the absence of the referral. Contrast this with the fee-for-service surgeon who suggests an operation. The patient at least has the opportunity to refuse if he feels the risks exceed the benefits, if he believes the operation is unnecessary, or for any other reason such as a belief that the surgeon only wants to make more money.

> Second, physicians must inform patients about the influences by which they have agreed to be bound. An HMO may have the initial responsibility to detail for its subscribers the incentives it places on its physicians. But the physicians in that HMO have explicitly agreed to be bound by those incentives . . . and are obligated to ensure that patients understand these economic factors that can influence their medical care.[82]

Not surprisingly, physicians who work in managed care resist this requirement. They argue that it is the MCO's duty to inform the patient, and that physicians do not want the responsibility because it makes patients even more distrustful of them.[83] This is a remarkable observation of how trust is eroded by conflicts of interest. Nevertheless, if patients are fearful that their physician is an agent

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B) Conclusions:

1. Some financial arrangements that physicians make with managed care plans create a conflict of interest with their patients in certain situations.
2. These conflicts of interests ought to be disclosed to patients.
3. These conflicts of interests ought to be disclosed in the information phase of obtaining informed consent.
4. Since physicians have the responsibility of obtaining informed consent, physicians have the responsibility of assuring that patients are aware of this conflict of interest at the time of the decision-making process. However, this does not necessarily mean that all patients have to be informed of the conflict of interest each and every time that informed consent is obtained.
5. Physicians cannot assume that patients understand the conflict of interest just because it is written in the literature that is distributed to patients at the time they enroll in the plan.
   - Whether in fact most patients understand this conflict of interest at the time they enroll in the plan is empirically verifiable (a prospective study could be done by questioning newly enrolled patients). However, even if 95% of the patients are found to clearly understand the conflict of interest at the time they enroll, physicians have a moral responsibility to ensure that the other 5% are informed of the conflict of interest. Moreover, there is no guarantee that even patients who understand the conflict of interest at the time of enrollment will remember it at the time of decision-making.
6. Physicians must disclose options for therapy or diagnostic procedures even if they are not available in the plan or are not covered by the plan.

82. E. HAAVI MORREIM, BALANCING ACT: THE NEW MEDICAL ETHICS OF MEDICINE'S NEW ECONOMICS 112 (1995).

83. This is based on my observation of working in a committee with managed care physicians discussing the ethical issues in managed care. These physicians so strongly opposed this concept that the committee was not able to reach consensus on this issue.

of the MCO, consider the impact if they began to believe that physicians are secret agents of the MCOs.

Disclosure also has been problematic for physicians regarding plan coverage. Should physicians working in an MCO inform patients of therapeutic options that are not covered by the plan?[84] Consider the case of a basketball player who sustains an injury to his knee, likely a meniscus tear. He belongs to an HMO whose orthopedic surgeons have much less experience with arthroscopic surgery than other orthopedists in the area who are specialists in sports medicine.[85] Should his physician inform the patient about the possibility that he might have a better outcome if he seeks care outside the plan from a sports medicine specialist? The three duties of the physician in a traditional physician-patient relationship discussed in this Part would all demand that the physician inform the patient of his options.

5. *Physician Powerlessness*—Trust is eroded not only by conflicts of interest, but also by patients' perceptions of physician powerlessness. In our fiduciary model of the traditional physician-patient relationship, patients expect physicians to work for their good, and to put patients' interests above their own. When patients' interests are threatened by insurance companies, the government, or MCOs, patients expect their physicians to protect them from these agencies. Patients fear, however, that physicians are powerless to challenge a nameless administrator who will deny them care when they most need it.

Patients' perception that physicians are powerless to deal with MCOs is not groundless. Physicians themselves feel powerless in

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84. *See* COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, *supra* note 30, at 144. The Council discusses the obligations of consent and disclosure:

> 2-e: Managed care plans must adhere to the requirement of informed consent that patients be given full disclosure of material information. Full disclosure requires that managed care plans inform potential subscribers of limitations or restrictions on the benefits package when they are considering entering the plan.
>
> 2-f: Physicians also should continue to promote full disclosure to patients enrolled in managed care organizations. The physician's obligation to disclose treatment alternatives to patients is not altered by any limitations in the coverage provided by the patient's managed care plan. Full disclosure includes informing patients of all of their treatment options, even those that may not be covered under the terms of the managed care plan. Patients may then determine whether an appeal is appropriate, or whether they wish to seek care outside the plan for treatment alternatives that are not covered.

Id.

85. *See* BERNARD LO, RESOLVING ETHICAL DILEMMAS: A GUIDE FOR CLINICIANS 297 (1995).

the face of giant MCOs. Despite complaints by obstetricians and pediatricians that sending women home within twenty-four hours of delivery places some women and their newborns at risk, MCOs refused to change their policy.[86] As a result, conservative physician groups have taken the extraordinary step of joining together to ask the government to legislate the practice of medicine. These groups have a history of opposing any government interference in the practice of medicine, yet the American Medical Association, the American College of Obstetrics and Gynecology, and the American College of Pediatrics have proposed legislation to Congress to ban "drive through deliveries."[87] Furthermore, physicians throughout the country are considering joining labor unions so that they will have collective power to deal with MCOs.[88]

6. Duty to Foster Trust: Conclusions—The traditional physician-patient relationship creates a duty to foster the growth of trust, because trust is such an important part of the therapeutic process. Unfortunately, as described above, trust is eroded by physician conflicts of interest, including the physician's role as gatekeeper[89] and the perception that physicians are agents of the MCOs. Also, trust is eroded by the patient's perception that physicians are powerless. Clearly, an important task for physicians working in the managed care environment is to restore patients' trust in their physicians.

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86. *See* Christina Kent, *Bill Would Put Brakes on Drive-Through Deliveries*, AM. MED. NEWS, Oct. 2, 1995, at 1.

87. *See id.* at 1, 36, 38.

88. *See generally* Jerome P. Kassirer, *Doctor Discontent*, 339 NEW ENG. J. MED. 1543 (1998); Julie Appleby, *Doctors Look for Union Label: Physicians Angry About Insurance Rules, Oversight, Cost Cutting*, USA TODAY, July 6, 1999, at B1; Michael Casey *The AMA Jumps on the Union Bandwagon*, MED. INDUSTRY TODAY, July 1, 1999.

89. *See* LA PUMA & SCHIEDERMAYER, *supra* note 3, at 87. La Puma and Schiedermayer define gatekeeping:

> Used by MCOs to coordinate care and contain costs, gatekeeping created early problems that both physicians and patients continue to face:
>
> (a) Underprescription of services
>
> (b) Uncertain criteria for acceptance and rejection of requested services requiring approval
>
> (c) Untimely referral of patients
>
> (d) Constrained choice of care
>
> (e) Overutilization of incentives to limit care
>
> (f) Minimal available information about the cost-effectiveness of routine medical practices.

Id.

IV. CHANGING ETHOS IN MEDICINE

As discussed in Section III, the traditional physician-patient relationship creates at least three separate duties for physicians: respect for autonomy, advocacy, and fostering trust. Respect for autonomy is limited by the moral agency of physicians. Advocacy is limited by law, by medical standards of care, by physician's sense of good stewardship, and by fairness, which sets an outer limit of advocacy at providing marginally beneficial services. Trust is eroded by conflicts of interest and perceptions of physician powerlessness. In addition, the risk that conflicts of interest will result in breaches of obligation is increased by the changing ethos in medicine.

In the past, the traditional physician-patient relationship was supported by a strong fiduciary ethos. As Brody points out, despite individual instances of abuse and the conflict of interest created by the fee-for-service system, "the majority of physicians, most of the time, made decisions that appeared to them to be in the patient's best interest . . . because of some deeply held professional values which forced them to put the [patient's interests first.]"[90] Unfortunately, this ethos is changing. Thus, the risks of conflicts of interest will be greater in the future. At the same time that the changing ethos is promoting financial conflicts of interest, the changing ethos is increasing the risk that these conflicts of interest will result in breach of obligation.

To illustrate this change in ethos, look at the change in language:

- Professionalism: entrepreneurialism
- Health care system: health care industry
- Medical practice: competitive business
- Patients: consumers
- Physicians: providers
- Patient's interests first: societal interests first
- Deontological view of the profession: utilitarian view of the profession.[91]

The best protection that patients have against the conflicts of interest inherent in medical practice is physicians' reaffirmation of

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90. Howard Brody, *Cost Containment as Professional Challenge*, 8 THEORETICAL MED. 5, 8 (1987).

91. *See* Relman, *supra* note 68, at 101.

their professionalism. Physicians must encourage organized medicine to take the lead and prohibit entrepreneurialism. Physicians must reaffirm that they care for patients, not consumers, that they practice medicine, not business, and that they work within a health care system in which they put patients' interests above their own and properly balance patient's interests and societal interests. Achieving the proper balance between patients' interests and societal interests will be discussed next.[92]

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92. *See* Edmund D. Pellegrino, *Interests, Obligations, and Justice: Some Notes Toward an Ethic of Managed Care*, 6 J. CLINICAL ETHICS 312, 315–16 (1995). Pellegrino observes:

> [T]hese dilemmas are not to be resolved at the bedside by the clinician. They are in the domain of distributive justice and corporate ethics. The physician must remain the patient's advocate, not the agent of the managed-care corporation.
>
> Clearly, commutative justice, which should govern the individual physician's obligations to his or her patient, and distributive justice, which should govern the physician's obligations to the collectivity, are in conflict.... In addition, whatever ethic is elaborated must somehow make room for a proper ordering of commutative and distributive justice to each other. The physician's emphasis as a physician is on commutative justice, but this cannot exist apart from a more comprehensive ethic of managed care that would include an ethic of the collective, corporate, and societal obligations to the care of the sick as well.
>
> On this view, a 'corporate ethic' of managed care should, at a minimum, include the following ethical components:
>
> First, it should be made clear to all—physicians, patients, and managers—that the physician's primary responsibility is to the patient with whom she or he has a covenant of trust....
>
> Second, as a corollary of (1), the physician has a moral obligation to use only those tests, procedures, and treatments that are effective, beneficial, and not excessively burdensome....
>
> Third, physicians should not enter contracts that include financial incentives or 'gag' clauses, which prevent full disclosure to patients of why they are denied treatments the physician believes optimal....
>
> Fourth, physicians should act collectively to resist, and refuse to participate in, plans that demonstrably produce harm to patients....
>
> Fifth, managed care must have quality of care as its primary aim....
>
> Sixth, investor ownership and profit taking from managed care cannot avoid irreconcilable ethical conflicts. Non-profit, cooperative organizations should be the rule.

Id.

V. BALANCING PATIENTS' INTERESTS WITH SOCIETAL INTERESTS

One of the questions posed in the Introduction to this Article was: How ought physicians be involved in rationing medical care? I explored the need for rationing and concluded that the rationing of health care is inevitable.[93] I also explored the limits of advocacy, and concluded that physicians need not provide marginally beneficial care.[94] This conclusion was based on two arguments: fairness (it is not fair for patients to demand disproportionate services), and stewardship (patients and physicians have a responsibility to be good stewards of our scarce resources). Next, I explored how conflicts of interest erode patient trust, and concluded that entrepreneurship ought to be prohibited and that financial incentives to limit care in managed care are problematic and are not the flip side of the incentive to do more in a fee-for-service environment. Finally, I noted how the changing ethos in medicine may increase the risk that conflicts of interest will result in breaches of obligation.

The implication from the above review is that conflicts of interest in this changing environment place patients at risk. Does the need for rationing justify this risk? The AMA Code 8.13 Managed Care states that "[e]fforts to contain health care costs should not place patient welfare at risk. Thus, financial incentives are permissible only if they promote the cost-effective delivery of health care and not the withholding of medically necessary care."[95]

No one would argue with the desire to provide cost-effective care. In fact, stewardship would demand that, all things being equal, physicians should provide the least costly alternatives. However, there is a difference between being a good steward of a scarce resource and being a profit manager for an MCO.

Current MCO financial incentives are designed to make profits for MCOs while at the same time keeping costs competitive so that employers will subscribe to the plan. Yet, MCOs justify their incentive schemes by asserting that the amount of money spent on health care must be decreased so that society can enjoy other social goods and so that there will be health care dollars available for other medical needs (preventive care, the uninsured). This argument is based on the need for good stewardship; however, the structure of the financial incentives employed by the MCOs as-

93. *See supra* Part II.

94. *See supra* text accompanying notes 40–46.

95. COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, *supra* note 30, at 144.

sumes that physicians will not act as responsible stewards, but will act only to increase their personal incomes.[96] This leads us back to an intolerable conflict of interest. Would it not be better if physicians were judged and rewarded based on the quality of the care they provided instead of on how much money they saved? This is not to say that controlling health care costs is not important and should not be considered by physicians. Physicians ought to consider the cost of care. All things being equal, they ought to use the least expensive options. Furthermore, as discussed above in Part III.B, physicians need not provide marginally beneficial services, and in fact, the provision of quality medical care should not include such services.[97]

A. Bedside Rationing

If one criterion for the provision of quality care is the avoidance of marginally beneficial services, then good physicians practicing responsibly would avoid providing marginally beneficial services. Because good physicians do not need financial incentives to provide quality care, one may ask what the financial incentives of MCOs are encouraging physicians to do. Are MCOs encouraging physicians to do less than what is clearly beneficial? Less than what is necessary? These rationing activities are termed bedside rationing, and despite the fact that nearly all MCOs employ gatekeepers, all MCOs deny utilizing bedside rationing. The refrain is: "We do not encourage physicians to ration medical care, rather we encourage physicians to avoid unnecessary care which is costly and possibly dangerous."[98] Bedside rationing is opposed by the codes of ethics of many—perhaps all—major medical organizations.[99] In

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96. In fact, under the current incentive plans, physicians are encouraged to act to increase their own personal incomes.

97. *See supra* text accompanying notes 40–46.

98. This refrain is my interpretation of a composite view of how MCOs want to be perceived. None want to be perceived as rationing health care, and so no plan description that I am aware of uses the term "rationing". MCOs want to be seen in a positive light. *See, e.g.*, KONGSTVEDT, *supra* note 2, at 61 ("Under a well-crafted capitation program, you are not paying physicians to underutilize services; you are sharing the savings of cost-effective care").

99. *See* COUNCIL ON ETHICS AND JUDICIAL AFFAIRS, *supra* note 30, at 7 (arguing that "[t]he treating physician must remain a patient advocate and therefore should not make allocation decisions"). The American College of Physicians promotes two rationing principles:

addition, it is nearly universally condemned by medical ethicists,[100] although recently there have been a few notable exceptions.[101] Generally, the oversimplified justification of the proponents of bedside rationing is as follows: given the need for rationing, rationing at the bedside is the least bad alternative. It is better than rationing at the macro-level and better than rationing with practice plans because it is more sensitive to the needs of individual cases.

Even if this argument were true, it does not comport with traditional ethics. That is why proponents of bedside rationing argue for a change in the traditional physician-patient relationship. Regardless of whether traditional ethics would have to be changed, patients would have to be warned of the possibility of bedside rationing. Like the problem with disclosure of conflicts of interest, disclosure of bedside rationing would also be problematic. Imagine the following sign hanging in your physicians' office:

> Warning: While I will strive to always put your needs first, my responsibility to all the other patients in your HMO may on occasion force me to limit care that may be of benefit to you.

It is easy to imagine how warnings of bedside rationing, no matter how subtle, would erode trust in the physician-patient relationship. Even if physicians engaged in bedside rationing for

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The just allocation of resources and changing reimbursement methods present the physician with ethical problems that cannot be ignored. Two principles are agreed upon:

> 1. As a physician performs his or her primary role as a patient's trusted advocate, he or she has a responsibility to use all health-related resources in a technically appropriate and efficient manner. He or she should plan workups carefully and avoid unnecessary testing, medications, surgery, and consultations.
> 2. Resource allocation decisions are most appropriately made at the policy level rather than entirely in the context of an individual patient-physician encounter. Physicians should participate in decisions at the policy level; should emphasize the value of health to society; and should base allocations on medical need, cost-effectiveness of treatments, and proper distribution of benefits and burdens in society.

Ethics Manual, 4th ed., *supra* note 32, at 588.

100. *See* Daniel P. Sulmasy, *Physicians, Cost Control, and Ethics*, 116 ANNALS INTERNAL MED. 920, 921–23 (1992).

101. *See generally* Orentlicher, *supra* note 10; Ubel & Arnold, *supra* note 8. *See also* HALL, MEDICAL SPENDING DECISIONS, *supra* note 7, at 127–34; Hall, *Rationing Health Care*, *supra* note 10, at 700–19; Miles & Koepp, *supra* note 8, at 308. For a discussion of the criteria necessary for an action to qualify as bedside rationing, see Peter A. Ubel & Susan Goold, *Recognizing Bedside Rationing: Clear Cases and Tough Calls*, 126 ANNALS INTERNAL MED. 74, 75 (1997).

social goals and even if they did not receive incentives for doing less (certainly a more ethically laudable situation), patients would still not know if physicians were acting in their best interest or were simply rationing care when they were reassured by their physicians that nothing more needed to be done.

Bedside rationing creates other problems in the physician-patient relationship in addition to loss of trust. As mentioned above, many codes of ethics prohibit bedside rationing.[102] Furthermore, many commentators have argued that physicians have no special ability to ration, and may not ration fairly.[103] Physicians may impose their own values when making rationing judgments because as a group they are no more insightful about their prejudices than any other professional group. Physicians do, however, ration bed space in intensive care units, and no evidence of systematic abuse has been documented.[104] Unfortunately, these are not analogous situations. When physicians engage in rationing ICU beds, they are directly comparing one patient's needs against another patient's needs. Any prejudices that they harbor in their subconscious would soon become evident to other physicians and to the nursing staff. These people would likely question the physicians' decisions. Physicians would become conscious of their prejudice and thus, as any group of people who are of good will, would avoid acting on them. In contrast, bedside rationing is more analogous to the subtle changes of behavior that may occur with conflicts of interest, and as pointed out in the discussion on conflicts of interest, physicians are no more immune than any other professional group to subtle influences on their behavior.

In deciding whether bedside rationing is a good idea, one must balance its benefits with its burdens. This is a classic risks versus benefits analysis. The burdens include the following: the erosion of trust, the risk to minorities of unfair treatment, and the need to alter fundamentally the nature of the physician-patient relationship. These burdens would have to be balanced against the gain in efficiency of using bedside rationing instead of some form of macro-level rationing. I believe that the burdens greatly outweigh the benefits, because trust is too important to the therapeutic relationship to allow this degree of erosion, and the risk of unintended unfairness in rationing would be too socially disruptive. The need for advocacy and the need to put patients first, especially during this time of changing ethos and financial incentives, is too great to

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102. *See* COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, *supra* note 30, at 144.
103. *See* Hall, *Rationing Health Care*, *supra* note 10, at 714–15.
104. *See id.* at 715.

allow the dissolution of the traditional physician-patient relationship. Physicians must not abandon their patients at the time when they are needed most.

Proponents[105] have countered that despite the pressures imposed by MCOs on physician behavior, the quality of health care under managed care has not suffered.[106] While it is true that quality indicators are an important check on whether cost-cutting incentives also cut quality, unfortunately, we currently have very poor measures of quality.[107] The current indicators are insensitive, and do not adequately take into account case mix.[108] Also, when so-called

105. *See, e.g.*, *id.* at 716; KONGSTVEDT, *supra* note 2, at 61.

106. *See generally* Fred J. Hellinger, *The Effect of Managed Care on Quality: A Review of Recent Evidence*, 158 ARCHIVES INTERNAL MED. 833 (1998) (surveying recent evidence about the relationship between managed care and quality).

107. *See* Francis B. Palummbo & C. Daniel Mullins, *Quality-of-Care Data from Managed-Care Organizations*, 336 NEW ENG. J. MED. 443, 443–44 (1997) (urging the Health Care Financing Administration to improve the collection of outcomes data on Medicare recipients enrolled in HMOs); *see also* Marcia Angell & Jerome Kassirer, *Quality and the Medical Marketplace—Following Elephants*, 335 NEW ENG. J. MED. 883, 883 (1996). They connect the sudden concern about quality of medical care to the fact that "[t]he quality of health care is now seriously threatened by our rapid shift to managed care as the way to contain costs." *Id.* at 883. They go on to discuss some of the problems with measuring quality. Two such problems are that it is much easier to measure quality in a population than in an individual and that preventive measures are often reported despite the fact that it is the care of the sick that most interests patients. *See id.* at 884 ("Finally, even if criteria are developed to measure and monitor the outcomes of treatment of complex illnesses, we have little confidence that they will ever be sensitive enough to individual variation to give us a solid basis for paying health plans according to case mix.").

For a detailed discussion of the quality of care, see generally the six-part series on Quality of Health Care: David Blumenthal, *Part 1: Quality of Care—What Is It?*, 335 NEW ENG. J. MED. 891 (1996) (examining alternative definitions of quality of care); Robert H. Brook et al., *Part 2: Measuring Quality of Care*, 335 NEW ENG. J. MED. 966 (1996) (discussing approaches to measuring quality of care); Mark Chassin, *Part 3: Improving the Quality of Care*, 335 NEW ENG. J. MED. 1060, 1060–62 (1996); David Blumenthal, *Part 4: The Origins of the Quality-of-Care Debate*, 335 NEW ENG. J. MED. 1146, 1146–48 (1996); Donald M. Berwick, *Part 5: Payment by Capitation and the Quality of Care*, 335 NEW ENG. J. MED. 1227, 1227–30 (1996); David Blumenthal & Arnold M. Epstein, *Part 6: The Role of Physicians in the Future of Quality Management*, 335 NEW ENG. J. MED. 1328, 1328–31 (1996).

In a response to the Letters to the Editor regarding this series, the Editors, Angell and Kassirer, conclude their comments by stating:

> Despite the optimism of Mr. Bailit and Boulter et al., quality measures are in their infancy. The question is whether they are good enough, even though not perfect, to counter the financial incentives to stint on care. We think they are not and that relying on them now would be falsely reassuring.

Marcia Angell & Jerome Kassirer, *Correspondence: Quality and the Medical Marketplace*, 336 NEW ENG. J. MED. 808, 809 (1997) [hereinafter Angell & Kassirer, *Correspondence*]. For more on the limitations in measuring the quality of care, see Jerome P. Kassirer, *The Quality of Care and the Quality of Measuring It*, 329 NEW ENG. J. MED. 1263, 1263–64 (1993).

108. *See* Angell & Kassirer, *Correspondence*, *supra* note 107, at 809.

"report cards"[109] are used to measure pre-defined specific criteria, MCOs simply focus their efforts on those specific criteria.[110] As a result, high scores do not necessarily reflect the quality of overall care. Also, measurements of patient satisfaction or utilization rate, parameters that are commonly measured, are not indicators of quality.[111] In fact, patient satisfaction regarding their health care experience may be much more dependent on the responsiveness of nurses and the quality of food than on the quality of the care they received.[112] Thus, arguments based on preservation of quality, at this stage of our ability to measure quality, are not convincing.

B. Macro-Level Rationing

It is clear that the burdens of bedside rationing are significant, but what about the benefits of increased efficiency? To put the question in reverse: if bedside rationing is the least bad alternative, just how bad are the other alternatives? Consider the following example of rationing at the macro-level: Assume that the artificial heart has been perfected and that it can be powered by an internal miniature nuclear power plant. There would be no external lines, no machine to be tethered to, and with the new valve design, no embolic strokes. It would be a marvel of technology, and hundreds of thousands of patients would benefit from this device. Some patients, however, would benefit much more than others, because some patients could be restored to a full quality of life, while other patients would still live a very restricted life. Furthermore, some patients could live an additional ten years or more, while other patients would die anyway in a short time. The major problem with this device is its high cost of over one million dollars. If it were implanted in everyone who would benefit, the cost would be over several hundred billion dollars plus recurring annual costs of several billion dollars as new patients developed a need. Clearly, society could not afford to implant this device in everyone who could benefit.

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109. An example of such a report card is the Health Plan Employer Data and Information Set (HEDIS). "HEDIS is the brainchild of the NCQA [National Committee on Quality Assurance] and rates five categories of MCO performance [quality, access, satisfaction, utilization, and finances]." LA PUMA & SCHIEDERMAYER, *supra* note 3, at 52.

110. *See* Lawrence O. Gostin, *Health Information Privacy*, 80 CORNELL L. REV. 451, 474 (1995).

111. *See* Blumenthal & Epstein, *supra* note 107, at 1328.

112. *Cf.* Susan M. Wolf, *Quality Assessment of Ethics in Health Care: The Accountability Revolution*, 20 AM. J.L. & MED. 105, 124 (1994).

The device must be rationed, and the rationing could be done in one of three ways. First, use of the device could be denied to everyone except participants of a small ongoing experimental study. Second, the device could be distributed based on a very strict set of criteria, such that those who would gain the most dramatic benefit receive the device. This approach has at least three problems:[113] 1) creating the criteria would be difficult and in the end would be somewhat arbitrary; 2) value judgments would be needed to decide which outcome would be better;[114] and 3) some individual patients might benefit greatly, but not meet the criteria. The third method of rationing the device would allow physicians to choose individual patients that they thought would benefit the most (bedside rationing). This would prevent the problem of excluding patients who would benefit greatly, but who were denied access because they did not meet the rigid criteria. While being more efficient (more sensitive to nuances of patient differences) in this respect, the approach suffers from the same problems as the rigid criteria. However, in this case the physicians would be setting the criteria and making the value judgments themselves. Additionally, there would be all the burdens engendered by the erosion of trust, the risk of unfair treatment, and the loss of the traditional physician-patient relationship.

This example may seem too esoteric; nevertheless, the biggest problem with the cost of health care is the steep slope of rising costs. The biggest reason for this steep slope is the emergence of new half-way technologies. As discussed above, these new technologies cost more for each margin of new benefit.[115] Dealing with new technologies is important in controlling health care costs. Clearly, macro-level rationing (while broad based, heavy handed, and insensitive to a few patients for whom the rationing criteria seems to treat unfairly) is capable of restricting the flow of new technology and thus of controlling costs.

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113. *See* Sara Rosenbaum et al., *Who Should Determine When Health Care Is Medically Necessary?*, 340 NEW ENG. J. MED. 229, 230–31 (1999). The authors include the following three items in their discussion of the problems and limitations of the use of generalized evidence of medical necessity. First, applying general rules arbitrarily to all cases is problematic. "Accounting for individual variation is part and parcel of clinical practice and is largely what medical practice is all about." *Id.* at 230. Second, "the choice of an outcome is inherently value-laden." *Id.* Third, "[m]uch of medical practice is the result of tradition and collective experience. Many basic medical interventions have not been studied rigorously." *Id.* at 231.

114. For example, which is the better standard, a longer life or a better-quality life? Elderly people would not live as long as younger people and so would be denied access if the former standard were used. On the other hand, disabled people might be the losers if the latter standard were applied.

115. *See supra* text accompanying notes 17–20.

A current example is the escalating cost of medication.[116] New drugs cost more, and demand is greater.[117] The demand is greater because of pharmaceutical advertising to physicians and direct market advertising to patients.[118] To control this demand, most HMOs have drug formularies that limit the number of drugs that the health plan will cover. Drugs prescribed that are not on the formulary usually cost the plan members considerably more money. Thus, drug formularies are an example of macro-level rationing. Rationing of drugs in this way avoids the conflict of interest created by bedside rationing and by incentives to spend less. Physicians may still advocate for their patient and in most plans can appeal the decision regarding coverage. Physicians may also have input into the selection of drugs for the formulary.

Another example of macro-level rationing is the use of practice plans. Practice plans are guidelines for the physician to follow in the treatment of a particular disease or for the workup of a specific sign or symptom. For example, there is a set of guidelines for dosing heparin (an anticoagulant or blood thinner that is administered intravenously).[119] The initial dose is based on weight and subsequent doses are based on the results of a clotting test (partial thromboplastin time).[120] Use of this guideline has been demonstrated to achieve anticoagulation more quickly and with fewer episodes of over-anticoagulation.[121] Thus, its use improves patient care and may shorten hospital stays and save money. Such guidelines, if based on good scientific evidence, and if used by physicians as a guide to thinking instead of as a substitute for thinking, can improve the quality of care while decreasing costs. Unfortunately, for many areas of medicine such guidelines would be too complicated to be useful or the scientific data would be too sparse to allow creation of scientifically sound guidelines. Also, scientifically sound, complicated guidelines can be very expensive, and can

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116. *See* William T. Elliott, *Pharmacology Update: The Latest Information on New Drugs and New Indications*, 3 PHYSICIAN'S THERAPEUTICS & DRUG ALERT 33, 34 (1998). Elliot notes:

> Drug costs continue to escalate at a rate of 12–15% each year representing the fastest growing segment of the healthcare economy. . . . Newer drug technologies may be more efficacious, safer, or easier to take than the older medications they are replacing, but the cost is often 10–100 times the cost of the older medication.

Id.

117. *See id.*

118. *See id.*

119. *See* Robert A. Raschke et al., *The Weight-Based Heparin Dosing Nomogram Compared with a "Standard Care" Nomogram*, 119 ANNALS INTERNAL MED. 874, 874–81 (1993).

120. *See id.* at 875.

121. *See id.* at 876.

become outdated before they are implemented. Finally, many HMOs promote guidelines solely to control costs, a back door to rationing.[122] Consequently, guidelines must be used with caution. Their scientific basis must be verified, and physicians must not use them as mere cookbooks, giving no thought to the suggestions.

Based on the examples given above, the promoters of bedside rationing are correct in saying that the alternatives to bedside rationing are problematic, but it does not necessarily follow that bedside rationing is the best alternative. In fact, given the extensive discussion above about the physician-patient relationship, the problems created by conflicts of interest, and the incompatibility of bedside rationing with the traditional physician relationship, I believe macro-level rationing is the better choice.

CONCLUSION

While rationing health care is clearly necessary, it does not follow that MCOs ration properly.[123] First, MCOs have refused to acknowledge their attempts to ration health care. Second, giving money to physicians to encourage them to spend less money on their patients creates an impermissible conflict of interest. Third, MCOs' practice of preventing full disclosure to patients regarding the financial incentives provided to physicians violates the duty of informed consent. Nevertheless, physicians also have to take responsibility for their role in rationing health care.

The traditional physician-patient relationship is a fiduciary relationship. Within this relationship, physicians owe their patients a duty to respect autonomy, a duty of advocacy, and a duty to create an atmosphere that will foster the growth of a trusting relationship. The duty of advocacy has limits imposed by law, by standards of

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122. *See* David Orentlicher, *Practice Guidelines: A Limited Role in Resolving Rational Decisions*, 46 J. AM. GERIATRICS SOC'Y 369, 369 (1998). Orentlicher starts with the assumption that practice guidelines are promoted "to allocate healthcare resources under managed care"; he then goes on to argue that despite what many people believe, "guidelines are not objective, medically based measures but are heavily value laden." *Id.* These values are camouflaged by "a veneer of scientific objectivity." *Id.*

123. In addition, under managed care the number of uninsured has continued to increase, and there are signs that health care costs are starting to escalate again. *See generally* Eli Ginzberg, *The Uncertain Future of Managed Care*, 340 NEW ENG. J. MED. 144, 144–46 (1999). Also, because MCOs have driven down revenues, many hospitals can no longer afford charity care. *See* Jennifer Preston, *Hospitals Look on Charity Care as Unaffordable Option of Past: Squeezed by Managed Care and Reduced Aid*, N.Y. TIMES, Apr. 14, 1996, at A1. For a cynical view of how MCOs make profits, see Jerome P. Kassirer, *The New Health Care Game*, 335 NEW ENG. J. MED. 433, 433 (1996).

medical practice, and by physicians' sense of good stewardship. Also, as I have argued, the duty of advocacy does not include the provision of marginally beneficial services. The duty to foster trust is seriously compromised by conflicts of interest, and because of the importance of trust in the therapeutic relationship, all conflicts of interest ought to be avoided whenever possible.[124] Patients' trust is also compromised by their perception that physicians are powerless to protect them from nameless administrators who might deny them needed care sometime in the future. Finally, trust is also compromised by bedside rationing.

While bedside rationing may be more efficient and sensitive to the nuances of individual patients, it is not the only way to ration health care. Macro-level plans are an effective means of rationing new technology and thus controlling the steep rate of growth of health care expenditures. Because of the importance of trust in the therapeutic relationship and the risk that bedside rationing imposes on that trust, macro-level rationing is preferred.

Physicians have a duty to their patients and to society. The future of medicine and health care depends on how these competing duties are balanced. I believe the duties physicians owe to society must be carried out in the context of the traditional physician-patient relationship. Rationing should be done at the macro-level. Bedside rationing and financial incentives to limit care should be abandoned. Physicians have a duty to practice efficiently and to use the least expensive effective options. In addition, they ought to avoid providing marginally effective, socially disproportionate care. They also have a duty to lend their expertise to help create the best possible macro-level rationing plans. On the other hand, physicians must advocate for their patients and foster the growth of trust with their patients.

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124. Conflicts of interest are inherent in medical practice and cannot be completely eliminated; however, they should not be encouraged. Also, some conflicts of interest are too strong to be permitted. For example, withholding more than 25% of a physician's salary to encourage decreased spending, placing a physician's contract at risk for advocating too strongly for denied care for her patient, or forcing individual physicians to pay out of their pocket for specialty referrals will likely compromise the ordinary physician's judgment.