

4-30-2015

A Defense of Physicians' Gatekeeping Role: Balancing Patients' Needs with Society's Interests

Jessica Mantel

Follow this and additional works at: <http://digitalcommons.pepperdine.edu/plr>

 Part of the [Health Law Commons](#), and the [Medical Jurisprudence Commons](#)

Recommended Citation

Jessica Mantel *A Defense of Physicians' Gatekeeping Role: Balancing Patients' Needs with Society's Interests*, 42 Pepp. L. Rev. 633 (2014)
Available at: <http://digitalcommons.pepperdine.edu/plr/vol42/iss4/1>

This Article is brought to you for free and open access by the School of Law at Pepperdine Digital Commons. It has been accepted for inclusion in Pepperdine Law Review by an authorized administrator of Pepperdine Digital Commons. For more information, please contact Kevin.Miller3@pepperdine.edu.

A Defense of Physicians' Gatekeeping Role: Balancing Patients' Needs with Society's Interests

Jessica Mantel*

Abstract

Although scholars and policymakers increasingly accept the need to ration health care, physicians doing so at the bedside remains controversial. Underling this debate is how to characterize the duty of care physicians owe their individual patients. Ethically, physicians are under strict fiduciary obligations that require them to give primacy to individual patients' best interests. However, new health care delivery models that hold providers financially accountable for health care costs assign to physicians a gatekeeping role, with physicians obliged to balance individual patients' needs with the competing societal goal of controlling costs. This Article explains that the choice between the traditional patient-centered duty of care and a dual duty of care that balances patient and societal concerns turns on which paradigm best promotes the public interest. It then argues that the public interest would be better served by a dual duty of care because bedside rationing is essential if the U.S. is to successfully control health care costs. In addition, a dual duty of care furthers the policy goals underlying recent federal and state health policy initiatives. This Article concludes by identifying several tenets of health law and ethics biased toward a patient-centered duty of care—physicians' duty of advocacy, the medical malpractice system, and informed patient consent—and contends that each should be reformed to accommodate physicians' dual duty of care.

* Assistant Professor, University of Houston Law Center. Thank you to Mark Hall, Allison Hoffman, Barbara Evans, Joseph Sanders, Theodore Rave, Jessica Roberts, and Emily Berman for their useful discussion and suggestions; and to Emily Lawson, Karrie Wheatley, and Patrick McMillin for their research assistance.

I. INTRODUCTION.....	634
II. THE PHYSICIAN AS FIDUCIARY: AN ABSOLUTE OR LIMITED ROLE?...	643
A. <i>Fiduciary Relationships and the Physician-Patient Relationship</i>	645
B. <i>The Nature and Scope of a Fiduciary's Duties</i>	649
III. A DEFENSE OF HEALTH CARE RATIONING	651
A. <i>Controlling Health Care Costs: The Necessity of Rationing</i> ..	652
B. <i>The Autonomy Rationale for a Patient-Centered Duty of Care</i>	660
IV. THE MERITS OF BEDSIDE RATIONING VS. OTHER FORMS OF RATIONING.....	664
A. <i>Centralized Rationing Through Government Entities</i>	666
1. The Merits of Centralized Government Rationing	667
a. <i>Preserving Patient Trust</i>	668
b. <i>Protecting Patients from Substandard Care</i>	672
c. <i>Legitimacy and Fairness</i>	677
2. The Problems with Centralized Government Rationing ...	685
a. <i>The Problem of "Tragic Choices"</i>	685
b. <i>The Impracticality of Administrative Rules for Rationing Care</i>	690
B. <i>Rationing Through Payors</i>	694
C. <i>Giving Patients More Skin in the Game Through Higher Cost-Sharing</i>	696
V. GOVERNMENT PROGRAMS PROMOTING PROVIDER FINANCIAL INCENTIVES.....	700
VI. THE PHYSICIAN-PATIENT RELATIONSHIP UNDER A DUAL DUTY OF CARE	707
A. <i>Physicians' Duty of Advocacy</i>	707
B. <i>The Malpractice System as a Barrier to a Dual Duty of Care</i>	711
C. <i>Reconsidering Informed Consent Law's Disclosure Requirements</i>	718
VII. CONCLUSION	725

I. INTRODUCTION

If a patient complains of recurring headaches, should the physician inform the patient about magnetic resonance imaging (MRI) if there is a

slight chance of discovering a brain tumor? Must the physician order an MRI if the patient requests one? If the patient's insurer denies coverage for an MRI that the physician believes to be in the patient's best interest, must the physician appeal to the insurer to reverse its decision? Should a physician avoid arrangements with payors and others that financially reward the physician for delaying or denying the patient an MRI or other beneficial care?

These questions have generated intense debate both within the medical profession and among scholars. Underlying this debate is the fundamental issue of how to characterize the duty of care that physicians owe their individual patients, namely whether physicians must give primary allegiance to their individual patients' best interests—what this Article will refer to as a patient-centered duty of care—or whether physicians should consider societal concerns together with patients' interests under a dual duty of care. In other words, should physicians be permitted to ration care at a patient's bedside? This Article argues that health law and ethics should reflect a dual duty of care.

The predominant view of the medical profession and bioethicists is that physicians owe their individual patients a patient-centered duty of care. A patient-centered duty of care imposes strict fiduciary obligations on the physician. Physicians must give their individual patients their undivided loyalty, “acting as the patient's selfless, scrupulous, dutiful agent.”¹ They also must subordinate both their own interests and those of others to the individual patient's best interest,² “do[ing] everything that they believe may benefit [the] patient without regard to costs or other societal considerations.”³

In fulfilling this duty, the physician should inform the patient of all potentially beneficial treatments, provide all medically appropriate care

1. Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899, 921 (1994); see also Edmund D. Pellegrino, *Managed Care at the Bedside: How Do We Look in the Moral Mirror?*, 7 KENNEDY INST. ETHICS J. 321, 322 (1997) (stating that the ordering principle that “provides the moral *sine qua non* . . . is the primacy of the moral obligation of health care professions to act in the best interests of the person who is ill”).

2. See, e.g., AMERICAN MED. ASS'N, CODE OF MEDICAL ETHICS, xiv, ¶ VIII (2004–05 ed.) (“A physician shall, while caring for a patient, regard responsibility to the patient as paramount.”); see also Susan M. Wolf, *Toward a Systemic Theory of Informed Consent in Managed Care*, 35 Hous. L. REV. 1631, 1641–42 (1999) (describing the norms of traditional medical ethics).

3. Norman G. Levinsky, *The Doctor's Master*, 311 NEW ENG. J. MED. 1573, 1573 (1984).

desired by the patient, and advocate on behalf of the patient when payors or others limit the patient's access to care. For example, a physician should inform a patient with recurring headaches about the availability of an MRI (if medically appropriate). Similarly, the physician should acquiesce to the patient's request for an MRI if the test might be beneficial to the patient. The physician also should appeal an insurer's decision to deny coverage for an MRI that the physician believes to be in the patient's best interest.⁴ In addition, the physician must avoid conflicts of interests that may lead the physician to compromise the patient's needs in favor of the physician's own interests or those of third parties.⁵ The physician therefore must avoid financial arrangements that reward her for choosing less costly care or for delaying or withholding beneficial care from her patients.⁶

In contrast, under what this Article refers to as a dual duty of care, the physician's fiduciary obligations to the patient would be limited by the physician's competing obligations to society. This dual duty of care includes promoting the societal goal of constraining health care costs and ensuring the equitable allocation of limited medical resources.⁷ The physician's traditional role as a patient advocate thus would give way to the physician acting as a gatekeeper. Accordingly, the physician would decide

4. See *Wickline v. California*, 239 Cal. Rptr. 810, 819 (Cal. Ct. App. 1986) (commenting that it is ultimately the physician's responsibility to determine whether or not a patient should be discharged from the hospital despite a contrary coverage decision from the insurer).

5. For example, the AMA Code of Medical Ethics provides as follows:

Under no circumstances may physicians place their own financial interests above the welfare of their patients For a physician to unnecessarily hospitalize a patient, prescribe a drug, or conduct diagnostic tests for the physician's financial benefit is unethical. If a conflict develops between the physician's financial interest and the physician's responsibilities to the patient, the conflict must be resolved to the patient's benefit.

AMA CODE OF MED. ETHICS § 8.03, *reprinted in* MEDICAL ETHICS: CODES, OPINIONS, AND STATEMENTS 35 (Baruch Brody et al. eds., 2000).

6. See Thomas H. Boyd, *Cost Containment and the Physician's Fiduciary Duty to the Patient*, 39 DEPAUL L. REV. 131, 158 (1989) (stating that the physician's fiduciary duty obligates the physician to "avoid any third-party arrangement that rewards them for choosing a particular facility or service for their patients or which rewards them for withholding services from their patients").

7. Competing models of the dual duty of care vary as to how to balance the individual patient's welfare and society's interests. For example, a physician may give equal weight to the patient's needs and society's interests, may focus on maximizing social welfare, or may give heavy but not dispositive weight to the patient's interest. See generally Pellegrino, *supra* note 1, at 324 (discussing the "strong" and "weaker" forms of professional ethics that considers the impact on society). Choosing among alternative visions of a dual duty of care is beyond the scope of this Article.

whether to grant a patient access to specific care based not only on the needs of the individual patient but also after consideration of the treatment's cost effectiveness, the needs of other patients, and competing demands on the public's purse.⁸ Consequently, while the importance of each patient as an individual would not be ignored, the physician must balance a patient's welfare with the community's welfare.

At times, then, a physician may place the interests of society above an individual patient's needs, withholding or delaying care that may be beneficial to that patient. For example, the physician may elect to forego an MRI for a patient with recurring headaches if that physician believes the likelihood of the patient suffering a serious condition is remote. The physician also may abstain from lobbying insurers to pay for care that is not cost-effective, even if such care would promote the patient's best interest. In addition, a dual duty of care would permit financial arrangements that incentivize physicians to fulfill their role as stewards of society's health care resources.

Prior to the managed care era, the health care system was structured in a manner that protected the physician's role as a patient's fully committed fiduciary.⁹ Physicians received a fee for all medically appropriate care provided to patients, with insurers and government payors deferring to the physicians' judgment about which services were medically appropriate for their patients.¹⁰ With little oversight or financial incentive to consider payors' costs, the so-called fee-for-service model allowed physicians to focus on their patients' welfare.¹¹ Professional norms thus reflected a

8. *See id.* (stating that under an ethical framework that emphasizes the population over the individual patient, the physician becomes a "gatekeeper," deciding "who is to receive scarce resources"); *see also* Richard S. Saver, *In Tepid Defense of Population Health: Physicians and Antibiotic Resistance*, 34 AM. J.L. & MED. 431, 434-35 (2008) ("The ideal physician gatekeeper makes referrals and grants patient access to health care services and technology on a discretionary basis, considering effectiveness and cost as well as the patient's needs in an attempt to manage limited resources equitably for the benefit of patients as a whole.").

9. *See* Dionne Koller Fine, *Physician Liability and Managed Care: A Philosophical Perspective*, 19 GA. ST. U.L. REV. 641, 642 (2003).

10. *See id.* at 644-45 (explaining the fee-for-service model).

11. *See id.* at 645 (explaining how the fee-for-service model protected physicians' ethical duty of absolute fidelity to the patient). A more cynical view of the fee-for-service model notes that it invites patterns of excessive care, which is arguably contrary to the patient's best interests, by rewarding physicians for doing more. *See* Mark A. Hall, *Rationing Health Care at the Bedside*, 69 N.Y.U. L. REV. 693, 768 (1994) [hereinafter Hall, *Rationing Health Care*] (noting that fee-for-service "causes not only vast economic waste but also leads to patient injury and death from overly

patient-centered duty of care—physicians were obligated to provide individual patients with all potentially beneficial, regardless of cost.¹²

Over time the fee-for-service model became unworkable because unconstrained financing produced continually rising health care costs.¹³ In response, health care payors turned to various mechanisms that aimed to lower health care costs, collectively called “managed care.”¹⁴ Under utilization review, for example, payors independently review a physician’s determination that care is medically necessary.¹⁵ Managed care plans also employ a range of tools that encourage physicians to use services more judiciously.¹⁶ For instance, physicians who provide costly care risk “deselection” or plans terminating the physician’s contract.¹⁷ Perhaps most importantly, managed care plans give physicians financial carrots and sticks designed to counteract the “cost is no object” mentality of fee-for-service.¹⁸

aggressive medication and invasive surgery”); David Orentlicher, *Rationing Health Care: It's a Matter of the Health Care System's Structure*, 19 ANNALS HEALTH L. 449, 458 (2010) [hereinafter Orentlicher, *Rationing Health Care*].

12. See E. Haavi Morreim, *Medicine Meets Resource Limits: Restructuring the Legal Standard of Care*, 59 U. PITT. L. REV. 1, 9 (1997) [hereinafter Morreim, *Medicine Meets Resource Limits*] (stating that the era of unconstrained fee-for-service promoted certain values, including that “any intervention that might help and is unlikely to harm should be used, regardless of cost”); see also Fine, *supra* note 9, at 646 (commenting that the fee-for-service system “overlooks society’s need to control health care costs and instead focuses on providing individual patients with all treatment that could possibly be beneficial” (citing MARK HALL, MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS, AND ECONOMICS OF RATIONING MECHANISMS (Oxford Univ. Press 1997))).

13. See generally Jessica L. Mantel, *Accountable Care Organizations: Can We Have Our Cake and Eat It Too?*, 42 SETON HALL L. REV. 1393 (2012) [hereinafter Mantel, *Accountable Care Organizations*] (explaining how fee-for-service promoted high volume and high intensity care and discouraged efficient practices).

14. See Jason H. T. Karlawish et al., *How Changes in Health Care Practices, Systems, and Research Challenge the Practice of Informed Consent*, 40 MED. CARE V-12, V-15 (2002) (explaining why in the 1980s payors turned to managed care in an effort to control rising health care costs).

15. See Michael A. Dowell, *Avoiding HMO Liability for Utilization Review*, 23 U. TOL. L. REV. 117, 117 (1991) (“The purpose of utilization review is to assure that payment is made only for services that are medically necessary and appropriate to the patient’s health care needs.”).

16. See Christine Tobin, *What is Managed Health Care?*, AM. ASS’N DIABETES EDUCATORS (1997) (discussing features of managed care, including payment systems that make physicians financially accountable for medical services).

17. See Bryan A. Liang, *Deselection Under Harper v. Healthsource: A Blow for Maintaining Patient-Physician Relationships in the Era of Managed Care?*, 72 NOTRE DAME L. REV. 799, 799–803 (1997) (explaining that deselection is driven by a managed care plan’s desire to minimize costs).

18. See Timothy S. Hall, *Bargaining with Hippocrates: Managed Care and the Doctor-Patient Relationship*, 54 S.C. L. REV. 689, 714 (2003) (explaining that managed care’s external review

These financial arrangements incentivize physicians to consider the economic consequences of their treatment decisions by placing physicians (or their affiliated organizations) at financial risk for the aggregate costs of caring for their patients.¹⁹ For example, under capitation payors give providers a single payment for each patient they care for, regardless of how much or little care is given a patient.²⁰ The capitated provider therefore assumes the entire financial risk of treating a patient, losing money if the cost of care exceeds the capitated payment and making money if the opposite occurs.²¹ Similarly, payors utilize various financial bonus and

systems were insufficient and that payors therefore had to counteract the perverse incentives of fee-for-service by giving physicians incentives to consider costs); David Orentlicher, *Health Care Reform and the Patient-Physician Relationship*, 5 HEALTH MATRIX 141, 170 (1995) [hereinafter Orentlicher, *Health Care Reform*] (stating that alternatives to giving physicians financial incentives to consider costs may not be sufficiently effective to contain costs).

19. See Joan H. Krause, *Reconceptualizing Informed Consent in an Era of Health Care Cost Containment*, 85 IOWA L. REV. 261, 281 (1999) (explaining that managed care's financial incentives put physicians at financial risk for the costs of care they furnish or initiate). Payors shift financial risk to providers either through direct contracts with individual physicians or through contracts with the organizations employing or contracting with individual physicians, such as physician groups, independent practice associations, physician-hospital organizations, or accountable care organizations (ACOs). See Brant S. Mittler & André Hampton, *The Princess and the Pea: The Assurance of Voluntary Compliance Between the Texas Attorney General and Aetna's Texas HMOs and Its Impact on Financial Risk Shifting by Managed Care*, 83 B.U. L. REV. 553, 555, 560–61 (2003) (explaining that managed care organizations shift financial risk to providers either directly or indirectly through providers' affiliated organizations). In the later scenario, financial incentives applied at the organization level often incentivize individual physicians to practice cost-sensitive care because the physician's income may rise or fall on the basis of the organization's financial performance. See generally Douglas A. Mains et al., *Physician Incentives: Managed Care and Ethics*, 2 INTERNET J. L., HEALTHCARE & ETHICS, no. 1, 2003. For example, the intermediary organization may utilize its own financial incentives in its contracts with physicians to motivate its physicians to make cost-sensitive treatment decisions. See Mittler & Hampton, *supra*, at 560 (explaining that the intermediary organizations contracting with insurers may "further downstream risk" to individual physicians). Even if the organization does not directly reward its physicians for considering the cost of care, organizations can affect physicians' clinical decisions through a culture that values lowering the cost of patient care. See Jessica Mantel, *The Myth of the Independent Physician: Implications for Health Law, Policy, and Ethics*, 64 CASE W. RES. L. REV. 455, 519 (2013) [hereinafter Mantel, *The Myth of the Independent Physician*] (explaining how an organization's culture impacts physicians' patient care decisions).

20. See Frances H. Miller, *Foreword: The Promise and Problems of Capitation*, 22 AM. J.L. & MED. 167, 168 n.9 (1996) (discussing the federal government's capitation efforts in hospitals that pay a flat sum for patients, "regardless of the amount of services an individual patient may consume").

21. See Ken Marcus Gatter, *The Continued Existence and Benefit of Medicine's Autonomous Law in Today's Health Care System*, 24 U. DAYTON L. REV. 215, 218 n.7 (1999) (explaining capitation). The annual capitated payment frequently covers the full scope of services provided to

penalty devices that tie providers' payments to whether the provider lowers costs by approving fewer ancillary tests, referrals to specialists, and hospital admissions.²² Payors also are experimenting with bundled payments—a single fixed payment for an episode of care that forces providers to economize so that they do not exceed the amount received.²³ Finally, some payors and providers have entered into shared savings arrangements with providers who collectively lower the cost of caring for a patient population receiving a percentage of the savings provided that they also satisfy certain quality measures.²⁴

While the beginning of the twenty-first century saw a decline in payors' aggressive use of financial incentives,²⁵ recent changes in the health care system have encouraged payors to again focus on alternatives to fee-for-service.²⁶ This increased use of provider financial incentives has encouraged

patients over the course of the year, although sometimes certain categories of care are carved out such as pharmaceuticals or hospital care. See Jeff Goldsmith, *The Future of Medical Practice: Creating Options for Practicing Physicians to Control Their Professional Destiny*, PHYSICIANS FOUND. 38 (2012), http://www.physiciansfoundation.org/uploads/default/Physicians_Foundation_Future_of_Medical_Practices.pdf.

22. See David Orentlicher, *Paying Physicians More to Do Less: Financial Incentives to Limit Care*, 30 U. RICH. L. REV. 155, 160 (1996) [hereinafter Orentlicher, *Paying Physicians More to Do Less*] (explaining arrangements that condition receipt of withheld amounts or bonus payments to various efficiency measures).

23. See Goldsmith, *supra* note 21, at 36 (explaining that bundled payments are a form of insurance risk because poorly coordinated care can result in higher costs that exhaust the fixed bundled payment, exposing the contracting group to losses); Orentlicher, *Paying Physicians More to Do Less*, *supra* note 22, at 160.

24. See Mantel, *Accountable Care Organizations*, *supra* note 13, at 1411 (explaining the shared savings model for accountable care organizations).

25. See John E. Kralewsky et al., *Strategies Employed by HMOs to Achieve Hospital Discounts: A Case Study of Seven HMOs*, in *MANAGED CARE STRATEGIES, NETWORKS, AND MANAGEMENT* 91, 95 (1994) (Montague Brown ed., 1994) (explaining that attempts by HMOs to share financial risk with small physician groups often failed—these groups were not viable risk-sharing units because they had too few patients to allow for forming effective risk pools). In addition, many larger provider organizations experienced economic distress under these new arrangements because they were unable to achieve greater efficiencies given their lack of experience in medical management and shortcomings in health information technology. See Mantel, *The Myth of the Independent Physician*, *supra* note 19, at 463–66 (explaining the failures of new delivery models that arose in response to managed care).

26. See Mantel, *The Myth of the Independent Physician*, *supra* note 19, at 463–66 (describing recent changes in the health care system); Jeroen Trybou et al., *The Ties that Bind: An Integrative Framework of Physician-Hospital Alignment*, 11 BMC HEALTH SERVICES RES. 1, 3 (2011) (commenting that payors are implementing a broad array of public and private sector initiatives that hold providers financially accountable for the cost of care, as well as improved quality of care).

physicians to consider costs when making treatment decisions.²⁷ Rather than focus solely on the patient's best interests, physicians may decline to order a diagnostic test or refer a patient to a specialist; use a less expensive intervention over more costly alternatives; or discharge a patient from the hospital sooner rather than extending her stay.²⁸ Therefore, the economic reality of today's health care system increasingly places physicians in the role of rationing care at the bedside, a role fundamentally incompatible with the physician being the patient's fully committed fiduciary.²⁹

Although managed care expects physicians to ration care, the medical profession, along with many scholars, continues to stipulate that physicians must act as their individual patient's loyal fiduciary and give primacy to an individual patient's health needs.³⁰ Various legal rules similarly reinforce this ethical bias.³¹ Consequently, physicians are caught between legal and ethical rules that impose on physicians a patient-centered duty of care and a marketplace that insists on a dual duty of care.³² Resolving this dilemma requires that society squarely choose between these conflicting paradigms of physicians' proper role.³³

This Article considers the merits of these competing paradigms of physicians' duties and argues in favor of a dual duty of care. Drawing on fiduciary law principles, Part I explains that the choice between the patient-centered and dual duty paradigms turns on considerations of public policy. Parts II, III, and IV then discuss whether the public interest is better served by holding physicians to the strict fiduciary obligations required by the patient-centered duty of care or the more limited fiduciary obligations reflected in the dual duty of care.

27. See Fine, *supra* note 9, at 644 (“The managed care model does not focus on what is best for individual patients, but instead on what is best for society . . . [which] cannot support dramatically escalating health care costs . . .”).

28. See *infra* note 214 and accompanying text.

29. See Fine, *supra* note 9, at 650 (stating that managed care forces physicians to ration care at the bedside rather than abide by the traditional ethic of placing patients first).

30. See *infra* notes 414–16 and accompanying text.

31. See *infra* Part V. See generally William M. Sage, *Relational Duties, Regulatory Duties, and the Widening Gap Between Individual Health Law and Collective Health Policy*, 96 GEO. L.J. 497 (2008) (arguing that current legal rules reflect the health care system's bias toward “relational duties” that require the physician to focus on individual patient's needs, to the detriment of “regulatory duties” that direct physicians toward issues of collective importance).

32. See Sage, *supra* note 31, at 503.

33. *Id.*

Part II considers the arguments of those who object to physicians rationing health care under a dual duty of care because they question the necessity or morality of rationing and concludes that these arguments do not support a patient-centered duty of care.

As discussed in Part III, other commentators opposed to a dual duty of care maintain that alternative mechanisms for rationing care—namely, vesting responsibility for rationing in patients, government regulators, or insurers—are superior to physicians implicitly rationing care at the bedside. Part IV assesses the merits of alternative approaches to rationing and finds that, although bedside rationing raises serious concerns, it nevertheless offers the most realistic model for addressing the complexities of modern medicine and rising health care costs.

Part V examines whether a patient-centered or dual duty of care is more compatible with recent federal and state initiatives in the health policy arena. It concludes that the strict fiduciary obligations reflected in a patient-centered duty of care would frustrate the government's health care agenda. In contrast, allowing physicians to implicitly ration care under a dual duty of care supports the policy goals underlying these new public initiatives.

Finally, Part VI looks at whether current legal and ethical rules that govern the physician-patient relationship support physicians' dual role as both the patient's caregiver and society's agent for rationing care. Part VI.A examines physicians' role as their patients' advocate and asserts that physicians' duty of advocacy should be constrained by the physicians' competing obligation to ensure the just and efficient allocation of medical resources. Part VI.B then argues that the current medical malpractice system may unfairly punish physicians who ration care at the bedside. Part VI.B thus calls upon courts and policymakers to reform the malpractice system to better support physicians' dual role. Lastly, Part VI.C considers the issue of informed consent and the requirement that physicians inform patients about *all* medically appropriate treatment alternatives, regardless of cost. Part VI.C concludes that this requirement undermines physicians' gatekeeping role, and it suggests that courts consider requiring only that physicians inform patients about treatment options that are both clinically *and economically* appropriate, while permitting physicians to stay silent about less cost-effective alternatives.

II. THE PHYSICIAN AS FIDUCIARY: AN ABSOLUTE OR LIMITED ROLE?

Modern tort principles of duty require that the reasonable person look beyond the interests of the parties to the litigation³⁴ and also consider the potential benefits and costs of her behavior to “others.”³⁵ In other words, the reasonable person balances the “social advantages against social disadvantages” arising from her conduct.³⁶ When the relationship between two parties is considered a fiduciary relationship, however, the law departs from ordinary duty principles and imposes heightened obligations on the actor who is another’s fiduciary.³⁷

Under traditional fiduciary principles, the fiduciary owes the beneficiary a duty of undivided loyalty, meaning the fiduciary must narrowly focus on

34. Modern tort law has rejected the narrow focus of the private rights view of liability, which considers only the individual rights and obligations of the parties before the court. John C.P. Goldberg & Benjamin C. Zipursky, *The Moral of MacPherson*, 146 U. PA. L. REV. 1733, 1756 (1998). Scholars who view tort law as a system of private law argue that in defining duty courts should narrowly focus on the individual rights and obligations of the parties before the court and not on the rights of others or utilitarian concerns such as social welfare. *See id.* at 1793–1811 (critiquing formulations of duty that consider utilitarian or cost-benefit concerns, rather than “rights-based reasoning”). The private-law view of torts, however, “is hard to square with doctrinal history” and generally has not been accepted by courts. Mark A. Geistfeld, *Social Value as a Policy-Based Limitation of the Ordinary Duty to Exercise Reasonable Care*, 44 WAKE FOREST L. REV. 899, 905 (2009). *See also infra* note 35 for a discussion of courts’ acceptance of a balancing approach to duty.

35. *See* RESTATEMENT (THIRD) OF TORTS: GENERAL PRINCIPLES § 3 cmt. e. While some have questioned whether courts are fully committed to a balancing approach for determining negligence, no American jurisdiction has rejected the approach. *See* Stephen G. Gilles, *On Determining Negligence: Hand Formula Balancing, the Reasonable Person Standard, and the Jury*, 54 VAND. L. REV. 813, 815–16 (2001) (“And while there is certainly still room for argument about how strongly the courts are committed to Hand Formula balancing, [Gary Schwartz, the Restatement’s Reporter,] rightly points out that there is *no* American jurisdiction ‘whose cases explicitly (or by clear implication) reject the balancing approach as an interpretation of the negligence standard.’”) (quoting RESTATEMENT (THIRD) OF TORTS: GENERAL PRINCIPLES § 4 cmt. c (Discussion Draft Apr. 5, 1999)). Moreover, the majority of state courts, the leading treatises, and most contemporary tort scholars recognize the balancing approach as “authoritative.” *Id.* at 815.

36. Alan D. Miller & Ronen Perry, *The Reasonable Person*, 87 N.Y.U. L. REV. 323, 330–31 (2012). Scholars have offered a range of approaches for how to value the advantages and disadvantages of an actor’s conduct. *See* Gilles, *supra* note 35, at 819–20 (describing various metrics for weighing interests). For purposes of this Article, it is not necessary to wade into this debate, but simply acknowledge that modern conceptualizations of the duty of reasonable care aggregate the interests of others in addition to the plaintiff and defendant.

37. *See* Mary Anne Bobinski, *Autonomy and Privacy: Protecting Patients from Their Physicians*, 55 U. PITT. L. REV. 291, 348 (1994) (“Ordinary tort duties may be expanded or amplified because of the perceived relevance of fiduciary principles.”).

the beneficiary's interests and abnegate all self-interest and the interests of third parties.³⁸ The fiduciary also must avoid any conflict of interest that pits the beneficiary's interests against the fiduciary's self-interest or subjects the fiduciary to conflicting duties to two or more parties.³⁹ Accordingly, if the physician-patient relationship were a fiduciary one, traditional fiduciary principles would require physicians to give primacy to their individual patient's welfare. The physician also must shun any provider financial incentives that create a conflict between the patient's interests and the physician's or payor's economic interests.⁴⁰ That is, traditional fiduciary principles would impose on physicians a patient-centered duty of care.⁴¹

However, the law often demands less from a fiduciary than absolute fidelity to the beneficiary. As described below, courts and policymakers frequently narrow the scope of a fiduciary's duties for public policy reasons, allowing a fiduciary to consider a third party or society's interests alongside the beneficiary's interests.⁴² So even if the physician-patient relationship is a fiduciary relationship, a physician's loyalty to her patients need not be absolute. Rather, a more limited fiduciary role for physicians, as reflected in the dual duty of care paradigm, would be justified if a departure from strict fiduciary obligations served the public interest. In other words, the choice between a patient-centered or dual duty of care ultimately turns on whether imposing on physicians' strict fiduciary obligations or more limited fiduciary obligations better serves society's interests.

This Part explains the role of public policy in determining whether to apply fiduciary law to two parties' relationship and concludes that characterizing the physician-patient relationship as fiduciary serves important societal interests. It then discusses the influence of public policy

38. See Deborah A. DeMott, *Beyond Metaphor: An Analysis of Fiduciary Obligation*, 1988 DUKE L. J. 879, 882 (1988) (discussing fiduciaries' duty of loyalty); Leonard I. Rotman, *Fiduciary Law's "Holy Grail": Reconciling Theory and Practice in Fiduciary Jurisprudence*, 91 B.U. L. REV. 921, 935 (2011) [hereinafter Rotman, *Fiduciary Law's "Holy Grail"*] ("[Fiduciary law] requires fiduciaries to abnegate all self-interest or the interests of third parties that may conflict with their beneficiaries' interests.").

39. See Rotman, *Fiduciary Law's "Holy Grail"*, *supra* note 38, at 956–57 (explaining the conflict of interest rules governing fiduciaries).

40. Krause, *supra* note 19 (noting that physicians must consider payor financial incentives in determining patient care).

41. Fine, *supra* note 9; see also Morreim, *Medicine Meets Resource Limits*, *supra* note 12.

42. Rotman, *Fiduciary Law's "Holy Grail"*, *supra* note 38, at 826 (noting that fiduciary law is built on protecting socially valuable relationships).

concerns in shaping the nature and scope of a fiduciary's duties.

A. *Fiduciary Relationships and the Physician-Patient Relationship*

Society characterizes a relationship as fiduciary when imposing fiduciary norms promotes important societal interests.⁴³ Perhaps most importantly, the law obliges an actor to serve as another's fiduciary to foster the trust necessary for maintaining a socially important relationship.⁴⁴ For

43. See Rotman, *Fiduciary Law's "Holy Grail"*, *supra* note 38, at 909 (“[O]nly an instrumental view of fiduciary obligation can address such a diversity of contexts.”); Leonard I. Rotman, *Fiduciary Doctrine: A Concept in Need of Understanding*, 34 ALBERTA L. REV. 821, 826 (1996) [hereinafter Rotman, *Fiduciary Doctrine*] (“Fiduciary law has its origins in public policy, specifically the desire to protect certain types of relationships that are deemed to be socially valuable or necessary.”).

In determining whether a particular relationship is fiduciary in nature, many scholars and courts focus on whether the relationship shares features common to classic fiduciary relationships, such as trustee-beneficiary, director-shareholders, lawyer-client, and guardian-ward. See Tamar Frankel, *Fiduciary Law*, 71 CALIF. L. REV. 795, 804–07 (1983) (explaining that some commentators impose fiduciary status on certain relationships based on the mechanical application of analogies to traditional fiduciary relationships); D. Gordon Smith, *The Critical Resource Theory of Fiduciary Duty*, 55 VAND. L. REV. 1399, 1413–14 (2002) (explaining that courts typically focus on the “common elements” of fiduciary relationships). A fiduciary jurisprudence based on analogy, however, fails to provide an adequate basis for applying fiduciary norms because numerous relationships that possess one or more traits common to the classic fiduciary relationships, such as dependence, vulnerability, and a disparity of power, are not considered fiduciary. See DeMott, *supra* note 38, at 902–05, 908–10, 914–15 (critiquing various theories on fiduciary obligation, including those based on the relationship's features, and arguing that attempts to impose fiduciary obligations based on characteristics of the parties' relationship, divorced from the specific context, are problematic, including theories that emphasize traits such as vulnerability and dependency); Smith, *supra*, at 1417 (stating that it is “error” to apply “concepts like *trust* and *vulnerability* to distinguish fiduciary from nonfiduciary relationships”); Rotman, *Fiduciary Law's "Holy Grail"*, *supra* note 38, at 833 (critiquing theories that focus on the nature or characteristics of the parties' relationship); *id.* at 931 (“The simple inequality of parties is not . . . determinative of the existence of a fiduciary relationship. Similarly, while vulnerability is an important factor in fiduciary interactions, its presence, on its own, is not conclusive of the fiduciary character of an interaction.”). For example, an employer is not considered a fiduciary to its employees despite the employer's position of power and the employees' dependence on the employer for their livelihood.

44. As explained by Leonard Rotman:

Individuals are far more apt to subject themselves to situations of dependence or reliance upon others if they can be assured that their interests and consequent vulnerability created by the relationship are protected. Fiduciary law satisfied this additional need by providing protection for beneficiaries . . . [thereby] allow[ing] for the continuation and proliferation of interdependent relationships

Rotman, *Fiduciary Doctrine*, *supra* note 43, at 827 (footnote omitted); see also Lawrence E. Mitchell, *The Death of Fiduciary Duty in Close Corporations*, 138 U. PA. L. REV. 1675, 1682–84

example, corporate directors' duty of loyalty to shareholders promotes investors "channell[ing] their limited resources to collective enterprises," thereby encouraging "growth of the entire economic system."⁴⁵ Reducing agency costs also supports treating a relationship as fiduciary because imposing fiduciary duties eliminates the need for the vulnerable party to actively monitor the other party's performance or include in the parties' contract comprehensive provisions that are protective of the vulnerable party's interests.⁴⁶ Trustees' strict fiduciary duties, for example, relieve the settlor from needing "to envision every possible way in which the trustee

(1990) (explaining that "at the heart of [the fiduciary] legal construct lie two assumptions about human nature—that persons can and will subordinate self-interest to the interests of others, and further that this is a social good the law can encourage" through the imposition of fiduciary duties) (footnote omitted). See generally John R. Boatright, *Fiduciary Duties and the Shareholder-Management Relation: Or, What's So Special About Shareholders?*, 4 BUS. ETHICS Q. 393 (1994) (discussing that the adequate basis for the fiduciary duties between officers and directors of a corporation and its shareholders is to found in considerations of public policy).

45. Daniele Marchesani, *A New Approach to Fiduciary Duties and Employees: Wrongful Discharge in Violation of Public Policy*, 75 U. CIN. L. REV. 1453, 1470 (2007); see also Boatright, *supra* note 44, at 401 (stating that corporate directors' fiduciary obligations come from considerations of public policy—"that institutions in which management is accountable primarily to shareholders provides the most socially beneficial system of economic organization").

Other examples of beneficial relationships supported by fiduciary law include lawyer-client and trustee-beneficiary relationships. The requirement that lawyers act with full dedication to a client's interests encourages individuals to trust and seek out lawyers. This in turn allows lawyers to fulfill their vital societal role in helping clients order their affairs, ensure that their conduct is lawful, vindicate their legal rights, and preserve the legal system as a non-violent alternative for resolving disputes. See ELLEN J. BENNETT ET. AL, ANNOTATED MODEL RULES OF PROFESSIONAL CONDUCT 92 (7th ed., 2011) (explaining that the lawyer's fiduciary obligation to keep her client's confidences encourages clients to seek legal assistance and communicate freely and fully with the lawyer, which in turn promotes the law being upheld because the lawyer can then advise her client to refrain from wrongful conduct). Likewise, the strict duty of loyalty imposed on trustees provides assurance "that [the trust's] beneficiaries will not be deprived of a trustee's disinterested and objective judgment." See RESTATEMENT (THIRD) OF TRUSTS § 78 cmt. b (2007). By reducing the risk of creating trusts, fiduciary law benefits society by encouraging individuals to entrust their financial interests to trustees. Cf. Claire A. Hill & Erin Ann O'Hara, *A Cognitive Theory of Trust*, 84 WASH. U. L. REV. 1717, 1753–54 (2006) (explaining that society benefits when fiduciary law promotes the residual trust that leads people to entrust important matters, including their finances, to others).

46. See Melanie B. Leslie, *Trusting Trustees: Fiduciary Duties and the Limits of Default Rules*, 94 GEO. L.J. 67, 89 (2005) (recognizing the absence of fiduciary duties increases agency costs because otherwise beneficiaries will have to contract with greater specificity to anticipate future conflict); Maxwell J. Mehlman, *The Patient-Physician Relationship in an Era of Scarce Resources: Is There a Duty to Treat?*, 25 CONN. L. REV. 349, 383 (1993) [hereinafter Mehlman, *The Patient-Physician Relationship in an Era of Scarce Resources*] ("[T]he goal of fiduciary doctrine is to reduce monitoring costs by promoting trust.").

could profit from its position as trustee and negotiate for contract provisions to preclude every instance of self-dealing.”⁴⁷ Similarly, in the legal context, lawyers’ commitment to zealously represent their clients has been defended on policy grounds—supporting judges and juries in their search for the truth.⁴⁸

Whether to characterize the physician-patient relationship as fiduciary then depends on whether holding physicians to fiduciary standards promotes society’s collective interests.⁴⁹ Although courts do not consistently hold physicians to fiduciary standards,⁵⁰ as discussed below, two important policy considerations support doing so. First, fiduciary obligations secure patients’ trust in their physicians, which in turn encourages individuals to seek out physicians’ care and guidance. Second, the population’s overall health may

47. Leslie, *supra* note 46, at 94.

48. See CHARLES W. WOLFRAM, *MODERN LEGAL ETHICS* 581 (1986) (stating that in response to criticism of the adversary system, “[t]he response of lawyers is that the adversary system is capable in the great majority of cases of determining where truth lies and justice is best served” and that lawyers’ zeal in representing their clients “is important to correct determinations by courts and possibly other agencies”).

49. Numerous scholars and courts have characterized the physician-patient relationship as a fiduciary one. See Hall, *Rationing Health Care*, *supra* note 11, at 760 (“[M]any courts and commentators have underscored doctors’ fiduciary status.”); Marc A. Rodwin, *Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System*, 21 AM. J.L. & MED. 241, 247 (1995) (“Contemporary literature in medicine and medical ethics assumes that physicians are indeed fiduciaries . . .”). These scholars emphasize that the physician-patient relationship shares many of the features common to classic fiduciary relationships like dependency and disparity of power. See Hall, *Rationing Health Care*, *supra* note 11, at 760 (noting that the physician-patient relationship has traits common to other fiduciary relationships, including control over vital decision making and vulnerability); Krause, *supra* note 19, at 274 (“Commentators assert that several characteristics of the physician-patient relationship are similar to traditional fiduciary relationships, including the disparity in the amount of knowledge and information possessed by physicians relative to their patients, the requirement that the physician keep patient information confidential, physicians’ control over medical resources, patients’ psychological dependence on physicians, and the potential for conflicts of interest.”); Rodwin, *supra*, at 245 (concluding that features of the physician-patient relationship closely resemble classic fiduciary relationships, including physicians specialized knowledge and expertise, control over medical resources, and patients’ dependence given their illness and anxiety). In conferring fiduciary status on the physician-patient relationship based on the relationship’s characteristics, however, these scholars misunderstand what makes a relationship a fiduciary one. As explained in note 44, *supra*, the question of whether a relationship is fiduciary ultimately turns on public policy considerations and not on whether the relationship is one of dependency or disparity of power.

50. See Rodwin, *supra* note 49, at 242, 247–48 (explaining that although the physician as fiduciary is “a dominant metaphor in medical ethics and law” and “courts sometimes label physicians as fiduciaries,” physicians are held to fiduciary standards in “limited circumstances”).

be best served when physicians are dedicated to their individual patient's best interests. A healthier population in turn promotes stronger economic growth for the benefit of everyone.

Patient trust in physicians serves the important societal goal of encouraging and protecting physician-patient interactions.⁵¹ With trust, patients are willing to submit to a physician's care, share with their physician-sensitive and confidential information, and follow a physician's treatment recommendations.⁵² Trust also may promote healing by strengthening the patient's own curative mechanisms because the physician may herself be "a placebo or a therapeutic agent."⁵³ Demanding that physicians act as the patient's fiduciary protects these important objectives by reinforcing patients' trust in their physicians.

Physicians' duty to promote their individual patient's health also may support stronger economic development.⁵⁴ Studies show that healthier populations foster stronger economies.⁵⁵ To the extent patients' health needs are better met when physicians are fully committed to patients' best

51. See Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 468 (2002) [hereinafter Hall, *Law, Medicine, and Trust*].

52. See *id.* (describing the instrumental value of trust in medical relationships); Orentlicher, *Health Care Reform*, *supra* note 18, at 148 ("The willingness of patients to turn to physicians for care, to speak openly about intimate and potentially embarrassing information, and to rely on their physicians' recommendations depends in large part on the ability of patients to trust that physicians are acting primarily to advance the interests of their patients.").

53. See Hall, *Law, Medicine, and Trust*, *supra* note 51, at 479.

54. See David E. Bloom & David Canning, *The Health and Wealth of Nations*, 287 SCIENCE 1207, 1207 (2000).

55. See *id.* (reporting that the results of economic analysis show that a population's health status is a significant predictor of economic growth).

Commentators have identified several reasons for why this may be so:

- Healthier individuals may have higher work productivity from improved physical and mental energy;
- Healthier individuals that are likely to live longer may invest more in their own education and skill development, further increasing productivity;
- Healthier individuals may participate in the labor force for longer, taking fewer sick days and retiring later;
- Expecting to live longer, healthier individuals may save more for retirement, increasing the funds available for investment in the economy; and
- A healthy and educated workforce may attract more foreign investment.

See *id.* (discussing reasons for why healthier populations may promote economic growth); COMM'N ON MACROECONOMICS AND HEALTH, *MACROECONOMICS AND HEALTH: INVESTING IN HEALTH FOR ECONOMIC DEVELOPMENT* (2001) (same).

interests, the population's health status improves.⁵⁶ Consequently, demanding that physicians narrowly focus on improving and maintaining patients' health may support our collective interest in economic growth.

In sum, strong policy rationales support treating physicians as their patients' fiduciary, with a corresponding expectation that physicians dedicate themselves to serving their patients' welfare. Nevertheless, this does not end the inquiry. Even when a relationship is appropriately characterized as fiduciary in nature, policy considerations may support limits on the fiduciary's duties of fidelity.

B. The Nature and Scope of a Fiduciary's Duties

Fiduciaries are subject to heightened duties of loyalty, zeal, and self-sacrifice.⁵⁷ The scope and nature of fiduciaries' obligations, however, varies depending on the broader policy context.⁵⁸ In its strictest form, fiduciary law requires absolute fidelity to the beneficiary's interests and avoidance of all conflicts of interests.⁵⁹ Nonetheless, courts and policymakers frequently impose less demanding obligations on fiduciaries when competing policy concerns outweigh the public interests served by strict fiduciary obligations.

To illustrate, corporate law deviates in several respects from the strict obligations reflected in classic fiduciary principles for reasons of public policy. Directors' fiduciary duties are tempered by the business judgment rule, which creates a presumption that management decisions are informed and motivated by a commitment to the shareholders' best interests.⁶⁰ Important policy considerations underlie the business judgment rule, including the concern that subjecting directors' decisions to judicial second-

56. See Bloom & Canning, *supra* note 54, at 1207.

57. Scott FitzGibbon, *Fiduciary Relationships are not Contracts*, 82 MARQ. L. REV. 303, 303 (1999).

58. See DeMott, *supra* note 38, at 908 ("The scope of the fiduciary's obligation, as well as the obligation's precise formulation, necessarily varies with the context of the relationship."); Rotman, *Fiduciary Doctrine*, *supra* note 43, at 830 ("The situation-specific nature of fiduciary doctrine also has a tremendous effect upon the nature of the duties and obligations which fiduciaries may owe to their beneficiaries . . .").

59. See FitzGibbon, *supra* note 57, at 311.

60. The business judgment rule requires "a presumption that in making a business decision the directors of a corporation acted on an informed basis, in good faith and in the honest belief that the action taken was in the best interests of the company." *Aronson v. Lewis*, 473 A.2d 805, 812 (Del. 1984).

guessing will render directors risk-adverse, thereby constraining economic growth.⁶¹ Similarly, corporate law generally allows directors to enter into self-interested transactions with the corporation.⁶² This deviation from traditional fiduciary law's strict prohibition against conflicts of interests again rests on policy grounds. First, courts and scholars note that transactions between the corporation and director may promote the corporation's interests.⁶³ Second, strict rules prohibiting conflicts of interests are unnecessary given market forces that deter directors from engaging in behavior harmful to the corporation.⁶⁴ In contrast, the absence of market pressures or countervailing policy concerns supports more stringent fiduciary obligations on trustees.⁶⁵

Policy considerations also support limits on lawyers' fiduciary duty of zealous advocacy. The American Bar Association's Model Rules of Professional Conduct include a general prohibition against lawyers "engag[ing] in conduct that is prejudicial to the administration of justice,"⁶⁶ and specific prohibitions against making false statements or assisting a client in committing a crime or fraud.⁶⁷ These limitations recognize that lawyers'

61. See Leslie, *supra* note 46, at 97–98 (explaining the rationales for the business judgment rule); Marchesani, *supra* note 45, at 1455, 1473–74 (same).

62. See Karen E. Boxx, *Too Many Tiaras: Conflicting Fiduciary Duties in the Family-Owned Business Context*, 49 HOUS. L. REV. 233, 247–48 (2012) (explaining that a director who engages in self-dealing can avoid liability by showing procedural and substantive fairness of the transaction, if the transaction is approved by a majority of disinterested directors or shareholders, or if the transaction was fair to the corporation).

63. See *id.* at 244 (explaining that a departure from a prohibition against conflict of interests is "necessary" as "self-dealing by business managers can benefit the business").

64. See *id.* ("[T]he shareholder is theoretically in a better position to protect his interests than a trust beneficiary because of . . . general controls of the market.").

65. See *id.* at 239–40 (explaining that the beneficiary has "restricted ability to monitor the trustee's actions" and that "[t]here is also no other monitoring mechanism in place to protect the beneficiary, such as . . . market forces affecting the price of stock in a publicly held corporation."); DeMott, *supra* note 38, at 908–09 (suggesting that the specific context of the trustee-beneficiary relationship supports more stringent restrictions on the trustee's dealings with trust property than are imposed on corporate directors in their personal transactions with the corporation); Leslie, *supra* note 46, at 99–100 (explaining that the absence of a version of the business judgment rule under trust law reflects differences in the broader context in which the trust and director-shareholder relationships arise, including the absence of strong market pressures in the trust context and the need to encourage trustees to take risks).

66. MODEL RULES OF PROF'L CONDUCT R. 8.4(d) (2011).

67. See *id.* R. 4.1; see also *id.* R. 3.3 (establishing a prohibition against making false statements to a tribunal and offering evidence known to be false, and requiring remedial measures if the lawyer knows the client intends to engage or has engaged in criminal or fraudulent conduct in an

advocacy on behalf of clients “take[s] place within a larger social purpose,” and as such should be limited when a lawyer’s advocacy works against the public interest.⁶⁸

Whether physicians’ duty of care should reflect a patient-centered or dual duty paradigm, then, ultimately turns on whether public policy considerations justify limiting physicians’ fiduciary obligations to patients. The resolution to this issue depends on the answers to two fundamental questions: (1) Should society ration medical care?; and (2) If so, should physicians serve as society’s agent for doing so? Part II addresses the first question, while Parts IV and V discuss the second.

III. A DEFENSE OF HEALTH CARE RATIONING

Many patients, politicians, and commentators object to society rationing health care.⁶⁹ Those opposed to rationing fall into two groups. The first group argues that health care costs can be successfully restrained without rationing care through the elimination of fraud and wasteful care, better management of patients with chronic conditions, and/or reducing excessive prices for medical care.⁷⁰ The second group, while acknowledging that lowering health costs may necessitate rationing care, contends that rationing is morally unjust because it compromises patient autonomy for reasons of social expediency.⁷¹ If either position proves defensible, physicians need not ration care but instead can devote themselves to doing everything possible to help restore or maintain their patients’ health, which is consistent with a patient-centered duty of care. This Part considers the arguments against health care rationing and concludes that they ultimately prove unpersuasive.

adjudicative proceeding).

68. Susan R. Martyn, *Justice and Lawyers: Revising the Model Rules of Professional Conduct*, 12 PROF. LAW., Fall 2000, at 20, 21.

69. See Mantel, *Accountable Care Organizations*, *supra* note 13, at 1395–1402 (summarizing the various arguments).

70. See Mantel, *Accountable Care Organizations*, *supra* note 13, at 1395–1402 (summarizing the arguments for how the United States can lower health care costs without sacrificing the quality of care).

71. Edmund D. Pellegrino, *Rationing Health Care: The Ethics of Medical Gatekeeping*, 2 J. CONTEMP. HEALTH L. & POL’Y 23, 30 (1986), available at <http://scholarship.law.edu/jchlp/vol2/iss1/6>.

A. Controlling Health Care Costs: The Necessity of Rationing

Headlines repeatedly proclaim the U.S. health care system “the most expensive in the world.”⁷² According to the Organization for Economic Cooperation and Development (OECD), per capita spending on health care in the United States for 2011 exceeded the average among OECD nations by two-and-a-half times, and was 50% higher than the two next largest spending countries.⁷³ The health care sector also consumes a growing percentage of the U.S. gross domestic product (GDP), accounting for 17.7% of GDP in 2011 as compared to only 5.2% in 1960.⁷⁴ Government economists project that health care will comprise almost one-fifth of GDP by 2022,⁷⁵ with others warning it may reach one-third by 2040.⁷⁶ In addition, public expenditures on health care consume a growing portion of federal government outlays—Medicare, Medicaid, State Children’s Health Insurance Program (“SCHIP”), and other federal health care programs cost an estimated \$861 billion in fiscal year 2013, almost 25% of all federal spending.⁷⁷ Rising Medicaid spending also strains state budgets.⁷⁸

72. KAREN DAVIS ET. AL, *MIRROR, MIRROR ON THE WALL: HOW THE PERFORMANCE OF THE U.S. HEALTH CARE SYSTEM COMPARES INTERNATIONALLY*, 7 (2014) (report for the Commonwealth Fund comparing the health care systems of eleven developed nations).

73. See ORG. FOR ECON. CO-OPERATION & DEV., *HEALTH AT A GLANCE 2013: OECD INDICATORS*, 154 (2013), available at <http://www.oecd.org/els/health-systems/Health-at-a-Glance-2013.pdf>.

74. See *id.* at 156. In 2011, the percentage of the U.S. GDP devoted to health care spending (17.7%) was approximately 6% above the next group of countries and far exceeded the average across OECD nations of 9.3% of GDP. See *id.*

75. See CTRS. FOR MEDICARE & MEDICAID SERVS., *NATIONAL HEALTH EXPENDITURES PROJECTIONS 2012–2022* (2012), available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/proj2012.pdf>.

76. See Peter J. Kalis & Judy Hlafesak, *Healthcare Reform: Let’s Act Locally*, 50 DUQ. L. REV. 253, 257 (2012) (stating that healthcare “is projected to reach 34% [of GDP] by 2040, if costs continue to grow at historic rates” (citing Exec. Office of the President: Council of Econ. Advisors, *The Economic Case for Health Care Reform*, WHITE HOUSE BLOG (June 2009), http://www.whitehouse.gov/assets/documents/CEA_Health_Care_Report.pdf)).

77. CBO estimates that federal spending on health care programs in fiscal year 2013 was \$861 billion, with total federal government outlays estimated at \$3.455 trillion. See CONGRESSIONAL BUDGET OFFICE, *UPDATED BUDGET PROJECTIONS: 2014 TO 2024*, at 3 tbl. 1, 6–7 tbl. 2 (2014), available at http://www.cbo.gov/sites/default/files/cbofiles/attachments/45229-UpdatedBudgetProjections_2.pdf. The \$861 billion in federal spending on health care programs was offset by approximately \$93 billion from premiums payments, recoveries of overpayments to providers, and amounts paid by states for savings on Medicaid’s prescription drug costs. See *id.* at 7 tbl. 2.

78. DAVID A. SQUIRES, *THE COMMONWEALTH FUND, ISSUES IN INTERNATIONAL HEALTH*

This sustained increase in U.S. health care costs raises numerous concerns. A health care system that honors patients' desire for all care of potential benefit, regardless of cost, raises insurance premiums and the cost of social insurance programs such as Medicare and Medicaid.⁷⁹ For employers providing health insurance to their employees, higher costs may make them less competitive internationally.⁸⁰ For their employees, higher premiums have contributed to stagnant wages.⁸¹ Employees also must contribute a growing percentage of their wages to both the employees' share of health insurance premiums and higher out-of-pocket health care costs.⁸² In the public sector, growing public expenditures for health care increases the public debt and threatens to push aside other priorities such as education, crime prevention, transportation, and welfare.⁸³ Alternatively, the federal and state governments will need to raise taxes to pay for the public health care programs, decreasing private investment in the economy and leaving taxpayers with less money for housing, food, college, and other personal needs.⁸⁴

Nevertheless, spending more on health care arguably would be justified if higher expenditures led to better health. After all, the United States is a

POLICY—EXPLAINING HIGH HEALTH CARE SPENDING IN THE UNITED STATES: AN INTERNATIONAL COMPARISON OF SUPPLY, UTILIZATION, PRICES, AND QUALITY 11 (2012) (“Medicaid spending also impacts state budgets, increasing faster than and potentially crowding out other socially desirable budget items, such as education and infrastructure.”).

79. See James P. Jacobson, *To Pay or Not to Pay, That is the Question: Coverage Disputes Between Health Plans and Members*, 29 *HAMLIN J. PUB. L. & POL'Y* 445, 447 (2008) (“[I]f health plans paid for everything that members wanted or believed they needed without restriction, premiums would escalate even faster than they do today.”); Russell Korobkin, *Comparative Effectiveness Research as Choice Architecture: The Behavioral Law and Economics Solution to the Health Care Cost Crisis*, 112 *MICH. L. REV.* 523, 525 (2014) (describing the impact of rising health care spending on the cost of private insurance).

80. See BIPARTISAN POLICY CTR., *WHAT IS DRIVING U.S. HEALTH CARE SPENDING?: AMERICA'S UNSUSTAINABLE HEALTH CARE COST GROWTH* 4 (2012). *But see* Henry J. Aaron, *Should Public Policy Seek to Control the Growth of Health Care Spending?*, *HEALTH AFFAIRS*, W3-28, W3-29 (2003) (stating that rising employer-financed health care costs do not reduce corporate profits but instead “eat into workers’ earnings”).

81. See Korobkin, *supra* note 79, at 525; Aaron, *supra* note 80, at W3-29.

82. See Korobkin, *supra* note 79, at 525 (stating that an estimated 46% of real wage increase went to the employees’ share of employer-sponsored health insurance each year from 2000 to 2009, while their plans’ out-of-pocket deductibles increased from 17% to 138% between 2006 and 2013, depending on the type of plan).

83. See BIPARTISAN POLICY CTR., *supra* note 80, at 4.

84. *Id.*

wealthy country and perhaps can afford to devote a large share of its national resources to health care. Unfortunately, despite the country's large health care outlays, the United States consistently lags behind other developed countries in life expectancy and on other health outcome measures.⁸⁵ While these differences may be due in part to factors independent of countries' health care systems such as behavior or genetics,⁸⁶ they also reflect the U.S.' health system's lower productivity.⁸⁷ Other OECD countries also have achieved larger declines in mortality for treatable conditions than the United States, despite the U.S. spending significantly more on health care.⁸⁸ So regardless of whether the United States spends too much on health care, much of its spending is inefficient as compared to other countries.⁸⁹

Research on regional variation within the United States similarly suggests a health care system plagued by inefficient spending on care of marginal value.⁹⁰ Studies have found that patients in high-spending regions do not enjoy improved life expectancy or better health outcomes than those residing in low-spending regions, despite visiting physicians more frequently; making greater use of specialists; and receiving more diagnostic tests, procedures, and inpatient care.⁹¹ These findings hold true even after

85. See U.S. Burden of Disease Collaborators, *The State of U.S. Health, 1990–2010: Burden of Diseases, Injuries, and Risk Factors*, 310 JAMA 591, 591 (2013) (summarizing a comparison of health measurements across thirty-four countries in the OECD).

86. See Alan M. Garber & Jonathan Skinner, *Is American Health Care Uniquely Inefficient?*, 22 J. OF ECON. PERSPS. 27, 33 (2008) (noting that “observed health outcomes vary with behavioral, genetic, and other factors unrelated to the healthcare system”).

87. For a given bundle of inputs—physicians, nurses, hospital beds, and capital—the aggregate impact on health outcomes in the United States is lower than in other countries. See *id.* at 33–36, 44 (concluding that productivity in the United States health care system is “inferior” to other countries).

88. Among select OECD countries, from 1997/98 to 2002/03, the United States ranked last on reductions in mortality rates for conditions deemed “amenable” to medical care, with the United States experiencing 5.1 reductions in “avoidable” deaths per 100,000 people, whereas other selected OECD countries reduced avoidable deaths from 10.8 to 27.2 per 100,000 people. See *id.* at 34, 41. Examples of conditions amenable to medical care include bacterial infections, treatable cancers, and certain cardiovascular disease. See *id.* at 41.

89. See generally *id.* at 28 (“[The United States] experiences a unique degree of allocative inefficiency, even when compared to other high-income countries.”).

90. See *infra* notes 91–93.

91. See JOHN E. WENNBURG ET AL., THE DARTMOUTH INST. FOR HEALTH POLICY & CLINICAL PRACTICE, TRACKING THE CARE OF PATIENTS WITH SEVERE CHRONIC ILLNESS: THE DARTMOUTH ATLAS OF HEALTH CARE 4, 13, 54 (2008) [WENNBURG ET AL., TRACKING THE CARE OF PATIENTS]. Much of the variation in regional spending was due not to differences in the prices for medical care but to differences in the volume of care. See *id.* at 2.

controlling for differences in the prevalence of disease and other population characteristics.⁹² In fact, some studies find that high-spending regions perform *worse* on certain measures, as medical interventions often expose patients to medical errors and other health risks.⁹³ These findings suggest that much of the medical care provided to patients in the United States is “unnecessary,” “inefficient,” or “wasteful.”

Some commentators contend that the United States can successfully constrain rising health without rationing beneficial care by improving the efficiency of the United States health care system. Specifically, they contend that reducing waste will generate significant savings.⁹⁴ They also argue that better management of patients with chronic conditions can reduce medical expenses downstream by avoiding the costly care associated with preventable complications such as avoidable emergency room visits, hospital admissions or readmissions, and expensive ancillary services.⁹⁵ Although these claims are not without empirical support, as I have argued elsewhere, reducing waste and improving patient management do not present a painless solution to the challenge of rising health care costs.⁹⁶

First, opponents of rationing overstate the scope of “wasteful” care that

92. *See id.* at 3 (noting that differences in the level of illness account for only a small fraction of the variation in the amount of care delivered).

93. As explained by researchers at the Dartmouth Institute for Health Policy & Clinical Practice, [T]he more time spent in the hospital, the greater [patients'] exposure to error, infection, and adverse events. As care becomes more complex, and as more physicians get involved in an individual patient's care, it becomes less and less clear who is responsible, and miscommunication—and medical errors—become more likely. Greater use of diagnostic tests increases the risk of finding—and being treated for—abnormalities that are unlikely to have caused the patient any problem Patients who receive care for conditions that would have never caused a problem can only experience the risk of the intervention.

JOHN E. WENBERG ET AL., THE DARTMOUTH INST. FOR HEALTH POLICY & CLINICAL PRACTICE, AN AGENDA FOR CHANGE—IMPROVING QUALITY AND CURBING HEALTH CARE SPENDING: OPPORTUNITIES FOR THE CONGRESS AND THE OBAMA ADMINISTRATION 3–4 (2008) [hereinafter WENBERG ET AL., AN AGENDA FOR CHANGE].

94. *See* Mantel, *Accountable Care Organizations*, *supra* note 13 at 1396–99 (discussing policy analysts' assertions that there exists the potential for significant savings from elimination of waste).

95. *See id.* at 1399–1402; NAT'L QUALITY FORUM, WASTE NOT, WANT NOT: THE RIGHT CARE FOR EVERY PATIENT 2, 4 (2009), available at http://www.qualityforum.org/Publications/2009/07/Waste_Not_Want_Not_The_Right_Care_for_Every_Patient.aspx (noting that emergency room visits and hospital readmissions could be avoided through better coordination of care and expanded access to primary care).

96. *See* Mantel, *Accountable Care Organizations*, *supra* note 13, at 1397–99, 1400–02.

can be eliminated without adversely impacting the quality of care.⁹⁷ Some medical interventions are ineffective or unsafe—tests that do not provide useful diagnostic or therapeutic information;⁹⁸ services that are not clinically effective in addressing a patient's condition;⁹⁹ and care that provides some clinical benefit to the patient but poses health risks that outweigh any potential benefit.¹⁰⁰ Some care is inefficient, such as duplicative procedures¹⁰¹ and costly tests and treatments that are no more effective than less costly alternatives.¹⁰² But much of the care considered “wasteful” falls under a different category of waste—care of uncertain or insufficient clinical effectiveness.¹⁰³ Curbing the provision of such care inevitably involves eliminating care that does some good because many interventions in this category provide marginal benefits to all or some.¹⁰⁴

97. See *infra* notes 98–39.

98. See Maxwell J. Mehlman, *Health Care Cost Containment and Medical Technology: A Critique of Waste Theory*, 36 CASE W. RES. L. REV. 778, 785 (1986) [hereinafter Mehlman, *Health Care Cost Containment*] (“A technology is ineffective if it produces no discernible benefit to the patient.”); Peter Boland et al., *Accountable Care Organizations Hold Promise, But Will They Achieve Cost and Quality Targets?*, MANAGED CARE (Oct. 2010), <http://www.managedcaremag.com/archives/1010/1010.ACOs.html> (stating that unnecessary care includes services that do not provide useful diagnostic or therapeutic information).

99. See Donald M. Berwick et al., *The Triple Aim: Care, Health, and Cost*, 27 HEALTH AFF. 759, 765 (2008) (asserting that wasteful care includes unscientific care); Timothy Stoltzfus Jost, *The American Difference in Health Care Costs: Is There a Problem? Is Medical Necessity the Solution?*, 43 ST. LOUIS U. L.J. 1, 13 (1999) (stating that a test or procedure is medically unnecessary if it is not appropriate or effective for addressing a patient's condition).

100. See Mehlman, *Health Care Cost Containment*, *supra* note 98, at 785 (“A technology or its particular use is considered unsafe, and therefore perhaps wasteful, when its risks exceed the benefits to the patient.”).

101. See Berwick et al., *supra* note 99, at 765 (stating that waste includes procedures, tests, and visits that represent rework); Boland et al., *supra* note 98, at 14 (stating that preventable ancillary services include duplicative procedures).

102. See Mehlman, *Health Care Cost Containment*, *supra* note 98, at 789 (footnote omitted) (“A technology might also be regarded as wasteful if it is expected to yield the same net benefit as another technology but at a greater cost—that is, if it is not the most efficient, cost-effective technology to treat or to diagnose the patient's condition.”).

103. See Henry J. Aaron, *Waste, We Know You Are Out There*, 359 NEW ENG. J. MED. 1865, 1866 (2008) (stating that “most” of the care labeled as waste is not useless care but provides some benefit); Ari Hoffman & Steven D. Pearson, *‘Marginal Medicine’: Targeting Comparative Effectiveness Research to Reduce Waste*, 28 HEALTH AFF. w710, w711 (2009) (noting that the most likely source of potentially wasteful care is marginal medicine—care lacking adequate evidence of clinical benefit and care whose costs exceed its marginal benefits).

104. See David M. Eddy, *Health System Reform: Will Controlling Cost Require Rationing Services?*, 272 JAMA 324, 328 (1994) (arguing that cutting “waste” involves rationing beneficial

Second, the potential cost savings from better management of patients with chronic conditions may be lower than often claimed. Although some protocols that improve the care provided to chronically ill patients could improve patient outcomes while containing costs, empirical studies show that most fail to produce net cost savings.¹⁰⁵ Better chronic care can reduce the frequency of costly acute treatments for complications, but these cost savings often do not make up for the costs associated with improved patient management, such as additional physician visits, increased use of medications, and patient counseling.¹⁰⁶ Indeed, some improvements in patient management result in *increased* health care spending.¹⁰⁷

Finally, even if initial efforts to eliminate wasteful care and improve patient management successfully lowered health care costs, inflationary pressures spurred by advances in medical technology would quickly dwarf any savings from such efforts.¹⁰⁸ By some estimates, advances in medical technology¹⁰⁹ account for one-half to two-thirds of annual medical spending

care because the largest category of waste includes beneficial care for which the magnitude of benefit is too small to justify the costs); Mantel, *Accountable Care Organizations*, *supra* note 13, at 1419–24 (explaining why elimination of some “wasteful” care will diminish the quality of care for some patients).

105. See CONG. BUDGET OFFICE, LESSONS FROM MEDICARE’S DEMONSTRATION PROJECTS ON DISEASE MANAGEMENT, CARE COORDINATION, AND VALUE-BASED PAYMENT 1 (2012) (concluding that the evidence of cost savings from disease management is quite limited); Joshua T. Cohen et al., *Does Preventive Care Save Money? Health Economics and the Presidential Candidates*, 358 NEW ENG. J. MED. 661, 662 (2008) (reviewing numerous studies of preventive measures and concluding that most do not save money); Soeren Mattke et al., *Evidence for the Effect of Disease Management: Is \$1 Billion a Year a Good Investment?*, 13 AM. J. MANAGED CARE 670, 670 (2007) (reviewing the literature on disease management and concluding that there is little evidence that disease management leads to a net reduction of direct medical costs); Bobby Milstein et al., *Analyzing National Health Reform Strategies with a Dynamic Simulation Model*, 100 AM. J. PUB. HEALTH 811, 812 (2010) (concluding that better preventive and chronic care does not typically reduce total health care costs).

106. See Milstein et al., *supra* note 105, at 812 (stating that good preventive and chronic care typically does not reduce total health care costs, even though it can reduce the frequency of more costly acute complications and urgent hospital visits because it requires additional visits and medications).

107. See KAISER FAMILY FOUND., HEALTH CARE COSTS: A PRIMER 25 (2012) (stating that one reason for growing health care costs is developments in medicine and medical technology that enable people to live longer, often with chronic conditions that require ongoing medical care).

108. See Jan Blustein & Theodore R. Marmor, *Cutting Waste by Making Rules: Promises, Pitfalls, and Realistic Prospects*, 140 U. PA. L. REV. 1543, 1566 (1992).

109. Technological advances include innovations and improvements in medical equipment, pharmaceuticals, and procedures. See Caryl E. Carpenter et al., *Issues of Cost and Quality: Barriers to an Informed Debate*, 4 J. EVALUATION CLINICAL PRAC. 131, 133 (1998) (defining medical

increases.¹¹⁰ Consequently, any initial savings achieved through the elimination of wasteful care or improved patient management eventually would be overcome by rising costs attributable to medical advances.¹¹¹ To successfully rein in rising health care costs, then, providers must continuously find new ways to achieve cost savings. Unfortunately, once providers exploit the “low hanging fruit” of demonstrably wasteful or inefficient practices, further cost savings in the absence of denying potentially beneficial care will prove difficult to achieve.¹¹²

Still, other commentators contend that the primary culprit for escalating health care costs in the United States is excessive prices for medical care,

technology advances).

110. See Mathias Goyen & Jörg F. Debatin, *Healthcare Costs for New Technologies*, 36 EUR. J. NUCLEAR MED. & MOLECULAR IMAGING S139, S140 (2009) (“Most experts believe that medical technology advances account for half to two-thirds of annual spending increases.”); see also Jessica Mantel, *Setting National Coverage Standards for Health Plans Under Healthcare Reform*, 58 UCLA L. REV. 221, 240 (2010) [hereinafter Mantel, *Setting National Coverage Standards*] (explaining that the largest factor contributing to increasing healthcare costs is advances in medical technology). While some new technologies decrease costs, most increase health care expenditures. See Carpenter et al., *supra* note 109, at 133 (“While some technologies are cost decreasing, the majority in health care are cost increasing.”). Because the price for new medical technologies generally is quite high, price inflation for healthcare typically exceeds the inflation rate for other goods and services. See Mantel, *Setting National Coverage Standards, supra*, at 240. In addition, new technologies that identify additional patients with a condition increase the population receiving care, which in turn increases health expenditures. See Carpenter et al., *supra* note 109, at 133 (“Some new technologies identify and expand the population in need of care without necessarily offering new or better ways to treat the conditions.”). Similarly, new technologies that allow treatment of previously untreatable conditions often raise health expenditures by increasing the number of patients receiving treatment. See Goyen & Debatin, *supra*, at S140 (stating that new technologies affect health care costs by developing treatments for previously untreatable conditions); Mantel, *Setting National Coverage Standards, supra*, at 240 (“By increasing the number of health conditions for which there exist potentially beneficial treatments, advances in medical technology have caused significant increases in aggregate utilization of healthcare services.” (citing WELLPOINT INST. OF HEALTH CARE KNOWLEDGE, WHAT’S REALLY DRIVING THE INCREASE IN HEALTH CARE PREMIUMS? 6 (2009))). New technologies that merely ameliorate symptoms but do not cure or slow-down a disease also result in higher expenditures. See Carpenter et al., *supra* note 109, at 134 (“[S]ome of our newest biotechnologies are not even aimed at cure but merely amelioration of symptoms. This is likely to result in higher expenditures because treatment will extend over a longer period of time without effecting a cure.”).

111. See Blustein & Marmor, *supra* note 108, at 1566 (arguing that savings achieved from a one-time reduction in expenditures would inevitably be dwarfed by rising costs attributable to the medical care inflation).

112. See Mantel, *Accountable Care Organizations, supra* note 13, at 1425–27 (arguing that providers who have achieved initial cost-savings, such as mature accountable care organizations, will be unable to achieve long-term savings without eliminating potentially beneficial care).

not a high volume and intensity of care.¹¹³ Aggregate health care spending is the product of the prices for medical care multiplied by the quantity of care provided. The mix of services provided also impacts spending, as more intensive care garners higher prices. Accordingly, reducing prices for health care may generate sufficient savings to foreclose the need to reduce the volume and intensity of care through rationing.

Those emphasizing the price side of the equation, as opposed to utilization, note that patients in the United States pay more for physician and hospitals services, but have *fewer* doctor visits than other OECD countries save Sweden, shorter lengths of stay for acute care, and fewer hospital discharges than the OECD median.¹¹⁴ Such statistics, however, ignore the interplay between health care prices and the intensity of care because higher prices may in part reflect providers using more resources per patient encounter.¹¹⁵ For example, hospitals' higher prices in the United States partly reflect the fact that hospital stays in this country are more resource-intensive than elsewhere.¹¹⁶ In addition, measures of physician and inpatient hospital utilization do not capture other forms of care. For example, providers in the United States substitute outpatient surgery for inpatient surgery at much higher rates than do providers in other countries, which may account for the United States' lower utilization of inpatient care.¹¹⁷ Moreover, unlike patients in other countries, the United States *consistently* ranks near the top across the various categories of utilization.¹¹⁸ As compared to the OECD average, providers in the United States perform 1.9 times more knee replacements, 2.1 times more cardiac catheterizations, 1.5 times more cardiac stents, 1.4 times more caesarian sections, and 3.0 times more cataract replacements.¹¹⁹ Providers in the United States also utilize

113. See, e.g., SQUIRES, *supra* note 78, at 4–5; Gerard F. Anderson et al., *It's the Prices, Stupid: Why the United States Is So Different from Other Countries*, 22 HEALTH AFF. 89 (2003); Steven Brill, *Bitter Pill: Why Medical Bills Are Killing Us*, TIME MAGAZINE (Apr. 4, 2013), <http://time.com/198/bitter-pill-why-medical-bills-are-killing-us/>.

114. See SQUIRES, *supra* note 78, at 4–5.

115. See Alan M. Garber & Jonathan Skinner, *Is American Health Care Uniquely Inefficient?*, 22 J. ECON. PERSP. 27, 43 (2008) (“Often apparent price differences are confounded by differences in the products or services . . .”).

116. See SQUIRES, *supra* note 78, at 5.

117. See Garber & Skinner, *supra* note 115, at 45.

118. See *id.* at 37, 45.

119. See Topher Spiro et al., *Price and Utilization: Why We Must Target Both to Curb Health Care Costs*, 157 ANNALS INTERNAL MED. 586, 587 (2012) (reporting utilization statistics across

diagnostic technologies, such as magnetic resonance imaging (MRIs) and computed tomography scanners, more frequently on average than other OECD nations.¹²⁰ These data indicate that utilization, particularly utilization of costly services, significantly contributes to the United States' high health care costs.

Finally, even if reducing prices in the United States for medical care initially generated substantial savings, in the absence of rationing, this one-time cost reduction would eventually be cancelled out by growth in the per capita volume and intensity of services. Because providers in the United States offer the most expensive treatments and are quick to adopt new innovations,¹²¹ each year the average patient in the United States receives a higher volume and intensity of care.¹²² Indeed, as noted above, some believe advances in medical technology account for as much as one-half to two-thirds of annual medical spending increases.¹²³ So even if prices for medical care in the United States are in fact excessive, controlling health care costs in the long-term also requires reducing the volume and intensity of care through rationing.¹²⁴

B. The Autonomy Rationale for a Patient-Centered Duty of Care

While recognizing rising medical costs as an important social problem, some nevertheless may object to compromising a patient's autonomy for reasons of social expediency.¹²⁵ Denying a patient potentially beneficial care

OECD nations).

120. *See id.* at 587–88.

121. *See* Garber & Skinner, *supra* note 115, at 43–45.

122. *See* ALTARUM INSTITUTE, HEALTH SECTOR ECONOMIC INDICATIONS—INSIGHTS FROM MONTHLY PRICE INDICES THROUGH JUNE 2014 4 (2014) (reporting year-over-year changes in per capita personal health care utilization).

123. *See supra* note 110 and accompanying text.

124. *See* Eddy, *supra* note 104, at 327–28 (explaining that controlling costs requires not only addressing medical price inflation in excess of general inflation but also the growth in per capita volume and intensity of services, the latter of which will require “tough decisions” as to whether a particular services provides sufficient value); Spiro et al., *supra* note 119, at 589 (“[T]o effectively curb health spending, policy interventions must target both excessive prices and excessive utilization . . .”).

125. *Cf.* Einer Elhauge, *Allocating Health Care Morally*, 82 CALIF. L. REV. 1449, 1457–59 (1994) (citing JONATHAN GLOVER, CAUSING DEATH AND SAVING LIVES 92–112 (1977)) (critiquing what he calls the absolutist position, which insists that health care should be provided when there is a potential health benefit, “denouncing as immoral any attempt to weigh health against mere monetary

undermines the patient's autonomy because individuals cannot participate fully in the political, economic, and social spheres of society if they are in poor health. For those who place individual autonomy at the pinnacle of the United States' value system, then a dual duty of care must be rejected as morally unjust.

One often hears that health care is of "special" moral importance or that individuals have a "right to health care."¹²⁶ The specialness of health care derives from the fact that health is central to an individual's ability to function autonomously and participate in the various spheres of life.¹²⁷ Individuals in poor health often are unable to continue their careers, pursue their interests, or enjoy their time with family and friends. By helping people achieve and maintain normal functioning, "health care preserves the capabilities individuals need to participate in the political, social, and economic life of their society. It sustains them as fully participating citizens—normal collaborators and competitors—in all spheres of social life."¹²⁸

Individuals, especially those who are ill, cannot achieve good health on their own. Instead, they must entrust their health to physicians, as "[d]octors have vastly superior experience in a complex body of skills and knowledge that is critical to preserving the life and restoring the health of their

costs"); Lawrence W. White & Mary Ellen Waither, *The Ethics of Health Care Rationing as a Strategy of Cost Containment*, in *ALLOCATING HEALTH CARE RESOURCES* 23, 46 (ed. James M. Humber & Robert F. Almeder) (1994) (arguing that rationing is "an assault on autonomy" that pits the desires of government against those of the individual).

126. See Dayna Bowen Matthew & Mark Earnest, *A Property Right to Medical Care*, 29 J. LEGAL MED. 65, 66–67 (2008) (contending that all Americans have a property right to medical care that should be legally protected); Kenneth Shuster, *Because of History, Philosophy, the Constitution, Fairness & Need: Why Americans Have a Right to National Health Care*, 10 IND. HEALTH L. REV. 75, 75 (2013) (arguing that access to health care is a right to which all Americans are entitled); Rebecca E. Zietlow, *Democratic Constitutionalism and the Affordable Care Act*, 72 OHIO ST. L.J. 1367, 1380–85 (discussing the right to health care from the perspective of both American and international law).

127. See NORMAN DANIELS, *JUST HEALTH CARE* 27 (1985) (arguing that what makes health care needs of special importance is that "impairments of normal species functioning reduce the range of opportunity open to the individual in which he may construct his 'plan of life' or 'conception of the good'"); Alfred Tauber, *A Philosophical Approach to Rationing*, 178 MED. J. AUSTL. 454, 454 (2003) ("[P]reventing and treating disease and disability assumes its moral importance by maximising [sic] the opportunity of individuals to participate in the social, political, and economic life of their society.").

128. NORMAN DANIELS & JAMES E. SABIN, *SETTING LIMITS FAIRLY: LEARNING TO SHARE RESOURCES FOR HEALTH* 15 (2d ed. 2008).

patients.”¹²⁹ Physicians also control access to the medical resources vital to maintaining or restoring a patient’s health.¹³⁰ Therefore, patients are highly dependent on their physician’s judgment and beneficence, giving physicians an inherent power over their patients.¹³¹

Individuals’ desire to achieve and maintain normal functioning, then, depends on physicians providing the care necessary to restore and maintain their patients’ good health. If “the treatment in question might save the patient’s life or markedly improve her physical or mental functioning,” rationing such care “may lead to impairment of the patient’s freedom of physical action.”¹³² In other words, individuals simply cannot realize full autonomy unless their physicians act as selfless, dutiful agents, placing individual patients’ health above all other interests. The patient-centered duty of care thus is rooted in a moral ethic that values individual autonomy.¹³³

The moral debate over physicians’ duty of care ultimately turns on whether the principle of individual autonomy trumps other social values. If so, then rationing—the denial of care that may enhance an individual’s autonomous functioning and life opportunities—violates the individual’s fundamental rights.¹³⁴ Accordingly, a dual duty of care that permits physicians to favor societal concerns over an individual patient’s welfare must be rejected as morally unjust. Instead, respect for patient autonomy must serve as the core value in the physician-patient relationship, as reflected in the patient-centered duty of care.

At times the law does indeed protect individual autonomy interests over the general public good by prohibiting certain autonomy-limiting conduct. For example, researchers cannot expose a patient to experimentation without

129. Hall, *Rationing Health Care*, *supra* note 11, at 760.

130. See Rodwin, *supra* note 49, at 245 (stating that physicians control the use of medical resources).

131. See Orentlicher, *Health Care Reform*, *supra* note 18, at 147 (commenting that physicians “possess an inherent power over their patients” and that “[p]atients must ultimately rely on their physicians’ judgment when their health, and indeed their life, may rest in the balance.”).

132. Hall, *Rationing Health Care*, *supra* note 11, at 746.

133. See *id.* at 739 (explaining that the prohibition against physician rationing and an expectation of undivided loyalty to the patient reflects an ethic that emphasizes the preeminence of patient autonomy).

134. See Tauber, *supra* note 127, at 455 (explaining that under the principle of individual autonomy, rationing “violates the free exercise of individual options, and thus denies the rights of patients”).

her consent, even if doing so would advance medical knowledge for the benefit of society.¹³⁵ As discussed below, however, the tradition of respecting individuals' autonomy is best understood not as a positive right to receive or be given something but as a negative freedom from interference.¹³⁶ In addition, principles of equality demand that legal rules afford equal respect for the autonomy interests of all individuals affected by a rule, and not simply the interests of the parties directly subject to the rule.

As explained by Candace Cummins Gauthier, autonomy requires that society respect individuals' capacity to choose their own goals and not impose its beliefs, attitudes, and values on others.¹³⁷ Society also must respect an individual's humanity and not treat an individual as a means to others' end.¹³⁸ In other words, the principle of autonomy gives rise to a right to be left alone; it does not support a right to demand that society give individuals the means to effectuate their right to self-determination.¹³⁹ Gauthier explains that applying these principles in the medical treatment context means, "the emphasis should be on the need for relevant information, informed and uncoerced decision making, and the opportunity to consent to or refuse medical interventions."¹⁴⁰ These principles, however, do not require "that patient demands for specific medical treatments be met without further justification."¹⁴¹

Equality principles also require us to respect not only the autonomy of an individual patient, but also the autonomy of other individuals within the community. Therefore, consideration should be given to how the content and scope of the physician's duty of care impacts others' autonomy.¹⁴²

135. 45 C.F.R. § 46.116 (2015) (stating that investigators generally must obtain from a research subject (or her legal representative) informed consent).

136. See Candace Cummins Gauthier, *Philosophical Foundations of Respect for Autonomy*, 3 KENNEDY INST. ETHICS J. 21, 33 (1993).

137. See Gauthier, *supra* note 136, at 25 (discussing John Stuart Mill's essay *On Liberty*).

138. *Id.* at 23–24, 33 (discussing the philosophies of Immanuel Kant and John Stuart Mill).

139. See *id.* at 34.

140. *Id.*

141. *Id.*

142. See Mary Ann Baily, *Futility, Autonomy, and Cost in End-of-Life Care*, 39 J.L. MED. & ETHICS 172, 173 (2011) ("Patients may well have some positive moral or legal rights to health care, but such rights cannot be unlimited. Other people deserve to have their autonomy respected also . . ."); Geistfeld, *supra* note 34, at 906–07 ("The liability rule must also equally respect the autonomy of other individuals in the community who would be affected by it. Consequently, the content of the right and scope of the correlative duty must depend on a social-value factor that addresses the issue of how the liability rule would affect autonomy interests other than those

In contrast to a dual duty of care, a patient-centered duty of care does not afford equal respect to the autonomy interests of others in the community, but it gives primacy to the individual patient's interests. As discussed above, a health care system that provides all potentially beneficial care leaves fewer resources available for other priorities, such as environmental protection, education, job creation, law order, and lower taxes.¹⁴³ Yet these alternative uses of public and private resources also impact health and individual opportunities.¹⁴⁴ A patient-centered duty of care thus compromises others' autonomy by crowding out other goods and services that support individuals' participation in the various spheres of life. In contrast, by encouraging physicians to conserve resources for other beneficial uses, a dual duty of care protects the autonomy interests of others in the community.¹⁴⁵ Consequently, the principle of respect for individual autonomy fails to justify a patient-centered duty of care.¹⁴⁶

IV. THE MERITS OF BEDSIDE RATIONING VS. OTHER FORMS OF RATIONING

Some commentators who oppose a dual duty of care recognize the need to place limits on patients' autonomy but object to anointing physicians as society's agents for rationing care.¹⁴⁷ They instead favor a rationing regime that vests decision-making responsibility in government entities, insurers, or patients.¹⁴⁸ Unlike bedside rationing, which relies on physicians making

represented by the private parties involved in the lawsuit.”).

143. See *supra* notes 79–84 and accompanying text.

144. See DANIELS & SABIN, *supra* note 128, at 18 (“Though health care is important to the protection of opportunity, it is not the only good that is important in this way. . . . Many things affect and protect opportunities. Education, job training, job creation—even law and order—contribute to protecting our opportunities and to supporting our relevant capabilities.”); BAILY, *supra* note 142, at 175 (arguing that raising premiums and taxes to support the provision of marginally beneficial care “would require too great a sacrifice in benefits from alternative uses of the resources.”).

145. See BAILY, *supra* note 142, at 175.

146. Cf. Marion Danis & Larry R. Churchill, *Autonomy and the Common Weal*, 21 HASTINGS CENTER REP. 25, 27 (1991) (arguing that patient's right to health care “is bounded by . . . the competing rights of others”); Gauthier, *supra* note 134, at 34 (arguing that under Mill's concept of respect for autonomy, because a policy of offering scarce or costly medical interventions to every patient would cause harm to others by jeopardizing either the medical situation of other patients or the financial stability of society, limits on the individual patient's personal liberty are justified).

147. See, e.g., E. Haavi Morreim, *Cost Containment and the Standard of Medical Care*, 75 CALIF. L. REV. 1719, 1727 (1987) [hereinafter Morreim, *Cost Containment*].

148. See Leonard M. Fleck, *Just Health Care Rationing: A Democratic Decisionmaking*

cost-benefit tradeoffs, centralized rationing regimes involve government agencies or insurers promulgating generally applicable rules that dictate what care patients receive.¹⁴⁹ Insurers also ration care through a process known as utilization review, with administrators determining on a case-by-case basis whether the services recommended by a patient's physician are medically necessary.¹⁵⁰ Alternatively, those who favor a consumer-driven rationing scheme believe patients should balance the benefits and costs of specific treatments.¹⁵¹ These commentators therefore advocate for redesigned health plans that give patients financial incentives to do so, such as high-deductible plans and health savings accounts.¹⁵²

In shifting responsibility for rationing care away from physicians, these alternatives to bedside rationing free physicians to focus exclusively on their individual patient's best interests.¹⁵³ Centralized and consumer-driven approaches to rationing thereby preserve the physician's fiduciary role as the patient's advocate and allow for a patient-centered duty of care.¹⁵⁴ The debate over the contours of a physician's duty of care thus more broadly reflects a debate over whether physicians should participate in the rationing of medical care.¹⁵⁵

The question of whether to adopt a dual duty of care over a patient-centered duty of care ultimately depends on the merits of physicians

Approach, 140 U. PA. L. REV. 1597, 1619–20 (1992).

149. See *infra* notes 165–66 and accompanying text (explaining centralized rationing).

150. See *supra* note 15.

151. See Marshall B. Kapp, *Patient Autonomy in the Age of Consumer-Driven Health Care: Informed Consent and Informed Choice*, 2 J. HEALTH & BIOMEDICAL L. 1, 15–31 (2006) [hereinafter Kapp, *Patient Autonomy*].

152. See *infra* notes 349–50 and accompanying text (explaining consumer-driven health plans and similar arrangements).

153. See Morreim, *Cost Containment*, *supra* note 147, at 1727 (stating that requiring people other than physicians to pursue society's goal of conserving resources would honor physicians' obligations to their patients by "leaving physicians free to focus solely on their patients' interests").

154. See Meir Katz, *Towards a New Moral Paradigm in Health Care Delivery: Accounting for Individuals*, 36 AM. J.L. & MED. 78, 86–89 (2010) (discussing approaches to rationing).

155. See Kenneth R. Wing, *American Health Policy in the 1980's*, 36 CASE W. RES. L. REV. 608, 636 (1986) ("The proprietization of hospital care and the modest growth in recent years of alternative delivery systems may somewhat dilute the traditional autonomy of physicians But the physician's role in determining the utilization and 'intensity' of all services . . . should be considered as important as the direct costs of physician services in evaluating the need for cost containment"); Note, *Rethinking Medical Malpractice Law in Light of Medicare Cost-Cutting*, 98 HARV. L. REV. 1004, 1004 (1985) ("This tension between hospitals' attempts to cut costs and physicians' efforts to avoid malpractice liability may impair the quality of health care.").

rationing care at the bedside relative to alternative approaches to rationing.¹⁵⁶ As discussed below, the problems with bedside rationing are not trivial and implicate core social values. Those opposed to bedside rationing argue that centralized or consumer-driven approaches to rationing care avoid the problems that plague bedside rationing while successfully restraining rising health care costs.¹⁵⁷ If any of these models for rationing care do indeed offer a feasible alternative to bedside rationing, there would be compelling public policy grounds for adopting a patient-centered duty of care over a dual duty of care.¹⁵⁸ Unfortunately, defenders of centralized and consumer-driven rationing overstate their claims that these alternative models will successfully control health care costs and achieve a fair distribution of medical resources.¹⁵⁹ In recognition of this reality, society should not hold physicians to a patient-centered duty of care, but instead it should allow physicians to assume a gatekeeping role under a dual duty of care.¹⁶⁰

A. *Centralized Rationing Through Government Entities*

Many leading scholars favor centralizing responsibility for rationing care in government entities, such as an independent public commission.¹⁶¹ Under a public, centralized model for rationing, the government develops generally applicable rules for rationing care that reflect public officials' balancing of patients' needs and cost-containment considerations.¹⁶² These

156. See Eugene C. Grochowski, *Ethical Issues in Managed Care: Can the Traditional Physician-Patient Relationship Be Preserved in the Era of Managed Care or Should It Be Replaced by a Group Ethic?*, 32 U. MICH. J.L. REFORM 619, 653 (1999) ("In deciding whether bedside rationing is a good idea, one must balance its benefits with its burdens.").

157. See Fine, *supra* note 9, at 642; Hall, *Rationing Health Care*, *supra* note 11, at 705 ("Adherents believe that rationing either is not necessary or that it must be imposed from external, societal sources.").

158. See Fleck, *supra* note 148, at 1603 ("[T]here are legitimate public interests in health care that need protection through public policy and these are moral interests as well. [S]ociety should not be indifferent about the distribution of health care . . ."); Grochowski, *supra* note 156, at 658.

159. See Katz, *supra* note 154, at 109.

160. See Hall, *Rationing Health Care*, *supra* note 11, at 731 ("Patients' welfare will best be advanced if their physicians can exercise wide discretion on their behalf rather than relegating doctors to a ministerial role [A] sensible account of patient benefit requires a cost-benefit analysis consisting of economic and medical considerations.").

161. William M. Sage et al., *Enterprise Liability for Medical Malpractice and Health Care Quality Improvement*, 20 AM. J.L. & MED. 1, 8 (1994).

162. *But see* Katz, *supra* note 154, at 97 ("The primary problem with centralized rationing of this kind stems from the fact that decisions are *centralized* and thereby bureaucratic. Allocators in that

rules take two forms: (1) broad coverage parameters; and (2) detailed practice guidelines.¹⁶³ Broad coverage parameters deny coverage for certain categories of care, such as in vitro fertilization or surgery for chronic, minor back pain.¹⁶⁴ Practice guidelines govern treatment decisions for patients with specific conditions and typically reflect accepted clinical protocols and clear evidence from clinical studies.¹⁶⁵ Although physicians are expected to comply with any centrally promulgated rules, physicians remain free to promote their individual patient's best interests within these externally imposed constraints.¹⁶⁶ Centralized rationing regimes thereby permit a patient-centered duty of care.¹⁶⁷

As discussed below, proponents of centralized, government rationing, sometimes referred to as explicit rationing, argue that it addresses many of the problems that plague bedside rationing. Although critics of bedside rationing raise legitimate concerns, this Article argues that they overstate the relative merits of centralized government rationing. Moreover, centralized government rationing regimes fail to achieve their fundamental goal—successfully constraining health care costs.¹⁶⁸

1. The Merits of Centralized Government Rationing

Proponents of centralized, government rationing argue that it addresses

context attempt to achieve the best results for the population they service, generally with little regard for the implications of those decisions in individual cases.”).

163. See Sage et al., *supra* note 161, at 8.

164. For example, the rationing scheme under Oregon's Medicaid program excludes coverage for certain medical treatments. See Chris Ham & Angela Coulter, *Explicit and Implicit Rationing: Taking Responsibility and Avoiding Blame for Health Care Choices*, 6 J. HEALTH SERV. RES. POL'Y 163, 163–64 (2001) (describing the Oregon Medicaid program's approach to rationing).

165. See *id.* at 164 (describing national approaches to rationing that rely on evidence-based guidelines).

166. See Leslie P. Scheunemann & Douglas B. White, *The Physician as Rationer: Uncertainty About the Physician's Role Obligations*, 33 SEMINARS RESPIRATORY & CRITICAL CARE MED. 421, 423 (2012) (stating that under explicit rationing the bedside physician is insulated from making rationing decisions and can then advocate for their patients within the constraints imposed at the administrative level).

167. See Fleck, *supra* note 148, at 1619–20 (stating that bureaucratically or legislatively generated rationing protocols extricate physicians from the moral dilemma posed by physicians acting as front-line rationers—denying patients care when the physician is “supposed to be a loyal and uncompromised advocate of her patients' best medical interests.”).

168. Richard Dolinar & S. Luke Leininger, *Pay for Performance or Compliance? A Second Opinion on Medicare Reimbursement*, 3 IND. HEALTH L. REV. 397, 403 (2006).

many of the problems that plague bedside rationing.¹⁶⁹ First, whereas bedside rationing threatens to erode patients' trust in physicians, centralized government rationing preserves patient trust.¹⁷⁰ Second, critics fear that the financial incentives associated with bedside rationing will lead physicians to provide substandard care.¹⁷¹ In contrast, because centralized government rationing does not depend on provider financial incentives, it minimizes the risk of substandard care.¹⁷² Third, physicians' rationing choices may lack legitimacy because they are not the product of democratic processes.¹⁷³ Moreover, physicians are not uniquely competent to resolve the difficult philosophical issues that arise when allocating medical care.¹⁷⁴ Furthermore, because of disparities in how physicians weigh patients' needs and competing considerations, bedside rationing risks wide inequalities in how care is allocated among patients.¹⁷⁵ Proponents of centralized government rationing argue that it achieves greater legitimacy and equity because it allows for public participation, transparency, and accountability.

a. Preserving Patient Trust

As discussed in Part II.A, commentators have long viewed patient trust in physicians as an essential aspect of the treatment relationship. Critics contend that physician rationing under a dual duty of care threatens to undermine patients' trust in physicians.¹⁷⁶ Patients' trust in physicians

169. See James A. Morone, *The Bias of American Politics: Rationing Health Care in a Weak State*, 140 U. PA. L. REV. 1923, 1932 (1992); see also Grochowski, *supra* note 156, at 647 (noting that "trust is eroded by physician conflicts of interest, including the physician's role as gatekeeper and . . . by the patient's perception that physicians are powerless.").

170. See Fleck, *supra* note 148, at 1635.

171. See *id.* at 1610; Susan L. Goldberg, *A Cure for What Ails? Why the Medical Advocate Is Not the Answer to Problems in the Doctor-Patient Relationship*, 1 WIDENER L. SYMP. J. 325, 337-38 (1996) ("The essence of a fiduciary relationship is . . . trust and reliance on a doctor's expertise [Centralized rationing] may transform the profession . . . [to] an interchangeable scientific technician delivering a prescribed set of treatments."); see also Grochowski, *supra* note 156, at 653 (citing "risk . . . of unfair treatment" as a problem associated with bedside rationing).

172. But see Fleck, *supra* note 148, at 1635.

173. *Id.* at 1616.

174. See *id.* at 1597; Goldberg, *supra* note 171, at 331 ("Pressures to reduce services under managed care may have an effect on patient health instead of finances." (citing Orentlicher, *Health Care Reform*, *supra* note 18, at 161)).

175. Mark A. Hall & Robert A. Berenson, *The Ethic of Managed Care: A Dose of Realism*, 28 CUMB. L. REV. 287, 296 (1997).

176. See Hall, *Rationing Health Care*, *supra* note 11, at 764 ("A very strict fiduciary ethic may be

depends in part on the belief that physicians prioritize an individual patient's needs over all other concerns.¹⁷⁷ However, when physicians withhold or delay care due to economic considerations, they "violat[e] a patient's trust by trading off the patient's interests for the medical or nonmedical interests of others."¹⁷⁸ Bedside rationing under a dual duty of care therefore may erode patient trust as patients come to doubt whether physicians have their best interests at heart.¹⁷⁹

While the supposition that provider financial incentives diminish patient trust has intuitive appeal, some argue that patient trust may be more resilient than assumed.¹⁸⁰ "Contrary to the assumption that we trust only when we have ample protections, we often confer trust in proportion to the power others have over us for it is trust that allows beneficial power to exist."¹⁸¹

needed to preserve the essential therapeutic role that trust plays in the treatment relationship."); Mehlman, *The Patient-Physician Relationship in an Era of Scarce Resources*, *supra* note 46, at 369 (arguing that fiduciary rules induce the patient to trust the physician); Grant H. Morris, *Dissing Disclosure: Just What the Doctor Ordered*, 44 ARIZ. L. REV. 313, 344 (2002) ("The physician's fidelity to the patient assures the patient's trust in the physician." (citing M. Gregg Bloche, *Clinical Loyalties and the Social Purposes of Medicine*, 281 JAMA 268, 272 (1999))).

177. See David Mechanic, *Dilemmas in Rationing Health Care Services: The Case for Implicit Rationing*, 310 BRIT. MED. J. 1655, 1659 (1995) [hereinafter Mechanic, *Dilemmas in Rationing Health Care Services*] (discussing the connection between patients' belief that their physicians have their interests at heart and patients' trust in physicians).

178. See Hall, *supra* note 11, at 730.

179. See Brendan Minogue, *The Two Fundamental Duties of the Physician*, 75 ACAD. MED. 431, 433 (2000) ("[I]f we as a society permit physicians to take the system into consideration when making health care decisions, then patients will lose trust in their physicians."); Orentlicher, *Paying Physicians More to Do Less*, *supra* note 22, at 167 ("[I]f physicians become responsible for rationing decisions, patients may become increasingly distrustful of their physicians. Patient trust may be eroded as individuals wonder whether they are receiving all necessary treatment or whether their physician is withholding some care because of the needs of other patients."). Some commentators, however, have questioned whether physician rationing of care would in fact unduly compromise patient trust. See Hall & Berenson, *supra* note 175, at 301–02 (questioning whether opponents of physician financial incentives overstate their case, as "trust in physicians is capable of withstanding many assaults given the intensity of the need for trust and a patient's helpless dependency on a physician's skill and judgment when suffering from a serious illness"); Minogue, *supra*, at 433 (questioning the assumption that an increase in distrust would harm overall patient outcomes); Peter A. Ubel & Robert M. Arnold, *The Unbearable Rightness of Bedside Rationing: Physician Duties in a Climate of Cost Containment*, 155 ARCHIVES INTERNAL MED. 1837, 1839 (1995) (arguing that the fear that patients will lose trust in physicians should not preclude bedside rationing because patients may accept some amount of bedside rationing).

180. Hall, *Rationing Health Care*, *supra* note 11, at 765 (suggesting that concerns about harm to trust in physicians as a result of bedside rationing "overstate their case because they assume a psychological basis for trust that is far too fragile.").

181. Hall & Berenson, *supra* note 175, at 302.

Patients' dependency on physicians' expertise, particularly when seriously ill, may then reinforce patients' trust in physicians.¹⁸² Accordingly, patient trust may be less fragile than some commentators suggest and "capable of withstanding many assaults."¹⁸³

Unfortunately, there exists a paucity of empirical studies on whether provider financial incentives erode patient trust, and the studies present mixed results.¹⁸⁴ One of the earliest studies on this issue found that although the "overwhelming majority of patients trust their physicians," regardless of payment method, patients of physicians reimbursed under non-managed care fee-for-service arrangements were more trusting of their physicians than patients whose physicians were paid by capitation, salary, or fee-for-service managed care.¹⁸⁵ In contrast, a later study found that diabetic and hypertension patients of physicians exposed to various cost containment strategies, including financial incentives to limit resource use, were "generally not less trusting or less satisfied with their physicians than other patients."¹⁸⁶ Similarly, another study found that disclosing physician payment methods to enrollees in HMOs "had no negative effects on trust" of physicians.¹⁸⁷ These more recent studies raise questions as to whether provider financial incentives do in fact diminish patient trust.

Surveys also find high levels of patient trust despite the spread of managed care.¹⁸⁸ For example, physicians continuously rank near the top of Gallup poll surveys that ask participants to rate the honesty and ethical standards of professionals in various fields, with only nurses, pharmacists, and grade school teachers viewed more favorably in the 2013 survey.¹⁸⁹

182. *See id.*

183. *Id.*

184. *See, e.g.,* Orentlicher, *Paying Physicians More to Do Less*, *supra* note 22, at 156.

185. Audiey C. Kao et al., *The Relationship Between Method of Physician Payment and Patient Trust*, 280 JAMA 1708, 1712 (1998).

186. Nancy L. Keating et al., *The Influence of Cost Containment Strategies and Physicians' Financial Arrangements on Patients' Trust and Satisfaction*, 30 J. AMBULATORY CARE MGMT. 92, 100 (2007).

187. Mark A. Hall et al., *How Disclosing HMO Physician Incentives Affects Trust*, 21 HEALTH AFF. 197, 197 (2002).

188. *See Honesty/Ethics in Professions*, GALLUP (Dec. 11, 2014), <http://www.gallup.com/poll/1654/honesty-ethics-professions.aspx> (summarizing survey results asking participants to rate the honesty and ethical standards of people in certain fields).

189. *See id.*; *see also* ROPER CENTER FOR PUBLIC OPINION RESEARCH, IPOLL QUESTION DETAILS FOR ROPER QUESTION ID: 1680444 (2006) [hereinafter ROPER CENTER] (reporting that 77% of respondents either agreed or strongly agreed with the statement "I trust my doctor to put my medical

Perhaps more surprisingly, the percentage of persons rating the honesty and ethical standards of physicians as “very high” or “high” has *increased* in recent years, hitting 69% in 2013, as compared to 63% in 2000, 52% in 1990, and only 50% in 1981.¹⁹⁰ Relatedly, only 3% of 2013 respondents rated the honesty and ethical standards of physicians as “low” or “very low”—the lowest percentage reported since Gallup began its survey in 1976.¹⁹¹

Nevertheless, although provider financial incentives and bedside rationing perhaps poses less of a threat to patient trust than many assume, the concerns of critics should be taken seriously.¹⁹² Trust, once lost, can be difficult to restore.¹⁹³ As explained by Professor Mark Hall,

Just as a trusting patient tends to forgive mistakes as unavoidable or unintended, a distrusting patient tends to view minor imperfections as symptomatic of an underlying malevolence or incompetence, and may view efforts at improvement as cynical, disingenuous ploys. This makes it extremely difficult to reverse a spiral of distrust.¹⁹⁴

Given the fundamental importance of trust to the treatment relationship, prudence favors avoiding actions that may diminish patient trust.¹⁹⁵ So as long as questions remain as to whether bedside rationing weakens patients’ trust in physicians, caution should be exercised before anointing physicians society’s agents for rationing care.¹⁹⁶

In contrast, centralized government rationing preserves patients’ trust in physicians.¹⁹⁷ By shifting the locus for rationing decisions from the provider level to the administrative level, centralized rationing spares physicians from having to compromise their role as a patient’s fiduciary.¹⁹⁸ Physicians would

needs above all other considerations when treating my medical problems,” with only 8% disagreeing or strongly disagreeing with the statement).

190. See ROPER CENTER, *supra* note 189.

191. See *id.*

192. See Hall, *Law, Medicine, and Trust*, *supra* note 51, at 505–06.

193. *Id.* at 469–70.

194. *Id.* at 508–09.

195. *Id.* at 470–72 (discussing the centrality and fundamental importance of patient trust).

196. *Id.* at 468–70.

197. Orentlicher, *Rationing Health Care*, *supra* note 11, at 451–53.

198. See *id.* at 452 (“The centralized model avoids a compromise of the duty of physicians to their patients.”).

continue to give primacy to individual patient's needs under a patient-centered duty of care.¹⁹⁹ Moreover, when centrally developed rules for rationing require physicians to deny their patients potentially beneficial care, physicians can deflect blame to the third parties responsible for the rules.²⁰⁰ Patients therefore may trust their physicians to remain committed to the patients' interests above all else.²⁰¹

b. Protecting Patients from Substandard Care

Critics of a dual duty of care also worry that the provider financial incentives that induce physicians to consider costs pose too great a danger to patient welfare.²⁰² As explained by one commentator:

If physicians have a personal economic interest in limiting the care they provide their patients, they may delay important tests and treatment or omit the tests and treatment entirely. They may schedule patients for return appointments at intervals between appointments that are too long, or they may try to manage their patients' care too long, unduly stretching the limits of their own expertise, before referring the patients to an appropriate specialist. Physicians may also accelerate the date of a patient's discharge from the hospital after surgery, increasing the risk that a complication of the surgery will develop at home where appropriate care may not be available quickly enough.²⁰³

Opponents of provider financial incentives thereby fear that physicians will unduly compromise patients' health in the interest of lower costs.²⁰⁴

These concerns find support in psychological research on cognitive

199. *Id.* at 452–53.

200. See Alex Walter et al., *Negotiating Refusal in Primary Care Consultations: A Qualitative Study*, 29 *FAM. PRAC.* 488, 495 (2012) (noting that physicians in the United Kingdom often deflect blame for rationing decisions to third parties, such as the government).

201. Cf. Daniel Strech et al., *How Physicians Allocate Scarce Resources at the Bedside: A Systematic Review of Qualitative Studies*, 33 *J. MED. & PHIL.* 80, 96 (2008) (“Explicit rationing . . . might put less pressure onto the physician-patient relationship.”).

202. Orentlicher, *Paying Physicians More to Do Less*, *supra* note 22, at 161–62.

203. *Id.* at 161 (citations omitted).

204. *Id.* at 161–62 (highlighting the federal government's reaction to the dangers of financial incentives for physicians in use by health care plans).

motivation.²⁰⁵ Although many physicians sincerely believe that financial incentives do not affect their professional judgment,²⁰⁶ psychologists have found that individuals are subconsciously motivated to process information in a manner that supports the outcome consistent with the individual's self-interest.²⁰⁷ Specifically, people have an unconscious tendency to form intuitions that suit their desired conclusion.²⁰⁸ Because these initial judgments are "first on the scene," they typically dominate an individual's subsequent thought processes.²⁰⁹ More conscious deliberations then perform the secondary role of rationalizing the self-serving conclusion.²¹⁰ Psychologists refer to this dynamic as cognitive motivation.²¹¹

205. See Dan M. Kahan, *The Supreme Court, 2010 Term—Forward: Neutral Principles, Motivated Cognition, and Some Problems for Constitutional Law*, 125 HARV. L. REV. 1, 19 (2011).

206. See Kevin Grumbach et al., *Primary Care Physicians' Experience of Financial Incentives in Managed-Care Systems*, 339 NEW ENG. J. MED. 1516, 1516 (1998) (reporting that although the majority of physicians reported pressure from managed care organizations to limit referrals, only 17% stated that such pressure compromised patient care); James D. Reschovsky et al., *Effects of Compensation Methods and Physician Group Structure on Physicians' Perceived Incentives to Alter Services to Patients*, 41 HEALTH SERVICES RES. 1200, 1209 (2006) (reporting that the majority of physicians with financial incentives to reduce services nevertheless believe they can provide high quality care to their patients and make clinical decisions in the best interest of patients).

207. Kahan, *supra* note 205, at 19–20.

208. See *id.* at 19 (describing "the unconscious tendency of individuals to process information in a manner that suits some end or goal"). For example, studies have found that individuals have faster reaction times when generating and endorsing memories and beliefs consistent with conclusions that promote an individual's self-interest or desired ends. See Ziva Kunda, *The Case for Motivated Reasoning*, 108 PSYCHOL. BULL. 480, 484 (1990) (summarizing studies on biased memory search).

209. See Don A. Moore & George Lowenstein, *Self-interest, Automaticity, and the Psychology of Conflict of Interest*, 17 SOC. JUST. RES. 189, 193 (2004) ("Automatic processes tends to dominate, in part because they tend to be 'first on the scene,' with controlled processes acting as an override."); Milton C. Regan, *Moral Institutions and Organizational Culture*, 51 ST. LOUIS U. L.J. 941, 954 (2007) ("[Intuitions] represent an immediate judgment about a situation.").

210. See Regan, *supra* note 209, at 959–60 ("[W]e typically engage in moral reasoning after our judgments have been formed, and . . . we engage in that exercise in order to justify, rather than arrive at, those judgments."). See generally DANIEL KAHNEMAN, *THINKING, FAST AND SLOW* 105 (2011) (explaining that deliberative processes merely endorse individuals' initial impressions by providing justifications for them). This does not mean deliberative reasoning cannot override our initial impressions—it can—but doing so requires mobilizing substantial mental focus, something individuals do infrequently, particularly when their mental capacity is otherwise taxed by the complexity of the situation or performing other tasks. See Moore & Lowenstein, *supra* note 209, at 193 (stating that although "controlled processes can override automatic processes," studies have found "that when mental capacity is constrained because people are under cognitive load, it is harder for them to engage in reflection and correction of automatic judgments."). See generally KAHNEMAN, *supra*, at 81 (describing the "laziness" of System 2 deliberative cognitive processes).

211. See Roy F. Baumeister & Kathleen D. Vohs, *Motivated Cognition*, in *ENCYCLOPEDIA OF*

The theory of motivated cognition thereby predicts that physicians may be subconsciously biased to make clinical decisions consistent with their own financial self-interest, despite their strong commitment to their patients' welfare.²¹² For example, if payors reward a physician for admitting fewer patients to the hospital, the physician will be cognitively motivated to reach a clinical conclusion that justifies treating the patient outside the hospital setting.²¹³ Indeed, much research suggests that financial incentives do in fact induce physicians to make more cost-sensitive clinical decisions.²¹⁴ Financial incentives therefore create the very real risk that physicians may *overvalue* society's cost concerns and their personal financial interests at the expense of patients' health needs.²¹⁵

In contrast, centralized government rationing minimizes the risk of undertreatment.²¹⁶ Rather than rely on provider financial incentives that encourage physicians to ration care, centralized government rationing allocates medical care based on administrative rules.²¹⁷ Centralized government rationing thereby shields physicians from provider financial incentives, curtailing the risk that physicians will withhold or delay appropriate care.²¹⁸ Moreover, because government-issued rules for

SOCIAL PSYCHOLOGY 594, 594 (2007) ("Motivated cognition refers to the influence of motives on various types of thought processes such as memory, information processing, reasoning, judgment, and decision making."); Kahan, *supra* note 205, at 19 ("What's meant when an extrinsic goal is said to motivate cognition is that it directs mental operations . . .").

212. See Grochowski, *supra* note 156, at 637 (asserting that when making decisions in the gray area, physicians' clinical judgments are subconsciously influenced by financial incentives); Mantel, *The Myth of the Independent Physician*, *supra* note 19, at 498–500 (explaining how physicians' self-interest subconsciously biases physicians to make clinical decisions consistent with their self-interest).

213. See Mantel, *The Myth of the Independent Physician*, *supra* note 19, at 501 ("[I]f [a health care organization] provides bonuses to physicians who reduce the rate of hospital admissions among their patients, physicians benefit financially when they conclude that a patient's condition does not warrant inpatient care. Cognitively motivated to reach this conclusion, a physician may unconsciously form initial perceptions and hypotheses about the patient's condition that support treating the patient outside the hospital setting.").

214. See Carine Chaix-Couturier et al., *Effects of Financial Incentives on Medical Practice: Results from a Systematic Review of the Literature and Methodological Issues*, 12 INT'L J. FOR QUALITY HEALTH CARE 133, 134 (2000) (summarizing results from studies and finding that financial incentives impact physicians' utilization and referral rates).

215. *Id.* at 134–35.

216. Orentlicher, *Rationing Health Care*, *supra* note 11, at 452 (stating that the centralized model avoids a compromise in care by physicians for their patients).

217. *Id.* at 451.

218. Orentlicher, *Paying Physicians More to Do Less*, *supra* note 22, at 161.

rationing care are subject to public scrutiny,²¹⁹ they are less likely to undervalue patients' health needs in favor of economic considerations.

That being said, fears that physicians will provide substandard care in response to financial incentives may be overstated.²²⁰ Psychologists have found that in justifying their initial, self-serving judgments, "people . . . attempt to be rational and to construct a justification of their desired conclusion that would persuade a dispassionate observer."²²¹ Consequently, individuals' ability to arrive at the desired conclusion "is constrained by their ability to construct seemingly reasonable justifications for these conclusions."²²² Therefore, physicians' "capacity for making self-serving clinical decisions is constrained by the plausibility of the justifications for such decisions."²²³ For this reason, physicians would not withhold or delay medically appropriate care when the standard of care is unambiguous, even if rationing such care financially benefitted the physician.²²⁴ Several studies of physicians' clinical decision-making support this hypothesis, finding that financial incentives to lower costs are associated only with a reduction in care of questionable or uncertain clinical benefit, with no reduction in care that available evidence shows to be efficacious.²²⁵

Additional considerations may also counteract physicians' financial incentives to provide substandard care. Physicians, fearful of malpractice lawsuits, may be deterred from denying patients care of clear clinical

219. See *infra* notes 266–70 and accompanying text (discussing the process for adopting administrative rules for rationing).

220. See Chaix-Couturier et al., *supra* note 214, at 134–35.

221. Kunda, *supra* note 208, at 482–83.

222. *Id.* at 480.

223. Mantel, *The Myth of the Independent Physician*, *supra* note 19, at 504–05.

224. See *infra* note 225 and accompanying text.

225. See Sean P. Elliott et al., *Reduction in Physician Reimbursement and Use of Hormone Therapy in Prostate Cancer*, 102 J. NAT'L CANCER INST. 1826, 1826 (2010) (finding that reductions in reimbursement rates for androgen-deprivation therapy (ADT) was associated with a reduction in overtreatment without a reduction in needed services); Vahakn B. Shahinian et al., *Reimbursement Policy and Androgen-Deprivation Therapy for Prostate Cancer*, 363 NEW ENG. J. MED. 1822, 1822 (2010) (finding that reductions in reimbursement for ADT was associated with a reduction in inappropriate and discretionary use of ADT, but not of use considered appropriate); Joannie Shen et al., *The Effects of Payment Method on Clinical Decision-Making*, 42 MED. CARE 297, 297 (2004) (finding that capitated payment leads physicians to reduce health care resource expenditures on discretionary care of relatively small or questionable benefits to the patient but not on care that offered large, undeniable benefits to patients).

value.²²⁶ In addition, physicians may worry that they will lose patients to competitors if they develop a reputation for providing low quality care.²²⁷ New reimbursement methodologies that reward physicians for providing high quality care with higher payments, and vice versa,²²⁸ may help neutralize financial incentives to undertreat patients.²²⁹

Pressures from health plans, hospitals, and health systems may also

226. See Mehlman, *Health Care Cost Containment*, *supra* note 98, at 858 (“The fear of malpractice suits is probably the most effective pressure on providers to refrain from denying nonwasteful technology to patients.”).

227. Although the difficulties that patients face in evaluating the care they receive may limit their ability to make informed choices among providers, some providers nevertheless are motivated to provide high quality care to protect their reputations. See DOJ & FTC, *IMPROVING HEALTH CARE: A DOSE OF COMPETITION* 17 (2004) (stating that although there exists informational and payment barriers to effective competition, competition can play an important role in enhancing quality of care); Anne Frølich et al., *A Behavioral Model of Clinician Responses to Incentives to Improve Quality*, 80 *HEALTH POL’Y* 179, 187 (2007) (discussing a study of Wisconsin hospitals that finds that public reporting of quality performance made hospitals more likely to adopt quality improvement programs); David A. Hyman & Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 90 *CORNELL L. REV.* 893, 957 n.364 (2005) (stating that one motive of providers for improving quality may be concern for their reputation).

228. For example, beginning in 2015, under the Medicare Physician Value-Based Payment Modifier program (VBP), Medicare will adjust payments to certain physicians, based upon their performance on various quality measures, with higher performing physicians receiving higher payments and poorer performing physicians receiving lower payments. *Value-Based Payment Modifier*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html> (last updated Mar. 19, 2015); see *Payment for Physician’s Services*, Social Security Act, 42 U.S.C.S. § 1395w-4(p), Pub. L. No. 113-237 (2014). For 2015, the Physician VBP Modifier will affect payments to physician groups with 100 or more “eligible professionals,” and in 2016 it will affect physician groups with ten or more eligible professions. *Value-Based Payment Modifier*, *supra*. In 2017, the VBP Modifier will be extended to all (or nearly all) physicians paid under the Medicare Physician Fee Schedule. See *id.* Similarly, private plans are increasingly linking physicians’ payments to their performance on selected quality measures. See MCKESSON HEALTH SOLUTIONS, *THE STATE OF VALUE-BASED REIMBURSEMENT AND THE TRANSITION FROM VOLUME TO VALUE IN 2014* 5 (2014) (stating that 90% of payors and 81% of providers are using value-based reimbursement, with the industry anticipating a significant expansion in value-based care in the future).

229. See David Orentlicher, *Controlling Health Care Costs Through Public, Transparent Processes: The Conflict Between the Morally Right and the Socially Feasible*, 36 *J. CORP. L.* 807, 820 (2011) [hereinafter Orentlicher, *Controlling Health Care Costs*] (arguing that “bonuses for higher-quality care . . . counteract the tendency to provide too little care”). However, as I have explained elsewhere, these so-called pay-for-performance arrangements may only afford patients limited protection against providers stinting on care given the inherent limitations of quality measures. See Mantel, *Accountable Care Organizations*, *supra* note 13, at 1429–35 (discussing the limitations of performance measures adopted under the Medicare Shared Savings Program in deterring accountable care organizations (ACOs) from stinting on care).

deter physicians from providing substandard care. Because these organizations may be held vicariously liable for physicians' malpractice, they have incentives to carefully monitor whether their affiliated physicians comply with existing medical standards.²³⁰ Relatedly, they may be unwilling to contract with or grant medical staff privileges to physicians who provide lower quality care.²³¹ Finally, payors with tiered provider networks—where plan enrollees pay lower cost-sharing when treated by providers in the lower-priced tier(s) and higher cost-sharing when treated by providers in the higher-priced tiers²³²—may assign poorer performing physicians to tiers with higher cost-sharing.²³³ This may result in poorer performing physicians losing patients to physicians assigned to lower cost-sharing tiers.

This Article does not mean to suggest that financial incentives never lead physicians to undertreat patients, but simply suggests that this concern rests on a weaker foundation than is often assumed. Nevertheless, a rationing regime that depends on government-promulgated rules poses less threat to patient welfare than one dependent on financial incentives and bedside rationing.

c. Legitimacy and Fairness

Critics of bedside rationing also question the legitimacy and fairness of physicians rationing care on a case-by-case basis.²³⁴ With physicians' rationing decisions hidden from public view, their decisions are not subject to public debate or scrutiny;²³⁵ nor are physicians held publicly accountable

230. See Orentlicher, *Paying Physicians More to Do Less*, *supra* note 22, at 196–97 (explaining that hospitals and health plans have incentives to monitor the quality of care provided by physicians).

231. See Craig W. Dallon, *Understanding Judicial Review of Hospitals' Physician Credentialing and Peer Review Decisions*, 73 TEMP. L. REV. 597, 616 (2000) (explaining that hospitals' credentialing processes take quality into account to fulfill a hospital's charitable mission and legal duties to protect patient welfare; maintain and enhance the hospital's reputation, attract patients, and protect the hospital from liability of injured plaintiffs).

232. See PAUL FRONSTIN, EMP. BENEFIT RESEARCH INST., TIERED NETWORKS FOR HOSPITAL AND PHYSICIAN HEALTH CARE SERVICES 3 (2003), available at <http://www.ebri.org/pdf/briefspdf/0803ib.pdf> (explaining tiered provider networks).

233. See *id.* (explaining that payors with tiered networks may assign providers to tiers based on their quality of care). Providers also may be assigned to tiers based on their costs. See *id.*

234. See Fleck, *supra* note 148, at 1604–05.

235. *Id.* at 1610–17 (arguing that “rationing is a rampant feature of Medicare [Diagnosis-Related Groups] DRGs, though hidden from effective public scrutiny”).

for their rationing choices.²³⁶ Consequently, the rationing decisions of individual physicians may not reflect the public's values or interests.²³⁷ Relatedly, their allocative decisions may not be “a product of rational deliberation, both moral and scientific,”²³⁸ but “arbitrary” and lacking a “rational relationship between medical need or likelihood of medical benefit and the diagnostic or therapeutic care that is actually given.”²³⁹

Several commentators also have questioned the appropriateness of physicians making the value judgments inherent in rationing because they do not possess any special expertise to do so.²⁴⁰ As Professor David Orentlicher has explained, questions regarding how best to allocate medical care cannot be resolved simply by applying medical expertise: “Rather, rationing decisions are ultimately value judgments about balancing benefits against costs and deciding when there is sufficient benefit to justify the use of society's limited health care resources. These are judgments that laypersons are as qualified as physicians to make.”²⁴¹

Physicians at times also do not consciously balance these competing considerations when rationing care. Instead cost-benefit tradeoffs are incorporated into physicians' professional intuition.²⁴² Therefore, physicians

236. *Id.* at 1612 (asserting that “invisible rationing decisions are ‘beyond the pale of public scrutiny or accountability,’ which means that criteria may be used that are ‘capricious, unreasonable, or dangerous’” (citing Ronald Bayer et al., *The Care of the Terminally Ill: Morality and Economics*, 309 NEW ENG. J. MED. 1490, 1490–91 (1983))).

237. *See id.* at 1617, 1621 (arguing that rationing decisions should be “democratic”—they should emerge from “a public conversation”—and that when health care providers and institutions make rationing decisions, “there is no connection at all between the values that drive these rationing decisions and the values of the patients whose welfare will be most affected by these decisions”).

238. *Id.* at 1617.

239. *Id.* at 1621.

240. *See* Grochowski, *supra* note 156, at 653 (“[M]any commentators have argued that physicians have no special ability to . . . ration fairly.” (citing Hall, *Rationing Health Care*, *supra* note 11, at 714–15)); Orentlicher, *Paying Physicians More to Do Less*, *supra* note 22, at 166 (“[P]hysicians have no special expertise in making rationing decisions.”).

241. Orentlicher, *Health Care Reform*, *supra* note 18, at 153.

242. *See* MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS, & ECONOMICS OF RATIONING MECHANISMS 118 (1997) (explaining that physicians often do not make explicit cost-benefit calculations when rationing care at the bedside but that “various mechanisms—education, peer influence and financial incentives—would cause physicians to internalize cost considerations within their intuitive clinical judgment, encouraging them to adopt a more conservative, less interventionist practice style”); Mantel, *The Myth of the Independent Physician*, *supra* note 19, at 504–05 (arguing that physicians' clinical decisions, including decisions to adopt a more conservative, low cost practice style, are subconsciously shaped by their peers and the culture of their health care organization).

may have difficulty distinguishing their clinical judgments from normative ones,²⁴³ taking the latter for granted and not subjecting them to careful reflection.²⁴⁴ These concerns raise serious questions about the legitimacy of physicians' rationing decisions.

Critics of a dual duty of care also argue that bedside rationing invites inconsistent and arbitrary allocation decisions. Equality principles demand that the rationing of medical care be done in a fair, evenhanded manner with variability in treatments due to differences in patients' clinical conditions or individual preferences.²⁴⁵ As explained below, however, when physicians ration care, whether a patient receives an intervention may depend in part on the personal values and biases of the physician and the patient's own attributes.²⁴⁶ Bedside rationing therefore introduces large inequalities into the practice of medicine.²⁴⁷

The inherent nature of medical decision-making renders inconsistencies in how physicians ration care unavoidable.²⁴⁸ The practice of medicine can be fairly characterized as involving a high degree of clinical uncertainty and ambiguous value trade-offs.²⁴⁹ Too frequently physicians lack authoritative evidence and guidelines on the appropriate course of treatment.²⁵⁰ Even when physicians possess information on an intervention's overall clinical effectiveness, its potential benefits and risks for an individual patient often

243. See David Mechanic, *Professional Judgment and the Rationing of Medical Care*, 140 U. PA. L. REV. 1713, 1736 (1992) [hereinafter Mechanic, *Professional Judgment*] (noting "the difficulty of distinguishing clinical judgments from normative assessments and the extent to which these issues become intermingled in an implicit rationing process").

244. See *id.* at 1737 (stating that a danger of bedside rationing is that physicians' "normative judgments are so taken for granted that they are no longer subject to circumspection").

245. See Samia A. Hurst & Marion Danis, *A Framework for Rationing by Clinical Judgment*, 17 KENNEDY INST. ETHICS J. 247, 254 (2007) (stating that fairness in rationing requires consistency and sensitivity to relevant individual variations).

246. See DAVID MECHANIC, *THE TRUTH ABOUT HEALTH CARE: WHY REFORM IS NOT WORKING IN AMERICA* 134 (2006) [hereinafter MECHANIC, *THE TRUTH ABOUT HEALTH CARE*] ("The darker side [of bedside rationing] is that it tends to give advantages to more educated, sophisticated, demanding and even obnoxious patients and provides opportunities for the doctor's nonmedical beliefs, prejudices, and discrimination to influence clinical decisions.").

247. *Id.*

248. See Mantel, *The Myth of the Independent Physician*, *supra* note 19, at 471–77.

249. See *id.* (discussing uncertainty and ambiguity in the clinical setting).

250. See 2 HANDBOOK OF HEALTH ECONOMICS 402 (Mark V. Pauly et al. eds., 2011) ("In many clinical situations, there are no authoritative guidelines or consensus treatment recommendations.").

remain uncertain given the substantial variation among patients.²⁵¹ Medical decision-making also involves ambiguous value choices, such as the tradeoff between a treatment's potential health benefits and risks.²⁵² Bedside rationing raises the additional ambiguous question of whether a particular treatment represents a worthwhile use of society's health care resources.²⁵³

The uncertainty and ambiguity in medicine invariably lead to wide disparities in how physicians ration care. When making clinical choices in the face of uncertainty and ambiguity, physicians rely on their professional intuition.²⁵⁴ A physician's professional intuition reflects her past experiences, her personal values and beliefs, her colleagues' practice style, and the organizational culture of her employer or practice group.²⁵⁵ Because these factors vary greatly from physician to physician, physicians' bedside rationing decisions also will vary.²⁵⁶ Whether a patient receives a particular

251. See Jerry H. Gurwitz et al., *The Exclusion of the Elderly and Women from Clinical Trials in Acute Myocardial Infarction*, 268 JAMA 1417, 1421 (1992) (“[A] priori exclusion of the elderly [from clinical drug trials] prevents collection of the very data clinicians and researchers need to make informed decisions when treating this important population.”); Jost, *supra* note 99, at 15 (“Given the infinite variability of patients and conditions, it is often quite difficult to know with any precision how useful any test or procedure will be *ex ante*.”); Mantel, *Accountable Care Organizations*, *supra* note 13, at 1420 (“[A] treatment's potential clinical benefits for an individual patient often remain uncertain, with some care that, on average, is of no, or merely marginal, benefit potentially benefitting some patients.”).

252. For example, a medical intervention may yield useful diagnostic information, prevent illness, cure or ameliorate a disease, increase a patient's life expectancy, or improve a patient's quality of life, but it may also expose a patient to pain, anxiety, health complications, or death. See Mantel, *The Myth of the Independent Physician*, *supra* note 19, at 475.

253. See generally Morreim, *Medicine Meets Resource Limits*, *supra* note 12, at 15 (noting that medical decision-making involves value choices, including “decisions about how much money is appropriate to spend” in an effort to achieve health-related goals (citing JANE M. ORIENT, *YOUR DOCTOR IS NOT IN: HEALTHY SKEPTICISM ABOUT NATIONAL HEALTH CARE* 81 (1994))).

254. See Mantel, *The Myth of the Independent Physician*, *supra* note 19, at 480–84 (explaining physician's cognitive schemas).

255. See *id.*

256. See Scheunemann & White, *supra* note 166, at 424 (stating that there likely will be substantial variability in how bedside rationing decisions are made because of “interphysician variability”). The development of general standards guiding individual rationing decisions would do little to reduce this variability. As explained by Professor David Orentlicher:

The appropriateness of a particular test or treatment depends on the balancing of a number of factors, such as cost, likelihood of benefit, potential degree of benefit and potential duration of benefit, which vary from treatment to treatment and from patient to patient, and there is no formula that can tell a physician whether a treatment's high potential degree or duration of benefit outweighs its low likelihood of benefit. The best we can do is establish some general principles that must be applied in individual cases to

intervention, then, may depend on her choice of physician, rather than any overarching principles for rationing care.²⁵⁷

Some also fear that bedside rationing will aggravate existing disparities in the care provided to certain socioeconomic groups.²⁵⁸ In balancing a patient's interests with society's cost concerns, physicians must assess the likelihood and magnitude of an intervention's benefit to the patient. This assessment necessitates that the physician make subjective judgments about the patient's motivation, personality traits, family circumstances, and quality of life.²⁵⁹ Despite physicians' attempts to be fair, such judgments too frequently reflect physicians' prejudices and social biases.²⁶⁰ Consequently,

make rationing decisions. Yet, just as general principles of law cannot determine the result for a particular legal question, general rationing principles cannot determine the result for individual rationing decisions.

Orentlicher, *Paying Physicians More to Do Less*, *supra* note 22, at 170 (citation omitted); *see also* Scheunemann & White, *supra* note 166, at 424 (explaining that, although ethical principles may guide physicians' weighing of the possible benefits of treatment for a patient against the costs to society, "it nonetheless involves individual judgment").

257. *See* Orentlicher, *Health Care Reform*, *supra* note 18, at 154–55 (arguing that under bedside rationing "there would be a good deal of inconsistency from physician to physician," and whether patients will be treated "may turn more on their particular physician's views than any overarching rationing principles"); Ubel & Arnold, *supra* note 179, at 1838 (explaining that variability among physicians means patients' "choice of physicians affects whether or not they get certain marginally beneficial services").

258. Numerous studies have documented disparities in care based on socioeconomic factors, such as race, ethnicity, and gender. *See, e.g.*, Florian B. Mayr et al., *Infection Rate and Acute Organ Dysfunction Risk as Explanations for Racial Differences in Severe Sepsis*, 303 JAMA 2495, 2495 (2010) (finding a significantly higher sepsis rate among black patients as compared to white patients, explained by both a higher infection rate and a higher risk of acute organ dysfunction in black individuals, rather than in white individuals); Mark J. Pletcher et al., *Trends in Opioid Prescribing by Race/Ethnicity for Patients Seeking Care in US Emergency Departments*, 299 JAMA 70, 70 (2008) (finding that white patients with pain were more likely to receive an opioid than black, Hispanic, or Asian/other patients); Viola Vaccarino et al., *Sex and Racial Differences in the Management of Acute Myocardial Infarction, 1994 through 2002*, 353 NEW ENG. J. MED. 671, 678 (2005) (finding differences in the treatment and outcome of myocardial infarction according to race and sex, with fewer black men and women receiving reperfusion therapy and coronary angiography, and with black women having the highest adjusted mortality rate among all sex and racial groups).

259. *See* Mechanic, *Dilemmas in Rationing Health Care Services*, *supra* note 177, at 1657 ("[D]octors make assumptions about benefit based on judgments about intelligence, family circumstances, personality traits, and the like."); Mechanic, *Professional Judgment*, *supra* note 243, at 1736 (explaining that physicians commonly make normative judgments about patient "motivation, capacity, function, and quality of life").

260. *See* MECHANIC, THE TRUST ABOUT HEALTH CARE, *supra* note 246, at 134 (explaining that, under bedside rationing, a doctor's decisions may reflect her prejudices and discrimination); Mechanic, *Dilemmas in Rationing Health Care Services*, *supra* note 177, at 1657 (explaining that

physician rationing of care may result in services being disproportionately withheld from patients of certain groups.²⁶¹

Finally, differences in patients' personalities and capabilities promote inequities in physicians' allocation of medical care. Studies of bedside rationing have found that an individual patient's characteristics strongly influence whether she receives a particular intervention, such as the patient's ability to articulate her wishes, exert pressure on physicians, or exhibit demanding behavior.²⁶² For example, physicians report that better educated patients more often request specific care and that patients who put pressure on physicians or "shout the loudest get the most."²⁶³ Therefore, under bedside rationing, better-educated and more demanding patients are likely to receive more and better care relative to less educated, more passive patients.²⁶⁴

Proponents of centralized government rationing argue that the model avoids the legitimacy and fairness concerns raised by bedside rationing.²⁶⁵ Publicly accountable government commissions and agencies ensure that society has a voice in the process for adopting rules for rationing care.²⁶⁶

doctors' judgments about potential benefits "commonly reflect social biases more than empirical reality"); see also M. Gregg Bloche, *Trust and Betrayal in the Medical Marketplace* 55 STAN. L. REV. 919, 941 (2002) (citing COMM. ON UNDERSTANDING & ELIMINATING RACIAL & ETHNIC DISPARITIES IN HEALTH CARE, INST. OF MED., *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* (Brian D. Smedley et al. eds., 2002), available at <http://www.nap.edu/books/030908265X/html>; M. Gregg Bloche, *Race and Discretion in American Medicine*, 1 YALE J. HEALTH POL'Y L. & ETHICS 95, 115 (2001) (discussing racial disparities resulting from cost containment strategies)) (arguing that, because bedside rationing makes cost management paramount, it creates "more room for stereotypes, biases, and differential empathy that engender racial and ethnic disparities in care").

261. See Ubel & Arnold, *supra* note 179, at 1838 ("If physicians are told that it is acceptable to ration at the bedside, they may disproportionately withhold services from patients of certain races or socioeconomic groups.").

262. See Strech et al., *supra* note 201, at 95 (summarizing the factors that determine whether or not a patient gets an intervention).

263. *Id.* at 91 (reporting comments of physicians asked about their rationing of care).

264. See Mechanic, *Dilemmas in Rationing Health Care Services*, *supra* note 177, at 1657 ("A common criticism of implicit rationing is that knowledgeable, sophisticated, and aggressive patients are more able to have their needs satisfied than docile patients.").

265. See Orentlicher, *Rationing Health Care*, *supra* note 11, at 452, 453.

266. See Len Doyal, *Rationing within the NHS Should Be Explicit*, 314 BRIT. MED. J. 1114, 1119 (1997) (stating that proponents of explicit rationing assume it is fairer because "the public can . . . democratically influence the process and outcome of rationing"); Orentlicher, *Controlling Health Care Costs*, *supra* note 229, at 808 ("If people will be denied medical tests or treatments that might preserve their life or maintain their health, we ought to ensure that all members of society have a

The allocation choices that emerge from a centralized government rationing scheme therefore carry greater legitimacy and are more likely to reflect public values than the rationing decisions of physicians.²⁶⁷ Furthermore, in producing uniform, generally applicable rules for rationing care, the centralized model promotes greater consistency than a rationing mechanism that vests decision-making in providers.²⁶⁸ Finally, because centralized rationing processes are more transparent, any rationing choices are subject to public scrutiny.²⁶⁹ This in turn may result in a more equitable allocation of medical care across patient groups.²⁷⁰

Such arguments, however, ignore the reality of special interest politics.²⁷¹ As I have explained elsewhere:

Getting elected (and reelected) requires campaign contributions and other political resources, which well-organized and well-financed special interest groups are positioned to deliver to politicians who promote policies that further the group's interests. Politicians therefore have strong incentives to advance the agendas of special interest groups representing those who would gain economically from the [coverage] of certain conditions or treatments . . . , such as healthcare providers and pharmaceutical and biotechnology companies. In addition, patients desiring [certain] treatments . . . , particularly treatments that represent patients' best hope of extending their lives or alleviating their pain and suffering, would

voice in the decision making process.”).

267. See Fleck, *supra* note 148, at 1620 (“Someone might argue that rationing protocols generated in the public sector have some moral legitimacy because the values they reflect are public values or public interests.”).

268. See Orentlicher, *Rationing Health Care*, *supra* note 11, at 453 (“The centralized model promotes consistency and fairness across different patients. If the responsibility for making rationing decisions is divided among many institutions or individuals, different patients will be treated differently depending on their particular decision maker.” (citing Daniel P. Sulmasy, *Physicians, Cost Control, and Ethics*, 116 ANNALS INTERNAL MED. 920, 921 (1992))).

269. See *id.* at 452, 453.

270. See Mantel, *Setting National Coverage Standards*, *supra* note 110, at 276 (arguing that subjecting the process of defining covered health benefits to transparency reduces “bias or favoritism toward any one group”); Michael J. Young et al., *Rationing in the Intensive Care Unit: To Disclose or Disguise?*, 40 CRITICAL CARE MED. 261, 263 (2012) (“Greater transparency can promote the goal of stewarding resources equitably by revealing potential areas of inequity and allowing for targeting of these areas to make allocation processes more fair in the future.”).

271. See Mantel, *Setting National Coverage Standards*, *supra* note 110, at 241–42.

be motivated to punish those politicians who ignore their interests by supporting opposing candidates.²⁷²

Therefore, politicians would be motivated to ensure that the protocols issued under a centralized government-rationing regime cover those services desired by powerful special interest groups, regardless of the merits of doing so.²⁷³ So, rather than produce a rational, equitable allocation of medical care, the burden of health care rationing may fall more heavily on patients represented by groups with less political influence.²⁷⁴

Nevertheless, rationing care on the basis of rules promulgated through democratic processes, rather than the idiosyncratic choices of individual physicians, arguably carries greater legitimacy than bedside rationing and avoids some of the latter's inequities.²⁷⁵ This Article suggests that the relative merits of centralized rationing, as compared to bedside rationing on these questions, may be smaller than many assume, given the inequities in the political process.

In conclusion, critics of a dual duty of care rightly argue that physicians' rationing care at the bedside raises legitimate moral concerns, although some of these concerns may be overstated.²⁷⁶ Centralized government rationing arguably avoids some of the problems that plague bedside rationing. However, history suggests that centralized government rationing faces its own challenges. Most fundamentally, the essential goal of constraining

272. *Id.* at 241–42 (citations omitted).

273. *See* Fleck, *supra* note 148, at 1620 (“[T]he reality seems to be that competing interest groups significantly shape the outcomes of the legislative process, and hence, the values of more powerful health interest groups would be reflected in any rationing protocols.”); *cf.* Mantel, *Setting National Coverage Standards*, *supra* note 110, at 231–33, 241–42 (arguing that politicians will ensure that government regulators define the “essential health benefits” that all health plans must cover under Section 1302(b) of the Affordable Care Act as including the medical items and services desired by powerful special interest groups).

274. *Cf.* Mantel, *Setting National Coverage Standards*, *supra* note 110, at 247 (arguing that national coverage standards would exclude conditions or services desired by patients “represented by groups that are poorly organized or otherwise possess little political power,” meaning that such patients “would disproportionately ‘pay’ for the mandates obtained by more powerful groups”).

275. *See* Hall, *Rationing Health Care*, *supra* note 11, at 718 (“It is true, as some argue, that a centralized rationing mechanism run according to democratic principles could in theory do a better job than individual physicians of applying rationing principles in an open, evenhanded, and predictable manner.” (citing Fleck, *supra* note 148, at 1636)). *See generally* Fleck, *supra* note 148, at 1636 (advocating that decision making process surrounding health care rationing should be a democratic process, not a private conversation).

276. *See* Grochowski, *supra* note 156, at 651–55.

health care costs cannot be achieved under a centralized government-rationing regime. In addition, centralized government rationing may not result in as fair an allocation of resources as its proponents contend.

2. The Problems with Centralized Government Rationing

While the concerns about provider financial incentives and bedside rationing are by no means trivial, centralized government-rationing regimes cannot achieve their overarching mission—successfully restrain rising health care costs.²⁷⁷ As explained below, the political challenges of rationing care through public processes inevitably weakens the effectiveness of centralized rationing regimes as a cost-containment tool. Centralized administrative processes also lack the clinical information and flexibility needed to develop timely, comprehensive rules for rationing care. In addition, relative to bedside rationing, centralized government rationing may not result in a more fair allocation of resources, given that its rules are insensitive to differences in patients' circumstances and values.²⁷⁸ In contrast, bedside rationing allows for resource allocation based on patients' unique needs.²⁷⁹

a. The Problem of "Tragic Choices"

Because rationing involves difficult trade-offs between deeply held values, "rationing decisions are not easily amenable to rational public deliberation,"²⁸⁰ and attempts to do so ultimately break down.²⁸¹ Rationing

277. See Mantel, *Setting National Coverage Standards*, *supra* note 110, at 237 (stating that "[p]lacing restrictions on the essential health benefits" serves an "important utilitarian [consideration] by lowering health insurance premiums and preserving government funding for other priorities").

278. See Hall, *Rationing Health Care*, *supra* note 11, at 718 ("In complex situations, however, rules sacrifice accuracy and individuality Fitting patients into preset categories for which their clinical circumstances and individual values are not suited might result literally in legs being chopped off to accommodate the rule.")

279. See *id.* at 705 ("[P]hysicians are required to do everything that they believe may benefit each patient without regard to costs or other societal considerations. In caring for an individual patient, the doctor must act solely as that patient's advocate, against the apparent interests of society as a whole, if necessary.") (quoting Levinsky, *supra* note 3, at 1574–75).

280. See Hall, *Rationing Health Care*, *supra* note 11, at 719.

281. See *id.* ("[T]his discussion requires an overt sacrifice of identifiable persons' lives or welfare. Therefore, society often prefers rationing mechanisms that are hidden or implicit." (citing GUIDO CALABRESI & PHILIP BOBBITT, *TRAGIC CHOICES* 19–21 (1978)).

promotes the important utilitarian goal of lowering health insurance premiums and preserving government funding for other priorities.²⁸² However, spending limits on medical care also represent a public acknowledgment that some lives are not worth saving or improving, a declaration that offends society's deeply held belief in the sanctity of life.²⁸³ Moreover, rationing undermines the commitment to basic egalitarian values because it involves favoring some patients over others.²⁸⁴ Finally, rationing compromises individual autonomy by encroaching upon patients' right to self-determination.²⁸⁵ Rationing therefore requires making trade-offs among our most fundamental values, values that many believe are beyond compromise.

As Guido Calabresi and Philip Bobbitt argue in their classic work on "tragic choices," public and transparent processes that require making trade-offs among fundamental values breed intolerable public discomfort.²⁸⁶ This conflict then undermines public support for the process, placing pressure on public officials to either abandon or scale back such efforts.²⁸⁷

282. See Mantel, *Setting National Coverage Standards*, *supra* note 110, at 237 (arguing that rationing promotes social utility).

283. See CALABRESI & BOBBITT, *supra* note 281, at 39 (explaining that when the political process refuses to provide certain groups with medical care, such as the aged who need hemodialysis, "[T]he clear assertion has been made that some lives are not worth saving. To the extent that our lives and institutions depend on the notion that life is beyond price, such a refusal to save lives is horribly costly."); Mantel, *Setting National Coverage Standards*, *supra* note 110, at 237.

284. See Mantel, *Setting National Coverage Standards*, *supra* note 110, at 237 (explaining how rationing compromises egalitarian principles). See generally CALABRESI & BOBBITT, *supra* note 281, at 38–39 (observing that a society that views its members as created equal cannot make allocative decisions based on individuals' differences without dissonance). As David Orentlicher explains:

When Americans have to choose who does and does not have access to health care, some important social values will be served but others may be sacrificed. If we provide treatment to the patients who can live the longest with care, we often will neglect the patients who have the greatest need for care (since the more advanced a patient's disease, the less amenable it is to treatment). Conversely, if we favor patients with the greatest need, we neglect patients who will live the longest.

Orentlicher, *Controlling Health Care Costs*, *supra* note 229, at 813 (citation omitted).

285. See Mantel, *Setting National Coverage Standards*, *supra* note 110, at 237 (stating that rationing encroaches on individual autonomy).

286. See CALABRESI & BOBBITT, *supra* note 281, at 36–41 (arguing that, because rationing through political processes exposes compromises in the egalitarian ideal, it has substantial shortcomings as an approach to allocating scarce resources).

287. See *id.* at 18–22 (explaining that when attempts at openly confronting situations of scarcity expose tragic choices, society moves from open processes to approaches that avoid openly disclosing

Consequently, when countries attempt to ration care through centralized processes, “those using the process never make the difficult choices that are needed, the difficult decisions that are made unravel and are abandoned, or the decision making process itself is discarded.”²⁸⁸

The stability of centralized rationing mechanisms is undermined not only by the public’s general discomfort with rationing but also by the lobbying of special interest groups and outcry from disaffected patients.²⁸⁹ Politicians, motivated to remain in office, not only desire to avoid antagonizing patients generally, but they also have incentives to advance the interests of patients and other groups who benefit when the health care system provides certain medical interventions.²⁹⁰ Moreover, the incentives to curry favor with such groups are particularly strong when the cost of doing so is spread across all taxpayers or plan subscribers.²⁹¹ Not surprisingly, then, public officials regularly support efforts to repeal or weaken explicit limitations on care for fear that opposing these efforts would alienate powerful special interest groups and patients who otherwise would be denied care.²⁹² As a result, the political pressure to weaken or overturn explicit rationing decisions significantly diminishes the effectiveness of centralized rationing mechanisms as a tool for constraining health care costs.²⁹³

the conflict in values).

288. Orentlicher, *Controlling Health Care Costs*, *supra* note 229, at 808. See *infra* note 293 for a discussion of failed attempts to ration care through centralized government processes.

289. See MECHANIC, *THE TRUTH ABOUT HEALTH CARE*, *supra* note 246, at 139 (arguing that explicit rationing is “extremely difficult to carry out, since it mobilizes disease advocates and professional interest groups and results in considerable political conflict”).

290. See *supra* notes 272–74 and accompanying text.

291. Cf. James Q. Wilson, *The Politics of Regulation*, in *THE POLITICS OF REGULATION* 367–72 (James Q. Wilson ed.) (1980) (explaining that when the costs of legislation are distributed over a large number of people, those burdened have little incentive to organize in opposition to the legislation).

292. See *infra* note 293; see also Mantel, *Setting National Coverage Standards*, *supra* note 110, at 241–46 (discussing the pressure on elected officials to weaken limits on care, as illustrated by Congress overriding the recommendations of the U.S. Preventive Task Force to reduce the frequency of mammograms).

293. See Mechanic, *Dilemmas in Rationing Health Care Services*, *supra* note 177, at 1658 (“Explicit rationing is also likely to confront government and the political process with unrelenting agitation for budget increases.”). The history of the Oregon Medicaid program and the U.S. Preventive Services Task Force (USPSTF) illustrate the instability of centralized rationing. See generally Lawrence Jacobs et al., *The Oregon Health Plan and the Political Paradox of Rationing: What Advocates and Critics Have Claimed and What Oregon Did*, 24 J. HEALTH POL. POL’Y & L.

Unfortunately, given the difficulties associated with rationing care through an open and transparent process, rationing can succeed only if hidden from public view.²⁹⁴ Bedside rationing provides a mechanism for doing so.²⁹⁵ Physicians often are unaware that they are rationing care.²⁹⁶

161, 162 (1999) (describing the Oregon Medicaid rationing plan). In the 1990s, Oregon launched an ambitious effort to lower its Medicaid program costs by rationing health care. *Id.* To do so, the state ranked over 700 medical conditions and treatments, vowing to cover only those treatments ranked above a specific threshold. *See id.* The list generated tremendous controversy, forcing state officials to make numerous revisions to the rankings. *See id.* Moreover, the initiative failed to meet its programmatic goal of producing cost savings through the rationing of care because the state legislature authorized enhanced funding for its Medicaid program, thereby allowing the program to provide more generous coverage than the typical private insurance plan. *See Orentlicher, Controlling Health Care Costs, supra* note 229, at 814 (discussing the failure of the Oregon Health Plan to meet its goal of rationing care). So, despite the initial aspirations of Oregon Medicaid officials, “little real rationing occurred.” MECHANIC, THE TRUTH ABOUT HEALTH CARE, *supra* note 246, at 136.

An effort by the USPSTF to reduce the frequency of screening mammograms similarly illuminates the difficulty of explicit rationing. *See* U.S. Preventive Servs. Task Force, Screening for Breast Cancer: U.S. Preventive Services Task Force Recommendation Statement, 151 ANNALS INTERNAL MED. 716, 716 (2009). In the middle of the health care reform debates in 2009, the USPSTF proposed reversing prior clinical guidelines that called for routine screening mammograms of women over the age of forty. *Id.* The proposed guidelines recommend against screening mammograms for women aged forty to forty-nine and recommended only biennial, rather than annual, screening mammograms for women aged fifty to seventy-four. *See id.* With proposed health care reform bills requiring that health plans fully cover only those preventive services recommended by the USPSTF, the proposal generated significant public backlash—several powerful interest groups spoke out against the proposal. *See generally* Mantel, *Setting National Coverage Standards, supra* note 110, at 245–46 (discussing the public outcry over the USPSTF’s proposed revisions to the mammography guidelines). This in turn led Congress to include in the Affordable Care Act a provision guaranteeing coverage of annual mammograms for women age forty and over, a step that is estimated to increase annual health care expenditures by \$6.7 billion as compared to the USPSTF’s guidelines. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1001, 124 Stat. 119 (2010) (amending Part A of title XXVIII of the Public Health Services Act to include new sections 2713(a)(4) and (5), requiring all group health plans and health insurance issuers offering group or individual health insurance to provide coverage for screening mammograms consistent with the guidelines issued by the Health Resources and Services Administration and the USPSTF prior to its new November 2009 recommendations); Cristina O’ Donoghue et al., *Aggregate Cost of Mammography Screening in the United States: Comparison of Current Practice and Advocated Guidelines*, 160 ANNALS INTERNAL MED. 145, 148 (2014) (estimating that annual mammography screenings for women ages forty to eighty-four would cost \$10.1 billion per year, as compared to estimated costs of \$3.5 billion per year under the USPSTF guidelines).

294. *See* Hall, *Rationing Health Care, supra* note 11, at 719 (stating that, because of the public aversion to overt rationing decisions, “society often prefers rationing mechanisms that are hidden or implicit” (citing CALABRESI & BOBBITT, *supra* note 281, at 19–21)); Orentlicher, *Rationing Health Care, supra* note 11, at 455 (“Because it is too difficult to establish rationing policies openly, society employs subterfuges that try to hide the fact that rationing decisions are being made.”).

295. *See* Hall, *Rationing Health Care, supra* note 11, at 719.

Studies in the fields of psychology and sociology suggest that cost considerations frequently influence a physician's clinical judgments at the subconscious level, outside of the physician's conscious awareness.²⁹⁷ Specifically, pressure to ration care will bias how physicians process and analyze clinical information, allowing the physician to rationalize withholding or delaying care on clinical, rather than economic, grounds.²⁹⁸

Even when consciously rationing care, physicians employ various subterfuges that keep their rationing hidden from patients.²⁹⁹ Physicians frequently avoid openly discussing with patients the influence of cost considerations on treatment decisions, instead persuading their patients that the more costly options are medically unnecessary or not clinically indicated.³⁰⁰ In doing so, physicians "create the impression that they are making their decision on the basis of objective, scientific considerations[,] rather than on the basis of non-medical value judgments about the appropriate allocation of scarce resources."³⁰¹ Many physicians also admit to remaining silent about treatment options withheld from patients, leaving patients unaware that they have been denied potentially beneficial care.³⁰²

In arguing that bedside rationing avoids the "tragic choice" problem that plagues centralized government rationing, this Article does not mean to minimize the moral concerns that arise when physicians ration care at the bedside. Even if various legal and ethical safeguards could reduce the potential for bias or abuse posed by bedside rationing, they cannot completely eliminate the risks. Nevertheless, because the public's aversion to overtly rationing care inevitably destabilizes more democratic approaches to rationing, these risks are a necessary evil if society wants to successfully

296. See Mantel, *The Myth of the Independent Physician*, *supra* note 19, at 501–05.

297. See *id.* (describing the role of cognitive motivation on physicians' clinical judgments).

298. See *id.*

299. See Marjorie E. Ginsburg et al., *A Survey of Physician Attitudes and Practices Concerning Cost-Effectiveness in Patient Care*, 173 W.J. MED. 390, 392–93 (2000).

300. See *id.* (summarizing survey results). For example, in the survey of physicians, only 30% of physicians reported that they frequently or always mention cost or cost-effectiveness when explaining why the physician considers the treatment inappropriate, with 21% reporting that they never do so. *Id.*

301. See Orentlicher, *Rationing Health Care*, *supra* note 11, at 455 (citing DAVID ORENTLICHER, MATTERS OF LIFE AND DEATH 158 (2001)).

302. See Strech et al., *supra* note 201, at 92 (reporting that doctors often implicitly ration care by remaining silent about more costly treatment options that are withheld).

constrain health care costs.³⁰³

b. The Impracticality of Administrative Rules for Rationing Care

Bedside rationing not only better addresses the “tragic choices” problem raised by health care rationing, but also offers the more realistic approach for managing the inherent complexities and uncertainties of treating patients.³⁰⁴ As discussed below, centralized government processes cannot produce the breadth of detailed practice guidelines necessary to support a comprehensive, explicit rationing regime.³⁰⁵ In addition, centralized rationing mechanisms lack the flexibility to account for differences in patients’ circumstances and values.³⁰⁶

Governmental entities simply cannot produce the wide-ranging rules essential for successfully constraining health care costs.³⁰⁷ First, with health care providers making thousands (or millions?) of different types of medical decisions,³⁰⁸ developing rules for the full range of treatment options would prove to be a Herculean task, one that would quickly exhaust available administrative resources.³⁰⁹ Second, regulators often lack the information

303. See Ubel & Arnold, *supra* note 179, at 1837 (“Although bedside rationing raises serious moral problems, these are outweighed by the important social goal of containing health care costs, while providing adequate health care to those who need it.”).

304. See *id.*

305. See Hall, *Rationing Health Care*, *supra* note 11, at 714.

306. *Id.*

307. See *id.*

308. See Orentlicher, *Paying Physicians More to Do Less*, *supra* note 22, at 168 (commenting on the number of different patient care decisions).

309. As explained by Mark Hall: “A complete and scientifically valid set of rationing rules would entail the impossible task of developing rigorous empirical information for each of the almost 10,000 diagnostic entries in the World Health Organization’s *International Classification of Diseases* and the almost 10,000 medical interventions listed in the AMA’s *Current Procedural Terminology*.” Hall, *Rationing Health Care*, *supra* note 11, at 702; cf. Scheunemann & White, *supra* note 166, at 424 (explaining that the infrastructure required to implement a rationing regime that includes explicit rules of rationing would be “costly to develop and maintain”).

The Oregon Medicaid program’s centralized process for rationing care illustrates this challenge. As explained by David Orentlicher, after spending years developing its list of covered and non-covered care, Oregon’s guidelines “only addressed a small percentage of rationing decisions.” Orentlicher, *Paying Physicians Mores to Do Less*, *supra* note 22, at 169. Specifically, Oregon identified broad categories of covered and non-covered care, but it provided no guidance for narrower decisions within covered categories. “For example, while Oregon cover[ed] treatment for heart attacks, its rationing plan [did] not make any effort to resolve the question [of] whether physicians should use streptokinase or t-PA as the medication to dissolve the clot that caused the

needed to develop hard and fast rules that distinguish warranted from unwarranted care.³¹⁰ Developing guidelines requires both balancing the potential benefits and costs of a specific treatment and comparing its cost-effectiveness to alternative interventions.³¹¹ Unfortunately, the paucity of evidence on the potential benefits and risks of many interventions³¹² means that regulators cannot perform the necessary cost-benefit analysis.³¹³ In addition, the value of care is not constant, but varies across locations due to differences in costs and resources.³¹⁴ This in turn limits the generalizability of any cost-effectiveness analysis, as the same intervention may be cost-effective in some settings but not others.³¹⁵ Third, even if regulators could overcome these challenges, constant advancements in medical knowledge and technology would require continuous modifications of the guidelines.³¹⁶

heart attack.” *Id.*

310. See Orentlicher, *Paying Physicians More To Do Less*, *supra* note 22, at 169.

311. See *id.* at 170.

312. See *supra* note 156 and accompanying text.

313. See Mechanic, *Professional Judgment*, *supra* note 243, at 1726 (arguing that uncertainty and the resulting lack of precision in medical care “makes offering directives that cover the entire range of clinical alternatives a risky proposition,” and therefore it may be “impossible to specify all of the contingencies that would distinguish justifiable from unjustifiable use”).

314. Evaluating an intervention’s cost-effectiveness requires consideration of not only initial costs but also subsequent “downstream” costs, such as patient monitoring and treatment for complications. See Jeffrey L. Anderson et al., *ACC/AHA Statement on Cost/Value Methodology in Clinical Practice Guidelines and Performance Measures: A Report of the American College of Cardiology/American Heart Association Task Force on Performance Measures and Task Force on Practice Guidelines*, 63 J. AM. C. CARDIOLOGY 2304, 2311 (2014). Similarly, the analysis should consider any cost savings in the form of prevented future clinical events, such as avoided hospitalizations. See *id.* However, these costs and savings vary across settings. For example, wages vary from region to region, and the per-patient amortized cost of infrastructure and technology depends on the size of the patient population utilizing the resources. See *generally id.* at 2309 (explaining that a limitation to incorporation resource and value considerations in the development of practice guidelines is “that the value of care (cost-effectiveness) is not constant; it may vary . . . from one location to another because of differences or changes in resource availability, efficiency, and cost structure”); Suzanne R. Hill et al., *Incorporating Considerations of Cost-Effectiveness, Affordability, and Resource Implications in Guideline Development*, 9 PROC. AM. THORACIC SOC’Y 251, 252 (2012) (explaining that considering cost and resource implications in developing guidelines is complicated by the fact that complex interventions are setting- and system-dependent; resource use varies among systems and settings).

315. See Gordon Guyatt et al., *Addressing Resource Allocation Issues in Recommendations From Clinical Practice Guideline Panels: Suggestions From an American College of Chest Physicians Task Force*, 129 CHEST J. 182, 184 (2006) (“Costs, available resources, and opportunity costs differ radically between and sometimes within clinical settings, compromising the generalizability of economic analyses.”).

316. See Orentlicher, *Paying Physicians More to Do Less*, *supra* note 22, at 169.

Because administrative processes lack the flexibility to respond rapidly to these changes, government guidelines would quickly become outdated.³¹⁷

Explicit rules also are insensitive to meaningful differences among patients, “sacrific[ing] accuracy and individuality.”³¹⁸ Centrally developed, evidence-based guidelines are based on a treatment’s overall clinical effectiveness for the patient population.³¹⁹ Population averages, however, may hide significant variation among patients—intervention may affect patients differently given disparities in patient conditions and characteristics.³²⁰ Consequently, a treatment that on average provides insufficient benefits to justify its costs may be very cost-effective for a small group of patients.³²¹ Explicit rules for rationing care thus may prove to be a “poor fit” for many patients.³²² In contrast, bedside rationing gives physicians the flexibility to account for important clinical variation among patients, “making [the] unwarranted withholding of efficacious services less likely.”³²³

Explicit rationing rules also fail to take into account individual patient

317. See Mechanic, *Dilemmas in Rationing Health Care Services*, *supra* note 177, at 1656 (“Explicit rules are unresponsive to rapidly changing medical knowledge . . .”); Orentlicher, *Paying Physicians More to Do Less*, *supra* note 22, at 169 (“Even if detailed guidelines could be developed, many of them would likely become outdated by the time they were issued. Medical knowledge is constantly evolving, so only reasonably general guidelines can account for changes in information and technology.”).

318. Hall, *Rationing Health Care*, *supra* note 11, at 718.

319. See Anderson et al., *supra* note 314, at 2307.

320. See Aaron, *supra* note 103, at 1866 (“A given intervention typically affects individual patients differently.”); Mantel, *Accountable Care Organizations*, *supra* note 13, at 1420 (commenting on the limitations of statistical projections for patient populations).

321. See Aaron, *supra* note 103, at 1866 (explaining that interventions that appear to be of marginal benefit may in fact be highly beneficial for some patients); H. Gilbert Welch, *Should the Health Care Forest Be Selectively Thinned by Physicians or Clear Cut by Payers?*, 115 ANNALS INTERNAL MED. 223, 224 (1991) (“Services that are totally eliminated may offer substantial benefit to selected patients. Protocols that are sensible for the general case may fail miserably for the specific one.”). The problems generated by a 2006 guideline for the treatment of diabetes illustrates this problem:

In 2006, the National Committee for Quality Assurance (NCQA) adopted a standard calling for the aggressive control of blood sugar. Data suggested that tight control would reduce the chances of long-term complications of diabetes, including heart disease, kidney failure, and loss of vision. Two years later, the NCQA withdrew the standard after data demonstrated that the new standard caused significant harm to some patients.

Orentlicher, *Rationing Health Care*, *supra* note 11, at 457 (footnotes omitted).

322. Orentlicher, *Rationing Health Care*, *supra* note 11, at 457.

323. Mechanic, *Professional Judgment*, *supra* note 243, at 1714.

circumstances and values.³²⁴ Because centrally developed guidelines are derived largely from clinical studies, they heavily value population-based health outcomes (e.g., how many lives will be saved by a particular intervention; how many patients will suffer serious complications).³²⁵ Other important considerations are largely neglected: the patient's ability to withstand pain and discomfort, her tolerance for risk, the desire to fight and overcome illness, her family's capacity to assume a caregiving role, and her need to keep working.³²⁶ Bedside rationing enables those with a greater understanding of patients' unique needs and values—their physicians—to account for patient differences.³²⁷ Consequently, bedside rationing allows for individualized decisions that are sensitive to patient variance, which in turn results in a fairer distribution of medical resources.

While commentators have rightly raised serious concerns about physicians rationing care at the bedside under a dual duty of care, centralizing rationing decisions in government entities does not offer a feasible alternative. Government rationing simply cannot successfully constrain health care costs given the method's political and informational challenges.³²⁸ Moreover, government rationing introduces new inequalities into the health care system due to disparities in groups' political power and an inability to account for patients' unique circumstances and values.³²⁹ In contrast, bedside rationing offers a more realistic approach for dealing with the complexities of rationing care and achieving true cost savings.³³⁰

324. See Doyal, *supra* note 266, at 1119 (“Individual strength of preference for health care is not accounted for by explicit rules”); Mechanic, *Dilemmas in Rationing Health Care Services*, *supra* note 177, at 1656 (“Explicit rules inevitably will be insensitive to the innumerable differences among people and circumstances[.]”).

325. See Karlawish et al., *supra* note 14, at V-12 (explaining that evidence-based medicine reflects a population perspective, focusing on easily measurable “hard” outcomes).

326. See *id.* (describing non-health outcomes that may be important to patients); Mechanic, *Professional Judgment*, *supra* note 243, at 1727 (discussing differences among patients).

327. See Mechanic, *Dilemmas in Rationing Health Care Services*, *supra* note 177, at 1658 (arguing that bedside rationing provides the flexibility to take differences among patients into account); Orentlicher, *Rationing Health Care*, *supra* note 11, at 457 (“Decentralized decision making allows for individualized decision making.”).

328. See Mechanic, *Dilemmas in Rationing Health Care Services*, *supra* note 177, at 1658.

329. See *id.* (explaining that “[e]xplicit rules will inevitably be insensitive to the innumerable differences among people and circumstances”).

330. See *id.*

B. Rationing Through Payors

Since the emergence of managed care, insurers have rationed patient care by denying coverage of certain treatments.³³¹ Similar to centralized government rationing schemes, managed care plans establish broad coverage parameters that disallow payment for certain categories of care.³³² Unlike centralized rationing at the government level, managed care rations care on a case-by-case basis through a process known as utilization review, with administrators determining whether a medical intervention is medically necessary for a specific enrollee.³³³ However, plans' utilization review processes typically require plan administrators to apply specific guidelines that dictate whether the plan will cover specific interventions for certain patients.³³⁴

Centralizing rationing at the level of insurers has similar advantages to government-based models of rationing. Delegating responsibility for rationing in third parties external to the physician-patient relationship preserves patient trust in physicians by protecting physicians' traditional fiduciary role. Insurers' rationing of care through broadly applicable coverage rules and guidelines also promotes greater consistency in the allocation of health resources, although some disparities will remain.³³⁵

Nevertheless, insurer-based rationing faces insurmountable practical challenges. Like government regulators, insurers simply cannot develop timely, detailed rules for the full range of treatment decisions given the breadth of the medical landscape, the lack of definitive clinical information, and constantly evolving medical knowledge.³³⁶ Nor does the utilization review process offer a feasible alternative to detailed rules for rationing care.

331. See Dowell, *supra* note 15, at 117.

332. See *id.*

333. See *id.* at 118 (describing how the first step in the utilization review process involves a "non-physician reviewer . . . appl[ying] a predetermined set of . . . criteria to the case presented").

334. See Richard A. Spector, *Utilization Review and Managed Health Care Liability*, 97 S. MED. J. 284, 284 (2004) (discussing the reliance on clinical guidelines in conducting utilization review).

335. Differences in health plans' coverage rules do lead to disparities in access to specific services. However, new coverage requirements under the Affordable Care Act likely will narrow the differences among what plans do and do not cover. See generally Tory J. Oechsner & Magda Schaler-Haynes, *Keeping it Simple: Health Plan Benefit Standardization and Regulatory Choice Under the Affordable Care Act*, 74 ALB. L. REV. 241 (2010) (explaining how the Affordable Care Act promotes greater standardization among health plans).

336. See *supra* notes 312–13, 317–20 and accompanying text (explaining the practical challenges of developing comprehensive rationing rules under a centralized process for rationing care).

Subjecting the full range of physicians' treatment recommendations to utilization review would quickly overwhelm plans' administrative resources and consume an excessive amount of physicians' time in light of the complexity of modern medicine.³³⁷ In contrast, physician rationing at the bedside is more efficient—it avoids a time-consuming administrative review process and assigns responsibility for rationing care to those most familiar with a patient's unique circumstances.³³⁸

As with centralized government rationing, public hostility to limits on patient care has frustrated insurer-based rationing schemes. Managed care plans' efforts to constrain costs through utilization review and clinical guidelines have been viewed by physicians and patients as an offensive intrusion into the clinical setting.³³⁹ The public also has long questioned insurers' motives, believing that insurers regularly place profits ahead of patients' needs.³⁴⁰

The public's skepticism about managed care has destabilized insurers' efforts to ration care. Insurers' coverage rules and denials frequently result in litigation,³⁴¹ with sympathetic judges and juries often siding with patients.³⁴² The initial public backlash against managed care also led to a wave of state and federal legislation mandating that health plans provide

337. See Krause, *supra* note 19, at 301–02 (stating that managed care organizations “simply cannot function if every treatment decision must be debated through administrative review processes,” as doing so would be “impractical”); Orentlicher, *Health Care Reform*, *supra* note 19, at 151 (arguing that “given the tremendous number of decisions that must be made,” third party review of physicians' clinical decisions “would be too cumbersome” and means “[p]hysicians would constantly be on the telephone . . . getting answers to coverage questions”).

338. See Orentlicher, *Health Care Reform*, *supra* note 18, at 155 (“[I]f physicians make [rationing] decisions, it will be administratively very efficient. Physicians will know much of the information about the benefits, risks, and costs of treatment that is relevant to making the rationing decisions that are before them.”).

339. See Leonard J. Nelson, *Helling v. Carey Revisited: Physician Liability in the Age of Managed Care*, 25 SEATTLE U. L. REV. 775, 777–78 (2002) (“There is widespread dissatisfaction with the intrusion of managed care bureaucrats into the physician/patient relationship.”).

340. See Peter D. Jacobson & Shannon Brownlee, *The Health Insurance Industry and the Media: Why the Insurers Aren't Always Wrong*, 5 HOUS. J. HEALTH L. & POL'Y 235, 235–36 (2005) (noting the health insurance industry's “reputation for acting in its own self-interest,” showing a greater interest in managing costs than in providing care).

341. See MECHANIC, *THE TRUTH ABOUT HEALTH CARE*, *supra* note 246, at 135 (stating that managed care organization's denials of care “resulted in much litigation”).

342. See Mark A. Hall & Gerard F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA L. REV. 1637, 1648–51, 1655–57 (1992) (describing courts reluctance to defer to insurers' decisions on the medical necessity of desired treatments).

coverage for certain services,³⁴³ further limiting the effectiveness of insurers' rationing efforts. In response, managed care plans have reduced their reliance on centralized administrative rules and utilization review, turning instead to provider financial incentives that induce physicians and other providers to ration care at the bedside.³⁴⁴

C. *Giving Patients More Skin in the Game Through Higher Cost-Sharing*

Some commentators have proposed giving patients, rather than their physicians, responsibility for making cost-conscious health care decisions.³⁴⁵ These commentators contend that generous health insurance leads patients to demand potentially beneficial care, no matter how slight the potential benefits or high the costs, because insurance insulates them from the full economic consequences of their medical care.³⁴⁶ They therefore favor giving patients more "skin in the game" by imposing higher cost-sharing under traditional plans³⁴⁷ or consumer-directed health plans (CDHPs).³⁴⁸ In doing

343. States have enacted over 2,200 laws mandating that health plans provide coverage for specified conditions or the services of certain providers. See VICTORIA C. BUNCE ET AL., COUNCIL FOR AFFORDABLE HEALTH INS., HEALTH INSURANCE MANDATES IN THE STATES 1 (2012).

344. See Nelson, *supra* note 339, at 777–78 (noting that in response to threats of lawsuits for coverage denials, as well as market forces, health plans have reduced their reliance on utilization review and instead adopted various mechanisms that force physicians to focus on the cost-effectiveness of medical treatment).

345. See, e.g., ARTHUR L. KELLERMANN ET AL., FLATTENING THE TRAJECTORY OF HEALTH CARE SPENDING 5 (2012), available at http://www.rand.org/content/dam/rand/pubs/research_briefs/2012/RAND_RB9690z1.pdf (recommending that patients have a financial interest in their care); Orentlicher, *Rationing Health Care*, *supra* note 11, at 462 (noting that many writers have proposed giving patients financial incentives).

346. If the cost of a specific intervention exceeds its value, patients nevertheless will desire such care if its value exceeds the patient's out-of-pocket costs, which for insured patients will usually be less than the intervention's full cost. See Orentlicher, *Health Care Reform*, *supra* note 11, at 462–63 (explaining how financial incentives for insured patients lead them to demand care with benefits below societal costs).

347. KELLERMANN ET AL., *supra* note 345, at 5 (explaining that giving patients more "skin in the game" means designing the size and structure of co-payments to encourage prudent choices).

348. Consumer-directed health plans are high deductible plans coupled with a health savings account, which is often funded by the employer. The employee uses funds in the health savings account to cover the cost of care up until the deductible is satisfied, with any unused funds roll over from year to year. See AMELIA M. HAVILAND ET AL., SKIN IN THE GAME: HOW CONSUMER-DIRECTED PLANS AFFECT THE COST AND USE OF HEALTH CARE 1 (2012), available at http://www.rand.org/content/dam/rand/pubs/research_briefs/2012/RAND_RB9672.pdf (explaining consumer-directed health plans); Orentlicher, *Health Care Reform*, *supra* note 11, at 463 (explaining

so, these plans place responsibility for rationing care on consumers, “ask[ing] the consumer to say ‘no’ to herself.”³⁴⁹

Proponents of these arrangements argue that they preserve the fiduciary nature of the physician-patient relationship, while simultaneously preserving patient autonomy and lowering medical expenditures.³⁵⁰ While the optimism of supporters of consumer-driven plans is not without some merit, unfortunately, these arrangements are unlikely to generate sufficient savings to make bedside rationing unnecessary. Therefore, the availability of CDHPs and similar plans does not justify a patient-centered duty of care.

In shifting a larger proportion of the costs of care to patients, CDHPs and other high cost-sharing plans give individual patients, rather than their physicians, responsibility for making financially prudent health care decisions.³⁵¹ In doing so these arrangements insulate physicians from outside financial influences, which frees them to focus exclusively on their patients’ best interests, consistent with a patient-centered duty of care.³⁵² Consumer-driven plans thereby preserve patients’ trust in their physicians.³⁵³ Consumer-driven plans also promote patient autonomy by having patients, rather than third parties, balance the patient’s health needs and cost considerations.³⁵⁴ This in turn allows for a fairer allocation of medical resources that respects patient differences, as patients are the best judges of

health savings accounts).

349. Wendy K. Mariner, *Can Consumer-Choice Plans Satisfy Patients?*, 69 BROOK. L. REV. 485, 496 (2004).

350. See generally Kapp, *Patient Autonomy*, *supra* note 151, at 15–31 (arguing that consumer-driven health care promotes patient autonomy, with health care professionals taking on the educational role of assisting their patients in exercising their rights and responsibilities); Marshall B. Kapp, *The Ethical Foundations of Consumer-Driven Health Care*, 12 J. HEALTH CARE L. & POL’Y 1, 6, 8–9 (2009) [hereinafter Kapp, *Ethical Foundations*] (consumer-driven health care preserves patient self-determination and is likely to reduce overuse of health care); Mariner, *supra* note 349, at 510 (noting that consumer-choice plans liberate physicians to focus solely on their patients’ interests).

351. See HAVILAND ET AL., *supra* note 348, at 1 (stating that proponents of consumer-directed health plans believe enrollees in such plans have economic incentives to make “prudent, cost-conscious decisions about using health care”).

352. See Mariner, *supra* note 349, at 510 (CDHPs and similar plans give “physicians freedom to make treatment decisions solely in the interests of their patients”).

353. See *id.* (“A consumer-choice plan that insulates physicians from an insurer’s financial influence might restore trust in the physician-patient relationship.”).

354. See Kapp, *Patient Autonomy*, *supra* note 151, at 24 (explaining that consumer-driven health plans preserve individual freedom of choice better than alternative rationing mechanisms).

their individual needs and priorities.³⁵⁵

Proponents of CDHPs and other high cost-sharing plans also rightly claim that such arrangements have the potential to lower health care costs. A recent study published by the RAND Corporation found that CDHPs do indeed lead to lower health spending, at least initially.³⁵⁶ Specifically, the study found that for the first year following enrollment in a CDHP, enrollees incurred 21% lower health care costs compared to their costs in the preceding year.³⁵⁷ The first-year savings resulted not only from a reduction in the number of initiated episodes requiring care but also from using fewer and less expensive services when seeking care.³⁵⁸ For example, enrollees used fewer name-brand drugs, made fewer visits to specialists, and had fewer hospitalizations.³⁵⁹

Although the findings of the RAND study are promising, CDHPs and similar arrangements cannot fully replace physicians' bedside rationing. First, patients with financial incentives to lower costs not only reduce their demand for marginally beneficial care but also forego high value care.³⁶⁰ For example, the RAND study found that enrollees in CDHPs curtailed their use of preventive care, such as childhood vaccinations, mammograms, screening for cervical cancer and colorectal cancer, and blood tests for glucose and cholesterol among diabetic patients.³⁶¹ These results mirror the findings of the well-known RAND Health Insurance Experiment (HIE), which found that enrollees in plans with higher levels of cost-sharing often cut back on highly beneficial care.³⁶² Critics of CDHPs and similar

355. See John C. Goodman, *What Is Consumer-Directed Health Care? Comparing Patient Power with Other Decision Mechanisms*, 25 HEALTH AFF. w540, w541 (2006) (stating that it is appropriate for patients to make decisions regarding whether an intervention's extra costs and risk is worth the marginal benefits because others cannot determine which is more valuable); Kapp, *Ethical Foundations*, *supra* note 350, at 8 (2009) ("An informed, economically empowered consumer is a better purchasing agent for his or her own health care than would be the government, a managed care organization, or health care providers . . .").

356. See HAVILAND ET AL., *supra* note 348, at 1 (presenting results of a study analyzing first-year effects for families switching from employer-sponsored traditional plans to consumer-driven plans).

357. See *id.* at 2.

358. See *id.*

359. See *id.*

360. See *id.*

361. See *id.* at 3. Enrollees in CDHPs had lower utilization rates for preventive care, even though most CDHPs fully cover most preventive care. See *id.*

362. ROBERT H. BROOK ET AL., THE HEALTH INSURANCE EXPERIMENT, available at http://www.rand.org/content/dam/rand/pubs/research_briefs/2006/RAND_RB9174.pdf (last visited

arrangements argue that patients who skimp on high value care will later develop conditions requiring costly treatment.³⁶³ If so, any early savings generated by CDHPs may be short-lived.³⁶⁴

Second, CDHPs and other high cost-sharing plans no longer serve as an effective control on patient spending once an enrollee's costs surpass plan cost-sharing limits. To protect individuals from catastrophic health care costs, the Affordable Care Act generally requires that plans cover the full cost of care once an individual's out-of-pocket costs exceed statutorily specified limits.³⁶⁵ With 5% of all individuals accounting for approximately half of all health care spending,³⁶⁶ much medical care will be provided to patients who have exceeded the out-of-pocket spending limits and no longer have financial incentives to consider the cost of their care.³⁶⁷ Consequently, CDHPs and similar arrangements that rely on patients becoming more cost-conscious consumers provide an incomplete strategy for constraining health care costs.

Jan. 18, 2015) (describing the results of the RAND Health Insurance Experiment).

363. See Mariner, *supra* note 349, at 510 (“[I]f people forego needed care because of cost, their problems may simply be delayed or exacerbated, affecting their lives and possibly requiring more expensive care in the future.”); Orentlicher, *Health Care Reform*, *supra* note 11, at 463 (arguing that giving enrollees financial incentives to lower their consumption of care may lead patients to “reduce their demand for important care,” as “non-physicians are not well-equipped to distinguish between essential and optional care”). Because the recent RAND study on CDHPs only looked at spending during the first year of enrollment, it is unknown whether those patients who skimp on high value preventive care will later develop conditions requiring costly treatment. See HAVILAND ET AL., *supra* note 348, at 3.

364. See HAVILAND ET AL., *supra* note 348, at 3 (explaining that whether CDHPs generate long-term savings is unknown).

365. In 2014, the maximum amount an individual with single coverage paid out-of-pocket was \$6,350, and a family's out-of-pocket spending was capped at \$12,700. 42 U.S.C. § 18022(c)(1)(A); Rev. Proc. 2013-25, 2013-21 I.R.B. 1110. The out-of-pocket spending limits are adjusted annually for inflation. 42 U.S.C. § 18071(c)(1)(B). Pre-existing “grandfathered” plans are exempt from the statutory limits. 42 U.S.C. § 300-gg-6(b).

366. See STEVEN B. COHEN & WILLIAM YU, AGENCY FOR HEALTHCARE RESEARCH & QUALITY, THE CONCENTRATION AND PERSISTENCE IN THE LEVEL OF HEALTH EXPENDITURES OVER TIME: ESTIMATES FOR THE U.S. POPULATION, 2008–2009 (2012), available at http://meps.ahrq.gov/mepsweb/data_files/publications/st354/stat354.shtml.

367. See Victor R. Fuchs, *The Doctor's Dilemma—What Is “Appropriate” Care?*, 365 NEW ENG. J. MED. 585, 586 (2011) (arguing that giving patients “more skin in the game” will not solve the nation's rising health care cost problem, as many health care decisions “will be made by and for patients whose costs have exceeded the [out-of-pocket spending] cap”); see also Orentlicher, *Health Care Reform*, *supra* note 11, at 463 (arguing that the financial incentives under health savings accounts will not be relevant for patients facing major surgeries or other very expensive care—those individuals' health savings accounts will be fully emptied).

Admittedly, the choice between a dual duty of care and a patient-centered duty of care is a close call, given the difficult policy and value trade-offs involved. Nevertheless, this Part has argued that despite its limitations, physicians' bedside rationing under a dual duty of care offers the best approach for controlling health care costs and achieving a fair distribution of medical resources. By no means does this conclusion compel exclusive reliance on bedside rationing; indeed, many countries' health care systems, including the United States', rely on a mix of rationing devices.³⁶⁸ Nevertheless, a comprehensive scheme for rationing care must depend in part on the discretion of physicians rationing care at the bedside on a case-by-case basis.

V. GOVERNMENT PROGRAMS PROMOTING PROVIDER FINANCIAL INCENTIVES

As explained in Part I, defining the nature and extent of physicians' fiduciary obligations necessitates examining the physician-patient relationship within a broader context that gives consideration to public policy concerns. Those public policy concerns should include the policy choices made by our democratically elected officials. That is, consideration should be given to whether physicians' ethical and legal obligations to patients fortify or frustrate the government's policy goals. This Part reviews recent initiatives at both the federal and state level and concludes that a dual duty of care that allows physicians to ration care at the bedside is more compatible with current health policy than a patient-centered duty of care.

The Affordable Care Act (ACA) fundamentally alters Medicare's payment policies in ways that promote a role for physicians consistent with a dual duty of care.³⁶⁹ Medicare's new Shared Savings Program encourages the formation of integrated entities known as accountable care organizations (ACOs).³⁷⁰ An ACO is a local organization comprised of and controlled by

368. See Mechanic, *Dilemmas in Rationing Health Care Services*, *supra* note 177, at 1655 ("All systems use a mix of rationing devices . . .").

369. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

370. CTRS. FOR MEDICARE & MEDICAID SERVS., DEP'T OF HEALTH & HUMAN SERVS., SUMMARY OF FINAL RULE PROVISIONS FOR ACCOUNTABLE CARE ORGAIZATIONS UNDER THE MEDICARE SHARED SAVINGS PROGRAM 2 (2014) [hereinafter SUMMARY OF FINAL RULE PROVISIONS], available at http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharesavingsprogram/Downloads/ACO_Summary_Factsheet_ICN907404.pdf. CMS has announced that in 2015, 424 ACOs

primary care physicians, specialists, and other providers that are jointly accountable for the cost and quality of care delivered to a patient population.³⁷¹ The Shared Savings Program holds ACOs accountable for the cost of care delivered to a patient population through various financial incentives that reward ACOs that meet or exceed target savings and, in some cases, penalize ACOs that fail to do so.³⁷² Although it is hoped that ACOs

servicing over 7.8 million beneficiaries will participate in the Shared Savings Program and the Pioneer Program (an alternative ACO demonstration established by CMS). See Sean Cavanaugh, *ACOs Moving Ahead*, THE CMS BLOG (Dec. 22, 2014), <http://blog.cms.gov/2014/12/22/acos-moving-ahead/>.

371. See KELLY DEVERS & ROBERT BERENSON, CAN ACCOUNTABLE CARE ORGANIZATIONS IMPROVE THE VALUE OF HEALTH CARE BY SOLVING THE COST AND QUALITY QUANDARIES? 1 (2009) (“An ACO is a local health care organization and a related set of providers (at a minimum, primary care physicians, specialists, and hospitals) that can be held accountable for the cost and quality of care delivered to a defined population.”); Boland et al., *supra* note 98, at 12 (“An ACO is generally defined as a local health care organization with a network of providers such as primary care physicians, specialists, and hospitals that are accountable for the cost and quality of care delivered to a particular population.”); Thomas L. Greaney, *Accountable Care Organizations: A New New Thing with Some Old Problems*, 10 HEALTH L. OUTLOOK 2 (2010) (“The ACO concept envisions a legal entity comprised of and controlled by providers that would assume financial responsibility for the cost and care of a defined population . . . while being subject to a variety of quality standards and information reporting requirements.”); Mark McClellan et al., *A National Strategy To Put Accountable Care Into Practice*, 29 HEALTH AFF. 982, 982 (2010) (“ACOs consist of providers who are jointly held accountable for achieving measured quality improvements and reductions in the rate of spending growth.”).

372. See SUMMARY OF FINAL RULE PROVISIONS, *supra* note 370, at 1. Under the shared savings payment model, the ACO continues to receive fee-for-service based payments, but Medicare also rewards an ACO that meets or exceeds its targeted cost savings with a bonus equal to a percentage of the savings. DAVID BALTO, CTR. FOR AM. PROGRESS, MAKING HEALTH CARE REFORM WORK: ACCOUNTABLE CARE ORGANIZATIONS AND COMPETITION 5 (2011), available at http://cdn.americanprogress.org/wp-content/uploads/issues/2011/02/pdf/aco_competition.pdf. The downward adjustment payment model similarly entitles an ACO to a percentage of any savings, but it also penalizes those who do not meet targeted cost savings with a downward adjustment in their fee-for-service payments. See *id.* (discussing the various models for giving ACOs incentives for cost control). The Shared Savings Program also includes economic incentives for ACOs to improve quality by tying a portion of an ACO’s reimbursement to its performance on quality benchmarks. *Id.* For example, an ACO that performs poorly on the relevant quality measures may be ineligible for any bonus payment under the shared savings or shared savings and risk payment models, even if the ACO lowers the cost of care. See, e.g., 42 C.F.R. § 425.100(b) (2012) (stating that ACOs participating in the Medicare Shared Savings Program are eligible for shared savings only if they meet the minimum quality performance standards, among other requirements). The Affordable Care Act also authorizes CMS to pay ACOs a capitated payment, but CMS elected not to implement a capitated payment model at this time; however, CMS has stated that it may do so in the future. Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,805 (Dep’t of Health & Human Servs. Nov. 2, 2011) (final rule), available at <http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf>.

will generate savings by reducing preventable complications and achieving other improvements in patient care, the program's financial incentives also induce ACO providers to make more cost-sensitive treatment decisions.³⁷³

Under its statutory authority to establish innovative payment models,³⁷⁴ the Center for Medicare and Medicaid Services (CMS) also has established the Medicare Bundled Payments for Care Improvement Initiative.³⁷⁵ Under this initiative, participating providers receive a single payment for an episode of care that then is allocated among all providers treating a patient.³⁷⁶ Similar to the capitated payment model, bundled payments encourage a patient's providers to lower costs to avoid exhausting the fixed payment.³⁷⁷ Indeed, CMS has identified lowering the costs of treating Medicare beneficiaries as a primary goal of the bundled payments initiative.³⁷⁸ Like the Shared Savings Program, then, the Bundled Payments

373. See Mantel, *Accountable Care Organizations*, *supra* note 13, at 1427–28 (arguing that although ACOs could successfully contain costs while improving the quality of care, they nevertheless have financial incentives to ration care in order to increase their shared savings or profit margins). In addition to the Shared Savings Program, CMS has established the Pioneer ACO Model (Pioneer Program) for organizations with experience operating as ACOs. *Id.* Under this program, participating ACOs will receive higher levels of reward and assume greater financial risk than ACOs participating in the Shared Savings Program. In year three of the Pioneer Program, CMS will begin testing a capitated payment model, with eligible ACOs receiving a monthly per-beneficiary amount in lieu of part of or all of the ACO's fee-for-service payments. *Id.*; see CTRS. FOR MEDICARE & MEDICAID SERVS., DEP'T OF HEALTH & HUMAN SERVS., PIONEER ACCOUNTABLE CARE ORGANIZATION MODEL: GENERAL FACT SHEET (2012), available at <http://innovations.cms.gov/Files/fact-sheet/Pioneer-ACO-General-Fact-Sheet.pdf>.

374. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3021, 124 Stat. 119 (2010) (explaining that the purpose of the Center for Medical Innovation is to “test innovative payment and service delivery models to reduce program expenditures . . . while preserving or enhancing the quality of care furnished to individuals . . .”).

375. See CTRS. FOR MEDICARE & MEDICAID SERVS., DEP'T OF HEALTH & HUMAN SERVS., FACT SHEETS: BUNDLED PAYMENTS FOR CARE IMPROVEMENT INITIATIVE (2014), available at <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-07-31.html?DLPage=1&DLFilter=bundled&DLSort=0&DLSortDir=descending> (providing an overview of the Bundled Payments for Care Improvement Initiative).

376. See Press Release, Ctrs. for Medicare & Medicaid Servs., CMS Announces New Initiative to Improve Care and Reduce Costs for Medicare (Jan. 31, 2013) [hereinafter CMS Announces New Initiative], available at <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-01-31.html>. The initiative tests four different bundled payment models—the models vary by the types of health care providers involved and the services included in the bundle. *Id.*

377. See Goldsmith, *supra* note 21, at 36 (explaining bundled payments).

378. See CMS Announces New Initiative, *supra* note 376 (“The objective of this initiative is to improve the quality of health care delivery for Medicare beneficiaries, while reducing program

for Care Improvement Initiative also incentivizes providers to forego more costly care.³⁷⁹

The ACA similarly establishes several demonstration projects that allow for greater experimentation with provider financial incentives under Medicaid.³⁸⁰ For example, section 2704 of the ACA allows up to eight states to use bundled payments for hospital and physician services under Medicaid.³⁸¹ Section 2706 allows qualified pediatric providers to be recognized as ACOs and receive shared savings payments under Medicaid.³⁸² Finally, section 2705 establishes a demonstration project pursuant to which five states must shift their payment structure for safety net hospitals from a fee-for-service model to a capitated payment model.³⁸³

Complementing efforts at the federal level, states also have enacted a wide variety of state-level programs that promote ACOs and alternative risk-based payment models. Much attention has been focused on Massachusetts, which in 2012 enacted far-reaching legislation that supports the development of ACOs and other arrangements that require providers to share the financial risk of providing patients costly care.³⁸⁴ The new law requires the state's health insurance exchange market to implement alternatives to fee-for-service "to the maximum extent possible,"³⁸⁵ including shared savings arrangements, bundled payments, and global or capitated payments.³⁸⁶ Private plans similarly are required to reduce their fee-for-service contracts in favor of alternative payment methodologies.³⁸⁷ The legislation also sets the ambitious goal of shifting 80% of the state's Medicaid population into

expenditures, by aligning the financial incentives of all providers" (quoting Acting CMS Administrator Marilyn Tavenner)).

379. Over 500 organizations are participating in the Bundled Payments for Care Initiative. *See id.*

380. *See generally* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010). As of the date of publication of this Article, CMS has not yet issued any guidance or otherwise taken steps to implement the demonstration projects authorized under sections 2704, 2705, and 2706 of the ACA.

381. *Id.* § 2704.

382. *Id.* § 2706.

383. *Id.* § 2705.

384. *See generally* MASS. GEN. LAWS ch. 224 (2012).

385. *Id.* § 280(a) ("[T]he group insurance commission, the commonwealth health insurance connector authority, the office of Medicaid and any other state funded insurance program shall implement, to the maximum extent possible, alternative payment methodologies").

386. *Id.* § 15 (defining alternative payment methodologies).

387. *Id.* § 280(c) ("Private health plans shall to the maximum extent feasible reduce the use of fee-for-service payment mechanisms in order to promote high quality, efficient care delivery.").

ACOs or alternative payment contracts by July 15, 2015.³⁸⁸

Other states have joined Massachusetts in promoting ACOs. In February 2013, CMS awarded Washington a grant to develop an ACO delivery model supported by a partnership among the state's health care agencies, private employers, and major payors.³⁸⁹ Other states, such as Hawaii, Oregon, Maine, and Vermont, similarly are engaged in collaborative efforts to spread the development of ACOs across their states.³⁹⁰ The Texas legislature has authorized the state Department of Insurance to certify ACOs, known as "health care collaboratives" (HCCs).³⁹¹ HCCs are permitted to

388. *Id.* § 261(iii) ("Not later than July 1, 2015, the office of Medicaid shall pay for health care utilizing alternative payment methodologies for no fewer than eighty percent or the maximum percentage feasible of its enrollees that are not also covered by other health insurance coverage, including Medicare and employer-sponsored or privately purchased insurance.").

389. See *State Innovation Models Initiatives: Model Pre-Testing Awards*, CTRS. FOR MEDICARE & MEDICAID SERVS. [hereinafter *State Innovative Model Initiatives*], <http://innovation.cms.gov/initiatives/state-innovations-model-pre-testing/> (last visited Jan. 31, 2014) (describing Washington's initiative to create ACOs through the state's quality collaboratives—the Bree Collaborative and the Puget Sound Health Alliance).

390. See generally *State Innovation Models Initiative: Model Design Awards Round Two*, CTRS. FOR MEDICARE & MEDICAID SERVS. [hereinafter *Model Design Awards Round Two*], <http://innovation.cms.gov/initiatives/State-Innovations-Model-Design-Round-Two/index.html> (last visited Jan. 18, 2015); *State Innovation Models Initiative: Model Test Awards Round One*, CTRS. FOR MEDICARE & MEDICAID SERVS. [hereinafter *Model Design Awards Round One*], <http://innovation.cms.gov/initiatives/state-innovations-model-testing/> (last visited Jan. 18, 2015). For example, Oregon has received a State Innovative Model grant from CMS to support spreading its Coordinated Care Organization's payment model beyond Medicaid to the state's Public Employees Benefit Board, individuals dually eligible for Medicare and Medicaid, and commercial payors. See *id.* (describing Oregon's grant); *State Innovation Model Grant*, OREGON.GOV, <http://www.oregon.gov/oha/OHPR/Pages/sim/index.aspx> (last visited Jan. 31, 2014) (same). CMS has also awarded State Innovative Model grants to Maine and Vermont for testing multi-payor shared savings ACOs. See *State Innovative Model Initiatives*, *supra* note 389 (describing Maine and Vermont's pilot programs). Hawaii also has received a grant from CMS to support its Health Project, which will implement ACO arrangements under the state's Medicaid program, health insurance exchange, and Hawaii Employer-Union Health Benefits Trust Fund. See *Model Design Awards Round Two*, *supra* (describing Hawaii's Health Care Project); *Phase II, THE HAWAII HEALTHCARE PROJECT*, <http://www.hawaiihealthcareproject.org/index.php/transforming-healthcare/phase-2.html> (last visited Jan. 18, 2015).

391. See TEX. INS. CODE ANN. art. 848.103 (West 2013) ("The department shall review a health care collaborative's proposed payment methodology in contracts with governmental or private entities to ensure compliance with this section."); see also 42A Tex. Jur. 3d Healing Arts and Institutions § 27 (2015) ("A health care collaborative is formed and governed as provided by statute. A health care collaborative must be certified by the insurance commissioner to lawfully accept and distribute payments to physicians and other health care providers using the reimbursement methodologies authorized by statute.").

accept alternatives to fee-for-service, including capitated payments and episode-based or bundled payments from both public and private payors.³⁹² Similarly, New York began certifying ACOs that may accept capitation and other risk-based payments.³⁹³

at least twenty other states—Alabama, Arkansas, California, Colorado, Connecticut, Hawaii, Illinois, Iowa, Maine, Michigan, Minnesota, New Jersey, New York, North Carolina, Oregon, Rhode Island, Texas, Utah, Vermont, and Washington—have initiated programs that shift their Medicaid programs from fee-for-service to risk-based payment models, including shared savings, bundled payments, and capitation.³⁹⁴ These initiatives range

392. TEX. INS. CODE ANN. art. 848.103 (West 2013) (explaining that in addition to accepting alternatives to fee-for-service, HCCs may also contract and distribute payments from public or private payors).

393. *Accountable Care Organization (ACO)*, N.Y. STATE DEP'T OF HEALTH, http://www.health.ny.gov/health_care/medicaid/redesign/aco/ (last visited May 6, 2015) (explaining that the New York State Department of Health “issued regulations establishing a process for the issuance of certificates of authority to ACOs that meet certain requirements” and that such regulations took effect on December 31, 2014). Thus far, the Department has issued certificates of authority for several Medicare-only ACOs. *Id.*

394. ARK. ADMIN. CODE § 016.06.35-181.000 (2013) (citing a regulatory program where collectively accountable principal accountable providers (PAPs) are eligible for risk-sharing and gainsharing payments based on the average cost of care for certain episodes of care); COLO. REV. STAT. ANN. § 25.5-5-415 (2012) (establishing the Medicaid Payment Reform and Innovative Pilot Program); 305 ILL. COMP. STAT. ANN. 5/5-30(a) (requiring that 50% of Medicaid beneficiaries be enrolled in risk-based coordinated care programs by 2015); MINN. STAT. ANN. § 256B.0755 (West 2013) (establishing the Minnesota Medicaid’s Health Care Delivery Systems Demonstration, which will test ACO contracts); N.J. STAT. ANN. 30:4D-8.1 (West 2013) (establishing the New Jersey Medicaid Accountable Care Organization Demonstration Project); 2009 N.C. Sess. Laws 50 (mandating that the state Medicaid program develop a plan that incorporates accountable budget and shared savings payment models); OR. REV. STAT. ANN. § 414.620 (West 2013) (establishing the Oregon Integrated and Coordinated Health Care Delivery System, consisting of Coordinated Care Organizations (CCOs) that operate under a fixed global budget); UTAH CODE ANN. § 26-18-402 (authorizing development of risk-based delivery models, including ACO contracts, under Medicaid); VT. STAT. ANN. tit. 129, § 6 (West 2009) (authorizing Vermont’s ACO pilot program); MAINE ACCOUNTABLE COMMUNITIES CONCEPT PAPER/EXECUTIVE SUMMARY (2012), *available at* http://www.maine.gov/dhhs/oms/pdfs_doc/vbp/Maine%20Accountable%20Communities%20concept%20paper%208%2014%2012.pdf (describing the state’s plan to allow Medicaid providers to enter into alternative contracts directly with the state, including contracts based on a shared savings model); *Medicaid Accountable Care Organizations: State Update*, CTR. FOR HEALTH CARE STRATEGIES, INC. (Mar. 2015), *available at* <http://www.chcs.org/media/ACO-Fact-Sheet-32515-ak.pdf> (showing that Connecticut, Iowa, Michigan, New York, Rhode Island, and Washington have all “begun to implement Medicaid accountable care organizations (ACOs) that align provider and payer incentives to focus on value instead of volume, with the goal of keeping patients healthy and costs manageable”); NAT’L BUS. COAL. ON HEALTH, CASE STUDY: CALIFORNIA PUBLIC

from pilot demonstrations that test ACOs and other risk-based payment models on a limited basis to far-reaching plans affecting large portions of a state's Medicaid population. For example, Colorado's pilot program has contracted with seven Regional Care Collaborative Organizations (RCCOs) that are held accountable for both the cost and quality of care provided to Medicaid beneficiaries, with the RCCOs receiving both utilization-based incentive payments and shared savings.³⁹⁵ More ambitiously, Alabama legislation approves a strategy to develop risk-bearing ACO-like entities—Regional Care Organizations—that will coordinate care for the majority of the state's Medicaid population.³⁹⁶

Collectively, these far-reaching initiatives by both the federal and state governments suggest that policymakers increasingly agree with the conclusion set out in Parts II and III—society cannot constrain health care costs unless physicians are allowed to ration care at the bedside. Therefore, rather than requiring physicians' undivided loyalty to their patients, the legal and ethical rules governing the physician-patient relationship should recognize physicians' dual role as both a patient's caregiver and society's agent for rationing care.³⁹⁷ Part VI examines several tenets of health law and

EMPLOYEES' RETIREMENT SYSTEM (CALPERS) I (2010), available at <http://www.calpers.ca.gov/ei-p-docs/about/press/news/health/case-study-final.pdf> (describing California's ACO pilot program covering 41,000 Medicaid beneficiaries); *Advancing Medicaid Accountable Care Organizations: A Learning Collaborative*, CTR. FOR HEALTH CARE STRATEGIES, http://www.chcs.org/info-url_nocat3961/info-url_nocat_show.htm?doc_id=1261402 (last visited Jan. 20, 2015) (describing the Center for Health Care Strategies initiative to help state Medicaid programs develop ACOs, including Texas); *Phase II*, *supra* note 390 (describing the Hawaii Healthcare Project, which supports development of Accountable Care-Like Organizations in public programs, including Medicaid); see also *infra* notes 395, 396 and accompanying text (discussing Colorado and Alabama's Medicaid initiatives).

395. COLO. REV. STAT. ANN. § 25.5-5-417 (West 2013) (recognizing Colorado Medicaid program's accountable care collaborative with regional care collaborative organizations); CO. DEPT. OF HEALTH CARE POL'Y & FIN., *Understanding the ACC Program*, available at <http://www.colorado.gov/pacific/sites/default/files/Overview%20of%20the%20ACC%20Program.pdf> (last visited Mar. 15, 2015) (describing Colorado's accountable care collaborative).

396. ALA. CODE 1975 § 22-6-153 (2013) (authorizing the state Medicaid agency to enter into risk-based contracts in each Medicaid region). Under the law, Alabama's Regional Care Organizations would accept capitated payments from Medicaid beginning in October 2016. *Id.*

397. *Cf.* Laura Athens Mellas, *Adapting the Judicial Approach to Medical Malpractice Claims Against Physicians to Reflect Medicare Cost Containment Measures*, 62 U. COLO. L. REV. 287, 304 (1991) (stating that when Congress in the 1980s altered Medicare payment policies, it chose to balance individual Medicare beneficiaries' interests and social welfare "in favor of the overall social good by placing limits on health care reimbursement . . . [—]a first step toward rationing of health care"—and that malpractice standards should therefore be "modified to accurately reflect these

ethics to determine whether they are consistent with a dual duty of care.

VI. THE PHYSICIAN-PATIENT RELATIONSHIP UNDER A DUAL DUTY OF CARE

Various legal and ethical standards that regulate the physician-patient relationship encourage physicians to give primacy to the individual patient, consistent with the patient-centered paradigm. Rationing care at the bedside fits uneasily in a health care system shaped by these legal and ethical norms, making it difficult for physicians to fulfill their role as stewards of society's medical resources. Therefore, law and ethics must be reformed to accommodate physicians' dual duty of care. That is, legal and ethical norms should no longer demand that physicians give absolute loyalty to individual patients, but instead should recognize that physicians' fiduciary role vis-à-vis the patient is necessarily limited by physicians' gatekeeping responsibilities. This Part discusses three areas of health law and ethics currently biased toward the patient-centered paradigm: physicians' duty of advocacy; the medical malpractice system; and informed patient consent.

A. *Physicians' Duty of Advocacy*

When ill, patients generally expect their physicians to provide them with all potentially beneficial care. The physician who fails to provide care consistent with prevailing standards of care may be held legally accountable in negligence.³⁹⁸ But what are a physician's legal and ethical obligations when the patient, based on her own values, reasonably desires care beyond the minimum standards of care?³⁹⁹ If the patient requests an additional diagnostic test or a more costly alternative to the intervention recommended by the physician, does a physician have a legal or ethical duty to honor the

social policy choices").

398. See *Boyce v. Brown*, 77 P.2d 455, 457 (Ariz. 1938).

399. Physicians do not have a legal or ethical duty to provide or advocate for care that the physician believes would be harmful or of no benefit to the patient. Ethically, the requirement under the Hippocratic Oath that physicians "do no harm" prohibits physicians from acquiescing to a patient's request for harmful treatment. See William M. Sage, *Physicians as Advocates*, 35 HOUS. L. REV. 1529, 1582 (1999) ("The Hippocratic invocation to 'do no harm' constrains physician deference to patients."). Similarly, state law generally permits physicians to refuse to render medically ineffective treatment. See, e.g., CAL. PROB. CODE § 4735 (West 2015); DEL. CODE ANN. tit. 16, § 2508(f) (West 2015); N.D. CENT. CODE § 23-06.5-09 (West 2013); see also TEX. HEALTH & SAFETY CODE ANN. § 166.046 (West 2013) (permitting the withdrawal of medically futile care).

patient's preferences or can the physician refuse the patient's request?⁴⁰⁰ Relatedly, if the patient's health plan denies coverage for the desired care or a health organization's treatment protocols disallow the requested care, must the physician actively protest or appeal such decisions on the patient's behalf?⁴⁰¹

Because a patient-centered duty of care requires from physicians an unwavering commitment to a patient's best interests, it encompasses a strong duty of advocacy.⁴⁰² This duty encompasses what Professor Charity Scott calls a duty of "care advocacy"—the obligation to provide all care desired by the patient if available and medically appropriate.⁴⁰³ Bedside rationing by the physician simply is not permitted.⁴⁰⁴ Similarly, the advocacy duty includes what has been called a duty of "economic advocacy"—an expectation that physicians zealously fight for a patient's interests when payors or others ration potentially beneficial care.⁴⁰⁵

While courts have been reluctant to impose a duty of advocacy on physicians,⁴⁰⁶ the medical establishment and scholars have been less reticent

400. Morreim, *Medicine Meets Resource Limits*, *supra* note 12, at 66 ("An important dimension in litigating physicians' advocacy responsibilities will be to distinguish between inadequate efforts by physicians and unruly obstacles imposed by health plans.").

401. *Id.* at 33 (stating that "[i]f the [health care] plan has denied authorization for a resource that the physician believes is clearly needed, the physician has at least some obligation to help the patient to appeal the denial." (citing *Wickline v. State*, 192 Cal. App. 3d 1630, 1644, 239 Cal. Rptr. 810, 819, 228 Cal. Rptr. 661, 670 (Ct. App.) *review granted and opinion superseded*, 727 P.2d 753 (Cal. 1986))).

402. Hall, *Rationing Health Care*, *supra* note 11, at 705 (citing Levinsky, *supra* note 3, at 1574–75) ("[P]hysicians are required to do everything that they believe may benefit each patient without regard to costs or other societal considerations. In caring for an individual patient, the doctor must act solely as that patient's advocate . . .").

403. See Charity Scott, *Doctors as Advocates, Lawyers as Healers*, 29 *HAMLIN J. PUB. L. & POL'Y* 331, 349–50 (2008) (distinguishing "care advocacy" from advocacy in the form of protecting or appealing a third party's denial of care or coverage, with the former is defined as a care-oriented view of patient advocacy).

404. Hall, *Rationing Health Care*, *supra* note 11, at 706 (citing Robert M. Veatch, *DRGs and the Ethical Reallocation of Resources*, 16 *HASTINGS CENTER REP.* 32, 38 (1986)) ("Ethicist Robert Veatch uses the following rhetorical . . . '[a]sking physicians to be cost-conscious . . . would be asking them to abandon their central commitment to their patients.'").

405. See E. Haavi Morreim, *Economic Disclosure and Economic Advocacy: New Duties in the Medical Standard of Care*, 12 *J. LEGAL MED.* 275, 292 (1991) (arguing that the principle of self-determination encompasses a physician's duty of economic advocacy, such as a duty to vigorously lobby recalcitrant utilization reviewers on the medical necessity of the physician's recommended treatment).

406. Generally, courts have not recognized a duty of care advocacy; as explained in Part V.B,

to do so. The American Medical Association's ("AMA") Code of Medical Ethics (the Code), for example, fully embraces an advocacy role for physicians.⁴⁰⁷ Opinion 8.13 of the Code provides that "[t]he duty of patient advocacy is a fundamental element of the patient-physician relationship . . . [, and] [p]hysicians must continue to place the interests of their patients first."⁴⁰⁸ The Code further obligates physicians to generally avoid cost considerations when making individual patient care decisions, admonishing that "[p]hysicians must not deny their patients access to appropriate medical services based upon the promise of personal financial reward" and "regardless of the financing and delivery mechanisms or contractual agreements between patients, health care practitioners and institutions, and third party payers."⁴⁰⁹ The Code also imposes on physicians a duty of

courts require physicians to provide care consistent with professional custom or the practices of a respectable minority. Accordingly, as long as a physician meets the minimum standard of care, she is not legally required to provide beneficial care above the minimum standard, even if medically appropriate and desired by the patient. *See generally* Jerry Menikoff, *Demanded Medical Care*, 30 ARIZ. ST. L.J. 1091, 1116–18 (1998) (explaining that malpractice standards do not grant patients the ability to demand medically appropriate care beyond the minimum standard of care). In the well-known *Wickline* decision, 192 Cal. App. 3d at 1645, 239 Cal. Rptr. at 819, 228 Cal. Rptr. at 671, the court in dicta hinted that physicians may have a duty of economic advocacy. Specifically, the *Wickline* court stated 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." *Id.* No court, however, has enforced the *Wickline* court's suggestion that physicians have a duty of advocacy. Indeed, a subsequent California decision rejected the notion, calling it "overbroad" and "error." *Wilson v. Blue Cross of S. Cal.*, 222 Cal. App. 3d 660, 674, 271 Cal. Rptr. 876, 885 (Ct. App. 1991).

407. *See infra* notes 408–10 and accompanying text. The AMA has promulgated "The Principles of Medical Ethics," a statement of basic rules for the ethical practice of medicine. Its Council on Ethical and Judicial Affairs ("CEJA") issues opinions which apply the Principles of Medical Ethics to specific ethical issues in medicine, such as fees and charges, and the relationships and interest among physicians, patients, and managed care organizations. These opinions are collected in an AMA publication, the Code of Medical Ethics. COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, AM. MED. ASS'N, CODE OF MEDICAL ETHICS (2014-2015 ed. 2014).

408. Am. Med. Ass'n Council on Ethical & Judicial Affairs, Op. 8.13(1): Managed Care (2002), available at <http://journalofethics.ama-assn.org/2012/11/pdf/coet1-1211.pdf>.

409. Am. Med. Ass'n Council on Ethical & Judicial Affairs, Op. 8.132: Referral of Patients: Disclosure of Limitations (2007), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion8132.page>; *see also* Am. Med. Ass'n Council on Ethical & Judicial Affairs, Op. 8.13(2)(a), *supra* note 408 (stating that rationing guidelines should be established at an administrative or policy level "so that individual physicians are not asked to engage in bedside rationing"). While Opinion 9.0652 of the AMA Code of Medical Ethics gives lip service to the idea of physicians as "prudent stewards of health care resources," it conspicuously omits cost and efficiency considerations as an appropriate factor when making treatment recommendations and decisions (only if the less costly treatment offers a "similar likelihood and

economic advocacy, stating that physicians should challenge a plan's denial of care that the physician believes would materially benefit the patient, even initiating appeals on the patient's behalf.⁴¹⁰ Many scholars likewise have argued in favor of physicians assuming a broad advocacy role.⁴¹¹ Moreover, with numerous state professional licensing boards modelling their ethical guidelines after the Code, a physician's failure to abide by the AMA's heightened duty of advocacy could serve as legal grounds for a professional disciplinary action, including revocation of the physician's medical license.⁴¹²

In emphasizing physicians' fiduciary obligations to patients, scholars, the medical establishment, and state licensing boards ignore physicians' competing responsibility under a dual duty of care—practicing good

degree of anticipated benefit[s]” as alternative treatments can the physician consider costs). Am. Med. Ass'n Council on Ethical & Judicial Affairs, Op. 9.0652: Physician Stewardship of Health Care Resources (2012), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion90652.page>. For example, omitting any reference to cost and efficiency considerations, Opinion 9.0652 states that physicians should “base recommendations and decisions on patients' medical needs” and “endorse recommendations that offer reasonable likelihood of achieving the patient's health care goals.” *Id.* Similarly, Opinion 2.09 of the Code states that cost considerations means physicians should “not provide or prescribe unnecessary medical services,” but that “concern for the quality of care the patient receives should be the physician's first consideration.” Am. Med. Ass'n Council on Ethical & Judicial Affairs, Op. 2.09: Costs (2003), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion209.page>.

410. Am. Med. Ass'n Council on Ethical & Judicial Affairs, Op. 8.13(2)(d), *supra* note 408; Am. Med. Ass'n Council on Ethical & Judicial Affairs, Op. 10.01(6) (1993), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion1001.page>.

411. See, e.g., Barry R. Furrow, *The Ethics of Cost-Containment: Bureaucratic Medicine and the Doctor as Patient-Advocate*, 3 NOTRE DAME J.L. ETHICS & PUB. POL'Y 187, 222–23 (1988) (arguing that physicians must go to bat for their patients); Wolf, *supra* note 2, at 1678 (same).

412. See, e.g., HAW. REV. STAT. ANN. § 453-8 (West 2014) (stating that any license to practice medicine may be revoked, limited, or suspended for “[c]onduct or practice contrary to recognized standards of ethics of the medical profession as adopted by . . . the American Medical Association”); IOWA ADMIN. CODE r. 653.13.20 (2013) (“The Code of Medical Ethics . . . prepared and approved by the American Medical Association . . . shall be utilized by the board as guiding principles in the practice of medicine . . . in this state.”); KY. REV. STAT. ANN. §§ 311.595, 311.597 (West 2015) (providing that a medical license may be revoked, suspended, or limited upon a showing that licensee has engaged in “dishonorable, unethical, or unprofessional conduct,” which includes conduct that fails “to conform to the principles of medical ethics of the American Medical Association”); N.H. CODE ADMIN. R. ANN. MED. 501.02 (2013) (“A licensee shall adhere [to the most current edition of] the Code of Medical Ethics . . . as adopted by the American Medical Association.”).

stewardship in allocating medical resources.⁴¹³ As stated by Norman Daniels, “physicians should be the advocates of their patients, abiding by the ethic of agency, *within the limits imposed by just resource allocation.*”⁴¹⁴ If after balancing individual patient and societal needs the physician concludes that the care desired by the patient is unwarranted, the physician must be allowed to reject the patient’s requests for such care⁴¹⁵ or refrain from advocating that others pay for or provide the care.⁴¹⁶ Physicians’ professional ethical standards therefore should be revised to provide for a more narrow duty of advocacy that allows for consideration of costs.⁴¹⁷

B. The Malpractice System as a Barrier to a Dual Duty of Care

The medical malpractice system performs the crucial function of determining whether a physician’s delay or denial of particular care constitutes negligence.⁴¹⁸ Where the courts draw the line between minimally necessary care and optional care establishes the boundaries of care that physicians may permissibly ration.⁴¹⁹ As explained below, the malpractice

413. See Mehlman, *The Patient-Physician Relationship in an Era of Scarce Resources*, *supra* note 46, at 352–53 (discussing these competing interests and whether “the rules of common law governing the patient-physician relationship require that the physician provide access to health care regardless of resource constraints.”).

414. Norman Daniels, *The Ideal Advocate and Limited Resources*, 8 THEORETICAL MED. & BIOETHICS 69, 77 (1987) (emphasis added).

415. *Cf.* Grochowski, *supra* note 156, at 635 (arguing that patients as well as physicians have a responsibility to be good stewards of available medical resources, and therefore that patients “should [not] be permitted to disproportionately use” resources or “insist on socially disproportionate care”); Menikoff, *supra* note 406, at 1115–17 (arguing that physicians have been “empowered as gatekeepers to the world of medical services,” and that patients do not have the power to demand any medically appropriate care).

416. See generally Sage, *supra* note 31, at 1621–26 (suggesting that physicians’ role as patient advocate is limited by physician responsibility for balancing individual and social needs).

417. See Orentlicher, *Rationing Health Care*, *supra* note 11, at 450 (arguing that there may be higher societal value in spending less on health care and more in areas such as education and offering alternative means of rationing health care).

418. *But see* Catherine S. Meschievitz, *Efficacious or Precarious? Comments on the Processing and Resolution of Medical Malpractice Claims in the United States*, 3 ANNALS HEALTH L. 123, 126 (1994) (arguing that very few patients harmed by medical malpractice actually bring claims or receive compensation).

419. See Edward B. Hirshfeld, *Economic Considerations in Treatment Decisions and the Standard of Care in Medical Malpractice Litigation*, 264 JAMA 2004, 2004 (1990) (explaining that the standard of care establishes the limits of permissibility for withholding medical services).

system sets minimal quality standards that reflect a patient-centered ethic,⁴²⁰ with cost considerations generally deemed an invalid justification for delaying or denying care.⁴²¹ Physicians thereby find themselves “stuck in the middle as they seek to meet both cost cutting goals and avoid liability under a standard of care that ignores cost containment.”⁴²² Moreover, a malpractice system that fails to accommodate physicians’ dual role threatens to undermine society’s cost-containment goals, as physicians fearful of malpractice liability may hesitate to implicitly ration care at the bedside.⁴²³ This underscores the need for new approaches to medical malpractice liability that would allow physicians to fulfill their dual role of balancing patients’ needs with society’s interests.⁴²⁴

To prevail on a claim for medical negligence, the plaintiff must show that her physician failed to exercise reasonable care.⁴²⁵ In defining the specific standard of care, courts defer to the medical profession’s customary practices.⁴²⁶ When medical opinion is divided, however, the respectable minority rule allows physicians to depart from customary practices and follow alternative schools of medical thought.⁴²⁷ Depending on the jurisdiction, the respectable minority rule requires that the non-customary practice be either regarded by the profession as “respectable” or embraced

420. See James F. Blumstein, *The Legal Liability Regime: How Well Is It Doing in Assuring Quality, Accounting for Costs, and Coping with an Evolving Reality in the Health Care Marketplace?*, 11 ANNALS HEALTH L. 125, 126 (explaining that in contrast to ordinary negligence standards that allow for economic considerations, medical malpractice standards accept the professional model of care that rejects a role for economics in medical decisionmaking); Fine, *supra* note 9, at 655 (“[T]he legal system incorporates the medical profession’s own standard of placing the patient first.”).

421. See Fine, *supra* note 9, at 642 (noting that current malpractice law rejects the notion of rationing or cost-control and “also speaks frequently of the physician having a duty to *resist* being tainted by the pressures of managed health care and cost containment”).

422. Christopher Smith, *Between the Scylla and Charybdis: Physicians and the Clash of Liability Standards and Cost Cutting Goals Within Accountable Care Organizations*, 20 ANNALS HEALTH L. 165, 166 (2011).

423. See *id.* at 170 (“[P]hysicians will resist cost containment initiatives for fear of incurring medical liability.”).

424. See Fine, *supra* note 9, at 693–94 (arguing that the medical profession should reform the standard of care in a way that reflects cost containment goals).

425. Meschievitz, *supra* note 418, at 126 n.6.

426. See DAN B. DOBBS ET AL., *THE LAW OF TORTS* § 292 (2d ed. 2013) (explaining that the standard of care to which health care professionals are held to is generally understood to be “the medical custom or practice with respect to the particular act of diagnosis or treatment”).

427. See *id.* § 293 (explaining the respectable minority rule).

by a considerable number of physicians (or meet both requirements).⁴²⁸ Accordingly, the physician who rations care at the bedside cannot defend the delay or withholding of care on cost-benefit grounds if such care fails to conform to either customary professional practices or the practices of a respectable minority.⁴²⁹

Some have argued that, over time, customary practices will reflect more cost-sensitive practices as physicians adjust to pressures to reduce costs.⁴³⁰ Countervailing factors, however, reinforce practice patterns that reflect costly, technology-driven standards of care. Many physicians continue to be paid in whole or in part on a fee-for-service basis that rewards the provision of more care.⁴³¹ Consequently, “[t]here is plenty of opportunity to provide too much care, and insurers will compensate physicians for doing so,” thereby inviting “practice patterns of excessive treatment.”⁴³² Physicians also quickly incorporate new technologies into their customary practices, reflecting both physicians’ desire to be on the cutting edge⁴³³ and their commitment to a professional ethic that requires giving patients the best possible care.⁴³⁴ In addition, fears of lawsuits that encourage overutilization reinforce higher standards of care, as customary practices come to reflect these defensive practices of medicine.⁴³⁵ A 2005 study reported in the

428. See Morreim, *Medicine Meets Resource Limits*, *supra* note 12, at 22 (explaining the respectable minority rule).

429. See Fine, *supra* note 9, at 657 (“[P]hysicians cannot assert as a defense to a malpractice action that they were under pressure from a managed care organization to delay or limit care.”).

430. See Blumstein, *supra* note 420, at 142 n. 92 (stating that the customary practice standard may be up to the task of accommodating cost-sensitive decisionmaking); Mark A. Hall, *The Malpractice Standard under Health Care Cost Containment*, 17 L. MED. & HEALTH CARE 347, 348 (1989) (arguing that customary practices may shift to accommodate changes in reimbursement methodology).

431. See Orentlicher, *Rationing Health Care*, *supra* note 11, at 458 (“Currently, physicians practice under a fee-for-service system of compensation that rewards the provision of more care . . .”).

432. *Id.*

433. See Morreim, *Medicine Meets Resource Limits*, *supra* note 12, at 20 (stating that physicians adopt new technologies because they are new and exciting and physicians hesitate to be out of step).

434. See E. Haavi Morreim, *Redefining Quality by Reassigning Responsibility*, 20 AM. J.L. & MED. 79, 83 (1994) [hereinafter Morreim, *Redefining Quality*] (stating that physicians’ patient-centered moral mandate, alongside generous reimbursement and legal liability concerns, helped to fuel medicine’s highly technological standards of quality).

435. See Boyd, *supra* note 6, at 134 (stating that the standard of care is based on defensive medicine); Kirk B. Johnson et al., *A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims*, 42 VAND. L. REV. 1365, 1395 (1989) (“Once physicians begin to practice

Journal of American Medicine (JAMA) suggests that the above concerns do indeed deter more cost-sensitive practices, finding that the “more physicians order tests or perform diagnostic procedures with low predictive values or provide aggressive treatment for low-risk conditions, the more likely such practices are to become the legal standard of care.”⁴³⁶

Even if customary practices gradually evolve in response to financial pressures to lower costs, such evolution may prove slow and fraught with legal risk for the cost-conscious physician.⁴³⁷ A physician whose cost-conscious practices depart from custom can avoid liability only if her practices conform to a respectable minority of physicians.⁴³⁸ However, various legal hurdles make it difficult for the cost-conscious physician to satisfy the respectable minority standard.

The respectable minority rule was introduced to accommodate legitimate *scientific* disagreements within the profession regarding how best to promote a patient's welfare.⁴³⁹ Consequently, the doctrine may not accommodate a paradigm that permits compromises in the quality of care on *cost-benefit* grounds.⁴⁴⁰ This may be particularly so given that much of the

defensive medicine, the customary standard necessarily tends to make defensive practices virtually mandatory to avoid liability.”); Morreim, *Redefining Quality*, *supra* note 434 (noting that physicians' adoption of emerging technologies due to liability fears “quickly become self-fulfilling prophecies”).

436. David M. Studdert et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, 293 JAMA 2609, 2616 (2005).

437. See Comment, *A Constant Containment Malpractice Defense: Implications for the Standard of Care and for Indigent Patients*, 26 Hous. L. Rev. 1007, 1018 (1989) (“Cost containment methods . . . along with their potential for allowing or even encouraging diminished quality of care, may generate malpractice situations.”); see also W. John Thomas, *The Medical Malpractice “Crisis”: A Critical Examination of a Public Debate*, 65 Temp. L. Rev. 459, 498–500 (1992) (suggesting that the increase in medical malpractice suits is the original cause of “defensive medicine,” and that reducing this type of spending will cause a reversion in which the number of malpractice suits arise).

438. See Comment, *supra* note 437, at 1023–24 (“The ‘respectable minority’ rule provides a defense to the customary standard of practice rule and has some of the flexibility of the accepted practice formula. Under this concept, ‘a physician does not incur liability merely by electing to pursue one of several recognized courses of treatment.’ Thus, a departure from custom does not constitute a breach of care when an acceptable body of authority advocates the departure.” (footnotes omitted)).

439. See Blumstein, *supra* note 420, at 133 (“[T]he ‘respectable minority’ rule provides some relief from the constraint of medical orthodoxy, and it is somewhat of an acknowledgment that even a scientifically-based professional norm may spawn scientifically-based disagreements and, therefore, a form of scientifically-validated pluralism.”).

440. See Blumstein, *supra* note 420, at 133 (explaining that because the respectable minority rule

medical profession embraces the traditional ethic of patient primacy, and therefore regards many cost-conscious practices as disreputable.⁴⁴¹ As a result, “the lone physician who dares to defy custom in the name of costs is likely to incur substantial legal risk.”⁴⁴² Moreover, in jurisdictions that consider departures from custom “respectable” only if a considerable number of physicians have adopted the practice, the respectable minority rule fails to protect the cost-conscious physician if few other physicians follow similar practices.⁴⁴³

The cost-conscious physician sued for malpractice thus faces an uphill battle in proving that her more conservative practice style is reputable.⁴⁴⁴ These legal challenges in turn may impede the progress toward more cost-sensitive practices, as physicians fearful of liability may be reluctant to compromise patient care in the name of cost-containment.⁴⁴⁵ Current malpractice doctrines thereby undermine society’s best means for constraining health care costs—physicians rationing at the bedside.⁴⁴⁶

Rather than compromise physicians’ gatekeeping role, malpractice law should be modified in a manner that reinforces physicians’ dual duty to balance individual patient’s needs with society’s interest in controlling costs. For example, courts could broaden their application of the respectable

is meant to accommodate professional/scientific disagreements, whether the “rule can be adapted to an economic paradigm that allows for cost-benefit analysis is unclear”); Morreim, *Cost Containment*, *supra* note 147, at 1733 (noting that allowances for departures from custom “are predicated upon the principle that the interests of the patient are paramount,” and thus “small diminutions of care could be legally pernicious”).

441. See Morreim, *Medicine Meets Resource Limits*, *supra* note 12, at 23 (“[P]hysicians who embrace artesian values [that require devotion to the patient’s best interests] will regard many of the cost-conscious practices of managed care physicians to be disreputable compromises of patient welfare.”).

442. Morreim, *Cost Containment*, *supra* note 147, at 1733.

443. See Blumstein, *supra* note 420, at 134 (noting that because the respectable minority doctrine requires meeting a quantitative and a qualitative requirement, “the ‘respectable minority’ doctrine ‘exposes innovators who depart from dominant medical practice to serious legal risks until such time as others follow their lead.’” (quoting Philip G. Peters, *The Quiet Demise of Deference to Custom: Malpractice Law at the Millenium*, 57 WASH & LEE L. REV. 163, 166 n.15 (2000))).

444. *Id.*

445. See Smith, *supra* note 422, at 170 (“[P]hysicians will resist cost containment initiatives for fear of incurring medical liability.”); cf. Jaime Staples King & Benjamin W. Moulton, *Rethinking Informed Consent: The Case for Shared Medical Decision-Making*, 32 AM. J.L. & MED. 429, 457 (2006) (“[B]y obligating physicians to follow in the patterns of those around them, the legal system has substantially limited the ability of the practice of medicine to evolve.”).

446. King & Moulton, *supra* note 445.

minority rule and instruct juries that cost-sensitive practices may be deemed respectable.⁴⁴⁷ Other commentators have advocated that malpractice law abandon its reliance on professional custom and instead evaluate physicians' practices using the same reasonable and prudent person standard applied in other negligence actions.⁴⁴⁸ These commentators argue that because the reasonable and prudent person standard incorporates risk-utility balancing, the standard would accommodate cost-conscious changes in clinical practices.⁴⁴⁹ Finally, some commentators favor allowing physicians to raise cost containment as an affirmative defense to deviations from customary or respectable professional practices.⁴⁵⁰

In theory, changes to the malpractice legal doctrines will protect physicians who reasonably balance an individual patient's welfare and societal cost concerns.⁴⁵¹ However, in practice such changes will successfully remove current legal obstacles to more cost-sensitive medical care only if juries abide by the new legal standard.⁴⁵² Unfortunately, juries

447. See Mellas, *supra* note 397, at 307 (proposing that courts permit physicians to invoke the respectable minority rule "to demonstrate a change in the standard of care in cases involving cost containment").

448. See, e.g., Blumstein, *supra* note 420, at 143 (suggesting that medical malpractice law should be unified with the rest of tort law under a reasonable and prudent practitioner standard); Nelson, *supra* note 339, at 783 (proposing adoption of a reasonable, prudent physician standard); Smith, *supra* note 422, at 172 (advocating applying in medical malpractice cases the reasonableness standard used in traditional tort law).

449. See Peters, *supra* note 443, at 202–03 ("If courts define reasonable physician behavior in the same risk-utility terms with which they have defined reasonable care in ordinary tort actions, then cost-conscious changes in clinical practices will be defensible (albeit risky) even if they depart from fee-for-service customs." (footnote omitted)).

450. See Mellas, *supra* note 397, at 308 (discussing proposals for a cost containment defense). A reasonable and prudent physician also would address concerns that a custom-based standard of care may fail to provide patients adequate protection should physicians collectively adopt overly conservative practices in response to changes in reimbursement policies. See Hall, *The Malpractice Standard*, *supra* note 430, at 352 (discussing the possibility that physicians as a group may cut back too much if cost-saving incentives are set too strong).

451. Peters, *supra* note 443, at 186 ("In theory, of course, the 'respectable minority' rule should protect physicians in case in which physicians differ. The purpose of the rule is to prevent the jury from deciding which approach is best. However, courts typically allow the jury to decide whether the defendant's school of thought is 'respectable' As long as the plaintiff's expert testifies that the defendant's conduct did not meet the standard of care, then the jury decides whether the defendant's approach was malpractice. As a consequence, the modern function of the respectable minority instruction is to remind the jury that more than one approach may be reasonable" (footnotes omitted)).

452. *Id.*

may not do so, choosing instead to disregard cost considerations out of sympathy for the plaintiff.⁴⁵³

Many individuals object to rationing care.⁴⁵⁴ These objections reflect both moral discomfort with denying care to those in need and skepticism about the necessity of doing so to control costs.⁴⁵⁵ Therefore, juries may be hostile to defendant-physicians who compromise a patient's welfare in the name of cost-containment, even if in doing so the physician reasonably balances the patient's needs with society's economic concerns.⁴⁵⁶ Even if in practice many jurors accepted the need for rationing, a medical professional that mistrusts the judicial system may presume otherwise.⁴⁵⁷ Consequently, physicians who are fearful that juries will apply a patient-centered duty of care may hesitate to adopt more cost-sensitive practices.⁴⁵⁸

One possible solution to the problem of jury nullification (or physicians' fears of jury nullification) would be to shift medical malpractice cases from the judicial system to administrative tribunals, or so-called health courts.⁴⁵⁹ For example, medical malpractice claims could be heard before one or more administrative law judges or a panel of health experts.⁴⁶⁰ If administrative law judges or neutral experts prove to be more tolerant than juries of the need to ration care (or physicians believe them to be more tolerant),⁴⁶¹

453. *Id.*

454. *See* Mantel, *Setting National Coverage Standards*, *supra* note 110, at 236–40 (explaining the reasons for individuals' resistance to limits on their medical care).

455. *Id.*

456. *See* Hirshfeld, *supra* note 419, at 2011 (“[J]udges and juries may not be willing to depart from a patient-oriented standard of care.”); Nelson, *supra* note 339, at 794–95 (“[T]he defendant may antagonize the jury by bringing up cost as a justification for her failure to employ what is arguably customary care.”).

457. *See* Nelson, *supra* note 339, at 795.

458. *Id.*

459. Prior proposals for health courts focused on other potential advantages, including promoting patient safety and deterring negligence, reducing the costs of litigation, and resolving malpractice cases more quickly. *See generally* Johnson et al., *supra* note 435, at 1390–94 (discussing the rationales for health courts); Philip G. Peters, *Health Courts?*, 88 B.U. L. REV. 227, 230–31 (2008) (same); Carter G. Phillips & Paul E. Kalb, *Replacing the Tort System for Medical Malpractice*, 3 STAN. L. & POL'Y REV. 210, 213–14 (1991) (same). This Article is the first to suggest that health courts may be a necessary component of a rationing scheme that is dependent on physicians rationing care at the bedside.

460. *See supra* note 459 (discussing the benefits of health courts and the composition being the primary difference—instead of a judge and jury, it would be a panel of health experts or administrative law judges).

461. Whether administrative tribunals would be more accepting of physicians implicitly rationing

physicians' defensive practices may lessen.

In sum, the current medical malpractice system stands as a barrier to physicians rationing care under a dual duty paradigm. An in-depth discussion of the relative merits of various reforms, both to the legal standard of care and the forum for considering malpractice claims, is beyond the scope of this Article. Instead, this Article urges scholars and policymakers to give careful consideration of how to best reform the malpractice system to promote medical decisionmaking that balances cost considerations with the individual patient's interests.

C. Reconsidering Informed Consent Law's Disclosure Requirements

The doctrine of informed consent requires physicians to discuss with their patients medically viable treatment alternatives and their relative risks and benefits.⁴⁶² Commentators have devoted much ink to debating the scope of physicians' disclosure obligation under the informed consent doctrine.⁴⁶³ Of particular concern is whether a physician must disclose to a patient treatment options that the physician wishes to withhold from the patient on economic grounds.⁴⁶⁴ Consider the MRI example discussed in the introduction. If the physician reasonably believes that the potential benefits of ordering an MRI for a patient are slight, must she nevertheless discuss the MRI option with the patient?⁴⁶⁵ Or consider the case of low-osmolar contrast dye, a safer option than the less costly high-osmolar contrast dye. If a physician reasonably concludes that the clinical benefits of the low-osmolar contrast dye relative to the high-osmolar contrast dye do not justify its additional cost, must the physician inform the patient about the low-osmolar contrast dye?⁴⁶⁶ This Part considers these questions and suggests

care remains an open question. Compare Johnson et al., *supra* note 435, at 1370–71, 1391 (arguing that juries are not as effective triers of fact as the expert triers of fact found in administrative proceedings), with Peters, *supra* note 459, at 246 (arguing that administrative law judges may not be better triers of fact than juries because “judges are vulnerable to the same kinds of cognitive biases that can affect juries” and “are not immune from normal human sympathy”).

462. See FAY A. ROZOVSKY, CONSENT TO TREATMENT § 1.02(A)(1), (2) (4th ed. Supp. 2013) (explaining the disclosure requirements for informed consent).

463. *Id.*; see also Robert Gatter, *Informed Consent Law and the Forgotten Duty of Physician Inquiry*, 31 LOY. U. CHI. L.J. 557, 558 (2000).

464. Gatter, *supra* note 463, at 568.

465. *Id.*

466. See Morreim, *Economic Disclosure and Economic Activity*, *supra* note 405, at 319 (asking

that, under a dual duty of care, the answer to these questions may be no.

Most scholars addressing the issue of informed consent have come down squarely on the side of patients and argued for a broad disclosure requirement.⁴⁶⁷ Consistent with the patient-centered paradigm, these scholars defend a broad disclosure obligation by emphasizing physicians' fiduciary obligation to help their patients exercise their right to self-determination. They maintain that patients who are informed about all appropriate medical alternatives can then meaningfully evaluate their options and ensure that their medical care reflects their personal preferences, values, and goals.⁴⁶⁸ A broad disclosure obligation thereby protects patients'

whether under informed consent laws patients are entitled to be told about the safer, but more costly, lower-osmolar contrast dye).

467. See, e.g., Matthew Robert Gregory, *Hard Choices: Patient Autonomy in an Era of Health Care Cost Containment*, 30 JURIMETRICS 483, 495 (1990) (arguing that the emergence of provider financial incentives such as prospective reimbursement "should increase, not decrease, the doctor's disclosure duties and incentives"); Krause, *supra* note 19, at 337 (arguing that informed consent law should require disclosure of all medically appropriate treatment alternatives, including noncovered treatment options); Maxwell J. Mehlman, *Fiduciary Contracting: Limitations on Bargaining Between Patients and Health Care Providers*, 51 U. PITT. L. REV. 365, 393 (1990) [hereinafter Mehlman, *Fiduciary Contracting*] ("[T]he patient has the right to expect total candor from the provider."); Nelson, *supra* note 339, at 812 (proposing that physicians should be liable "for failure to disclose more costly alternative treatments or diagnostic treatments where this information would be material to a reasonable patient"); Hunter L. Prillaman, *A Physician's Duty to Inform of Newly Developed Therapy*, 6 J. CONTEMP. HEALTH L. & POL'Y 43, 51 (1990) (contending that any medically accepted alternative should be disclosed if the reasonable patient would deem information about the alternative material to her decision of whether to undergo the treatment recommended by the patient's physician); Marc A. Rodwin, *Conflicts in Managed Care*, 332 NEW ENG. J. MED. 604, 605 (1995) (arguing for disclosure of all treatment options); Marjorie Maguire Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219, 291 (1985) (arguing in favor a dignitary tort that would impose a broad disclosure duty on physicians). *But see*, Mark A. Hall, *A Theory of Economic Informed Consent*, 31 GA. L. REV. 511, 567 (1997) [hereinafter Hall, *Economic Informed Consent*] (suggesting that patients waive their right to be informed of treatment alternatives withheld or denied on rationing grounds when they freely enroll in a plan).

468. See Menikoff, *supra* note 406, at 1119 ("A patient's right to make decisions about his own body is less meaningful to the extent that he lacks the appropriate information about the choices available to him, and the consequences of those choices."); John Petrila, *The Emerging Debate Over the Shape of Informed Consent: Can the Doctrine Bear the Weight?*, 21 BEHAV. SCI. & L. 121, 122 (2003) (explaining that if a patient is to exercise informed choice, the patient "must have sufficient knowledge" to "evaluate knowledgeably the options available and the risks attendant upon each." (quoting *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972))); Evelyn M. Tenenbaum, *Revitalizing Informed Consent and Protecting Patient Autonomy: An Appeal to Abandon Objective Causation*, 64 OKLA. L. REV. 697, 718 (2012) ("The purpose of informed consent laws is to ensure that patient autonomy is respected—that the patient's personal preferences, values, and goals are given deference . . .").

autonomy.⁴⁶⁹ Courts generally have agreed and adopted broad disclosure rules that promote patient self-determination.⁴⁷⁰

A broad disclosure obligation was compatible with the unconstrained financing that dominated the pre-managed care era, the era during which courts adopted the doctrine of informed consent. Prior to managed care, insurers were willing to fully reimburse all medically appropriate care. The choice among viable treatment alternatives then could be given to the patient, with expansive informed consent laws helping to ensure that patients' exercise of this choice was an enlightened one.⁴⁷¹ Today's health

469. See, e.g., Dayna Bowen Matthew, *Race, Religion, and Informed Consent—Lessons from Social Science*, 36 J.L. MED. & ETHICS 150, 156 (2008) (“[T]he law of informed consent directly reflects the notion of patient control and self-determination.”); Morris, *supra* note 176, at 339 (2002) (“Under a negligence theory, the disclosure duty is imposed . . . to protect the patient’s right to medical self-determination.”).

470. See generally George J. Annas & Frances H. Miller, *The Empire of Death: How Culture and Economics Affect Informed Consent in the U.S., the U.K., and Japan*, 20 AM. J.L. & MED. 357, 379 (1994) (“U.S. informed consent law . . . tends to expand the possibilities for patient choice through more thoroughgoing informed consent requirements.”). Although no court has adopted legal rules that broadly allow physicians to withhold from patients information on treatment alternatives the physician would deny on economic grounds, numerous commentators argue that the current informed consent law falls short of giving full protection to patient autonomy. In defining the scope of physicians’ disclosure obligations, courts look either to professional norms (*i.e.*, physicians’ customary practices) or the reasonable patient. Critics of the professional norm standard question whether physicians can be relied upon to customarily disclose all information that may be relevant to patients’ decisions. See Comment, *Rx for the Elderly: Legal Rights (and Wrongs) within the Health Care System*, 20 HARV. C.R.-C.L. L. REV. 425, 457 (1985) (criticizing the professional medical standard of disclosure because “[w]hat doctors traditionally tell their patients about a procedure bears no inherent relationship to what people find significant in making their own choices”); Shultz, *supra* note 467, at 286 (“Once it is determined that a duty of disclosure applies, breach of that duty ought to be judged not by the standards of expert behavior but by the standards appropriate to protection of patient autonomy.”). Critics of the reasonable patient standard argue that because patients vary widely in their information preferences, “our objective legal standards of informed consent that depend on the informational needs of a ‘reasonable patient’ may deny many patients the amount of information they require to give an informed consent to treatment.” King & Moulton, *supra* note 445, at 431. In addition, most courts have adopted an objective standard for the causation element of an informed consent claim based in negligence, requiring a patient to show that a reasonably prudent person with the patient’s medical condition would not have consented to the procedure performed if fully informed. Scholars note that the focus on the hypothetical reasonable patient undercuts the goal of ensuring that an individual patient’s decision is based on their individual preferences and goals, as most patients follow their physicians’ reasonable recommendations. See, e.g., Tenenbaum, *supra* note 468, at 697 (critiquing an objective causation requirement); Aaron D. Twerski & Neil B. Cohen, *The Second Revolution in Informed Consent: Comparing Physicians to Each Other*, 94 NW. U. L. REV. 1, 9 (1999) (same).

471. As explained by Professor Mark Hall, “Vigorous enforcement of informed consent law fit hand-in-glove with open-ended, charge-or-cost-based reimbursement and free choice of physician.

care system, however, is a far cry from the “blank check” approach of the past. With patients facing limits on their care—limits increasingly imposed by physicians at the bedside—the merits of a broad disclosure obligation should be re-examined.

Some scholars who recognize the need for limits on patients' medical options nevertheless argue that patients should continue to be informed of all available treatment alternatives so that they can protect their own interests. Specifically, these scholars argue that the patient armed with knowledge about alternative options can challenge a physician's rationing decision, switch to another physician,⁴⁷² or pay for the more costly alternative out-of-pocket.⁴⁷³ To the extent fiduciary principles alone determine a physician's duty to her patient, these arguments provide a persuasive case for requiring total candor from the physician.⁴⁷⁴ Under a dual duty of care, however, consideration also must be given to whether a legal rule requiring physicians to disclose all medically appropriate treatment options undermines physicians' gatekeeping role.

If a patient informed of all medically appropriate treatment alternatives demands a more costly option, her physician may feel pressured to acquiesce to the patient's request.⁴⁷⁵ In an increasingly competitive healthcare market, physicians may worry that a disgruntled patient will switch to another provider.⁴⁷⁶ Websites comparing healthcare providers only intensify the

This blank check form of insurance was fully compatible with eliciting and effectuating the full range of patients' personal values and preferences at every stage of medical care.” Hall, *Economic Informed Consent*, *supra* note 467, at 513.

472. See generally Paul S. Appelbaum, *Must We Forgo Informed Consent to Control Health Care Costs? A Response to Mark A. Hall*, 71 MILBANK Q. 669 (1993) (arguing that disclosure of alternatives supports patients electing to pay for treatment out of pocket or switching physicians or insurance plans).

473. See Robert Marcus, *Should You Tell Patients About Beneficial Treatments That They Cannot Have?*, 334 BRIT. MED. J. 826, 826 (2007) (arguing in favor of a broad disclosure requirement in part so that patients have the opportunity to “spend their own money on treatment”).

474. Cf. Morreim, *Economic Disclosure and Economic Advocacy*, *supra* note 405, at 318 (arguing that fiduciary considerations and the principle of self-determination require physicians to disclose medically viable alternatives, including those not covered by their health plan, so that patients may “look out for their own interests,” including challenging or changing their insurance plans and purchasing health care options not otherwise funded by third-party payment).

475. See Karlawish et al., *supra* note 14, at V-15 (stating that disclosing all treatment alternatives could cause the unwanted outcome of physicians yielding to demands for less cost-effective care).

476. See Thomas L. Hafemeister & Richard M. Gulbrandsen, *The Fiduciary Obligation of Physicians to “Just Say No” If an “Informed” Patient Demands Services that Are Not Medically Indicated*, 39 SETON HALL L. REV. 335, 359 (2009) (observing that pressure to sustain and increase

competitive pressures to please patients.⁴⁷⁷ Similarly, emerging reimbursement methods that tie a portion of physicians' compensation to the results of patient satisfaction surveys compound the pressure to keep patients happy.⁴⁷⁸ Physicians also may fear that a patient who is angry about being denied care "is a lawsuit waiting to happen."⁴⁷⁹ Finally, a physician may yield to a patient demand to avoid an uncomfortable confrontation with the patient.⁴⁸⁰ For physicians tasked with lowering the cost of care, then, "patient knowledge can be expensive."⁴⁸¹

Some commentators have expressed skepticism that a broad disclosure requirement leads to higher aggregate health care spending. Professor Richard Saver, for example, has suggested that "few physicians" order interventions they regard as "wasteful," particularly for big-ticket-items such as MRIs.⁴⁸² Professor Joan Krause similarly has questioned the assumption that "fully informed patients will always opt for the more expensive therapy," particularly if higher copayments and similar cost-sharing strategies sensitize patients to the cost of their care.⁴⁸³ Studies of physician-patient interactions provide some support for these arguments. Patients who

"patient flow" causes physicians to "feel pressure to satisfy and retain patients as if they were customers in a retail business").

477. See *id.* at 359–60 n.137 (stating that physician pressure to satisfy and retain patients is "being compounded by the recent trend to make available to prospective medical care consumers comparative rankings of healthcare providers.").

478. See Virginia Teas Gill, *Patient "Demand" for Medical Interventions: Exerting Pressure for an Offer in a Primary Care Clinic Visit*, 38 RES. ON LANGUAGE & SOC. INTERACTION 451, 452 (2005) ("Many health insurers now base a portion of physicians' pay on patient satisfaction, which may provide physicians with a financial incentive to be responsive to patients' requests for medical services by giving them what they ask for.").

479. Beth Huntington & Nettie Kuhn, *Communication Gaffes: A Root Cause of Malpractice Claims*, 16 BAYLOR U. MED. CENTER PROC. 157, 159 (2003).

480. See Mechanic, *Dilemmas in Rationing Health Care Services*, *supra* note 177, at 1658 ("[P]atients when insistent are probably more likely to receive the interventions they seek because doctors typically are uncomfortable with the tensions these patients introduce.").

481. Krause, *supra* note 19, at 264.

482. Saver, *supra* note 8, at 472.

483. See Krause, *supra* note 19, at 363; see also Karlawish et al., *supra* note 14, at V-15 (stating that although disclosure of treatment alternatives could result in a loss of patient trust in physicians and "demands for less cost-effective care that likely result in inefficient health care delivery . . . , it is equally plausible that open disclosure of economic constraints could actually enhance trust in the health care system without undermining its cost-effectiveness goals"); Morreim, *Economic Disclosure and Economic Advocacy*, *supra* note 405, at 320 ("As economic constraints impinge upon patients and providers . . . , one may hope that physicians and patients can engage in more economically cautious conversations about the costlier options of care.").

learn of and demand more costly treatment alternatives often do in fact fail to persuade their physicians to provide the desired intervention.⁴⁸⁴ Similarly, some physicians state that at times they can dissuade a patient from continuing to demand the more costly alternative.⁴⁸⁵ Nevertheless, these same studies also reveal that physicians frequently manage patient conflict by deferring to patients' requests.⁴⁸⁶

Many physicians report difficulty in fulfilling their gatekeeping role, as they often "are reluctant to ration care at the bedside because they have the desire to satisfy their patients."⁴⁸⁷ For example, in a survey of California physicians, respondents indicated that 41% of the time they either "explain why the intervention is not appropriate *but order it anyway, if the patient continues to insist*" or "do not try to talk the patient out of the intervention and *will order it anyway*."⁴⁸⁸ Other physician surveys and focus group interviews similarly reveal that, when patients desire certain interventions, physicians frequently yield to patient demands,⁴⁸⁹ as "[s]aying no is no easy

484. In a survey of California physicians, respondents reported that 56% of the time that they "try to explain why the intervention is not appropriate and do not order it, even if the patient insists." Ginsburg et al., *supra* note 299, at 392; *see also* Walter et al., *supra* note 200, at 492–94 (reporting that general practitioners in the United Kingdom participating in focus group interviews indicated that they sometimes refuse patient requests, especially if the patient has come to trust the physician over time).

485. *See* Ginsburg, *supra* note 299, at 393 (stating that physicians reported that approximately half of patients accept their physician's explanation for refusing to provide care desired by the patient "once they understand that the intervention would waste resources"); Walter et al., *supra* note 200, at 492 (explaining that some physicians report that involving patients in the debate about rationing is "the key to saying no").

486. *See, e.g.*, Stretch et al., *supra* note 201, at 91 (summarizing the findings of various studies that involved focus group interviews with physicians).

487. *Id.*

488. Ginsburg et al., *supra* note 299, at 302 (emphasis added); *see also* Benedicte Carlsen & Ole Frithjof Norheim, "Saying No Is No Easy Matter": A Qualitative Study of Competing Concerns in Rationing Decisions in General Practice, 5 BIOMEDICAL CENT. HEALTH SERVS. RES. 1, 5 (2005) (reporting that Norwegian general practitioners participating in focus group interviews reported that "they often give in when the patient is not convinced" by the physicians' explanation for not wishing to authorize an intervention or referral). At the time of the Norwegian study, Norwegian general practitioners were paid in part through capitation, with general practitioners paid a fixed amount for each person listed on their service. *Id.* at 2. The capitated payment coupled with patients' right to switch physicians, enhanced competition for patients among Norwegian general practitioners. *See id.* (describing Norway's payment system for general practitioners). Therefore, Norwegian physicians face many of the same pressures as their American counterparts. The comments of Norwegian physicians thus are instructive for how a broad disclosure requirement under informed consent law influences the practices of American physicians.

489. *See* Ginsburg et al., *supra* note 299, at 393 (finding that many physicians, "if pressed, will

matter.⁴⁹⁰

In sum, disclosing all medically credible treatment alternatives to patients leads some patients to demand options that their physicians are reluctant to provide on cost-benefit grounds. While physicians sometimes successfully navigate this conflict without compromising their gatekeeping role, not uncommonly they neglect the latter in the interest of keeping patients happy. Consequently, informed consent law's broad disclosure requirement may frustrate society's efforts to control health care costs through implicit rationing at the bedside. In contrast, a narrower disclosure requirement—one that would permit physicians to say nothing to patients about treatment alternatives the physician wants to withhold on cost-benefit grounds—would allow physicians to avoid the patient pressures that stymie their gatekeeping responsibilities.⁴⁹¹

Ultimately, the question of how broadly or narrowly to define the scope of physicians' disclosure obligations requires carefully balancing the cost concerns discussed above with countervailing societal interests—respecting patient autonomy, preserving patient trust in physicians, and protecting patients from substandard care.⁴⁹² Resolving this important issue would

provide an intervention even when they think it is not indicated or not cost-effective"); Barrett T. Kitch et al., *Systems Model of Physician Professionalism in Practice*, 19 J. EVALUATION CLINICAL PRAC. 1, 9 (2013) (stating that physicians reported that they sometimes acquiesced to patient demands to avoid losing a patient to another physician, receiving bad ratings on patient satisfaction surveys, or being sued for malpractice); Kristin B. Lysdahl & Bjorn M. Hofmann, *What Causes Increasing and Unnecessary Use of Radiological Investigation? A Survey of Radiologists' Perceptions*, 9 BIOMEDICAL CENT. HEALTH SERVS. RES. 1, 4 (2009) (reporting that in a survey asking radiologists about the reasons for increased use of radiological interventions in Norway, 98% of respondents indicated that "peoples' increased demands for certain knowledge about their own health" was a cause "to a large or very large extent" (72.5% of respondents) or "to some extent" (25.4% of respondents)); Strech et al., *supra* note 201, at 91–93 (summarizing the findings of various studies that found physicians at times refrain from rationing care at the bedside because they wish to satisfy their patients' demands); Walter et al., *supra* note 200 (highlighting examples of general practitioners describing their "giving in" to patient demands).

490. Carlsen & Norheim, *supra* note 488, at 4 (quoting a physician participant in focus group interviews with Norwegian physicians).

491. See generally Annas & Miller, *supra* note 470, at 391 (theorizing that a country's overall health care expenditures can be strongly influenced by the amount of honest prognosis information made available to patients); Note, *A Tale of Two Countries: Parallel Visions for Informed Consent in the United States and the United Kingdom*, 39 VAND. J. TRANSNAT'L L. 253, 285 (2006) (explaining that the British health care system achieves lower costs relative to the United States in part due to English law's narrowed informed consent requirements, which discourages full disclosure).

492. See Schuck, *supra* note 1, at 940 (arguing that, as the health care system shifts to a more cost-conscious system in which patients are denied full autonomy, the benefits to patients of

benefit from additional research on the extent to which a broad disclosure obligation increases health care costs, and the extent to which a narrow disclosure requirement would diminish both patient trust in physicians and the quality of patient care.⁴⁹³ For purposes of this Article, I simply want to suggest that the issue of whether to impose a broader disclosure requirement is a closer case than most scholars acknowledge.

VII. CONCLUSION

Physicians' commitment to their individual patient's welfare is one of the most cherished attributes of the U.S. health care system. Indeed, the medical profession's norms demand that physicians give primacy to the individual patient's best interests, a fiduciary norm reinforced in many respects by the law. Although this patient-centered duty of care clearly serves important societal goals, including preserving patients' trust in their physicians and promoting healthier populations, the public interest would be best served if law and medical ethics no longer require of physicians absolute fidelity to individual patients. This Article instead argues for a dual duty of care, with physicians permitted to balance the individual patient's needs with society's interest in constraining health care costs and ensuring the equitable allocation of limited medical resources. So while patient loyalty would remain an important value, the physician's fiduciary obligations to patients would be limited by the physician's competing obligations to society. Therefore, law and medical ethics should be reformed to accommodate physicians' dual duty of care.

While this Article has argued for a dual duty of care, it leaves unanswered the fundamental questions of how physicians should perform their dual roles and how society should oversee their doing so. Providing physicians with guidance on how to balance their role as society's rationing agent with their role as the patient's fiduciary is one of the most important challenges currently facing medical ethicists. Moreover, in recognition that provider financial incentives may lead some physicians to do too little for their patients, consideration must be given to what safeguards and

informed consent must be weighed and balanced against other policies).

493. See Karlawish et al., *supra* note 14, at V-15 ("Clearly, research is needed to determine how [disclosure of medically appropriate options] affects the patient-provider relationship, patient satisfaction, and cost.").

protections, both legal and ethical, are necessary to prevent abuse. In presenting the case for a dual duty of care over a patient-centered duty of care, my hope is that the debate over whether physicians should play a role in rationing care will cease. Moving forward, commentators and policymakers should focus on how society can best support and regulate physicians' bedside rationing.