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Physician Liability and Managed Care: A Philosophical Perspective

Dionne L. Koller
University of Baltimore School of Law, dkoller@ubalt.edu

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PHYSICIAN LIABILITY AND MANAGED CARE: A PHILOSOPHICAL PERSPECTIVE

Dionne Koller Fine*

INTRODUCTION

Rapid and far-reaching changes in health-care delivery have reshaped the way the physician practices medicine. Often, the physician's legal and ethical obligations to provide care are in direct conflict with society's push to limit its cost.[1] On the one hand, the physician must adhere to the law and the medical profession's code of ethics, which generally dictate that the individual patient's needs should come first.[2] On the other hand, unlike the passive third-party payer of the past, managed care organizations (MCOs) seek to control health care costs by controlling physicians' utilization and provision of health care services.[3] The reality of a physician's participation

* Dionne Koller Fine is Assistant Director for Academic Achievement and Lecturer, University of Maryland School of Law. B.A., *cum laude*, University of Massachusetts at Amherst; J.D., *with honors*, George Washington University Law School; M.A., George Washington University.

1. *See generally* Robert I. Field, *New Ethical Relationships Under Health Care's New Structure: The Need for a New Paradigm*, 43 VILL. L. REV. 467 (1998).

2. *See* Edward B. Hirshfeld, *Should Ethical and Legal Standards for Physicians Be Changed to Accommodate New Models for Rationing Health Care?*, 140 U. PA. L.REV. 1809, 1839-40 (1992).

3. *See* BARRY R. FURROW, ET AL., HEALTH LAW, PRACTITIONER TREATISE SERIES, vol. 1, chs. 1-11, 289-90 (West Group 2d ed. 2000).

with a managed care plan is that she simply must ration care.

The liability standards applied to physicians have largely remained unchanged despite the drastic change in the role of the third-party payer in the physician-patient relationship. Courts continue to rely on traditional formulations of physicians' duties in malpractice cases, and Congress and the states have focused on passing targeted legislation aimed at ensuring that MCOs' overriding interest in controlling costs does not subvert patient care.[4] The physician is caught in the middle, and this catch-22 presents a significant policy problem.

The specific policy problem grows out of this tension between the physician's legal and ethical obligations and the requirements imposed on the physician by managed health care. The problem manifests itself in two distinct ways. First, and most directly, the issue confronts the physician in the context of malpractice liability. Unlike the fee-for-service system, in which physicians enjoyed almost complete autonomy over patient care, MCOs now impose on physicians a significant amount of direct and indirect control over the way they practice medicine. This control often forces physicians to ration care. Although in many cases rationing at the bedside may result in eliminating arguably unnecessary health care, frequently it involves limiting care that may be beneficial and within the current standard of care. Such rationing subjects the physician to malpractice liability risks. Current medical malpractice law enhances this risk because the standard of care not only rejects the notion of rationing or cost-control as a defense, it also speaks frequently of the physician having a duty to *resist* being tainted by the pressures of managed health care and cost containment.

The second manifestation of the policy problem grows out of the first and involves physicians' vulnerability in their relationship with a managed care plan. Physicians' contracts with third-party payers have a central role in the way they practice medicine. Such contracts commonly provide that physicians who do not control costs in

4. Catherine M. Hedgeman, *The Rationing of Medicine:* Herdrich v. Pegram, 10 ALB. L.J. SCI. & TECH. 305, 306-08 (2000).

accordance with an MCO's cost-containment policies face deselection or termination from the plan. Such an outcome could seriously injure or even destroy physician practices.

This article examines these issues and potential solutions using a philosophical framework. Such an approach will demonstrate that significant ethical issues arise when physicians dispense managed health care within the current liability framework. The problems discussed here do not simply affect individual patients, but physicians and society at large. Such issues must not be ignored when policymakers craft health care reform initiatives.

Part I of this article describes the traditional fee-for-service model of health-care delivery and the current managed care system. Part II explains the legal framework in which physicians practice medicine. Part III of this article asserts that the law's failure to account for the change to managed care and the resulting change in the way physicians practice medicine has created a situation that is fundamentally unfair to physicians. The law holds the physician to a fee-for-service level of care, which generally rejects considerations of costs, while physicians' obligations to MCOs often require that they ration care. MCOs, with their market power and ability to set the terms of contracts with participating physicians, are able to terminate physicians who do not sufficiently contain costs, often with little notice. This section argues that the continued adherence to outdated principles of liability is deficient from a utilitarian perspective. The current legal framework does not further society's overall goal of lowering health care costs.

Finally, Part IV of this article discusses the possible solutions to this policy problem such as federal and state legislation that would impose greater liability on MCOs and leave physicians' legal obligations in place. This section evaluates proposed solutions and identifies the ethical strengths and weaknesses of each. The article concludes that the superior solution is one that relies on the profession itself to mitigate the unfairness and address the utilitarian concerns posed by the policy problem. This solution draws on existing legal rules, which give great deference to the medical

profession to set its own standards in malpractice cases. The solution envisions a proactive role for the profession and suggests that such an approach is in fact morally required.

II. THE FEE-FOR-SERVICE AND MANAGED CARE MODELS

To understand the ethical implications of the physician's current role in delivering health care services, it is important to understand the fee-for-service and managed care models. Generally speaking, the fee-for-service model is based on principles of physician fidelity and patient autonomy. At its best, the model reflects the notion that every individual, at least every *insured* individual, is entitled to all medical care that could be beneficial, regardless of how much the care might cost.[5] Therefore, the physician's interest and patient's interest are aligned to provide as much health care as could possibly be of benefit.

The managed care model does not focus on what is best for individual patients, but instead on what is best for society. As society cannot support dramatically escalating health care costs, the managed care system draws its moral strength from its ability to control these costs and therefore ensure that health care remains affordable for the largest number of individuals. At its best, the model reflects the notion that much of the health care currently being delivered is wasteful and unnecessary. By weeding out the waste, the hope is that managed care will not only control costs, but also improve care.

A. The Fee-for-Service Model

The fee-for-service model is one where physicians are paid on a retrospective basis, and in full, for all "medically necessary" services provided to the patient.[6] Traditionally, the physician alone determined what services were medically necessary. Therefore, "physician income is directly proportional to the billing generated by

5. *See* MARK HALL, MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS, AND ECONOMICS OF RATIONING MECHANISMS (Oxford Univ. Press 1997).

6. *See* Field, *supra* note 1, at 468-69.

services rendered to patients."[7] Third-party payers had no role in the physician-patient relationship.[8] As a result, no financial or other incentives in the model encourage physicians to limit care.[9] Significantly, critics noted that, because of the lack of any oversight over physicians, they had no incentive to consider the costs of the services they provided, and indeed, the system actually encouraged physicians to provide unnecessary or marginally beneficial care.[10] The fee-for-service model did not incorporate the view that doctors needed to or should control health-care costs.

1. Ethical Strengths and Weaknesses of the Fee-for-Service Model

The fee-for-service model is based on the ethical duty of absolute fidelity to the patient, which requires physicians to work in the interests of their patients first and foremost, even over their own personal interest.[11] Therefore, the physician's interests generally align with those of her patient. The fee-for-service system reinforced this ethic by "exclud[ing] outside influences from the doctor-patient relationship, enabling physicians to devote [their] full attention to patients."[12] Accordingly, the fee-for-service system isolated the treatment relationship from the workings of the market. Only physicians were subject to financial incentives, and the incentive was not to withhold care. It was traditionally held that physicians could counter this inducement with ethics.[13] The model draws moral strength from the egalitarian principle that individuals are entitled to the best care, regardless of its cost. At its best, the fee-for-service model honors the dignity of individuals and value of all human life because cost is generally not a consideration in determining the care that should be delivered.

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7. Daniel P. Sulmasy, *Physicians, Cost Control, and Ethics*, *in* THREE REALMS OF MANAGED CARE 155, 166 (John W. Glaser & Ronald P. Hamel eds.) 1997).

8. *See id.*

9. *See id.*

10. *See id.* at 469-70.

11. *See* TROYEN BRENNAN, JUST DOCTORING: MEDICAL ETHICS IN THE LIBERAL STATE 35 (Univ. of Cal. Press 1991).

12. *See* BRENNAN, *supra* note 11, at 32.

13. *See id.* at 33.

However, the fee-for-service system is not without ethical weakness. The underlying assumption of the fee-for-service system is that "physicians are morally superior people."[14] In fact, the power the physician has over the patient, the nature of greater knowledge, and the ability to dictate the terms and course of treatment, provide the possibility the physician will "exploit patients' vulnerability."[15] Therefore, the fee-for-service model can encourage over-treatment, which aside from its costs, holds significant physical risks.

> [I]t is a well-documented fact that the sanctity of the ideal patient-physician relationship in fee-for-service arrangements has been overestimated. Under that model, financial conflicts of interest among medical professionals also existed. However, doctors could more easily hide financially motivated behavior since their interests were often aligned with those of their patients.[16]

Perhaps the chief weakness of the fee-for-service system is that it overlooks society's need to control health care costs and instead focuses on providing individual patients with all treatment that could possibly be beneficial.[17] Because resources that can be devoted to health care are finite, however, the fee-for-service system is self-destructing.[18] Some scholars argue the ethically superior approach, therefore, is an approach that takes account of what is best for society, and therefore the greatest number of individuals.[19]

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14. KENMAN WONG, MEDICINE AND THE MARKETPLACE 65 (Univ. of Notre Dame Press 1998). Wong asserts that "the belief that, as a profession, physicians can be completely trusted as the exclusive guardians of the health of patients is one that should be held loosely." *Id.*

15. E. HAAVI MORREIM, BALANCING ACT: THE NEW MEDICAL ETHICS OF MEDICINE'S NEW ECONOMICS 44 (Georgetown Univ. Press 1995).

16. WONG, *supra* note 14, at 67.

17. HALL, *supra* note 5, at 131.

18. *Id.* at 131-32.

19. *See id.* at 130-33.

C. The Managed Care Model

Managed care attempts to control health care costs by controlling physician behavior and limiting patients' utilization of services through a variety of techniques.[20] Therefore the term managed care "can be used to include virtually any financing arrangement where there is third-party management or supervision that attempts in some structured way to oversee quality and, particularly, the costs of services delivered to the plan's beneficiaries."[21] Courts have noted that MCOs often wear two hats, providing administrative support for an insurance plan, including making determinations of eligibility or coverage, and acting "as an arranger and provider of medical treatment."[22] Therefore, MCOs integrate financing and delivery of health care. Managed care encompasses many different types of health care delivery structures, including Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Independent Practice Associations (IPAs). The principles underlying the different managed care structures, however, are the same.

MCOs use many techniques to force physicians and patients to consider the costs of care.[23] For instance, MCOs often require pre-authorization for certain services, restrict access to specialists, deny payment for services provided outside of their provider "network," and restrict coverage for prescription drugs. Many MCOs pay physicians on a capitated basis, whereby physicians agree to receive a fixed monthly fee per enrolled patient from the MCO, regardless of what services patients ultimately need and receive.[24] MCOs also frequently offer participating physicians bonus incentives tied to certain utilization levels.[25]

One of an MCO's primary cost containment tools is utilization

20. *See* John P. Little, *Managed Care Contracts of Adhesion: Terminating the Doctor-Patient Relationship and Endangering Patient Health*, 49 RUTGERS L. REV. 1397, 1402, 1478 (1997).

21. KENNETH R. WING, ET AL., THE LAW AND AMERICAN HEALTH CARE 84 (Aspen Law & Business 1998).

22. Corporate Health Ins. v. Texas Dep't of Ins., 215 F.3d 526, 534 (5th Cir. 2000).

23. FURROW, ET AL., *supra* note 3, at 290, 404.

24. *See id.* at 399-400.

25. *See id.* at 400.

review, which "is designed to evaluate the medical necessity and appropriateness of health services from the payer's perspective, in light of norms of acceptable practice."[26] Utilization review is "based on two assumptions: that there are wide variations in the use of many medical services; and that careful review of medical care can eliminate wasteful, unnecessary care or harmful care."[27] It mainly consists of prior review, before services are delivered, and concurrent review and case management.[28] Prior review includes "pre-admission review" before hospitalization for elective procedures, "admission review" for emergency admissions, review during hospital admission to determine the length of stay, and "pre-procedure review" to determine the appropriateness of certain recommended procedures.[29] In addition to these techniques for standard plan participants, MCOs have case managers who closely monitor treatment for high-cost plan members suffering from costly or chronic conditions.[30]

D. Ethical Strengths and Weaknesses of the Managed Care Model

The managed care model purportedly recognizes that society's health care resources are scarce.[31] It is not self-destructing, as the fee-for-service model is said to be, but will in fact sustain the level of quality health care with which we are accustomed while promoting the societal goal of reducing costs.[32] The concern for costs, in this view, gives managed care an ethical edge over fee-for-service medicine in that it does not consider individuals at the expense of society.[33] Society benefits because more individuals will be able to obtain care.

The primary ethical objection to managed care is that the cost-

26. *Id.* at 414.
27. *Id.*
28. *See* FURROW, ET AL., *supra* note 3, at 415.
29. *Id.* at 45.
30. *Id.*
31. *See* Norman Daniels, *Why Saying No to Patients in the United States Is So Hard*, *in* CHOICES AND CONFLICT: EXPLORATIONS IN HEALTH CARE ETHICS 57 (Emily Friedman ed., 1992).
32. *See* HALL, *supra* note 5, at 132.
33. *See id.*

containment strategies that MCOs commonly employ alter the traditional physician-patient relationship.[34] Critics assert that physicians can no longer exclusively act as the patient's advocate and consider the patient's needs without regard to considerations of cost.[35] Because of the structure of many MCO-physician contracts, physicians' incomes are put in conflict with the well-being of their patients.[36] Critics also assert that MCOs induce physicians to deny necessary treatment, unlike the fee-for-service model.[37] Accordingly, MCOs force physicians to ration care at the bedside, a role critics point out is unethical.[38] An additional ethical problem stems from the fact that MCOs are for-profit enterprises. "These institutions have conflicting roles in their attempt to function both as traditional businesses, which have financial obligations to shareholders, and as medical entities, which have duties to uphold the best interests of patients."[39] The emphasis on the bottom line provides a strong incentive for such companies to enroll only healthy participants, who are likely to have lower health care costs, and avoid enrolling chronically ill or disabled individuals.[40] Commentators refer to this incentive as "cream skimming," and it raises significant issues regarding health care coverage options for the most vulnerable members of society.[41] Additionally, MCOs lack organizational ethics that would draw from work that has been done in corporate ethics.[42] As MCOs continue to grow, there must be some investigation and development of organizational ethics in light of the tension between the MCO's for-profit status and the patient-centered ethic of medicine.[43]

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34. *See* Field, *supra* note 1, at 478.
35. *See id.* at 478-79; Andrea K. Marsh, *Sacrificing Patients for Profits: Physician Incentives to Limit Care and ERISA Fiduciary Duty*, 77 WASH. U. L.Q. 1323, 1323-24 (1999).
36. *See* Sulmasy, *supra* note 7, at 160-61.
37. *See* Marsh, *supra* note 35, at 1324.
38. *See* HALL, *supra* note 5, at 114.
39. WONG, *supra* note 14, at 1.
40. *Id.* at 66.
41. *Id.* at 66-67.
42. *Id.* at 4.
43. *Id.* at 5.

E. The Two Models and Health Care Rationing

The two models of health care delivery outlined above ultimately diverge on the issue of health care rationing. The fee-for-service model explicitly rejects rationing as unethical.[44] In contrast, the managed care model embraces certain rationing techniques and, in many cases, requires physicians to ration care.[45] A policy problem emerges as the law, to a great extent, sanctions rationing by MCOs, but forbids it by physicians. "Despite consensus among most experts that health care costs must be contained, great controversy surrounds whether it is ever acceptable to ration health care."[46]

F. Rationing and Patients

A popular misconception about health care is that more care is better than less.[47] Some scholars note that the demand for health care is "virtually unlimited."[48] A related belief, sometimes referred to by scholars as our "medical egalitarianism," is that society is unwilling to accept that some people are not entitled to at least a minimum level of health care due to their inability to pay.[49]

> [W]e are libertarians to the extent that we leave individuals free for the most part to engage in highly risky behavior, but our humanitarian and egalitarian values come to the forefront when we observe people who are actively suffering from whatever causes, including their own improvidence . . . . This strong rescue ethic . . . means that our society will care for people in serious and obvious distress regardless of whether they can

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44. *See* Field, *supra* note 1, at 469.

45. *See id.* at 473.

46. PETER UBEL, PRICING LIFE: WHY IT'S TIME FOR HEALTH CARE RATIONING 11 (MIT Press 2000).

47. WILLIAM J. CURRAN ET AL., HEALTH CARE LAW AND ETHICS 9 (5th ed. 1998).

48. *Id.* at 111.

49. PAUL T. MENZEL, STRONG MEDICINE: THE ETHICAL RATIONING OF HEALTH CARE 116-17 (Oxford Univ. Press 1990).

pay.[50]

These beliefs no doubt underlie the backlash against managed care. Although individuals want to control health care costs, they do not want to sacrifice the type or amount of care they can access. The law has not accepted such sacrifices either.

G. Rationing and Physicians

Patients' reluctance to cut back when it comes to their own care is likely a learned response to years of fee-for-service medicine and the fee-for-service ethic of the medical profession. The medical profession has long held that the physician's individual patient must always come first, and considerations of cost should never be part of the treatment relationship.[51] Physicians have an "ethic of absolute quality;" in the physician's view, "literally any marginal medical benefit, no matter how small, is worth absolutely any price because we want doctors in their role as healers to behave as if each of our lives is priceless."[52] Therefore, most physicians and other experts are opposed to care rationing because it violates commonly understood physician duties to their patients and therefore erodes the trust that is the foundation of the physician-patient relationship.[53] Moreover, physicians often assert that they are simply not trained to ration care, which creates the possibility that they will not ration fairly.[54]

Physicians find rationing difficult because "providers cannot appeal to the justice of their denial;"[55] in other words, there is no clear connection between the resources saved when health care is limited for one patient and resources spent on others.[56] Physicians have no guarantee that their bedside rationing will result in better health care, only that, in general, they are helping to reduce the

50. HALL, *supra* note 5, at 32.
51. *See* BRENNAN, *supra* note 11, at 48.
52. HALL, *supra* note 5, at 115.
53. *See* UBEL, *supra* note 46, at 109.
54. *See* UBEL, *supra* note 46, at 109.
55. Daniels, *supra* note 31, at 59.
56. *Id.*

pressure of growing health care costs.[57] Therefore, physicians have no greater ethic to follow than their own professional ethic, which mandates that the patient always comes first.[58] Ethical beliefs and professional norms often lead physicians to avoid rationing imposed by MCOs at all costs. Indeed, citing their ethic of fidelity to their patients, a large number of physicians have indicated that they have or would submit inaccurate billing statements to insurers in an attempt to secure for their patients what they believe to be necessary medical care.[59]

Despite this seemingly categorical opposition to care rationing, bedside rationing in fact is part of many physician-patient relationships, although physicians likely will not admit it.[60] "[I]n the current health care environment, most clinicians have been taught that [rationing] is immoral. Thus, they rely on euphemisms . . . without having to acknowledge that they are rationing."[61]

H. Rationing, the Law, and Managed Care

From a legal perspective, not all health care rationing is impermissible. For the most part, the law does not prevent the type of implicit rationing by the free market that regularly occurs in our society. Although federal law does require emergency departments to initially screen and stabilize all patients who present themselves for treatment,[62] nothing in the law requires physicians to accept patients who cannot pay.[63] The law also permits the explicit rationing involved in coverage determinations, such as scrutinizing requested services to make sure they fall within the scope of covered

57. *Id.*

58. *Id.* at 89.

59. Victor G. Freeman, *Lying for Patients: Physician Deception of Third-Party Payers*, 159 ARCH. INTERN. MED. 2263, 2263 (1999).

60. UBEL, *supra* note 46, at 137.

61. *Id.* Ubel states that bedside rationing is "ubiquitous." *Id.* He gives the example of an orthopedic surgeon repairing an elderly individual's hip. *Id.* Ubel notes that the surgeon will choose a less expensive and lower-quality hardware for the procedure based on the patient's life expectancy. *Id.* at 111.

62. Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (2001).

63. *See* Hirshfeld, *supra* note 2, at 1840.

circumstances.[64] The law draws the line on rationing, however, when "it affects the recommendations for care made by the physician."[65] Therefore, under current malpractice law, physicians cannot make treatment recommendations that deny patients beneficial care. There is "unanimity between ethical and legal communities in their opposition to bedside rationing."[66] As mentioned above, rationing is central to managed health care, and has been accepted on some level as necessary to control health care costs. Much of the recent law involving managed care reflects the conflict over whether rationing is necessary or acceptable.[67] In cases involving MCOs, courts uphold the utilization review and incentive structures that are key to controlling physician behavior, which effectively require physicians to ration care.[68] Cases against physicians, however, do not openly embrace these principles.

This article assumes that some form of health care rationing is necessary and even inevitable.[69] It also assumes that managed care adopts a system of implicit rationing, whereby physicians cut back on the treatment they provide at the bedside. As discussed below, the law should sanction implicit rationing as part of a policy solution to mitigate the unfairness to physicians currently caught in the middle of managed care's drive for cost-containment, as well as to better promote society's goals of reducing overall health care costs.

II. THE LEGAL FRAMEWORK IN WHICH THE PHYSICIAN PRACTICES MEDICINE

To evaluate whether the current liability framework affecting physicians is fair (and justified from a utilitarian perspective), it is important to keep in mind key areas of the law that have an impact on the physician. This discussion of the legal framework is intended as a brief review and only presents the issues to the extent they are

64. *See* Pegram v. Herdrich, 530 U.S. 211, 219 (2000).
65. *See* Hirshfeld, *supra* note 2, at 1841.
66. HALL, *supra* note 5, at 117.
67. *See, e.g., Pegram*, 530 U.S. at 221.
68. *See, e.g., id.* at 219.
69. *See generally* HALL, *supra* note 5.

relevant to evaluating the policy problem and potential solutions.

A. Medical Ethics

Although principles of medical ethics do not have the force of law, the physician's ethical framework is important because the law reflects these ethics and they are indeed the backbone of many of the physician's legal obligations.[70] The concept of medical ethics began with the Hippocratic Oath. Medical ethics then grew out of "[t]he variety of codes, essays by physicians, theologians, and philosophers," whose writings had a common thread—physicians' responsibility to their patients.[71] Therefore, "a physician is said to act morally when he or she places the patient's welfare above all other considerations."[72] Medical ethics continuously evolved until 1912, around which time "the emphasis on patient trust, doctor control, and economic noninterference was institutionalized."[73] These ethical principles are demonstrated by the method with which health insurance traditionally was structured, as well as in physicians' legal obligations to their patients.[74] "[T]he [c]ommitment to the patient is . . . nourished by a wealth of themes and images deeply embedded in medical culture."[75] Indeed, these images are also embedded in the legal culture that developed around modern medicine.

B. Fiduciary Duties

Legally, physicians have a fiduciary relationship with their patients.[76] The patient, who is in a vulnerable state, places his trust and confidence in the physician who, due to her training and experience, has vastly superior knowledge of the patient's condition

70. *See generally* BRENNAN, *supra* note 11.

71. *Id.* at 33.

72. *Id.*

73. *Id.* at 32.

74. *See generally id.* at 44-45.

75. *See* MENZEL, *supra* note 49, at 4.

76. In this relationship, "trust and confidence are reposed by one party in the influence or dominance of another, creating in the latter a duty to act with greater diligence and care than that required by a common negligence standard of due care." *See* MORREIM, *supra* note 15, at 44; Neade v. Portes, 739 N.E.2d 496, 500 (Ill. 2000).

and options for care.[77] This relationship requires fidelity, and as such, physicians "must be dedicated to serving their patients' interests, even above their own."[78] Therefore, in imposing fiduciary duties on physicians, the legal system incorporates the medical profession's own standard of placing the patient first.

From the fiduciary nature of the relationship, the law derives several duties that it imposes on physicians, including the duty to maintain confidentiality, avoid conflicts of interest, and secure informed consent from the patient.[79] The law that has developed in the area of informed consent is a good example of the way in which the law defers to or incorporates the standards of the medical profession. In cases brought by patients alleging that the physician administered treatment without informed consent, the standard applied by the majority of states is whether the physician disclosed information that the reasonable, prudent *physician* would disclose to a patient under similar circumstances.[80] This view rejects the other standard, applied by a handful of jurisdictions, requiring the physician to disclose what, in the physician's view, the reasonable *patient* would need to know to make an informed decision as to whether to proceed with treatment.[81] The majority view is that physicians should not have to be "mind readers" to determine what a patient would need to know before deciding to undergo treatment.[82] Therefore, courts in informed consent cases defer to what the medical profession thinks patients need to know as opposed to what a patient believes she would need or want to know.[83] The implications of the law's deference to the standards of the medical profession will be discussed below with respect to the optimal policy solution.

77. *See* MORREIM, *supra* note 15, at 44.
78. *Id.* at 44.
79. *See* FURROW, ET AL., *supra* note 3 at 150, 315.
80. *See* Culbertson v. Mernitz, 602 N.E.2d 98, 100 (Ind. 1992).
81. *Id.* at 100-01.
82. *Id.* at 103.
83. *Id.* at 100.

C. Malpractice

Malpractice law is another area where the law has incorporated the standards of the medical profession. In the usual negligence case, the jury decides whether the defendant's conduct was appropriate with reference to how a "reasonable person" would have acted in similar circumstances. Courts, however, decide medical negligence very differently. The prevailing belief is that the jury lacks sufficient knowledge and training to determine whether a physician's actions in treating a patient were reasonable.[84] Juries, therefore, evaluate a physician's actions in a particular case not by what the jury believes is right or "reasonable," as in ordinary cases, but by the custom or standard of care that prevails in the medical profession. Unlike other negligence claims, "[t]he standards for evaluating the delivery of professional medical services are not normally established by either [the] judge or jury. The medical profession itself sets the standards of practice and the courts enforce these standards . . . ."[85]

Drawing on general principles of negligence, medical malpractice is defined as "a failure to exercise the 'required degree of care, skill and diligence' under the circumstances," which failure causes injury to the patient.[86] Courts determine the standard of care by which to measure a physician's negligence with reference to the level of skill and knowledge that a reasonable physician should possess, considering the facilities and equipment available in that physician's locality.[87] The particular standard of care that is ultimately applied in a malpractice suit is derived from leaders in the medical profession and the interaction of physicians through peer-reviewed journals and professional meetings.[88] These standards often account for different practice styles and expectations that frequently exist in different regions of the country.[89] Recently, physicians' groups have developed practice guidelines for various specialties, which parties to

84. *See* FURROW, ET AL., *supra* note 3, at 270.
85. *Id.*
86. *Id.* at 269.
87. *See id.* at 269, 470.
88. *Id.* at 271.
89. FURROW, ET AL., *supra* note 3, at 271.

a suit can use as evidence in determining whether a physician exercised due care.[90] The usefulness of such guidelines in fashioning a solution to the policy problem will be outlined below. Most courts "give professional medical standards conclusive weight, so that the trier of fact is not allowed to reject the practice as improper."[91] Notably, physicians cannot assert as a defense to a malpractice action that they were under pressure from a managed care organization to delay or limit care.

With the rise of managed care has come a new twist on malpractice liability. Recent malpractice cases are premised not simply on medical mistake, but on the fact that in rendering treatment, the pressure to ration care corrupted or tainted the physician's judgment.[92] Although punitive damages are relatively rare in malpractice cases, "[t]he potential for punitive damages may be vastly heightened as juries increasingly begin to learn of the financial incentives that HMOs and other forms of constrained insurance create for doctors to minimize treatment costs."[93] As will be discussed below, this liability has important fairness and utilitarian implications that define the policy problem and support the need for a policy response.

D. Contract Law

Contract law previously had little to do with the relationship between physicians and insurers or third-party payers.[94] Traditionally, health insurance contracts "incorporate[d] by reference the norms and standards of the medical profession."[95] Payer and provider obligations in such contracts were defined exclusively by physicians and insurance contracts typically agreed to provide

90. *Id.* at 271-72.

91. Barry R. Furrow, *Pain Management and Provider Liability: No More Excuses*, 29 J. L. MED. & ETHICS 28, 31 (2001).

92. *See* CLARK C. HAVIGHURST, HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM 112 (AEI Press 1995).

93. WILLIAM J. CURRAN ET AL., HEALTH CARE LAW AND ETHICS 331 (5th ed. 1998).

94. *See* HAVIGHURST, *supra* note 92, at 110.

95. *See id.* at 112.

payment for health care services that were "medically necessary."[96] Only the physician, subject to certain ethical and legal constraints, would define what was and was not medically necessary.[97] Given that the medical profession specifically rejects considerations of cost as part of determining what is medically necessary, traditional health insurance contracts effectively contained no provision for rationing care.[98] In addition, by incorporating professional norms into traditional insurance contracts, these contracts reflected the medical profession's requirement that third-party payers had no place in the treatment relationship.[99] To physicians, contracts had little to do with the way they practiced medicine.

However, the development of managed care has given contracts a much more central role in both the physician-payer relationship and the physician-patient relationship.[100] First, although "medical necessity" may still be a necessary benchmark for whether a health plan will pay for services, it is no longer sufficient.[101] In addition, contract law has become an important part of the delivery of health care partly because managed care has penetrated to such a level that most physicians now must participate in a managed care plan to keep their practices viable.[102] MCOs are able then to use this power to require physicians to adhere to standard form contracts that contain many provisions that are not only friendly to the MCO, but also directly affect the way in which the physician practices medicine.[103] Therefore, MCOs have successfully drawn on contract law and used it as part of their strategy to control the physician's delivery of health care services.[104] For example, standard managed care contracts typically contain "hold harmless" clauses in which MCOs attempt to shift liability for poor patient outcomes to the participating

96. *Id.* at 112, 125.
97. *See id.* at 125-26.
98. *Id.* at 112, 125.
99. *Id.* at 112.
100. *See* Little, *supra* note 20, at 1405.
101. *See* HAVIGHURST, *supra* note 92, at 125-26.
102. *See* Little, *supra* note 20, at 1405.
103. *Id.* at 1402, 1407.
104. *Id.* at 1407.

physicians, even if the patient's injury can be attributed to the MCO's denying authorization for, delaying, or otherwise not covering a physician's recommended procedure or plan of treatment.[105] In addition, standard managed care contracts typically contain the terms of both negative and positive financial incentives for physicians to limit care.[106] Finally, one of the most significant provisions contained in most standard MCO contracts allows the MCO to terminate the physician from the managed care plan with little notice or opportunity for a hearing if the physician does not sufficiently comply with the MCO's cost-containment strategies.[107] Though once of little consequence, contract law now clearly provides a powerful vehicle for implementing MCO's cost-containment strategies by providing the means to control physician behavior and shaping how medical treatment is delivered.

E. The Employee Retirement Income Security Act

"The Employee Retirement Income Security Act of 1974 (ERISA) is undoubtedly the most influential statute affecting the financing of health care in the United States."[108] Despite this fact, Congress did not intend for ERISA necessarily to deal with health care financing, but instead passed it, long before managed care, in response to reports of fraud and mismanagement of employee retirement funds.[109] Congress primarily intended to safeguard employee pensions by regulating employee benefit plans.[110] Because ERISA applies to all employee benefit plans, however, it covers employer-provided health insurance. "ERISA plans are now the leading source of payment for health services nationwide, with more than seventy five percent of all managed care plans ERISA-qualified."[111]

ERISA has a significant effect on health benefit plans by providing

105. *See id.*
106. *See id.*
107. *See id.* at 1400-01.
108. FURROW, ET AL., *supra* note 3, at 423.
109. *Id.* at 424.
110. *Id.*
111. *Id.* at 441.

substantial protection to MCOs.

> ERISA itself imposes few requirements on employee health benefit plans, and provides minimal remedies for employees who are adversely affected by health plan decisions. On the other hand, ERISA preempts a wide range of state laws and remedies intended to protect health plan beneficiaries, often leaving plan beneficiaries wholly stripped of legal protection from health plan abuses.[112]

ERISA has this impact for several reasons. First, the Act expressly preempts "any state law which 'relates to' an employee benefit plan."[113] This preemption is significant because it has left states unable to significantly regulate MCOs and has left plan participants with limited or no remedies against such plans.[114] "As ERISA does not itself regulate or provide remedies against health plans except to a very limited extent, ERISA preemption generally results in a regulatory and liability vacuum, allowing health plans to behave as they choose with little accountability to their members or to the public."[115]

Second, ERISA not only preempts state law relating to employee benefit plans, but also has been interpreted to preempt state jurisdiction and remedies with respect to employee health benefit plans.[116] Because state jurisdiction, substantive law, and remedies are all preempted, a plaintiff injured by a health benefit plan must bring suit in federal court, and may only recover the benefits due to her under the terms of the plan. ERISA does not allow recovery of compensatory or punitive damages to compensate a plan participant for injuries and, therefore, restricts substantially the amount of recovery possible in what would be an ordinary tort case.[117]

In the early years of managed care, ERISA was used successfully

112. *Id.* at 424.
113. 29 U.S.C. § 1104(a) (2002); *see also* FURROW, ET AL., *supra* note 3, at 424.
114. *See* FURROW, ET AL., *supra* note 3, at 424.
115. *Id.* at 429.
116. *Id.*
117. *Id.* at 442.

to provide nearly complete protection from tort liability for managed care plans.[118] Recently, however, some federal courts have limited this preemption, finding that many tort claims have little impact on the administration of an employee benefit plan.[119] However, for the most part, courts have continued to interpret ERISA preemption broadly, holding in most cases that state laws regulating insurance and managed care "relate to" an ERISA plan and are therefore preempted.[120] MCOs therefore have been able to continue to use ERISA preemption to severely limit the remedies available to plaintiffs who claim MCO negligence. Despite some recent cases holding that ERISA preemption does not apply to some types of MCO conduct,[121] the Act remains a formidable defense for managed care plans.

F. Managed Care Legislation

The legal framework surrounding managed care is a work in progress. In addition to triggering new applications of existing law, managed care has been the subject of numerous legislative initiatives at both the federal and state levels. Indeed, more than 1,000 bills were introduced in response to public outrage over managed care from 1995 through 1997.[122] Significantly, none of these laws permit physicians to ration health care.

Commentator David Hyman gives an overview of managed care legislation by dividing the measures into two categories.[123] He describes Type I as "provisions which affect the relationship between health care providers and managed care organizations" and Type II as "provisions which affect the relationship between health care providers and patients, including the scope of covered services."[124]

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118. *See id.* at 430-31.

119. FURROW, ET AL., *supra* note 3, at 432.

120. *Id.* at 433.

121. *See, e.g.*, Corporate Health Ins. v. Texas Dept. of Ins., 215 F.3d 526 (5th Cir. 2000) (holding that ERISA does not preempt state provisions imposing liability on HMOs).

122. David A. Hyman, *Consumer Protection and Managed Care: With Friends Like These . . .*, *in* HEALTH LAW HANDBOOK 286 (Alice Grossfield ed., West 1998).

123. *See id.* at 286-87.

124. *Id.*

Examples of Type I legislation include "any willing provider" state laws, which restrict the ability of MCOs to contract with whichever physicians they choose; contain due process provisions; and prohibit "gag" clauses that prevent the physician from discussing with the patient treatment options that the plan does not cover or authorize.[125] Examples of Type II legislation include "consumer protection" measures that ensure direct access to some specialists; mandatory coverage of certain procedures such as reasonable emergency room visits; and forty-eight hour hospital stays after childbirth.[126] In addition, many states have mandated external appeals of coverage denials.[127] Some states have passed comprehensive regulatory schemes.[128] As discussed above, ERISA has limited to a great extent these state reform efforts through preemption.

On the federal level, several proposals, some in the form of a "Patients' Bill of Rights," would provide individuals, along with other protections, a right to sue MCOs and thereby effectively eliminate the ERISA protections MCOs now enjoy.[129] These targeted federal and state initiatives, while somewhat helpful, do not fully alleviate the effects of the policy problem.

III. THE POLICY PROBLEM

The policy problem is a general one, but with very specific effects. This article assumes, as a starting point, that society must control health care costs. The policy problem stems from the fact that the rules that have an impact on the way physicians practice medicine reflect an era in which fee-for-service medicine predominated, and the physician operated with nearly complete autonomy, including the freedom to ignore costs.[130] The shift to managed care, with its significant third-party payer role in the treatment relationship, does more than simply add a layer of accountability to health care delivery.

125. *See id.* at 287.
126. *Id.* at 288.
127. Hyman, *supra* note 122, at 289.
128. *Id.* at 287; *see, e.g.*, Tex. Civ. Prac. & Rem. Code § 88.0001 et seq.
129. *See* Hyman, *supra* note 122, at 289.
130. *See supra* Part II.

Managed care fundamentally changes a physician's obligations and incentives with respect to providing health care and also puts in direct conflict the physician's traditional ethical and legal obligations toward her patient and the physician's obligation to control health care costs.[131]

A. The General Policy Problem

Health care scholars Mark Hall and Haavi Morreim have discussed this general policy problem in detail. Hall notes that managed health care requires physicians to ration at the bedside because MCOs reward physicians for cutting costs in delivering health care and penalizes them in various ways for spending more on health care delivery than the MCO has determined is an appropriate level.[132] He explains, however, that the dominant view is that there is an absolute moral prohibition against physicians considering the costs of treatment.[133] This moral prohibition is reflected in physicians' ethics as well as in writings by a variety of health care scholars about the physician-patient relationship.[134] Hall explains that the law strongly disfavors physicians making medical spending decisions or rationing.[135]

Hall supports this assertion by detailing research he conducted reviewing all judicial opinions on health insurance for the past thirty-five years that involved a question as to whether a proposed treatment was medically appropriate and therefore should be covered by insurance.[136] He concluded that both public and private insurers lost nearly 60% of the coverage denials that they sought to uphold in court, and courts found few factors that would affect an insurer's success in having the denial sustained.[137] In addition, Hall found that judicial review of proposed coverage denials was most stringent

131. *See* HALL, *supra* note 5, at 131.
132. *See id.* at 114.
133. *See id.* at 115.
134. *Id.* at 114-15.
135. *Id.* at 115-16.
136. *Id.* at 68.
137. HALL *supra* note 5 at 68.

when courts suspected that an economic motivation, and not the lack of medical justification, was the reason behind the denial of coverage.[138] Hall notes that in such instances, courts "see a profit-making insurer who has already received its premium refusing to honor reasonable treatment requests by a sick patient."[139] Other types of health-care cases also demonstrate the preference for providing all beneficial care, regardless of cost.[140]

Hall asserts that this preference no longer makes sense, that current legal rules disfavoring, even prohibiting, health care rationing by physicians are "out of step with current economic and medical realities."[141] Indeed, it is not just that the law fails to reflect current realities, but that the failure to reflect these realities and allow for rationing is a significant moral issue.[142] Hall argues that "the fact that a number of thoughtful physicians and patients feel strongly and sincerely about the moral degeneracy of HMOs provides no basis for framing those personal beliefs in absolutist or categorical ethical terms."[143] Physicians' ethical requirement to provide patients with all care that could possibly be of benefit, regardless of cost, and the demise of the fee-for-service system and subsequent rise of managed health care clearly illustrates, according to Hall, the contingency of moral values.[144] Viewed in this way, the physician's ethic to provide all care "is an idiosyncratic artifact of the culture of attitudes and behavior generated by outmoded forms of insurance."[145] Requiring physicians to provide all potentially beneficial health care, while

138. *See id.*

139. *Id.*

140. *See, e.g.*, In re Baby K, 16 F.3d 590, 598 (4th Cir. 1994) (holding that the hospital must provide care to anencephalic infant, where mother requested it, despite the fact that physicians maintained care was futile, and it cost well over one million dollars).

141. HALL, *supra* note 5, at 117.

142. *Id.*

143. *Id.* at 131. Hall notes that philosopher Alasdair MacIntyre argued that moral values are contingent upon the nature of the culture in which they operate, and are not universally true. *Id.* at 130. MacIntyre thus warns against elevating individual beliefs to the scale of a universal moral principle. *Id.* at 131.

144. *Id.* at 131.

145. *Id.* Troyen Brennan highlights this point in stating that "[t]he ethical theory of medicine was thus integral to, and sustained by, the economic and political structure of medical practice." BRENNAN, *supra* note 11, at 49.

ignoring its cost, assumes that society has unlimited resources.[146] In Hall's view, therefore, outside of the fee-for-service system, no ethical basis exists for requiring physicians to provide all potentially beneficial health care regardless of cost.[147]

Haavi Morreim supports this conception of the policy problem.[148] She notes that "the law, it appears, suffers from the same economic naivete that infuses traditional moral notions of fidelity."[149] With the drive to control health care costs, it is necessary to take another look at physicians' traditional ethic of uncompromised fidelity to their patients.[150] It may no longer be realistic to expect that physicians will pursue their patients' interests over those of society, third-party payers, and even themselves.[151]

> It is no longer plausible to demand that physicians literally always place patients' interests above their own, for in some cases this will entail a self-sacrifice that is surely beyond the call of duty. And we can no longer presume absolutely that the physician will promote his patients' interests above the competing claims of other patients, or of payers, institutional providers, and society as a whole. We must therefore consider more closely just what the physician owes his patient and, equally important, what he does not owe.[152]

Traditional notions of fidelity to patients, reflected in medical ethics as well as the law, require physicians to promote their patients' interests above all others. Yet the economics of health care make this requirement unrealistic.[153] This longstanding indifference to the cost of health care is now untenable because it requires the physician to deliver care with resources that he does not control.[154]

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146. HALL, *supra* note 5, at 131.
147. *Id.*
148. *See* MORREIM, *supra* note 15, at 64.
149. *See id.* at 86.
150. *Id.* at 64.
151. *Id.*
152. *Id.*
153. *Id.* at 86.
154. MORREIM, *supra* note 15, at 86.

> [A] particular medical morality has developed. The physician is duty bound to treat the patient with greatest respect. The physician must maintain a loyalty to the patient and engender the patient's trust. The patient must 'come first' even if this requires some self-effacement and sacrifice on the part of the physician . . . . Other concerns should not intrude on this relationship. The moral code of beneficence works best if it is isolated from the usual concerns of the liberal state, especially the competitive market.[155]

The law reinforces this isolation of the medical profession and its ethics from the consequences of the costs of the care it delivers.[156] The result is that the law exposes the physician to potential liability for "failing to do the impossible."[157]

In summary, the general policy problem stems from the fact that the law with respect to physician liability does not fully account for changes that have arisen as a result of the change from fee-for-service medicine to managed health care. This conflict takes on greater importance because the physician is not simply put in an ethical dilemma by managed health care. She faces potential legal liability and severe economic harm.

B. Potential Malpractice Liability

One of the specific manifestations of the general policy problem is that physicians who are forced to ration at the bedside because of participation in the managed care system face potential malpractice liability.

> [P]hysicians must choose between long-standing medico-legal expectations and the reality of cost-containment measures. As a result of the profound economic changes in the health care delivery system, a practicing physician . . . has essentially

155. BRENNAN, *supra* note 11, at 48.
156. *See* MORREIM, *supra* note 15, at 86.
157. *See id.*

> become the administrator of medical resource allocation. This new role has impinged on the traditional standard of care required of physicians . . . . The jurisprudential dilemma arises when the medico-legal unitary standard of care is applied to the physician's other role as a resource manager.[158]

One of the earliest cases to illustrate the issue is *Wickline v. State of California*.[159] The central issue in that case was whether a plaintiff could sue a third-party payer, Medi-Cal, for negligence where a cost-containment strategy allegedly affected the treating physician's judgment and the patient subsequently suffered harm.[160] The patient, Lois Wickline, received health care benefits under California's Medi-Cal program.[161] Doctors diagnosed Wickline with arteriosclerosis, which caused an obstruction of the terminal aorta.[162] Her physician recommended surgery and obtained authorization from Medi-Cal for the procedure and ten days of post-operative hospitalization.[163] Wickline had complications following the surgery and required two subsequent surgeries to eliminate clotting and restore blood flow to her leg.[164] Due to these and other potential complications, her physician recommended that she remain in the hospital an additional eight days.[165]

The hospital completed the required forms and submitted them to Medi-Cal requesting the additional eight-day stay.[166] Medi-Cal's first-line utilization review agent, a registered nurse, did not believe the request warranted an additional eight days.[167] She referred the

158. Hedgeman, *supra* note 4, at 306-08. Scholar Clark Havighurst states simply that "[a]t this stage in the managed care revolution . . . corporate health plans have assumed extensive responsibility for the cost of care without accepting more than nominal responsibility for its quality. Only a minute's reflection should suggest that this situation is unlikely to be satisfactory as a matter of public policy." Clark C. Havighurst, *Vicarious Liability: Relocating Responsibility for the Quality of Medical Care*, 26 AM. J.L. & MED. 7, 13 (2000).

159. 239 Cal. Rptr. 810 (Cal. Ct. App. 1986).

160. *Id.* at 811.

161. *Id.* at 812.

162. *Id.*

163. *Id.*

164. *Wickline*, 239 Cal. Rptr. at 812.

165. *Id.* at 813.

166. *Id.*

167. *Id.* at 814.

case to a Medi-Cal physician "consultant," who instead authorized four additional days.[168] The physician consultant based his decision on factors that Wickline and her physicians contended were irrelevant to her circulatory condition.[169] Additionally, the physician consultant did not discuss the case with a Medi-Cal consultant who specialized in vascular surgery before making his decision.[170] Wickline's physicians complied with Medi-Cal's decision and released her from the hospital after four additional days.[171] Nine days later, Wickline returned to the hospital with a severe infection and clotting problems.[172] Her physicians found it was necessary to amputate her leg below the knee to save her life.[173] Wickline's lawsuit alleged that had she remained in the hospital the additional days, she would not have lost her leg.[174] Yet in bringing suit, she did not allege that her physicians committed malpractice or were in any way liable.[175] The case attracted attention because the court held:

> Third party payors of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms as, for example, when appeals made on a patient's behalf for medical or hospital care are arbitrarily ignored or unreasonably disregarded or overridden.[176]

Yet the court went on to qualify its holding with respect to third-party payers by stating that "the physician who complies without protest with the limitations imposed by a third-party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care."[177] The court continued to say that "[h]e

168. *Id.*
169. *Wickline*, 239 Cal. Rptr. at 815.
170. *Id.*
171. *Id.*
172. *Id.* at 816.
173. *Id.*
174. *Wickline*, 239 Cal. Rptr. at 817.
175. *Id.*
176. *Id.* at 819.
177. *Id.*

cannot point to the health care payor as the liability scapegoat when the consequences of his own determinative medical decisions go sour."[178]

Significantly, the court stated that, although Medi-Cal intimidated Wickline's physician, he should have made more of an effort to challenge its determination that her coverage entitled her to only an additional four days in the hospital.[179] The court noted that Wickline's physicians authorized her discharge, and as such, "Medi-Cal was not a party to that medical decision and therefore [could not] be held to share in the harm resulting if such decision was negligently made."[180] The court concluded by stating:

> This court appreciates that what is at issue here is the effect of cost containment programs upon the professional judgment of physicians . . . . While we recognize, realistically, that cost consciousness has become a permanent feature of the health care system, *it is essential that cost limitation programs not be permitted to corrupt medical judgment.*[181]

Although the *Wickline* case was noteworthy because it allowed for the fact that, in some cases, a third-party payer might be legally responsible for poor medical outcomes that can be linked to cost-containment strategies,[182] the case is also significant from a policy perspective regarding the role of physicians in cost containment. While recognizing that cost containment in health care was a new policy that "ha[d] become a permanent feature of the health care system," the court's opinion perpetuated a long-held policy with respect to physician liability.[183] The court's narrow and unrealistic interpretation of the facts of the case, that essentially Wickline's treating physicians were divorced from the cost containment

178. *Id.*
179. *Wickline*, 239 Cal. Rptr. at 819.
180. *Id.*
181. *Id.* at 820 (emphasis added).
182. With respect to third-party liability, subsequent opinions limit the *Wickline* case, and it has not provided the basis for any meaningful liability for MCOs enforcing cost-containment policies.
183. *Wickline*, 239 Cal. Rptr. at 820.

decisions made with respect to her health benefits, ensured that physicians still retained full liability for treatment decisions, even though they no longer solely make these decisions.

The policy revealed by the *Wickline* case is illustrated in more recent cases as well. For instance, in *Neade v. Portes*,[184] the plaintiff brought suit against her husband's physician and his practice for medical malpractice and breach of fiduciary duty.[185] The central issue in the case was whether, in the context of a medical malpractice action, a patient has a cause of action for breach of fiduciary duty against the physician for failing to disclose that the physician had financial incentives to limit care pursuant to an arrangement with an MCO.[186]

In *Neade*, the plaintiff's husband consulted his primary care physician for chest pain and shortness of breath.[187] Neade had a family history of heart disease, suffered from hypertension, was overweight, smoked heavily, and had high cholesterol.[188] The primary care physician briefly hospitalized him and conducted certain tests, including a thallium stress test and an electrocardiogram (EKG).[189] Doctors concluded that the results of these tests were normal, and the hospital discharged him with a diagnosis of a hiatal hernia and/or esophagitis.[190]

Several days later, Neade returned to his primary care physician still complaining of chest pain.[191] The physician, relying on the results of the thallium stress test and EKG, determined that the chest pain was not cardiac related.[192] Neade returned the following month, complaining of severe chest pain.[193] Neade's primary care physician requested that his associate examine him.[194] Based on this exam, the

184. 739 N.E.2d 496 (Ill. 2000).
185. *Id.* at 499.
186. *Id.* at 498.
187. *Id.*
188. *Id.*
189. *Neade*, 739 N.E.2d at 498.
190. *Id.*
191. *Id.*
192. *Id.*
193. *Id.*
194. *Neade*, 739 N.E.2d at 498.

primary care physician's associate recommended an angiogram, a test that is better at diagnosing coronary artery disease than a thallium stress test.[195] The primary care physician refused to order the angiogram.[196] Several months later, Neade returned to his primary care physician again complaining of chest pain.[197] Once again, an associate of the primary care physician recommended an angiogram, but his primary care physician refused, citing the normal thallium stress test.[198] A few months later Neade suffered a massive heart attack and died.[199]

The plaintiff alleged that her husband's primary care physician had negotiated a contract with an HMO pursuant to which the physician's group would receive from the HMO $75,000 per year, called the "Medical Incentive Fund," to be used by the group to cover costs for patient referrals and outside tests.[200] Under the contract with the HMO, whatever portion of the Medical Incentive Fund that the practice group did not use for referrals or outside tests was divided up at the end of the year; the primary care physician's group received 60% of the remaining funds and the HMO received 40%.[201] If the fund was depleted, the HMO required the primary care physician and his group to make up the difference.[202] The plaintiff was not aware of this arrangement at the time her husband sought care.[203] The court held that the plaintiff could not state a claim for breach of fiduciary duty separate from a medical malpractice claim; the breach of fiduciary duty claim was unnecessary because the "traditional medical negligence claim sufficiently addresses the same alleged misconduct."[204] The court did hold, however, that to the extent the primary care physician testified in his defense at trial, the plaintiff could use evidence of the Medical Incentive Fund and the physician's

195. *Id.*
196. *Id.*
197. *Id.* at 499.
198. *Id.*
199. *Neade*, 739 N.E.2d at 499.
200. *Id.*
201. *Id.*
202. *Id.*
203. *Id.*
204. *Neade*, 739 N.E.2d at 503.

potential gain from it to impeach his credibility.[205]

Like *Wickline*, *Neade* is significant in that it illustrates the potential for liability where a physician acts to control costs. Unlike *Wickline*, the decisions in *Neade* were solely in the hands of the treating physician. However, the policy issue is the same. The court held that considerations of cost in treating a patient and any resulting harm were squarely within the realm of a malpractice suit.[206] The court even went so far as to say that financial incentives that aim to control costs by placing the physician's interests directly at odds with those of the patient could be used at trial as evidence against the physician to impeach his credibility.[207] Clearly, the prevailing public policy is that limiting care with cost in mind should not be part of the physician-patient relationship.

Though *Wickline* and *Neade* directly address the physician's role in cost containment activities by MCOs, other cases in which the physician receives little attention from the court illustrate the policy problem. In both *Pegram v. Herdrich*,[208] and *Andrews-Clarke v. Travelers Insurance*,[209] the courts noted that, although the plaintiffs had brought suit against the managed care organization, separate suits were pending against the providers.

In addition, traditional malpractice liability may, at least in some states, expand to include liability for failing to advocate on behalf of the patient for the approval of health benefits. In those situations, plaintiffs would premise negligence on a duty that requires more than care and skill in directly treating the patient. In *Nealy v. U.S. Healthcare HMO*,[210] the plaintiff alleged that a physician delayed in submitting the appropriate form to the HMO requesting authorization for a visit with an out-of-network cardiologist.[211] The HMO ultimately denied authorization, and the patient died.[212] The court

205. *Id.* at 506.
206. *Id.* at 504.
207. *Id.* at 506.
208. 530 U.S. 211 (2000).
209. 984 F. Supp. 49 (D. Mass. 1997).
210. 711 N.E.2d 621 (N.Y. 1999).
211. *Nealy*, 711 N.E.2d at 622-23.
212. *Id.* at 623.

held that ERISA did not preempt the claim against the physician and that it could proceed in state court under a malpractice theory because the complaint alleged the physician failed to take timely action to treat the patient.[213] As the court stated in *Pryzbowski v. U.S. Healthcare, Inc.*,[214] "*Nealy* stands for the proposition that under New York law the physician's duties in providing care to his/her patients may be broader than the mere medical treatment decision."[215] In *Pryzbowski*, the plaintiff brought a claim against her treating physicians claiming they had a duty to advocate on her behalf for the timely approval of benefits.[216] The court rejected the claim, but left open the possibility for such a claim in the future.[217]

In summary, the law clearly does not fully embrace the notion of physicians' cutting costs in health care when such decisions result in limiting services to individual patients. This policy choice raises important issues of fundamental fairness. In addition, and more importantly, the policy of viewing physicians and health-care payers as being on different teams with respect to cost containment has significant utilitarian effects.

C. The Threat of Deselection/Termination from an MCO

A second manifestation of the policy problem is that physicians who participate with managed care plans often face termination or "deselection" from the plan at any time, without a showing of cause.[218] Physicians who do not ration care or control costs in line with MCOs' policies, or who advocate too strongly for patient care, fear and often face termination from the plan.[219] However, as discussed above, rationing care to comply with an MCO's cost-containment strategy often carries the threat of malpractice liability.

In an effort to contain health-care costs, MCOs select physicians

213. *Id.* at 625.
214. 245 F.3d 266, 280 (3rd Cir. 2001).
215. *Id.* at 280.
216. *Id.* at 270.
217. *Id.* at 281-82.
218. *See* Richard S. Liner, *Physician Deselection: The Dynamics of a New Threat to the Physician-Patient Relationship*, 4 AM. J.L. & MED. 511, 516 (1997).
219. *See generally* Liner, *supra* note 218, at 516-18.

who will provide quality health care at the lowest cost to be part of their plans.[220] Once physicians are on the plan, MCOs use several strategies to ensure their health-care costs remain controlled. These strategies include capitation arrangements, financial incentives, utilization review, and other methods. An important part of the cost containment strategy, however, is tracking the economic performance of individual physicians.[221] Physicians who do not meet MCO's economic performance criteria and, less often, quality criteria, are terminated or "deselected" from the plan.[222] MCOs reserve the right to terminate without cause through a typical provision contained in MCO-physician contracts.[223] Such provisions often permit the plan to deselect the physician with little or no notice at any time during the contract period.[224] Similarly, these provisions typically give the MCO the power simply not to renew the agreement at the end of the contract term.[225] "Deselection acts as a check on physicians by allowing MCOs to eliminate those physicians providing unnecessary or excessive care, or exceeding the MCO's expected costs for patient care. . . . Terminations without cause, however, often have more to do with economic factors than competence or quality."[226]

The economic factors that weigh into the deselection decision are often not apparent to the physician.[227] "Physicians . . . often have no knowledge of their MCO's economic expectations in the credentialing process."[228] Indeed, physicians' treatment decisions, scrutinized by MCOs for economic efficiency, are usually within the accepted standard of care. The standard of care does not generally incorporate cost considerations in the treatment equation.

On the one hand, the power to deselect physicians who are not facilitating an MCO's cost-containment strategy is an important

220. *Id.* at 513.
221. *Id.* at 516-17.
222. *Id.* at 516-17.
223. *Id.* at 516.
224. Liner, *supra* note 218, at 516.
225. *Id.* at 516.
226. *Id.* at 516-17.
227. *Id.* at 517.
228. *Id.*

one.[229] In striving to keep costs down, MCOs must have the ability to remove physicians from their respective plans, or controlling health care costs might be doomed to fail. However, deselection is problematic when viewed in light of the circumstances in which this power is deployed. Physicians are now economically dependent upon MCOs.[230] Participation with an MCO, especially in some practice areas, is necessary for physicians to have a sufficient patient pool to sustain their practices.[231] Due to MCOs' market power, physicians not only must participate in the plan, but they also have little ability to negotiate the terms under which they deal with the plan.[232]

Physicians report that MCOs have threatened deselection or even terminated physicians for appealing an adverse coverage decision on behalf of a patient.[233] This report is particularly troublesome given that, in some jurisdictions, a physician may be liable for not working hard enough through appeals or otherwise to secure treatment for the patient.[234] Moreover, some physicians privately confess that they are reluctant to take on new patients who may be severely or chronically ill, because of the high costs involved in treating such patients.[235]

The consequences of deselection for the physician are greater than simply losing patients and income.[236] Other MCOs are less likely to accept a previously deselected physician.[237] Additionally, deselection may damage physicians' reputations.[238] Even when a physician has not faced deselection, the threat of termination without cause, at any time, causes great anxiety, often motivating physicians to consider their livelihood and the MCO's interest ahead of, or at least concurrently with, the patient's needs.[239] However, these

229. Liner, *supra* note 218, at 516.
230. *See id.* at 517; Little, *supra* note 20, at 1402.
231. *See* Little, *supra* note 20, at 1427-28.
232. *See id.* at 1402.
233. *See id.* at 1446; Ken Terry, *No Cause Terminations: Will They Go Up in Flames?*, MED. ECON., Jan. 12, 1998, at 130.
234. *See supra* Part III.B.
235. *See* Terry, *supra* note 233, at 130.
236. Liner, *supra* note 218, at 517.
237. *Id.*
238. *Id.*
239. *Id.* at 517-18.

considerations can lead to potential malpractice liability.[240]

Some states have recognized that terminating or deselecting a physician from a plan has important public policy effects.[241] In the last several years, at least twelve states have enacted legislation to deal with the issue.[242] These laws generally require that the MCO inform the physician of the reason for termination in writing, provide some type of appeals process, or provide physicians with the criteria for the "economic credentialing" that is often the reason for deselection.[243] MCOs point out that the more protections physicians receive, the greater the chance of passing the costs on to the consumer. Physicians assert that most state statutes are ineffective because they provide MCOs with too many loopholes.[244] For instance, some states that require an appeals process permit the MCO to appoint the review panel, effectively making it an in-house appeal.[245] Additionally, state laws generally do not cover contract renewals. MCOs are able to wait until the end of the contract term (typically the end of the year) and simply refuse to renew a physician's contract instead of deselecting him or her mid-year.[246] Therefore, these initiatives do not provide complete protection for physicians. Indeed, despite these efforts to alleviate some of the concern over deselection, physicians still fear that MCOs could terminate them. Both the actual termination from an MCO and the fear of termination have important policy effects.

D. Ethical Issues Raised by the Policy Problem

Some commentators argue that, with relatively few published decisions evidencing any actual physician liability for rationing decisions made within the context of managed care, the problem is not as significant as has been asserted. Similarly, it may be argued

240. *See supra* Part III.B.
241. *See generally* Terry, *supra* note 233.
242. *See id.* at 130.
243. *Id.*
244. *See id.* at 134.
245. *See id.* at 140.
246. Terry, *supra* note 233, at 134.

that MCOs actually terminate few physicians from plans, and therefore the threat of termination is not enough to raise an ethical concern. This is simply not the case. Although holding physicians liable for rationing decisions made under pressure from MCOs raises significant ethical issues, the threat or fear of liability or termination felt by physicians has perhaps even more important policy effects.

1. Fundamental Fairness

The first area in which the policy problem presents troubling ethical issues is with respect to notions of fundamental fairness. Society faces a pressing need to control health care costs. Controlling costs necessarily involves physicians, who are the agents responsible for actually delivering care. Yet our current legal framework, while sanctioning cost-cutting programs by MCOs, does not also sanction cost cutting through bedside rationing by physicians.[247] Therefore, MCOs that encourage and indeed require physicians to control costs routinely escape liability for poor patient outcomes, while physicians do not. This problem forms the basis for an ethical claim that the current legal structure is fundamentally unfair.

Craig Carr explains the moral value of a fairness claim in his work *On Fairness*.[248] He notes that fairness "raises significant moral concerns, and claims about being treated unfairly carry considerable moral weight—at least as much, if not more, than claims about being treated unjustly or unequally."[249] Carr states that there are several features of fairness derived from the "meager literature" on the subject:

> 1. Fairness involves not disadvantaging others.
> 2. Fairness involves being unbiased, impartial, or neutral in our treatment of others.
> 3. Fairness involves sharing burdens or benefits equally, or maintaining a proper proportion between benefit and

247. *See, e.g.*, Pegram v. Herdrich, 530 U.S. 211, 221-22 (2000).
248. CRAIG L. CARR, ON FAIRNESS (Ashgate 2000).
249. *Id.* at 1.

> contribution.
> 4. Fairness involves treating equal or similar cases equally or similarly.
> 5. Fairness involves adhering to the rules.
> 6. Fairness involves treating others with the concern and respect they deserve.[250]

In addition to this list, Carr suggests that fairness involves another dimension. He

> locate[s] fairness within the context of moral concerns that govern the activity of joining with others and pursuing some type of cooperative venture. Fairness . . . matters from a moral point of view because it is a central virtue of cooperation, and we are, of course, social beings who both want and need to cooperate with one another.[251]

Carr finds that fairness requires that people perform their share of the work and that they get their share of what they helped produce.[252] Fairness "precludes a particular type of free-riding; people who benefit from the fact that others submit to certain rules are presumed to stand under an obligation to submit to these rules themselves."[253] The situations in which the principles of fairness have particular moral force are those where the individuals involved are linked in some way as fellow participants in a social practice or activity.[254] Therefore, according to Carr, the moral heart of fairness is that parties who are linked in some type of cooperative venture must share the burdens as well as the benefits.[255] In the case of physicians and MCOs, it can be argued that the parties are linked in a cooperative venture—providing health care while controlling costs. Though many physicians might assert that they are in no way working

250. *Id.* at 2.
251. *Id.* at 2-3.
252. *Id.* at 26.
253. CARR, *supra* note 248, at 26.
254. *Id.*
255. *Id.*

together with MCOs, and in fact perceive themselves to be in an adversarial relationship with them, the fact remains that each is an indispensable party to the goal of providing health care while controlling costs. Today, nearly all physicians are dependent upon MCOs for patients and reimbursements, and MCOs cannot control costs without relying upon physicians to make judgments that ration care at the bedside.[256]

There is an obvious organizational link between physicians and MCOs: "While the values of individual physicians undoubtedly play a critical role in clinical decision making, the organizations involved also wield tremendous amounts of power to shape the context in which ethical challenges arise. They play an important part in creating cultures that influence physician practices."[257] Physicians and MCOs are also linked by public policy. The framework of our current health care system, which supports employer-provided health insurance and encourages cost-containment through managed care, envisions and indeed forces physicians and MCOs to work together on some level.

Given that physicians and MCOs are "in it together," so to speak, principles of fairness require a just distribution of the burdens of providing health care while containing its cost. As a result of the policy problem, however, the burdens are not fairly distributed. The current policy of encouraging control of health care costs through the use of MCOs, which achieves (or attempts to achieve) health care cost reductions through the use of bedside rationing, is unfair because physicians and MCOs do not share the liability burdens for such rationing. While MCOs reap significant benefits through the use of cost-containment strategies, the liability burden falls squarely on the shoulders of physicians because the law provides MCOs with powerful immunity through ERISA. Moreover, the law has not accounted for changes in the delivery of health care by modifying physician liability.

256. *See* Liner, *supra* note 218, at 516.
257. *See* WONG, *supra* note 14, at 4.

The *Andrews-Clarke*[258] case illustrates this unfairness. The plaintiff brought suit against the MCO that administered the health benefit plan she carried through her employer.[259] The plaintiff's husband had a severe drinking problem and was hospitalized repeatedly for treatment.[260] The hospitalizations were only long enough to treat whatever acute problem was caused by the husband's alcoholism.[261] Despite physicians' recommendations for an extended, in-patient treatment program, the plaintiff's health insurer did not authorize such treatment.[262] The plaintiff's health benefit plan, however, explicitly provided for at least one thirty-day in-patient rehabilitation program per year.[263] After the hospital released him from a final, alcohol-related overnight stay, the plaintiff's husband consumed more alcohol and was subsequently found dead in a parked car.[264] The plaintiff sued the MCO, claiming that its refusal to grant the extended in-patient alcohol treatment that was recommended by her husband's physicians, and part of her benefit package, caused her husband's death.[265] The plaintiff also brought state law malpractice claims against the hospitals that treated her husband.[266] The court noted that "[u]nder traditional notions of justice, the harms alleged—if true—should entitle [the plaintiff] to some legal remedy on behalf of herself and her children against [the MCO]."[267] However, the court noted that ERISA preempted all of her claims.[268] The court explained that "the practical impact of ERISA in this case is to immunize Travelers and Greenspring from *any* potential liability for the consequences of their denial of benefits."[269]

258. Andrews-Clarke v. Travelers Ins. Co., 984 F. Supp. 49 (D. Mass. 1997).
259. *Id.* at 50.
260. *Id.* at 50-51.
261. *Id.* at 51.
262. *Id.*
263. *Andrews-Clarke*, 984 F. Supp. at 51.
264. *Id.* at 51-52.
265. *Id.* at 52.
266. *Id.*
267. *Id.*
268. *Andrews-Clarke*, 984 F. Supp. at 53-55.
269. *Id.* at 55-56 (emphasis in original).

The *Andrews-Clarke* case is typical and clearly illustrates the effect of ERISA preemption. As the court stated, "the shield of near absolute immunity now provided by ERISA cannot be justified."[270] Yet it is not just the unfairness to plaintiffs left without a meaningful remedy that is troubling about this policy. There is also a less apparent effect on physicians. The court in *Andrews-Clarke* noted this by stating:

> [T]his Court notes that the immunity currently afforded to insurers and utilization review providers unfairly leaves doctors, "quite literally, caught in the middle in the battle over treatment between patients and the HMOs" (citation omitted). Doctors who complain too vigorously about denials of care by the managed care plan face the risk of being kicked out of the plan's network of approved providers (citation omitted). Yet, thanks to ERISA, when a treating physician makes a decision to discharge a patient because an insurance company refuses to pay benefits, the patient's sole recourse is against the physician, and insurers are quick to abandon him to litigation (citation omitted). Indeed, when asked what remedy was left to [the plaintiff], the insurer's lawyer said, "Sue the providers," (i.e., sue the doctors and hospitals—but not us) (citation omitted). This result contravenes fundamental principles of joint tort liability.[271]

As the *Andrews-Clarke* case illustrates, MCOs receive a significant benefit from the current policy that holds physicians fully responsible for negative patient outcomes that result from cost-containment strategies, but very often immunizes the health plans, who actually drive such decisions. Although some recent cases have indicated that in limited circumstances MCOs might be liable for actions that negatively affect patient outcomes, such exceptions are not sweeping or certain enough to mitigate the unfairness of the current liability scheme. Moreover, the costs to litigate such issues

270. *Id.* at 63.
271. *Id.* at 63-64, n.74.

raise significant utilitarian concerns.

Accordingly, although under the former, retrospective fee-for-service system, where passive third-party payers simply reimbursed a physician for whatever care deemed "necessary," the tort liability scheme was fair, the same is not true today. Under the former system, physicians enjoyed autonomy over their medical decisions. They controlled the care the patient received, and by and large, they could marshal the resources as part of the care. There was little issue of shared responsibility for negative patient outcomes; the physician stood alone as the captain of the ship. Thus, the tort liability faced solely by physicians might be fair, as a policy matter, if the decision of whether to ration care remained solely in the control of physicians.

2. Utilitarianism

Though the policy problem outlined above raises significant issues of fundamental fairness, this problem alone might not be enough to justify a policy change or policy solution. Indeed, if a weightier ethical consideration, such as controlling health care costs to keep our health care system sustainable and accessible to as many people as possible justified the unfairness to physicians, the matter might end there. The physician's right to fair treatment with respect to legal liability might have to yield in the face of a strong utilitarian justification for keeping such a policy in place. However, this is not the case. In addition to significant issues of fundamental fairness, the policy problem presents a much larger ethical issue, implicating significant utilitarian concerns. Specifically, our current policy serves ultimately to undermine society's goals of controlling health care costs. The costs of the policy problem far outweigh the benefits, and as such we are not maximizing health care resources or positive health care outcomes.

An examination of the differences between *act* utilitarianism and *rule* utilitarianism best explains the effects of the policy problem. An agent satisfies act utilitarianism "if and only if he does an act which has at least as good consequences as any other available under the circumstances. Thus, an agent who satisfies [act utilitarianism] in

any situation produces the best consequences he can possibly produce in that situation."[272] In contrast, rule utilitarianism directs "each agent to satisfy the set of rules it would be best for everyone to satisfy . . . ."[273] As will be discussed below, the current liability framework applied to physicians is flawed from a rule utilitarian perspective. While the prior fee-for-service system and the legal rules that were shaped by it might have some ethical justification, this system ultimately does not encourage conduct that is best for everyone to satisfy. Physicians' attempts to satisfy the current liability rules do not achieve the best overall health care outcome.

The policy problem is a complex one, in that the current legal framework is not without benefits. First, providing a virtual liability shield to MCOs allows them to employ important cost-cutting strategies that lead to reduced overall health care spending. As the court explained in *Pryzbowski v. U.S. Healthcare, Inc.*,[274] "a holding that Pryzbowski's claims against U.S. Healthcare are not completely preempted would open the door for legal challenges to core managed care practices (e.g., the policy of favoring in-network specialists over out-of-network specialists), which the Supreme Court eschewed in *Pegram*."[275] Moreover, keeping liability to a minimum for employing cost-containment strategies ultimately keeps the costs of health insurance down, so that presumably, more individuals can have access to health care.

Another benefit to the current policy is that traditional liability rules carry the weight of consistency. They are premised on many fundamental principles of medical ethics, which we believe to be important, such as physician loyalty to the patient. The public, by and large, is comfortable with these rules. Moreover, current liability rules play an important role in encouraging physicians to deliver quality care and providing a remedy to patients when physicians do not deliver such care. Therefore, it is important to stress that it is not the system of rules providing for physician liability that is flawed, but

272. DONALD H. REGAN, UTILITARIANISM AND CO-OPERATION 18 (Clarendon Press 1980).
273. *Id.* at 83.
274. 245 F.3d 266 (3d Cir. 2001).
275. *Id.* at 274-75.

rather, the rules' specific formulation and implementation through the standard of care. Therefore, the current standard of care, defined by the medical profession and imposed by the law, is ethically troubling from a rule utilitarian perspective.

Despite the benefits described above, the costs of the policy on physician liability have become too great. Commentators may argue that principles of act utilitarianism, among other things, justify physicians' actions with respect to health care delivery. That is, by committing themselves to maximizing health care outcomes for each individual patient, physicians might assert that the delivery of health care with little regard to overall cost nevertheless maximizes utility. Physicians' fiduciary and ethical duties, which require the patients' needs to be put first, buttresses this moral justification. Also, the fact that it is difficult to assess the impact on others of this "patient first" practice strengthens the argument. Therefore, one might assert that the negative utility of such a system is too speculative compared to the benefits of the prevailing health care delivery system. Yet, while we cannot specifically state that ignoring costs for one patient leads to less treatment for another, the overall impact of such actions is clear—escalating health care costs, which generally threatens the health care system. An act utilitarian justification is really illusory, and the costs of the policy far outweigh the benefits.

At first glance, this conclusion might seem intuitively incorrect. It may appear that summing up positive health care outcomes produces the greatest overall health care consequences. However, if physicians work to maximize individual health care outcomes in any given medical situation, regardless of societal costs, we do not achieve the best possible overall health care results. Such a system ultimately cannot be sustained.[276] Requiring physicians to provide all potentially beneficial care to individuals without considering overall societal costs is problematic because such a system does not necessarily produce a better individual health care outcome.[277] The marginal utility of additional costly treatments, tests, procedures, and

276. *See* HALL, *supra* note 5, at 117.
277. *See id.* at 131.

office visits for a given patient is often very low. Incorporating sensible cost considerations into the treatment decision often does not in any way diminish individual health care outcomes.

"Because physicians play such an integral role in health care delivery, cost containment is impossible unless they make it an essential factor in their decision making."[278] The current policy undermines this effort by subjecting physicians to liability for rationing care as a way to control costs.[279] Because physicians face such liability, they will not and do not fully embrace cost containment efforts.

For instance, recent studies have documented that physicians will, and often do, lie for their patients to obtain what physicians believe to be necessary care.[280] Indeed, studies have documented that this "gaming the system," as physicians often call it, is more prevalent under managed health care.[281] Because physicians do not see themselves as on the same team with MCOs in cutting health care costs, and because physicians feel an ethical and legal obligation to provide care, they will often engage in deception, for example, by exaggerating a diagnosis to obtain authorization and coverage for a recommended treatment.[282] A recent study found sanctioning of deception occurred more frequently in markets with higher managed care penetration.[283] An overwhelming majority of physicians studied indicated that they believed that, in many cases, deception was consistent with their professional obligations, and that they in fact had to resort to deception to advance their patients' interests.[284] In addition, it has long been documented that so-called "defensive medicine" is responsible for a significant amount of health care costs.[285] Although commentators dispute whether the figure is as

278. Robert J. Herrington, Herdrich v. Pegram*: ERISA Fiduciary Liability and Physician Incentives to Deny Care*, 71 U. COLO. L. REV. 715, 716 (2000).

279. *Id.* at 719-20.

280. *See* Victor G. Freeman, et al., *Lying for Patients: Physician Deception of Third-Party Payers*, 159 ARCHIVES OF INTERNAL MED. 2263 (1999).

281. *Id.* at 2263.

282. *Id.*

283. *Id.*

284. *Id.* at 2267.

285. *See* MENZEL, *supra* note 49, at 152.

high as the fifty-two billion dollars estimated by the American Medical Association, "[l]iability suits have undoubtedly constituted a cost-escalating pressure in medicine."[286]

Additionally, the current policy has significant costs because it creates an adversarial relationship between MCOs and physicians, and to some extent physicians and their patients. Therefore, not only is current liability policy failing to produce and maximize overall positive health care outcomes, it is also in many cases failing to produce even positive individual health-care outcomes. For example, the problem of terminating physicians from plans because of over-utilization or advocating for patients breaks up the continuity of physician-patient relationships.[287] These points have been highlighted in the literature discussing the effects of managed care, and therefore will not be discussed here. However, it is important to note that the policy problem has had negative effects not just on physicians, but on patients as well.

Physician liability rules, instead of maximizing utility, in fact undermine society's overall goal of lowering health-care costs, and therefore the rules fail to produce the greatest overall health care "good."[288] Therefore, changing these rules is necessary and ethically justified, and must be done in such a way that guides physicians toward reaching the best overall result, even if it sometimes produces a less than optimal outcome in individual cases. The rules must be structured so that physicians no longer feel compelled by law and their "patient first" ethics to maximize their individual patients' health outcomes at the expense of society's goal of controlling health care costs.[289]

IV. EVALUATION OF POTENTIAL SOLUTIONS

There are several potential solutions to the policy problem. First, proponents of the status quo believe that physicians must operate

286. *See id.* at 151.
287. *See* Liner, *supra* note 218, at 518; Little, *supra* note 20, at 1402.
288. *See* Hirshfeld, *supra* note 2, at 1842.
289. *See id.* at 1842.

under the same standards and requirements as they always have because any changes to account for the effects of managed care would be detrimental to patients. Second, there are proposals for greater MCO liability by removing ERISA immunity. A third solution envisions targeted legislation to control the negative effects of managed care. Finally, a fourth potential solution proposes changing the malpractice standard to allow for considerations of cost.

A. Maintain the Current Standard of Care

One approach to the policy problem is to leave in place the "patient-interest oriented" standard of care, and instead find ways to consider costs outside the physician-patient relationship.[290] Commentators argue that cost considerations should be brought into health care through explicit rationing mechanisms that work outside the physician-patient relationship.[291] The foundation of this argument is that changing the standard of care to incorporate cost considerations would "dramatically alter the fiduciary nature of the physician-patient relationship," and such an alteration should be avoided at all costs.[292]

Maintaining the current standard of care is an attractive solution because it appeals to notions of absolute physician fidelity.[293] This approach has long been the driving ethical justification of the model physician-patient relationship and, therefore, as a policy solution it has the appeal of continuity and the support of intuition. Yet this approach is problematic for several reasons. First, it centers on preserving the so-called sanctity of the physician-patient relationship. Though the fiduciary nature of the relationship is important, it is equally important to keep in mind the extent of the fiduciary duty. Proponents of the current standard of care argue that changing the standard would essentially give the physician "permission to consider matters that [are] not necessarily in the patient's interest when

290. *See id.* at 1845-46.
291. *See id.* at 1846.
292. *Id.* at 1844.
293. *See* Hirshfeld, *supra* note 2, at 1844.

evaluating a course of treatment."[294] They assert that, by considering cost, the physician "might even be required or allowed to recommend a course of care that [is] not optimal."[295] Yet this argument for avoiding any consideration of cost takes an unrealistic view of the physician-patient relationship. The ideal of the physician-patient relationship has been exaggerated; the potential has long been present for the physician to take action that might not be in the best interests of the patient, for example, by recommending too much care because it was in the physicians' economic interest to do so.[296]

Second, proponents of maintaining the standard of care argue that changing the standard to accommodate society's interest in controlling costs would be difficult and problematic because it is not clear how to take such considerations into account in a "consistent and equitable manner."[297] Though bringing cost into the treatment relationship would not be easy, this objection is not a reason to maintain the status quo. Applying the current standard of care in a "consistent and equitable manner" has proven problematic as physicians take many different approaches to treating similar illnesses, with variances based on little more than the geographic location of the physician and patient. There is no reason to think that clinical-practice guidelines, supported by the government, and modifications to medical education could not do as good a job, if not better, at maintaining consistency in approaches to treating illness.

Also problematic is the assumption that explicit rationing mechanisms can accomplish cost-containment with the current standard of care. First, such an approach likely would not work because it would encourage physicians to manipulate the system to secure resources for patients. By leaving physicians off of the cost-containment team, explicit rationing would therefore have little legitimacy and staying power. Indeed, such an approach would likely breed the same hostility among physicians that managed care has, with physicians seeing themselves as warriors for patients in the fight

294. *Id.*
295. *Id.*
296. WONG, *supra* note 14, at 65.
297. *See* Hirshfeld, *supra* note 2, at 1844.

against the forces that seek to control costs.[298] Moreover, explicit rationing based on government or third-party guidelines would leave little room for the uniqueness of individual cases.[299]

In summary, the status quo approach is problematic because it perpetuates both unfairness to physicians and the old thinking shared by patients and the medical community that physicians should not consider costs in the treatment decision. This approach raises significant utilitarian concerns.

B. Targeted Legislation

Another possible solution to the policy problem is for the federal government or states to pass targeted legislation. Indeed, many states have attempted initiatives aimed at minimizing unfairness to physicians and protecting the physician-patient relationship. While these reforms can, in some instances, be helpful, they are not the best solution to the policy problem.

Numerous pieces of targeted legislation focus on aspects of the policy problem. For instance, California has a statute, similar to those in other states,[300] that aims to "provide protection against retaliation for physicians who advocate for medically appropriate health care for their patients."[301] The statute provides:

> The application and rendering by any person of a decision to terminate an employment or other contractual relationship with, or otherwise penalize, a physician and surgeon principally for advocating for medically appropriate health care consistent with that degree of learning and skill ordinarily possessed by reputable legal physicians practicing according to the applicable standard of care violates the public policy of this state. No person shall terminate, retaliate against, or otherwise penalize a physician and surgeon for that advocacy, nor shall any person

298. *See* Field, *supra* note 1, at 481-82.
299. *See* Hirshfeld, *supra* note 2, at 1845.
300. *See, e.g.*, 215 ILL. COMP. STAT. ANN. 134-35 (West 2001); PA. CONS. STAT. § 991.2113 (2000).
301. CAL. BUS. & PROF. CODE § 2056 (West 2001).

> prohibit, restrict, or in any way discourage a physician and surgeon from communicating to a patient information in furtherance of medically appropriate health care.[302]

Other examples of targeted managed care legislation exist on the federal level. For example, in 1996, Congress passed the Newborns' and Mothers' Health Care Protection Act[303] in response to public concern over so-called "drive-through deliveries" whereby health plans required hospitals to discharge mothers and newborns from the hospital, assuming no major health complications existed, within twenty-four hours after delivery. The legislation required all health plans to provide coverage for a minimum forty-eight hour hospital stay. Other bills have required health plans to cover specialized women's health services such as minimum hospital stays for mastectomies and lumpectomies,[304] annual mammograms for women over forty, and certain gynecological services.[305]

Targeted federal and state initiatives, while in some cases helpful, do not address the full policy problem. Indeed, such initiatives, assuming they are not preempted by ERISA, can create additional problems that ultimately undermine the central goal of the drive to reform health care—lowering costs. "Consumer protection against managed care is particularly subject to 'mom-and-apple-pie' rhetoric and legislative posturing."[306] This posturing can lead to "misdirected" legislative initiatives in that, "[e]ven when the legislature successfully identifies a real problem, the issue is invariably more complex than it first appears, and the proposed reforms suffer from their own shortcomings, even without factoring in the (usually carefully ignored) economic implications."[307]

There are many examples of this problem. First, statutes like the one in California, while providing some protection for physicians

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302. *Id.*

303. Pub. L. No. 104-204, 110 Stat. 2935 (1996) (codified at 29 U.S.C. § 1185).

304. Breast Cancer Patient Protection Act of 2001, H.R. 536, 107th Cong. (2001); Women's Cancer Recovery Act of 2001, H.R. 1485, 107th Cong. (2001).

305. Mammogram Availability Act of 1997, H.R. 617, S. 727, 105th Cong. (1997).

306. Hyman, *supra* note 122, at 303.

307. *Id.* at 303-04.

against retaliation, do so imperfectly. It is often difficult to show the real reason why a physician was terminated from a plan.[308] In addition, such statutes would ultimately increase litigation by physicians against health plans. Although the litigation may be well-founded, it would almost certainly drive up the cost of health care by creating additional costs for health plans.

In addition, piecemeal legislation does nothing to get the physician involved in cutting the costs of health care. The assumption underlying many such legislative initiatives is that physicians should practice medicine like they did in the fee-for-service days, putting individual patients first and advocating for all treatment that is within the current standard of care. The standard of care does not include considerations of cost. Therefore, while providing some measure of relief for physicians, on its own, targeted legislation likely would do little to encourage a reduction in health care costs. This problem makes such legislation weak from a utilitarian perspective because it could do more overall harm than good.

C. Provide for Direct MCO Liability

A third possible solution to the policy problem is federal legislation either to amend ERISA or, standing on its own, to give patients a direct right to sue their MCOs for injury caused when cost-containment decisions may have contributed to a poor patient outcome. Numerous lawmakers and commentators advocate this approach. Recently there have been several "Patients Bill of Rights" proposals in Congress.[309] Such proposals would not only give patients a right to sue their MCOs, but would also guarantee a right to direct access to certain specialists such as obstetricians, gynecologists and pediatricians. They would also require MCOs to have an external appeals process in place if a patient wanted to challenge a coverage decision.[310] In addition to legislative initiatives to give patients a direct right to sue MCOs, some courts recently have shown

308. Liner, *supra* note 218, at 517.
309. *See* Hyman, *supra* note 122, at 289.
310. *See id.* at 291-92.

a willingness to limit the ERISA preemption shield that MCOs have enjoyed.[311]

The court in *Andrews-Clarke* summarized the benefits of imposing direct liability on MCOs. The court criticized piecemeal approaches to managed care regulation and stated that instead of attempting to regulate managed health care procedure-by-procedure, "the more efficient approach is to allow insurers and utilization review providers to make benefit determinations on a case-by-case basis, but hold them legally accountable for the consequences of their decisions."[312] The court in that case and others have noted that, by holding MCOs directly accountable, unwarranted cost-cutting in the utilization review process will not be cost-free to the MCO, and therefore MCOs will have greater incentives to ensure high-quality services as well as lower costs.[313]

This solution to the policy problem is attractive in that it would mitigate at least some of the unfairness that currently results from making physicians primarily liable for cost-cutting treatment decisions. Such an approach is intuitively and legally appealing because MCOs would be subject to liability and therefore accountable for their actions. Enacted on the federal level, such a right would apply to all MCO subscribers and would therefore have the appeal of uniformity of a remedy for those who allege injury, as well as uniformity of requirements and legal precedent for the MCOs who would be subject to liability. Despite the apparent benefits of this proposal, however, it is not the solution that would produce the overall best outcome for health care.

Although guaranteeing patients a right to sue their health plans is politically popular, it is clear even to proponents of the legislation that such a right will increase the costs of health insurance. Similarly, recent cases denying ERISA preemption and allowing claims to go forward against MCOs involve significant costs. The cost to litigate such complex lawsuits will ultimately get passed on to

311. *See, e.g.*, Cristantielli v. Kaiser Found. Health Plan, 113 F. Supp. 2d 1055, 1063 (N.D. Tex. 2000).

312. Andrews-Clarke v. Travelers Ins. Co., 984 F. Supp. 49 (D. Mass. 1997) (emphasis in original).

313. *Id.* at 63.

health insurance subscribers.[314] These cost increases likely will lead to a growing number of uninsured individuals.[315] Furthermore, such initiatives, standing alone, do little to change the perception that rationing care is wrong and that cost should not be a component of the treatment decision. While it helps physicians and MCOs to share more fully the liability burdens of cost containment, it does little to encourage individual physicians and the medical profession to do more to contain health care costs. To some extent, such a proposal is ultimately premised on the theory that physicians should practice medicine the way they did in the fee-for-service days. The direct liability proposal, therefore, suffers from important utilitarian flaws. Accordingly, though such a proposal is not inconsistent with an ideal policy response, standing alone it does not do enough.

A fourth proposal is to modify the malpractice standard applied to physicians. As explained below, this solution, in conjunction with legislation aimed at protecting physicians from the unfairness of the current scheme, is the most promising for several reasons.

VI. PROPOSED SOLUTION – REFORM THROUGH THE MEDICAL PROFESSION

The best overall solution to the policy problem is for the medical profession to take the initiative and institute reforms in the way they practice medicine such that they responsibly and effectively incorporate considerations of cost into the treatment decision. By doing this, the medical profession can gradually modify the legal standard of care can so that a physician no longer faces or fears liability if she does not do "everything" for a patient regardless of cost. This approach does not require lowering the standard of care, but rather makes the standard of care more reflective of the current state of health care and matches the goals of health-care reform. Additionally, a modified standard of care would work with targeted

314. *See* Hyman, *supra* note 122, at 304.

315. *See id.* Indeed, we are currently seeing the effects of increases in malpractice insurance as a result of increased malpractice litigation and awards—physicians are leaving their practices because they cannot afford the premiums.

legislation to guarantee physicians fair treatment in their relationships with MCOs, yet still encourage utility-maximizing practice styles. While physicians would still face liability for treating a patient in a manner that does not comport with acceptable medical practice, the law would no longer pretend that costs should not be considered in the treatment decision.

A. Policy Change Through the Profession

As discussed above, traditional ethical and legal requirements that the physician put the individual patient first can no longer stand.[316] As an ethical matter, such policies have the effect of being fundamentally unfair to physicians and, from a utilitarian perspective, the costs far outweigh the benefits. Therefore, while it is clear that physicians should not completely discard fiduciary duties to patients, it is equally clear that the medical profession must alter its way of doing business—no longer rejecting the notion of any type of bedside rationing.[317] Although the medical culture surely cannot change overnight, the profession can take concrete steps to effect a solution to the policy problem outlined above. The first and most important step is to begin altering the traditional meaning of the standard of care.

The traditional notion of the standard of care rests on "patient first" principles. While maintaining a standard that demands quality medical treatment is important, this standard must no longer naively require physician fidelity to the individual patient without any regard to costs. Striking such a balance may seem difficult, but such a solution is not out of reach. There are two possible options to effectuate a change in the standard of care. The first is to pass legislation that would incorporate cost into the standard of care.[318] The broad principles that underlie the standard of care could change to focus less on the individual patient, and instead provide that "care would not be deemed necessary unless it had a high probability of

316. *See* MORREIM, *supra* note 15, at 86.
317. *See id.*
318. *See* Hirshfeld, *supra* note 2, at 1842.

resulting in a substantial benefit to the patient."[319] Legislation could require physicians to balance a duty to society to control health-care costs against the duty to the individual patient.[320] Finally, a legislatively-created defense to a malpractice action could protect a physician who treats a patient where there are insufficient resources available to finance the recommended treatment.[321] The second option is to allow the standard to evolve in the courts.[322] This option implies some evolution within the medical profession itself as the standard of care is derived from the prevailing views of appropriate practice by physicians themselves.[323]

Putting the burden on and giving the power to the medical profession to address the policy problem makes sense for several reasons. As an initial matter, an argument can be made that physicians have a duty to participate in lowering the costs of health care. This duty stems from the fact that the escalating costs of health care in some measure are the result of the autonomy physicians have enjoyed over the past several decades and the influence physicians have had over the structure of health insurance and reimbursement.[324] Because physicians have, arguably, reaped substantial benefits from the fee-for-service system, one could assert that they now must bear some of the burdens of working toward a solution.

A second reason supporting a solution generated by the medical profession is that, while recognizing that physicians have a duty to work toward a solution, it also respects physicians' autonomy and professional status. One of the main objections by physicians to managed health care is that it erodes their autonomy with respect to clinical matters. Leaving physicians to appropriately modify the standard of care empowers them and moves their status from being part of the problem to part of the solution. The profession will thus "buy in" to the policy solution in a way that, clearly, they have not

319. *Id.*
320. *See id.* 1842-43.
321. *See id.*
322. *See id.*
323. Hirshfeld, *supra* note 2, at 1845.
324. PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 332 (Basic Books 1982).

done with the externally-imposed rules of the government and MCOs. This buy-in is important because physicians who feel that third parties are inappropriately affecting their clinical decision making may resort to deception to provide the care they think is in their patients' best interests; they feel ethically and legally justified in doing so. As discussed above, this "act utilitarianism" serves to subvert the goals of health care cost containment and has significant "rule" utilitarian effects.

Similarly, it is important to respect the profession and allow it to redefine the goals of medical practice. These goals should not be externally imposed, but should come from within, and can be a part of a larger rethinking of the accepted aims of medical practice. As stated by an international committee studying health-care reform, "unless such an examination is carried out, and some new and better ideals and directions formulated, the enterprise of medicine and the health care systems of which it is a part will be . . . economically unsustainable."[325] One way to bridge the gap between the actions of individual physicians on behalf of individual patients and the effects on society is to empower physicians so they can make the necessary changes to their pattern of practicing medicine.

Additionally, leaving the medical profession to modify the standard of care is preferable because physicians are in the best position to know what care is cost-effective and provides marginal benefits in any given clinical situation. Moreover, because of their specialized training, physicians can most effectively study and evaluate treatments for cost-effectiveness and determine whether a particular treatment is justified given its costs and expected benefits.

B. Modification Through Clinical Practice Guidelines

Once it is accepted that the medical profession is in the best position to bring about a policy change to alleviate the effects of the policy problem, the question becomes whether the profession in fact has the tools to do so. Courts have long recognized that they do.

325. THE GOALS OF MEDICINE: THE FORGOTTEN ISSUE IN HEALTH CARE REFORM 12 (Mark J. Hanson & Daniel Callahan eds., Georgetown University Press 1999).

Courts defer to the medical profession to determine the appropriate standard of care in medical malpractice cases.[326] The standard traditionally has been gleaned from a variety of sources, including professional journals and conferences, as well as the "complex interaction" of the members of the medical profession.[327] Over time, the opinions and comments of members of the profession, if accepted, grow into a "clinical policy," and then the standard of care.[328] For any given medical problem, there is not merely one correct standard of care.[329] Variations exist, and courts allow juries to determine precisely which standard of those presented at trial should govern in any particular case.[330] Cost can begin to become part of the standard of care; one of the methods for incorporating sensible cost considerations into the standard is through clinical practice guidelines.[331]

Simply stated, clinical practice guidelines, also referred to as critical pathways, clinical practice protocols, and practice parameters, are "sets of suggestions, described in decision rules, based on current medical consensus about how to treat a certain illness or condition."[332] Such guidelines are meant to assist both the physician and patient in making decisions about appropriate care in specific circumstances.[333] Clinical practice guidelines have attracted attention not just as a quality and cost control device, but also as a tool for defining the appropriate standard of care in a malpractice case:

326. *See, e.g.*, Culbertson v. Mernitz, 602 N.E.2d 98, 100 (Ind. 1992).

327. Jodi M. Finder, *The Future of Practice Guidelines: Should They Constitute Conclusive Evidence of the Standard of Care?*, 10 HEALTH MATRIX 67, 77 (2000).

328. *Id.*

329. *Id.* at 78.

330. Barry R. Furrow, *Imposing Liability for the Undertreatment of Pain by Physicians, Hospitals, Nursing Homes, and Managed Care Organizations*, 29 J.L. MED. & ETHICS 28 (2001).

331. *Id.* at 32. This paper does not discuss the technical legal issues involving the weight, in a given malpractice case, to be given to clinical practice guidelines, whether such guidelines should be conclusive of the standard of care, and other related issues. This article assumes that such guidelines would, at a minimum, be considered in determining the standard of care. *See* Arnold J. Rosoff, *The Role of Clinical Practice Guidelines in Health Care Reform*, 5 HEALTH MATRIX 369, 390-91 (1995).

332. Furrow, *supra* note 330, at 32.

333. Finder, *supra* note 327, at 70.

> The development and proliferation of clinical practice guidelines has speeded the process by which good evidence-based medical practice becomes recognized and disseminated as such. In response to the rapid growth in medical research and published findings, these guidelines have become one of the transforming forces in current medical practice."[334]

The medical profession has "expended substantial effort" on developing practice guidelines, many of which have been produced by medical specialty societies and individual medical centers.[335] In the last ten years, the federal government has also sponsored efforts to develop clinical practice guidelines through the Agency for Healthcare Policy and Research (now known as the Agency for Healthcare Research and Quality, "AHRQ").[336] Between 1992 and 1996, the agency sponsored the development of nineteen clinical practice guidelines.[337] AHRQ maintains the National Guideline Clearinghouse, which is a free, publicly available database of clinical practice guidelines, produced in partnership with the American Medical Association and the American Association of Health Plans. "[T]he fact that they are produced by national medical specialty societies and the government means that they will be influential."[338] Although critics label clinical practice guidelines as "cookbook" medicine,[339] in fact, studies have shown that they can be effective in both improving health care quality and cutting costs. Studies have also demonstrated that physicians, when properly trained in the use of such guidelines and when audited for compliance, follow the guidelines and believe they can be helpful.[340] Moreover, physicians can use clinical practice guidelines to educate patients and involve them in the effort to make sensible health care choices. Indeed,

334. Furrow, *supra* note 330, at 35.

335. *Id.* at 32, 35.

336. AHRQ Profile, *available at* http://www.ahrq.gov/about/profile.htm.

337. Agency for Healthcare Research and Quality: Clinical Practice Guidelines Online, *available at* http://www.ahrq.gov/clinic/cpgonline.htm.

338. Furrow, *supra* note 330, at 32.

339. Glenn Flores et al., *Pediatricians' Attitudes, Beliefs, and Practices Regarding Clinical Practice Guidelines: A National Survey*, 105 PEDIATRICS No. 3, 500 (Mar. 2000).

340. *Id.*

patients rights advocates view guidelines as a means of improving patient autonomy, made easier because the guidelines are available online.[341]

In a study published in the Journal of the American College of Surgeons, researchers stated that, if adopted and practiced, clinical practice guidelines "can improve performance and lower the cost of health care by reducing provider variability and error and controlling geographic practice patterns. [Clinical practice guidelines] have been demonstrated to be effective in lowering costs and improving outcomes in several surgical, medical, trauma, and ICU settings."[342] Despite these results, the researchers found that variations in clinical practice may still exist, in part due to the fact that, at many medical centers, treatment orders are delegated to "junior members" of the medical team who may order treatment that exceeds the requirements of the guidelines out of inexperience.[343] Likewise, more senior physicians might over treat "out of rote."[344] With respect to both the less experienced physicians and the more senior physicians on staff, the researchers found that a system that simply reminds physicians of the guidelines and then audits for compliance yields a significantly higher incidence of compliance with, and benefit from, the guidelines.[345] In the study, compliance with the guidelines was 48% before the institution of continuous surveillance by a nurse who was trained as a clinical resource manager.[346] Compliance was 74% after surveillance was instituted, with all deviations from the guidelines deemed to be medically justified.[347]

The researchers noted that for the two conditions studied, over a two month period, the cost of "over" treatment due to noncompliance with the guidelines was $22,760.35. The researchers concluded that, with proper oversight, there was "a significant preliminary potential

341. *See* Finder, *supra* note 327, at 71; Furrow, *supra* note 330, at 33.
342. Heidi L. Frankel et al., *Strategies to Improve Compliance with Evidence-Based Clinical Management Guidelines*, 189 J. AM. SURG. 533 (1999).
343. *Id.* at 533.
344. *Id.*
345. *Id.*
346. *Id.*
347. Frankel et al., *supra* note 342, at 533.

for cost savings" with clinical management guidelines.[348] Indeed, specific estimates found in the guidelines themselves support this conclusion. For instance, in a clinical practice guideline dealing with the treatment of pressure ulcers, the authors explain that in economic terms, the reported cost of pressure ulcer treatment can vary greatly. The guideline estimates that the total national cost of pressure ulcer treatment exceeds $1.335 billion. Implementation of the recommendations is estimated to reduce the cost of pressure ulcer treatment by 3% or $40 million.[349]

Through the use of clinical practice guidelines, cost considerations can become a legitimate component of the standard of care for several reasons. First, the guidelines will help minimize wasteful or unnecessary care as well as treatment variations based on little more than geographic location of the physician and patient. Second, the guidelines will alert physicians to treatment patterns that are most cost-effective or that represent the greatest cost benefit in any given situation. With appropriate institutional and professional oversight and incorporation into medical education, physicians can therefore learn to practice more cost-effective medicine, and do so in a way that avoids haphazard, forced rationing.

Finally, making cost a legitimate component of the treatment decision will serve to lessen the chance that an MCO would deselect or terminate a physician from a plan for practicing medicine in too costly a manner. To the extent MCOs still threatened termination or imposed unreasonable cost limitations, targeted legislation like that discussed above would work hand-in-hand with a new standard of care to protect the physician while encouraging more cost-efficient medical practice.

Critics may argue that the proposal to change the governing standard of care to allow for considerations of cost in the treatment decision sanctions bedside rationing. Critics point out that such rationing is not legitimate because it places physicians in an ethical

348. *Id.* at 537.

349. Pressure Ulcer Clinical Practice Guideline, *available at* http://www.ahrq.gov/clinic/cpgonline.htm.

dilemma—pitting patient needs against treatment costs.[350] They argue that rationing must move away from the bedside and into public view as part of the democratic process.[351] In this way, rationing choices are open to debate, and physicians can establish clear guidelines.[352] Such guidelines would free the physician from having to make these choices and would involve individual patients in making the difficult decisions.[353] Moreover, critics argue that bedside rationing can be haphazard and even discriminatory.[354]

Yet under the policy solution advocated here, bedside rationing need not be as ethically deficient as critics argue. First, despite the fear that such rationing will pit physicians against patients and erode the trust patients have in their physicians, this is not necessarily the case. Physicians are still "one of the most highly trusted professional groups."[355] Indeed, when faced with the fact that rationing in some way must be a part of modern health care, most patients would prefer that their physician, whom they trust, do the rationing, as opposed to MCOs or government organizations.[356] Additionally, some such rationing already takes place in health care.[357] Giving it a scientific basis and bringing it out into the open will likely lend the practice credibility and ultimately serve to enhance the trust already present in the physician-patient relationship.[358]

Second, such rationing decisions, although made at the bedside, would be more open than they are today. Changes to the standard of care would require changes within the medical community, beginning with the way we educate physicians. Physicians would have an opportunity to participate in crafting suggested practice guidelines and could then discuss openly with their patients the efficacy of treatments in light of their cost. With the availability and usefulness

350. *See* UBEL, *supra* note 46, at 137.
351. *See* WONG, *supra* note 14, at 45.
352. *See id.*
353. *See id.*
354. *See* UBEL, *supra* note 46, at 139-41.
355. *Id.* at 139.
356. *Id.* at 140.
357. *Id.* at 140.
358. *See* WONG, *supra* note 14, at 45.

of clinical practice guidelines in educating and informing patients, bedside rationing need not be a secretive, illegitimate practice as it traditionally has been viewed. Additionally, bedside rationing, under the solution envisioned here, would not be as haphazard or discriminatory as imagined. Through the use of clinical practice guidelines, with appropriate oversight as necessary, physicians would achieve bedside rationing in an even-handed and more scientifically-supported way. Moreover, a broadening of the standard of care to encompass cost considerations, with the use of practice guidelines, would best succeed if the principles were a part of medical education and training. Therefore, once they reached practice, physicians would be properly equipped to make responsible bedside rationing decisions. Bedside rationing has two moral strengths.[359] It is "indispensable" in that reducing the costs of health care cannot be achieved without the efforts of physicians, and it allows health care to be rationed in a way that accounts for individual patient needs in unique clinical settings.[360]

Finally, some sanctioning of bedside rationing and modification of the standard of care need not and should not mean the elimination of all liability for physicians, nor must it weaken important ethical duties with which we are comfortable. It is possible to preserve some of the most important benefits of the current liability framework while mitigating its unfairness and minimizing the costs. Because modifying the current standard of care leaves in place traditional liability principles, the solution proposed here provides a realistic and more incremental approach to resolving the policy problem.

CONCLUSION

As explained above, the policy problem is one with deep roots in our legal, medical, and popular culture. Its ethical complexity illustrates that a simple, politically popular legislative fix, whether in the form of targeted state or federal legislation or a "Patients Bill of

359. *Id.*
360. UBEL, *supra* note 46, at 147.

Rights," may be necessary, but not enough, for an optimal solution. The optimal solution must include an initiative from the medical profession to responsibly embrace cost considerations that temper the "patient first" ethic with utility-maximizing practice patterns. A new standard of care coupled with state or federal legislation that protects the physician from the unfairness of the current policy (such as legislation preventing termination from an MCO where the MCO's cost-containment goals exceed a new, cost-conscious standard of care) can go a long way toward solving the policy problem. In this way, legislation that might otherwise have perpetuated the cost-escalating style of medical practice can work hand-in-hand with the medical profession to produce the cultural changes that health care desperately needs.