The Ethics of Cost-Containment: Bureaucratic Medicine and the Doctor as Patient-Advocate

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INTRODUCTION

Physicians are feeling the heat of cost containment. Pressures on doctors to contain costs have mounted — from hospital and Health Maintenance Organization (HMO) administrators, from state and national government, from medical staffs. Medicare payment reforms, corporate and insurer demands, and market pressures have all come together to pressure health care providers to cap escalating health care costs. This article posits that such pressures to control costs are not always counter to the patient's best interests and that the ethical debate needs to incorporate the emergence of bureaucratic medicine and its sensitivity to cost. The pressure to reduce cost has intensified the tension felt by physicians as they balance their ethical obligations to treat their patients and their desires to maintain the financial health of their health care institutions and their own financial security. The line between pure medical decisions and economic decisions has blurred. The essence of the complaint is simply stated: "... economic imperatives may weaken what should be a strong fiduciary relationship between doctor and patient. A physician cannot easily service his patients as trusted counselor and agent when he has economic ties to profit-seeking businesses that regard those patients as customers."*
The current ethical debate seems to revolve primarily around middle class medicine, where physician autonomy in treating patients has been most dramatically limited by new modes of health care delivery and reimbursement. Prospective payment mechanisms have been implemented through the federal Medicare program, but hospitals have applied DRG categories across the board to their delivery of health care. As hospitals struggle to contain costs, they have implemented cost controls that affect a doctor’s practice generally and not just that segment involving Medicare patients.

Can Hospitals Reward Physicians for Reducing Unnecessary Utilization?, Fed. Am. Hosp. Rev. 45 (Sept. - Oct. 1985). The authors note that “[s]ome systems are so complex that they utilize sophisticated computer programs which analyze past performance and the severity of illness of individual patients, while others merely reward a physician if the hospital’s costs for a specific patient are less than the DRG payment.” See also Morreim, The MD and the DRG, 15 Hastings Center Rep. 30 (June 1985).

4. Those treating the poor have always been aware of the rationing aspects of the process. See generally Rosenblatt, Medicaid Primary Care Case Management, the Doctor-Patient Relationship, and the Politics of Privatization, 36 Case W. Res. L. Rev. 915 (1986), particularly at 917-18 and accompanying notes. Much of the problem discussed here does not address the real “emergency” delivery of health care to under or uninsured patients, or Medicaid patients. For whole classes of our population, the rationing dilemma experienced by the doctor is far more of a vise grip than a gentle squeeze. The population affected thus makes a large difference to the ethical debate. With the poor, the level of scrutiny is at the political level, a macroallocation question as to inadequacy of resources available as a pool for the poor group. Schroeder, Strategies for Reducing Medical Costs by Changing Physicians’ Behavior: Efficacy and Impact on Quality of Care, 3 Int’l J. Tech. Assess. in Health Care 39, 47 (1987). “Whether attempts to reduce medical costs by changing physicians’ behavior will harm patient care depends upon the population affected and the services withheld. If the burden of cost containment falls upon those who already have poor access to care, then the quality of care will surely fall.” Id. at 48. He concludes: “... how cost-containment measures affect the quality of care depends upon their type and efficacy, the prevalence of unnecessary care, and the vulnerability of the patients whose clinical services would be reduced, and the type of services withheld.” Id. See also Dallek, Commentary, 36 Case W. Res. L. Rev. 969 (1986).

Physicians serving the poor make more of the tradeoffs discussed here than do those doctors who treat the middle class in HMOs or hospitals.

This article addresses the debate at the level of middle class medicine, while conceding that the harder issues are raised by the scarce resource problems involved in treatment of the poor.

Berenson has written that “it has not been unusual for me... to have to negotiate with Medicare patients over my recommended drug regimens in order to accommodate patients’ very real budgetary constraints.” Berenson, A Physician’s Perspective on Case Management, 2 Bus. & Health 22, 22-23 (1985).
I. Overview of Methods to Reduce Medical Costs

In 1982 Congress approved prospective reimbursement of hospitals on a diagnosis-related groups (DRGs) basis for Medicare. This system was designed to provide incentives for cost containment by creating an administered price system under which hospitals are paid a predetermined price for services based upon an average cost calculation for a patient with a particular diagnosis. This replaced the previous fee-for-service system under which the hospital billed the federal government for the actual charges incurred and was paid with little risk of challenge. Medicare's new system covers hospital care for Medicare patients in every state except New Jersey, Maryland, New York, and Massachusetts. Some private insurers have also adopted some version of it as well to control their reimbursement costs.

Financial institutional arrangements in hospitals also seek to control and channel physician behavior in cost-saving directions. Such "cost constraints" are "a source of pressure upon clinical decisionmaking through hospital rules or monitoring systems which tie physician salary, staff privileges, or other benefits to effective control of costs." The evidence suggests that the most effective mode of changing medical practice is the alteration of the financial incentives that affect physicians. That is precisely the goal of incentive systems and institutional designs, such as HMOs. Strategies for altering physician behavior have ranged from education, feedback, regulatory approaches such as Certificates of Need (CON), insurance coverages, to financial incentives, either within hospitals or inherent in structural forms such as HMOs.

A. Ethical Dilemmas Posed by Cost Containment

The ethical tensions confronting the physician in an era of cost-containment are complex. The conflicts experienced by the physician may vary in intensity, depending upon the source of cost pressures and the nature of the institution.
The range of financial incentive schemes is quite extensive. Thus, prospective payment schemes such as the Medicare DRG system do not order the doctor or the hospital not to treat or hospitalize a patient. Rather the message is that the provider can do what it wants, but will only get paid whatever the categories allow. Given the need to balance a budget, institutional incentives to follow the payment categories are strong.9

Incentive systems in some institutions tie physician performance to level of utilization in a variety of ways. Capitation systems such as HMOs put physicians at risk by conscious design. The capitation principle means that payment is determined in advance for each subscriber to the HMO, and the HMO will lose money if its costs per patient exceed the amount they have collected. Physician gatekeepers attempt to discourage overutilization in the HMO; the norms of practice of physicians in HMOs tend toward lower levels of utilization generally.10 Staff privileges may be indirectly tied to overutilization as well.11 Physician-owned clinics and other medical centers likewise provide very direct and strong incentives for physicians to practice profitable medicine. Overall, cost considerations have become an integral part of medical practice.12

9. See Furrow, supra note 7, at 990.

10. The literature on practice patterns in prepaid group practices supports the hypothesis that diagnostic and treatment patterns differ from fee-for-service settings. See Pineault, The Effect of Prepaid Group Practice on Physicians’ Utilization Behavior, 14 MED. CARE 121 (1976); Dorsey, Use of Diagnostic Resources in Health Maintenance Organizations and Fee-For-Service Practice Settings, 143 ARCH. INTERN. MED. 1865 (1983); Hartzema and Christensen, Nonmedical Factors Associated with the Prescribing Volume Among Family Practitioners in an HMO, 21 MED. CARE 990 (1983); Yelin, Henke, & Kramer, A Comparison of the Treatment of Rheumatoid Arthritis in Health Maintenance Organizations and Fee-For-Service Practices, 312 NEW ENG. J. MED. 962 (1985).

11. See Knapp v. Palos Community Hosp., 125 Ill. App. 3d 244, 465 N.E. 2d 554 (1984), where a hospital denied a staff physician’s reappointment. The hospital inquiry concentrated on the doctor’s excessive use of lung scans, medications, tests, pacemakers, and pulmonary angiograms. The doctor’s peers also testified that his excessive testing resulted in 30% higher costs to the institution.


For a discussion of hospital responses to the new competitive environment, see Waldholz, Most Hospitals Quickly Learn to be Profitable, WALL ST. J., Aug. 28, 1985, at 6, col. 1. See also PROSPECTIVE PAYMENT ASSESSMENT COM-
Critics of using economic incentives to change physician behavior are concerned about the desirability of the end results of such behavioral changes on health care delivery and quality of care. Alexander Capron worries, for example, that exposing physicians to financial risks through incentive systems and prepaid plans will exacerbate access problems for significant percentages of our population that are already underserved. He writes: "Capitation programs, packaging of services, and prepaid arrangements such as HMOs have a built-in disincentive to accept the sickest and poorest patients, the very ones who have the hardest time obtaining health care."13 Thus, before we implement a variety of incentive systems and cost constraints, we must be satisfied that the physician-patient relationship will still function and that patient care will not suffer as a result.

B. Rationing

The specter of physicians consciously engaged in rationing at the bedside has excited much commentary.14 Of course, rationing of a scarce supply of health care resources is

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14. See Bayer, Callahan, Fletcher, Hodgson, Jennings, Monees, Sieverts & Veatch, The Care of the Terminally Ill: Morality and Economics, 309 NEW ENG. J. MED. 1490 (1983); Morreim, The MD and the DRG, 15 HASTINGS CENTER REP. 30, 36 (1985). As the reimbursement purse strings have tightened at all levels, physician awareness of the tradeoffs has become acute. Fuchs writes:

Increasingly, physicians are being asked to resolve this problem; that is one reason why the issue of "rationing" takes on a new urgency. The pressure to be more economical in the provision of care will force physicians to make decisions that are contrary to the best interests of individual patients, even though these decisions may make a great deal of sense from the viewpoint of society as a whole. Moreover, pressure to control costs will raise explicitly the question of who gets how much care. In the past this question was often answered implicitly by where the patient lived and whether he could pay. In the future, in the interest of maintaining equity while controlling costs, it may be necessary to withhold care from patients who have ample income or complete insurance and who therefore believe that they are entitled to "everything possible.”

Fuchs, The 'Rationing' of Medical Care, 311 NEW ENG. J. MED. 1572, 1573 (1984).
nothing new. Physicians have always engaged in the rationing of health care, in the sense of distributing a limited supply.\textsuperscript{18} This distribution was usually accomplished implicitly in a variety of ways that concealed or disguised it. The choices that a rural practitioner might offer her patient would be more limited in many cases than those available to her urban counterpart, both because of the lack of medical or institutional resources, such as high technology diagnostic tools, and because of the income differentials among patients. Such common sense rationing has received legal approval in malpractice case law.\textsuperscript{16} The ability of the consumer to pay within the health care marketplace was the dominant mode of rationing health care as recently as two decades ago, when more than half of individual health care payments were made directly by patients.\textsuperscript{17}

Second, the geographic location of the patient made a large difference in the quality of care available, since the accident of geography meant access to more or less hospital care of varying quality and to specialists of various kinds.\textsuperscript{18} The inner city thus typically has few doctors, often foreign born, counterbalanced in some cities ironically with powerful teaching hospitals; the suburbs have physicians in an office practice; rural areas few practitioners widely scattered.\textsuperscript{19}

Third, definitions of diseases by physicians and insurers affect reimbursement for such care. Denial of a treatment as not "medically necessary" is a direct form of rationing of that care. Controversies over reimbursement by insurers of psy-
chotherapeutic services, sex change operations, or "experimental" therapies have reflected this form of rationing.\footnote{20}

Fourth, as Victor Fuchs comments, "the amount and kind of care that physicians provide is still constrained by how busy they are, what facilities, equipment, and auxiliary personnel are available, how much training the physicians have had, and the informal messages that they receive from peers about what constitutes 'appropriate' care in any particular situation."\footnote{21} Rationing is still ubiquitous in the delivery of health care services, although it may not be recognized or defined as such in the practice of middle class medicine.

1. Third Party Payment Blunts Rationing Impact.

Initially, the growth of private and governmental third party payment mechanisms reduced the role of patient income as a rationing device. Beginning in the 1950's, the increasing availability of health insurance through Medicare and Blue Cross Blue Shield vastly improved middle class access to medical care,\footnote{22} although social values, geographic differences, and skill and resource differences of health care providers still result in significant variation in access to health care. This emergence of government funded health care insurance had removed much of the decisionmaking tension from both doctor and patient over the past two decades, since cost did not have to be a factor in most treatment decisions.\footnote{23} The availability of third-party insurance thus became the driving force behind the tremendous expansion of health care expenditures in the United States, since "... when a third party is paying, the patient will want additional care and the conscientious physician will provide it, even though its cost to society exceeds the benefit to the patient."\footnote{24} The prevalence of insurance has allowed access to care by a much

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20. When I was in private practice in Boston, representing Blue Cross and Blue Shield of Massachusetts, the insurer's physician panel considered within one two year period such issues as the desirability of including within a definition of "medical necessity" chemopapain treatment for lower back pain and sex change operations. Given the long term cost of these treatments, a decision not to provide coverage to subscribers of the plans would make such treatments impossible for a large percentage of those who desired them.


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larger percentage of the public, and has therefore served important social functions. It has also shielded both patient and doctor from the need for careful scrutiny of the costs of the services rendered.25

2. Cost Containment Reasserts Rationing Pressure.

The current “rationing” problem is now more strongly felt by physicians in middle class practice because suddenly rationing is again out in the open, rather than concealed by structural and geographic differences. The HMO doctor must now examine the necessity for the more expensive third generation antibiotic rather than the cheaper ones available; he must weigh the need for extended hospitalization of a patient. As hospitals try to reduce the volume of costly diagnostic workups, doctors must face the uncertainty of less information. Patients are being pushed out of hospitals earlier, reducing the margin of safety that some physicians would like. Doctors and ethicists are searching for strategies to avoid physician responsibility for these cost-based decisions, so-called “tragic choices” that, like the sun, cause discomfort when looked at directly.28

C. Why Worry?

Why are we so worried about doctors and their dilemmas? Lawyers ration care for clients all the time, based primarily on the client’s willingness and ability to pay, unless the suit is a contingency fee liability case. Are medical services ranked higher on a hierarchy of social values and social needs than legal care? Certainly most individual clients, except criminal defendants, are not in life-threatening situations. But neither are most consumers of health care. For those doctor-patient encounters that involve debilitating diseases, pain, or the prospect of long term disabilities, however, it is understandable that we are concerned. Obstetrics, oncology, treatment of heart disease and diabetes — all involve illnesses

25. See R. Fein, Medical Care, Medical Costs: The Search for a Health Insurance Policy 168 (1986). Fein gives a good account both of the relationship of health insurance and rising health care costs, and the benefits of such insurance.

26. G. Calebresi and P. Bobbitt, Tragic Choices (1978). These authors were the first to discuss these dilemmas that lack clear answers, create discomfort, and therefore lead to avoidance or concealment of the conflicts through a variety of strategies. See also Dyer, Patients, Not Costs, Come First, 16 Hastings Center Rep. 5 (1986).
that can end badly. We are unhappy with the older system of rationing based on ability and willingness to pay, an approach that restricted access to care in an arbitrary fashion. The closest legal analogy is state-paid defense of the indigent criminal defendant, where we view access to legal services as essential. The legal system is experiencing some movement toward greater access to a range of legal services, with the increasing availability of prepaid legal services offered by some employers. The principle of access to necessary services is an expanding notion in our culture, and the special claims of medicine may soon be joined by other professional groups, as society's definition of need expands. The discussion which follows explores a number of ethical models in search of a more satisfactory method of rationing health care services.

II. ETHICS: A GUIDE TO ACTION

A. The Traditional Model

The delivery of health care inevitably involves ethical problems. Ethics offers guidance to help resolve specific problems, based upon the application of general moral principles. Applied ethics offers "procedures and standards for deliberation and justification" in dealing with problems of health care delivery and therapeutic practice.

Ethical discussions have traditionally focused on the physician-patient relationship and dilemmas of the treatment setting and the immediate life in peril. This ethical focus has excluded broader concerns affecting present and future patients (will medical resources be left for them, after the particular patient is aided?), or society (is the zealous treatment of the particular patient necessary or desirable or too

27. See L. Friedman, Total Justice (1985) for a development of the cultural forces that have raised our expectations.
29. As H. Tristam Engelhardt writes:
The health professions are practiced within a terrain of concepts and values that presupposes particular relations between concepts and values for which philosophers function as the geographers . . . . Philosophers can call attention to neglected features, forgotten relationships, and unforeseen contradictions. Philosophers can aid in better mapping and in critically evaluating the conceptual and value commitments involved in particular actions and choices.

costly?).\textsuperscript{30} The explanation for a patient-centered ethic has been that ethics derived from physicians worried about particular problems they faced, reflecting an individualistic perspective of the "good doctor" and his or her concerns in the treatment setting.\textsuperscript{31}

Four principles are generally applied to medical interventions: nonmaleficence, beneficence, autonomy, and justice. The principle of nonmaleficence derives from the maxim \textit{primum non nocere}, translated as "above all, or first, do no harm." It overlaps conceptually with the principle of beneficence, but is usually treated as a distinct principle, as it overrides beneficence in some situations. The principle of nonmaleficence is defined by Beauchamp and Childress to mean that "one ought not to inflict evil or harm (what is bad)."\textsuperscript{32} Nonmaleficence resonates for the lawyer in many tort liability rules based on a standard of care that aims to avoid harm to others through one's affirmative acts.\textsuperscript{33} Like many tort rules, it requires that "agents be thoughtful and act carefully," minimizing risks created toward others.\textsuperscript{34} Nonmaleficence asks what risks are posed by the intervention, and what level of stress and indignity will the patient have to endure.\textsuperscript{35} It is a first principle, prima facie valid. One who seeks to violate the principle carries a heavy burden of justification.

The principle of beneficence goes one step beyond the principle of nonmaleficence. It derives from a specific moral

\textsuperscript{30} See generally Ethics and Health Policy xix (R. Veatch and R. Branson, eds. 1976).

\textsuperscript{31} See Jonsen and Hellegers, Conceptual Foundations for an Ethics of Medical Care, 17, in Veatch and Branson, supra note 30.

In sum, code ethics, as they presently exist, might be called the archeological ruins of a doctrine of medical virtue. The codes are, in their present form, collections of pragmatic physician-patient covenant.

\textit{Id.} at 22.

\textsuperscript{32} T. Beauchamp and J. Childress, supra note 28, at 108.


\textsuperscript{34} T. Beauchamp and J. Childress, supra note 28, at 110.

\textsuperscript{35} Id. at 106-47.
relationship of the doctor and the patient. It addresses the affirmative obligations required of a moral actor, and not just acts that must be avoided. Beauchamp and Childress sum it up with obligations: "One ought to prevent evil or harm . . . . One ought to remove evil . . . . One ought to do or promote good." The principle of beneficence thus allows the actor more discretion than nonmaleficence, requires less risk-taking, and is more dependent upon roles and relationships.

The principle of patient autonomy forces the physician to look at the patient's desires and fears. What is the patient's desire, once informed of the balance of probabilities? The patient as autonomous decisionmaker is entitled to make the cost tradeoffs. How should a doctor respond if a patient has no insurance and is unwilling to pay for an expensive procedure, or simply decides to forego a treatment after making his or her own cost tradeoffs? Must the doctor be satisfied with giving the patient less medical care than is possible, and less than would in a qualitative sense help the patient?

The principle of justice is the most difficult to define. Philosophers and ethicists have not reached agreement on the common grounds for a principle of justice. The question can be put in a cost containment setting, but it conceals as much complexity as it uncovers in the process. Does the expected benefit to this particular patient justify the cost in resources to the community?

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36. Id. at 108.
37. Id. at 158.
38. As A. Donabedian writes:

[I]n real life, we do not have the option of excluding monetary costs from the individualized definition of quality. Their inclusion means that the practitioner does for each patient what the patient has decided his circumstances allow. In so doing, the practitioner has discharged his responsibility, provided that he has helped the patient to discover and use every available means of paying for care.

A. DONABEDIAN, THE DEFINITION OF QUALITY AND APPROACHES TO ITS ASSESSMENT 27 (1980). Donabedian foreshadows the role of the physician as patient-advocate, recognizing that the doctor may have an obligation to help the patient search for reimbursement. We will take up this theme again in the discussion of the Wickline case, see infra text accompanying notes 92-104.

40. The inquiry into the distributive principle to guide analysis of justice is far too complex to treat in this article. T. Beauchamp and J. Childress list five alternative principles:
   1. To each an equal share
   2. To each according to his need
scarce resources is often broken down into problems of macroallocation and microallocation. Macroallocation decisions look at decisionmaking at the level of government and institutions, asking how much of social resources "should be used for various goods, including health-related expenditures, as well as how priorities are to be established for the distribution of these resources. There are at least two aspects of such decisions: What quantity of our total available financial resources should be allotted to health-related enterprises (such as medical research, routine services, clinical practice, and health education), and of the total amount so allocated, what quantity should go to which specific projects (such as cancer research and dialysis programs)?"

Microallocation decisions occur at the level of implementation, when health care providers decide who should get what.

B. The Strong Version of Beneficence

The principle of beneficence is at the heart of much contemporary bioethical discussions of cost containment and the physician. Current bioethical discussions begin with an established doctor-patient relationship. The roles are already in place, the physician has a contractual relationship with the patient, and now it is a question of treatment choices and cost tradeoffs. Current bioethical discussions often adopt as a governing principle what I will term "strong" beneficence. A doctor must do all that is within his or her power to help the patient, regardless of cost. Medical ethicists speak of the special duties of the doctor in his relationship to the patient, characterizing the doctor as a special friend to the patient, with the bonds of loyalty that we normally subsume within the meaning of friendship. Hans Jonas describes the duty owed by the physician to a patient as a "sacred trust," an obligation to ignore social and other concerns which interfere with the care of the specific patient. The Principles of Med-

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3. To each according to his effort
4. To each according to societal contribution
5. To each according to merit

Id. at 187. A rich philosophical tradition supports each principle of justice.

41. Id. at 201-202.

42. See Veatch, DRGs and the Ethical Reallocation of Resources, 16 Hastings Center Rep. 32 (1986).

43. Charles Fried has developed this analogy most forcefully, in C. Fried, RIGHT AND WRONG 179 (1978).

44. Note the intensity of Jonas' description:
The Ethics of the American Medical Association (AMA) are almost as forceful in stating the principle of beneficence as dominant:

A physician has a duty to do all that he can for the benefit of his individual patients without assuming total responsibility for equitable disbursement of society's limited health resources. To expect a physician in the context of his medical practice to administer governmental priorities in the allocation of scarce health resources is to create a conflict with the physician's primary responsibility to his patients that would be socially undesirable. The AMA principles place cost concerns second: "While physicians should be conscious of costs and not provide or prescribe unnecessary services or ancillary facilities, social policy expects that concern for the care the patient receives will be the physician's first consideration." The Ethical Code of the World Health Association states: "A Doctor owes a patient . . . all the resources of his science." Levinsky puts it even more strongly: "[p]hysicians are required to do everything

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


46. Id. at 2.08.

47. A philosophically expanded version of these ideals is described by Norman Daniels as the "ethics of agency." A physician's services are limited by requirements that: clinical decisions be competent, respectful of the patient's autonomy, respectful of the other rights of the patient (e.g. confidentiality), free from consideration of the physician's interests, and uninfluenced by judgments about the patient's worth. Daniels, Why Saying No to Patients in the United States is So Hard: Cost Containment, Justice, and Provider Autonomy, 314 NEW ENG. J. MED. 1380, 1382 (1986).
that they believe may benefit each patient without regard to costs or other societal considerations." 48

1. Justifying the Principle and Strong Beneficence.

Justifications for a strong beneficence principle of personal care and the zealous pursuit of the patient's interests fall into three general categories. First, the relationship of personal care with the physician as patient-advocate fosters patient trust, confidence and candor, feelings that are valuable in themselves as part of a special social relationship akin to friendship. 49 Such patient attitudes are arguably also conducive of a better, more effective physician-patient relationship. Bedside cost-cutting, it is feared, will cause deterioration in the doctor-patient relationship from the patient's perspective. 50 Marcia Angell has argued that "[a]nything short of full efforts to heal the individual patient . . . must involve an element of deception — an ethically untenable condition." 51 The patient expects total loyalty, and the doctor-patient relationship "would not endure any other stated purpose." 52

Second, physician motivation to heal will be enhanced by putting the specific patient's needs ahead of economic considerations extrinsic to treatment of the specific patient. The motivation of doctors to care for their patients will otherwise be weakened if they are forced into a case-by-case tradeoff of the patient's interests and the institutions, theirs or society's. 53 It is this vision of the physician dedicated to her pa-

49. See C. Fried, supra note 43.
50. See generally Morreim, supra note 3. Victor Fuchs writes: Physicians have traditionally idealized the ethic of duty to their patients, and patients have derived considerable comfort from believing that physicians hold to this ethic . . . . Patients' perceptions of a conflict of interest can lead to an erosion of the trust, confidence, and candor that are essential elements in the physician-patient relationship and in the delivery of high-quality care. Fuchs, The Counterrevolution in Health Care Financing, 316 New Eng. J. Med. 1154, 1155 (1987); see also T. Beauchamp and J. Childress, supra note 28, at 213.
52. Id. at 13.
53. See Fuchs, supra note 14, at 1573: For physicians to have to face these trade-offs explicitly every day is to assign to them an unreasonable and undesirable burden. The commitment of the individual physician to the individual patient is
tient that is often at the heart of objections to cost constraints. The loyalty of the physician to patient leads the physician, the argument continues, to pursue that patient's interests zealously. Critics fear that muddying the purity of that loyalty will lead the physician into a motivational conflict of interest, resulting in poorer care for the patient. Critics argue that admitting cost considerations into clinical practice will lead to a standard of practice like that observed by Aaron and Schwartz in England, where the standard of care arguably has shifted downward, diminishing the quality of care delivered.

The pure fiduciary model of doctor and patient presumes freedom from financial limitations, no conflicting role tensions, and access to the available tools for diagnosing and treating. As with any model, it assumes away some real world limitations as part of defining the ideal. And as with

one of the most valuable features of American medical care. It would therefore be a great mistake to turn each physician into an explicit maximizer of the social-benefit/social-cost ration in his or her daily practice.

Id.


55. See H. Aaron & W. Schwartz, THE PAINFUL PRESCRIPTION: RATIONING HOSPITAL CARE (1984). Interestingly, however, Aaron and Schwartz thought that American medicine could learn something from the British experience, as do many British physicians:

Good medicine would call for fewer tests when the gain in information is slight and for less surgery and less use of costly drugs when the advantage of expensive over inexpensive therapies is small. In short, U.S. doctors would begin to build into their norms of good practice a sense of the relation between the costs of care and the value of the benefits from it. They would be led to weigh not only the medical aspects of diagnosis and treatment but also the peculiar circumstances of each patient: his age, his underlying health, his family responsibilities, and his chance of recovering enough to resume a normal life.

This process would require a far-reaching change in attitude for the many American doctors who believe it unprofessional, if not immoral, for doctors to consider costs in deciding what actions to take on behalf of patients.

Id. at 127.

For a strong statement by a leading British physician of the importance of medical training in health economics, see Lister, Resource Allocation: Educating for the Rationing of Care, 3 INTL. J. TECH. ASSESS. IN HEALTH CARE 91 (1987).

56. Rosenblatt has examined the changes in the AMA Code of Ethics over the past three decades, and has pointed up some fascinating changes. See Rosenblatt, supra note 4, at 923-28.
any model, it is only valuable if it can be expanded to consider as many commonly occurring real world constraints as possible. A behavioral analysis of physician behavior, as of any human actor's behavior, reveals that their motivations are a complex mixture of forces. Eisenberg, who has written extensively on the forces affecting medical decisionmaking, observes that "[p]hysician decision making is a complex interaction of attempts to satisfy the physicians' personal desires and those of the patient... . A substantial part of the physician's satisfaction with practice is fulfilled by serving successfully as the patient's advocate." He also notes however that such decisionmaking has substantial components of self-interest in terms of desires to retain the patient, keep income high, and calm physician anxiety.

Doctors are often ignorant of the price of medical care services and the portion that patients must pay. Doctors may adjust their utilization to maintain income. They may also consider the portion of their fee paid out of pocket by the patient. Doctors are influenced by cost in the number of tests they prescribe as well, with 24-38 percent of test ordering price sensitive, and the rest driven by clinical considerations. Eisenberg notes:

This behavior of the physician as the patient's economic agent may not be entirely altruistic. The physician may serve as the patient's advocate in order to retain the patient as a client. By this argument, the more competitive

57. J. Eisenberg, Doctors' Decisions and the Cost of Medical Care 57 (1986).
58. Eisenberg describes six components of the physician as agent:
(1) the physician will defend the patient's economic well-being, although the economic interests of the two may conflict;
(2) clinical factors play a role, and the role as healer is central;
(3) doctors are influenced by their patient's preferences;
(4) concern about malpractice suits and resulting defensive practices are also driven by both patient preferences and physician anxieties;
(5) patient's characteristics;
(6) patient's convenience.

Id.
60. See J. Eisenberg, supra note 57 at 15-18, summarizing the studies that looked at physician ability to induce demand and finding strong linkages.
61. Id. at 59.
the medical market is, the more the physician should act as the patient’s agent. In addition to reducing out-of-pocket expenses for the patient, the physician who acts as the patient’s economic agent by reducing the number of nonphysician expenses, such as tests, drugs, or hospital days, may also be making it possible for the patient to spend more of his health care dollar on physician fees.62

These observations are not intended as a pejorative comment on the purity of the ethical model of the physician as patient advocate and agent. They are rather intended to point out that the model must account for existing motivational forces, as well as new economic pressures, if it is to be a useful action-guide.

Third, critics worry that physician discrimination against patients may result, on the basis of age or other characteristics, as doctors employ a calculus that aims to conserve social resources where the treatment is likely to be “wasted,” as with a short survival rate for an elderly patient.63 This may then reinforce existing biases in medical decisionmaking, particularly negative biases toward the old, or members of stigmatized minorities such as homosexuals.64 This is a legitimate worry in evaluating any cost containment approach.

2. Qualifying the Principle of Strong Beneficence.

Why should we not offer the patient everything that is available in the arsenal of medicine? The parade of horribles presented by the critics in the face of cost containment is enough to terrify even the strong of heart. Yet the job of an ethical analysis is to “explore the terrain,” and search for weaknesses in a principle even while sympathizing with its general thrust. First, even the strongest statement of the principle of beneficence stops short of promising everything. The principle operates within a world of scarce resources from the outset, since even the most expansive statement concludes that everything must be done which is “within the power of the physician.” The first limit on the absolutist statement of the principle of beneficence therefore reflects a world of substantial variation in the tools available to the individual physician. The strong statements of the principle somehow miss this. Levinsky is representative:

62. Id. at 60.
63. Levinsky, supra note 48, at 1574.
64. Id.
Physicians can help control costs by choosing the most economical ways to deliver optimal care to their patients. They can use the least expensive setting, ambulatory or in-patient, in which first-class care can be given. They can eliminate redundant or useless diagnostic procedures ordered because of habit, deficient knowledge, personal financial gain, or the practice of "defensive medicine" to avoid malpractice judgments. 65

The qualifications here are notable: "first-class care;" "optimal care." Levinsky and others simply dodge the cost question while giving it lip service, by telling the physician to make nonchoices. Angell likewise seems to concede a role for physicians in cost containment when she writes that "the profession should take an active role in containing costs, but it should do so without participating in efforts that would deny patients beneficial care." 66 Yet the cloak of "beneficial care" means that Angell likewise dodges the hard decisions as to uncertainties in treatment and statistical medicine.

Second, tests of efficacy and quality of care impose a set of limits that are more important than the ethical maxims and their defenders seem willing to acknowledge. Medical care has costs, not only in the direct financial charges in providing such care, but in the risks of overtreatment, iatrogenic effects, and cascade effects. 67 Failing to think through diagnosis and treatment with these iatrogenic risks in mind raises a serious ethical objection, on a par with violating the specific norm of beneficence to the patient in peril.

Third, patient preferences, protected by the principle of autonomy, are significant constraints on intervention. The advocates of expanded informed consent in medical practice suggest that physicians must learn to share information about treatment uncertainties and the risks of medical interventions with their patients. 68 Such sharing of information is likely, as Jay Katz contends, to lead to a substantial reduction in medical intervention generally. 69

65. Id. at 1575.
66. Id.
67. See Furrow, supra note 7.
69. Katz goes on to observe that:
Acknowledgement of uncertainty about intervention or delay to patients would compel both to share responsibility for the decision ultimately made . . . . Both must learn that there is considerable value in living with uncertainty and not resolving it peremptorily
Fourth, uncertainty in medical practice must be forthrightly acknowledged. The practice of medicine is considerably more complicated than the abstract statements of the ethical model. In many situations, the doctor as "special friend" might well conclude that he should resist a futile desire to continue to treat when further intervention is useless. Even the extreme statement of the duty — that the doctor should let nothing interfere with the patient's interest "in being cured" — suggests the natural limits on such a duty. The uncertainty in much medical practice, the evidence of medical practice variation, the tendencies toward intervention when in doubt — all lead us toward a need to set limits when the possibility of "cure" is uncertain and the costs of intervention to both the patient and others are evident. Jennett aptly sums up these concerns in his five tests for deciding whether to reject a medical intervention, four of which force close scrutiny of the specific treatment by the physician. A treatment should be rejected if it is:

Unnecessary — because the desired objective can be achieved by simpler means . . .

Unsuccessful — because the patient has a condition too advanced to respond to treatment . . .

Unsafe — because the complications outweigh the probable benefit . . .

Unkind — because the quality of life after rescue is not good enough or its duration for long enough to have justified the intervention.

Unwise — because it diverts resources from activities that would yield greater benefits to other unknown patients.70

Only Jennett's last test, "unwise," invokes the principle of justice and the dilemmas of rationing, while the others are tests that the treating physician should legitimately apply in the treatment of each patient.

Fifth, the purity of the strong beneficence model has never even been approached, given the complexity of incentives acting upon both doctor and patient. American doctors may choose whom to serve, based upon ability to pay among

in favor of action.

Id. at 196-197.

other considerations.\textsuperscript{71} Once the relationship is formed, cost is not supposed to enter.\textsuperscript{72} That is, the doctor's economic interests are to be excluded, although the patient's economic status may be important.\textsuperscript{73} A doctor is not expected to pay for medicine or treatment that a patient cannot afford, nor to impose treatment on a patient who refuses it on the basis of an inability to pay.

The role of uncertainty in medical decision making may also lead, as Wennberg reports, to substantial medical practice variation from region to region.\textsuperscript{74} Given the substantial uncertainties surrounding much of medical treatment, physicians who want to provide optimal care are often influenced by forces outside the doctor-patient interaction — primarily the influence of peers and professional leaders, but also effects of commercial sources such as drug and medical equipment companies.\textsuperscript{75} Patient taste and desires, the prices paid and patient resources, as well as clinical need — all shape demand.\textsuperscript{76} Patient demand likewise is a part of the physician's decision as to treatment, and as Eisenberg notes, "[t]o the extent that patient demand can be generated by altering patients' belief, the information that physicians provide patients gives them potential control over the amount and type of patient demand for medical services."\textsuperscript{77}

Optimal care is not just defined by the physician with reference to an ideal static internalized model of good medical treatment. Other influences can be powerful shapers of treatment. The physician's ethical obligation to further the principle of beneficence requires that he or she consciously recognize and sort out the variety of influences on treatment choices and eliminate the improper ones.

\textsuperscript{71} See American Medical Association (AMA), Principles of Medical Ethics § VI (1980), in T. Beauchamp & J. Childress, supra note 28, at 332.

\textsuperscript{72} See, e.g., Levinsky, supra note 48, at 1573.

\textsuperscript{73} See Rosenblatt, supra note 4, at 926 n.43.


\textsuperscript{75} J. Eisenberg, supra note 57, at 68.

\textsuperscript{76} Id.

\textsuperscript{77} Id. at 67.
C. Expanding the Model

1. The changing face of medical practice.

The traditional model need be neither discarded nor rigidly defended. The rationing dilemma will continue to be a real one, but we need to restate the magnitude of the problem. While some physicians chafe at the suggestion of statistical and cost effective medicine, there is surely room for substantial improvement in the analysis of medical care, its benefits and effectiveness.

a. Statistical medicine.

Medical technology is not just machines, but also a way of thinking statistically, of placing the patient in a risk category for a disease, and basing diagnosis and treatment on the behavior of a statistically significant group. The tension between the patient as unique and as member of a statistical pool is inherent in modern clinical medicine. The concept of the patient as unique, a special individual in peril, misses much of a modern medical progress. The patient as a member of a statistical grouping means that the very act of defining and diagnosing the patient's medical problem has moved the patient from a unique being to the status of the member of a class. The ethical model of medical practice has largely

80. Jonsen, supra note 78, at 63. Jonsen writes:
    [a]s physicians think through diagnosis and devise therapy, they do so technologically. This is, of course, an enormous benefit to the patients: their treatment is not based on the random experience and untested intuition of their doctor. At the same time, the certitude of statistical thinking is limited: decisions based upon that thinking depend really on a profoundly moral factor: the risk of being wrong that physicians and patient are able and willing to tolerate. Because many physicians fear that risk, they repudiate the statistical in favor of a "do everything" attack. They are the physicians who will always take the "last ditch" stand, who see no case as hopeless, who will pursue every diagnostic clue regardless of cost. Other physicians, will accept the risk, hew close to the statistical and, in so doing, appear cold and careless of the individual patient.
Id.
81. For a discussion of the patient as a unique entity, a "particular," see Gorovitz & MacIntyre, Toward a Theory of Medical Fallibility, 1 J. MED. & PHIL. 51 (1976).
coincided with the older clinical model of medical practice, which views each patient in isolation in relation to the treating doctor. Statistical medicine poses a sharp ethical problem akin to the rationing problem: with a rationing choice, the patient may get worse because of the use of lower cost care or cheaper drugs; with a statistical analysis, the patient may get worse because he was not treated, or suffered the adverse side effects of treatment, that only a small probability of patients were likely to suffer. Medicine therefore always poses constant ethical tradeoffs. Yet the house of medicine has not collapsed because of physician motivational failures or patient withdrawal of trust. The problem has rather been that clinicians have failed to pay enough attention to probability estimates. Data has often been lacking, or ignored when available. Even when a proponent of a strong beneficence principle recognizes the value of sorting out effective from ineffective practices, or practicing careful statistical medicine, the effect on physicians is viewed as destructive. Thus Veatch writes that “. . . [a]sking physicians to be cost-conscious . . . would be asking them to abandon their central commitment to their patients.”

b. Cost effective medicine.

Cost is always a part of the clinical decision, in the sense that a cost is incurred when a diagnosis is missed or an error results in an injured patient. If a treatment goes badly, it will cost money — to the patient, to the institution, and to the society. The simplest medical decisions inherently involve risk-benefit calculations. Explicit cost-effectiveness calculations of medical technologies are desirable whenever possible. The problems in defining, detecting and eliminating waste and achieving cost-effective calculations are substantial, but the medical model nonetheless will in the long run be enriched by such efforts, just as statistical medicine has enriched clinical practice.

82. See Jonsen, supra note 78.
84. Veatch, supra note 48, at 38.
86. For a detailed discussion of the problems with so-called “waste theory” and medical technology, see Mehlman, Health Care Cost Containment
Doctors need an ethic that factors in cost-effectiveness in deciding when medicine is bad medicine. Such a cost-sensitive approach is essential, as Lester Thurow writes,

not simply because it has absolutely no payoff or because it hurts the patient — but also because the costs are not justified by the marginal benefits . . . . Health-care costs are being treated as if they were largely an economic problem, but they are not. To be solved, they will have to be treated as an ethical problem. 87

The beneficence based model needs to be expanded to account in a rich way for both statistical and cost-effective medicine. The strategy for handling such cost issues has generally been to shift the decisionmaking to the level of macroallocation — how much money should we pay as a society for treatment of certain classes of people, and with what range of tools; 88 or to impose a variety of administrative layers to shield the clinician from the cost considerations. 89 These strategies for extricating physicians from the horns of their rationing dilemma have value; we do need to face resource choices as a society, rather than overloading the doctor who treats the poor with rationing choices. As a stratagem to leave the doctor as a pure clinical decisionmaker, however, they are both doomed to failure and blind to the complexity of bedside decisionmaking.

2. The transition to bureaucratic medicine.

A third amendment to the beneficence model is needed, and the notion of bureaucratic medicine captures it. Most health care is now delivered by physicians within institutions, whether HMOs or hospitals or clinics. 90 This care is paid for by third party insurance, government insurance, or employers. 91 The physician is now subject to a range of direct pres-

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88. See Angell, supra note 51, at 13.
89. See Veatch, supra note 42, at 32.
90. This point has been well discussed by Paul Starr, supra note 2, in discussing the emergence of the modern hospital.
91. This statement is largely accurate for the middle class. By contrast, Rosenblatt notes, "... public insurance for poor patients under the Medicaid program is typically characterized by restrictive eligibility and substandard coverage, reimbursement, and administration." Rosenblatt,
sures and indirect incentives that were foreign to practice thirty years ago. The recent decision in California in the 
Wickline case allows us a chance to test and amend the ethical model of strong beneficence in light of reimbursement cost constraints. The hope is to strengthen the patient-centered model, and narrow the range of difficult rationing cases.

III. Bureaucratic Medicine

Can a doctor ever be held responsible, legally and morally, for choosing a less expensive treatment or a shortened hospital stay, if the patient ends up getting worse because of the doctor's choice? Can the doctor argue cost limitations as a defense, or shift the burden onto the third party payer who denied payment? The case of Wickline v. State presents the tradeoff between cost containment and a clinically desired course of action, looking at prospective utilization review and its downside. The case deserves extended discussion, for it presents both a cross section of the world of bureaucratic medicine and a chance to scrutinize the role of the doctor as the patient’s economic agent and advocate.

A. The Wickline Case

Ms. Wickline had back and leg problems, and in 1976 she was treated by Dr. Daniels, a physician in general family practice. She failed to respond to physical therapy and was admitted to Van Nuys Community Hospital and examined by Dr. Polonsky, a specialist in peripheral vascular surgery. He diagnosed Leriche's Syndrome, a condition caused by obstruction of the terminal aorta due to arteriosclerosis. He recommended surgery. Ms. Wickline was eligible for Medi-Cal, California's medical assistance program. Dr. Daniels submitted a treatment authorization request to Medi-Cal, which authorized the surgery and 10 days of hospitalization. Dr.
Polonsky then performed the surgery, which involved removing a part of Ms. Wickline's artery and substituting a synthetic artery. She then developed a clot and a second operation was required. Her recovery after these two procedures was described as "stormy."

Ms. Wickline was to leave the hospital on January 17, 1977. Dr. Polonsky decided on January 16 however that it was "medically necessary" for her to remain in the hospital for another eight days beyond the scheduled discharge date. He was worried about infection, and also about his ability to respond quickly to any emergency that might develop in her legs. He therefore filed a Medi-Cal form 180. The physician puts on this form the patient's diagnosis, significant history, clinical status and treatment plan, in order to permit the Medi-Cal representative — either an "on-site nurse" and/or the Medi-Cal physician consultant — to evaluate the request. The form as filled out by Dr. Polonsky was complete and accurate, and was signed off by Dr. Daniels and submitted to the nurse responsible for completing such forms. The nurse, Doris Futerman, felt that she should not approve the entire eight-day extension. She therefore telephoned the consultant, Dr. Glassman, who authorized only four days beyond the original discharge date. He could not later recall why, and the form contained no reasons for disapproval by either Futerman or Glassman. After reviewing the form, however, Dr. Glassman indicated that he had rejected the request for several reasons:

. . . there was no information about the patient's temperature which he, thereupon, assumed was normal; nothing was mentioned about the patient's diet, which he then presumed was not a problem; nor was there any information about Wickline's bowel function, which Dr. Glassman then presumed was functioning satisfactorily. Further, the fact that the 180 form noted that Wickline was able to ambulate with help and that whirlpool treatments were to begin that day caused Dr. Glassman to presume that the patient was progressing satisfactorily and was not seriously or critically ill.

He did not consult with a specialist in peripheral vascular surgery before making his decision, although such specialists were available as consultants. The plaintiff argued that Dr.

94. See 228 Cal. Rptr. at 663-64.
95. Id. at 666.
Glassman's decision was based upon irrelevant symptoms, failing to focus on those symptoms that an "ordinary prudent physician" would find relevant.

Doctors Polonsky and Daniels each then wrote discharge orders based on the limited four day extension. As the court described their actions, "[w]hile all three doctors were aware that they could attempt to obtain a further extension of Wickline's hospital stay by telephoning the Medi-Cal consultant to request such an extension, none of them did so." 96

Ms. Wickline was discharged. At the time of her departure from the hospital, her condition appeared stable, with no evidence that her leg was in danger. Dr. Polonsky testified that he felt his hands were tied as to further appeals on his part:

... he felt that Medi-Cal Consultants had the State's interest more in mind than the patient's welfare and that the belief influenced his decision not to request a second extension of Wickline's hospital stay. In addition, he felt that Medi-Cal had the power to tell him, as a treating doctor, when a patient must be discharged from the hospital ... . He testified that had Wickline's condition, in his medical judgment, been critical or in a deteriorating condition on January 21, he would have made some effort to keep her in the hospital beyond that day even if denied authority by Medi-Cal and even if he had to pay her hospital bill himself. 97

The medical experts in the case agreed that Dr. Polonsky was within the standard of practice in discharging Wickline on January 21.

Within a few days of her arrival home, Ms. Wickline had problems with her right leg, which had begun to change color. She was ordered back to the hospital on January 30, nine days after her last discharge. Attempts to save the leg were unsuccessful, and on February 8, Dr. Polonsky amputated Wickline's leg below the knee, to save her life. On February 17, because of the failure to heal, her leg was amputated above the knee. Dr. Polonsky testified that if she had remained in the hospital, he would have observed the leg's change in color, realized that a clot had formed, and ordered her back into surgery to reopen the graft to remove the clot.

96. Id.
97. Id. at 667.
He testified to a reasonable medical certainty that she would not have lost her leg if she had remained in the hospital.

This lengthy recital of facts prefatory to the court's decision reveals that the Medi-Cal consultant took a casual approach to his review, and that the treating physicians acted passively in the face of the initial Medi-Cal rejection. Medi-Cal then argued that the decision to discharge was made by each of the plaintiff's three doctors, and Medi-Cal had no part in the discharge. Both sides agreed that "[t]he decision to discharge is . . . the responsibility of the patient's own treating doctor."  

The chief Medi-Cal consultant testified that if any of the three doctors had filed another request for an extension based upon their determination of medical necessity, such a request would have been given.

The California court held that Medi-Cal could not be responsible, on the facts of the case. Their decision is most interesting for its suggestion as to future liability in prospective utilization review cases. They addressed the obligations of both the treating physicians and the bureaucratic reimbursement reviewers. Their first proposition was that a patient may recover in cases of undertreatment related to reimbursement decisions.

The patient who requires treatment and who is harmed when care which should have been provided is not provided should recover for the injuries suffered from all those responsible for the deprivation of such care, including, when appropriate, health care payers.

The fiscal payers must do their job according to proper careful standards of review.

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

So design and implementation procedures become important in avoiding negligence liability. But the doctor is not off the hook, whether the payer's procedures are well designed or not. The doctor as patient advocate emerges from the deci-

98. Id. at 670.
99. Id.
100. Id. at 670-71.
sion in a central way, an advocate who must tackle the administrators and the payers, in the pursuit of resources for his patient.

However, the physician who complies without protest with the limitations imposed by a third party payer, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient’s care. He cannot point to the health care payer as the liability scapegoat when the consequences of his own determinative medical decisions go sour.\(^{101}\)

Such a role is not a comfortable one for doctors raised in a tradition of unlimited third party reimbursement for medical treatment. The doctors treating Ms. Wickline manifested their discomfort by showing anger and a curious kind of passivity. They said on the one hand that such an “early” discharge was within the realm of reasonable treatment. On the other hand, they said that even if it were not, they were helpless in the face of the bureaucrats.

There is little doubt that Dr. Polonsky was intimidated by the Medi-Cal program but he was not paralyzed by Dr. Glassman’s response nor rendered powerless to act appropriately if other action was required under the circumstances . . . . All the plaintiff’s treating physicians concurred and all the doctors who testified at trial . . . agreed that Dr. Polonsky’s medical decision to discharge Wickline met the standard of care applicable at the time. Medi-Cal was not a party to that medical decision and therefore cannot be held to share in the harm resulting if such decision was negligently made.\(^{102}\)

The court concluded:

. . . what is at issue here is the effect of cost containment programs upon the professional judgment of physicians to prescribe hospital treatment for patients requiring the same. While we recognize, realistically, that cost consciousness has become a permanent feature of the health care system, it is essential that cost limitation programs not be permitted to corrupt medical judgment.\(^{103}\)

What does the court mean, “corrupt medical judgment?”

The court is responding to the ambivalent response of Dr.

\(^{101}\) Id. at 671.

\(^{102}\) Id.

\(^{103}\) Id. at 672.
Polonsky, who could be heard to say that in a world of unlimited reimbursement, he would have kept Ms. Wickline in the hospital for observation for another four days. Since the medical testimony, however, supported Polonsky's concurrence in discharge before a full eight day extension, the State of California was not liable, as a matter of law, for the injuries suffered by Ms. Wickline.

B. Extending the Wickline Case: The Role of the Physician as Patient Advocate

What does this case mean, to the doctor, the patient, and to society? First of all, the court allows clinical judgment to trump cost-oriented discharge judgments by third party payers. But at what point does the marginal benefit from added hospital days cease to outweigh the cost? At least when the medical profession agrees, so that a doctor requesting added time for his patient would not be acting as a reasonable and prudent doctor.

Second, and most important, a physician is expected to be a patient's advocate, trying to squeeze out of tight-fisted payers the level of care which he feels is necessary. He must engage in bureaucratic appeals and negotiation, exhausting rights of appeal when the utilization review process has rejected his recommendation. If he discharges a patient against his better medical judgment when reimbursement was denied, he risks liability for malpractice.

The appellate arguments for the State of California in Wickline suggested that the state designed the reimbursement system with a very conservative bias in the expectation that doctors, acting as patient advocates, would lobby in the tough cases. The attorney general argued in Wickline that the state's prospective review system was constructed with a very conservative mandate, and that doctors were expected to appeal decisions. The assumption was that the provider would always request an extension if the Medi-Cal consulting physician made a mistake.104 This line of argument suggests an

104. The appellate brief for the State of California argued:

In sum, each of the three doctors knew that the consultant was just a "telephone call away." In light of these facts, could not Medi-Cal justifiably assume that the doctor or nurse or hospital charged with the responsibility of acting in the best interests of the patients would always at least telephonically request an extension [reversal of the original Medi-cal decision] when the need arose?

Quoted in Miller, Rationing Care: The Consequences of Cost-Driven Decision
ethical and legal obligation on the physician to provide complete information to the utilization reviewer, and to act as an effective advocate for the patient, seeking approval of care the physician has decided is medically necessary. The evidence of shoddy record keeping in *Wickline* suggests that the review system was premised on the assumption that the attending physician would appeal a denial, and then adequate documentation would be produced and properly considered. This may not be the best way to run a railroad, or a health care reimbursement system, but it does place the doctor in the important role of patient advocate.

Third, if the third-party utilization review body negligently reviews the record and denies payment prospectively, it may be liable for patient harm "when appeals made on a patient's behalf for medical or hospital care are arbitrarily ignored or unreasonably disregarded or overridden." But we have a burden of proof problem at this point. Does the court mean that the third-party payer can be liable only when the initial request is denied, or only when the doctor as patient advocate has pushed further, with documentation, and then a second denial occurs? The liability issues in *Wickline* raise a host of questions beyond the scope of this paper.

The physician, as medical ethics has so passionately stated it, is the agent of the patient. In that capacity it makes sense to demand that he fight the battle with cost-sensitive administrators. This is not a familiar or happy role for most doctors, who have been accustomed under fee-for-service medicine to a free hand in diagnosis, treatment, and hospitalization. *Wickline* is an important decision. Its principles are applicable to any utilization review situation, including hospital implementation of DRG's and third-party insurer prospective review. It reveals judicial lack of sympathy for the argument that cost constraints should easily get a physician off the hook for patient injury, or that sloppy utilization review is tolerable. It also exposes the transition in medical practice—from an autonomous mode of practice for doctors, largely free from external review on grounds of cost—to a period of eroding autonomy in which the doctor as clinician must also be the doctor as advocate and bureaucrat. ¹⁰⁵ As a mem-

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¹⁰⁵. *See* Starr, supra note 2, particularly at 446-48. Starr notes that
ber of a bureaucracy that has its own imperatives of continued survival of the institution, his financial and other personal interests are closely interwoven with those of the medical and reimbursement bureaucracy and its success. Finding an ethical perspective that properly handles the emerging complexity of the physician-patient-institution relationship requires sorting out the various roles of the physician in his or her overlapping universes of decisionmaking, and developing criteria for deciding when one role trumps another. The voices of the medical professional in distress can sidetrack us from the needs of larger society, or even the financial well-being of the health care provider of which the doctor is a part. We need to analyze these roles and test out strategies for best handling cost — quality tradeoffs in medical treatment.

IV. THE OUTLOOK FOR ETHICAL MEDICINE

A. Strategies for Coping with Cost and Quality

Rationing of health care is unavoidable, at all levels, from the political arena to the clinical bedside. Physicians and ethicists often seem to concede this, but then demand that it be done at a level that leaves the physician's motivations unfettered by cost concerns.\textsuperscript{106} Bedside conflicts cannot be avoided, but they can be confronted and minimized through a variety of strategies. I would argue in fact that physician awareness of the whole range of resource and institutional limits on the delivery of care will improve the care delivered. I therefore propose four strategies for physician advocacy in refining the beneficence principle in the world of cost constraints, each one occurring at a different level of decision-making as to resource use.

1. Policy Making — the Physician as Lobbyist.

Major resource allocation decisions are made at the state and federal levels. Government at all levels finances a tremendous variety of health care institutions and programs. In 1985, for example, government spending accounted for $147.5 billion, or 39.7 percent of the total national expendi-

\textsuperscript{106} See, e.g., Veatch, supra note 42, at 38.
tures on personal health care. The design and implementa-
tion of such programs as the DRG system for Medicare
and Medicaid programs for the poor have a major effect
on the resources available to large segments of our popula-
tion for health care services. Major expensive treatment ap-
proaches are typically selected in our society at the level of
legislative appropriations or regulatory approval within ad-
ministrative agencies, as witnessed by federal reimbursement
for kidney dialysis at present and limited coverage of heart
transplants. Certificate of need programs and other regula-
tory approaches have made some equipment or drugs un-
available in the arsenal of diagnosis and treatment. The
federal DRG program likewise constrains the options availa-
ble to hospitals by shifting to them the burden of managing a
limited payment pool, instead of the blank check of earlier


The federal government provides health care to veterans in 172
veterans' hospitals and in the community; to the active and retired
military and their dependents in 168 military hospitals and
through the civilian Health and Medical Program of the Uni-
formed Services (CHAMPUS); to the nearly one million native
Americans in over 600 hospitals, health centers and clinics run by
the Indian Health Service; and to a variety of special groups
through block grants to the states for maternal and child health,
alcohol and drug abuse treatment, mental health, preventive
health, and primary care. States provide health care through
mental and tuberculosis hospitals, university hospitals, aid to the
medically indigent (AMI) and worker's compensation programs.
County and local governments operate local hospitals and AMI
programs. By far the largest public health care programs, how-
ever, are the federal Medicare program, which spent $70.5 billion
dollars on personal health care in 1985, and the state and federal
Medicaid program, which spent $39.8 billion. (602)

Id.

108. For a description of the Diagnosis-Related Groups (DRG) pro-
gram, see id. at 455-464; Phillips & Wineberg, Medicare Prospective Payment:

109. See Health Law, supra note 107, at 602-68.

110. Id. at 672.

111. The Certificate of Need programs were a primary tool of health
planning, which aimed to constrain the supply of health care resources.
The federal government has largely abandoned health planning and the
CON programs, but in several states it is still active. See generally P. Joskow,
Controlling Hospital Costs: The Role of Government Regulation 76-
99 (1981); Salkever & Bice, The Impact of Certificate-of-Need Controls on Hos-
pital Investment, in Economics and Health Care 294 (J.B. McKinlay ed.
reimbursement structures. Some procedures, such as organ transplants, have been handled as experimental, and therefore controlled at least partially through a licensing approach where medical devices are involved. Once such policies are set, the pressures on the clinician are relieved, and he can say, "I will treat you with all the resources within my power, but I lack certain powers." These constraints are preexisting and he is not forced to withhold them on a case-by-case basis. But the physician can work to expand the arsenal of treatment choices by lobbying at the legislative level. Doctors have shown a willingness to politicize the tort liability system by aggressive lobbying for malpractice reform. The same energy directed toward fair policies of treatment, research and financing would be well spent. Physicians are often skeptical that money saved in one area of medical practice through stringent medical cost cutting and careful management will


New surgical procedures and treatments, such as those developed for organ transplantation, fall into a regulatory gap. Human experimentation may be subject to regulation by the Department of Health and in whole or part by the federal government. These regulations require that the institution sponsoring the research create Institutional Review Boards (IRBs). These IRBs evaluate the research to determine whether human subjects might be "at risk" and if so, how to protect them. See 45 C.F.R. § 46.101 (1985). If the institution does not receive federal funds nor use a medical device of a new or experimental sort, then clinical experimentation may proceed without any sort of government scrutiny.

114. Fried makes a useful point: the physician represents one level of obligation; the bureaucrat another.

Since the department of health, the legislature, and maybe even the director of the hospital do not have the kind of personal relations with patients that call into being the rights in personal care, respecting these rights is not a constraint upon persons at that level. Since administrators and bureaucrats are dealing in large, impersonal statistical groups, the primary moral norms applicable to relations with such abstract entities are precisely those of efficiency and justice. To be sure, planners and bureaucrats must not direct individual physicians to violate personal rights, but questions about the enjoyment of those rights can only be determined rationally on norms of efficiency and equity.

be diverted to other social uses than health care. They may disagree with congressional or regulatory choices made. They must therefore operate as lobbyists.115


Most clinical policies are established in a decentralized way by a flow of reports in the medical literature, at medical meetings, and in peer discussions.116 This process may lead to the proliferation of new technologies and treatments before adequate proof of effectiveness is in.117 Where consensus is lacking, medical practices vary widely, with adverse implications for the cost of care.118 Morreim proposes a collective enterprise wherein physicians "share information and ideas concerning the best ways to revise their routine medical practice."119 This suggests the need for medical education and professional efforts at standard setting, attempting to define quality treatment as effective treatment, thereby trimming certain unproven or marginally effective but costly procedures. Doctors should be pressured toward discriminating use of high-cost high technologies, particularly of diagnosis. We know that the costs of diagnostic tools may add up to as much as one quarter of total hospital costs and a substantial portion of ambulatory care costs.120 Clinical decisionmaking needs to move toward quantitative approaches that give the physician the ability to compare and assess the necessity of various diagnostic interventions.121 Morreim hopes that such a protocol revision approach will help to identify the basic effective elements of good care, so that physicians "will be able to tell us when we must confront genuine scarcity."122 The physician

115. Fried talks of the professional as citizen, with obligations to lobby for values he holds dear. See Fried, supra note 54. Angell proposes that the medical profession "should certainly be involved in informing debates over health policy." See Angell, supra note 51, at 13.
118. Wennberg, supra note 74, at 7.
121. Id.
122. Morreim, supra note 119, at 37.
as specialist needs to be conscious of the origins and justifications of medical standards of care, in order to select the proper approaches.

3. Local Administrative Practices — The Physician as Bureaucrat.

The practice of medicine within institutions is subject to substantial scrutiny by hospital administrators and by the hospital committee structure mandated by the Joint Commission on the Accreditation of Hospitals.\(^{123}\) Utilization review committees, such as Professional Review Organizations (PROs) organized under the Medicare program to control cost while improving quality, view costly overutilization of tests and hospitalization as directly related to bad medicine. Professional Review Organizations are under contract with the federal government to evaluate institutions serving Medicare populations (as most hospitals do).\(^{124}\) Internal staff review committees are also proving sensitive to costly procedures. Thus in Knapp v. Palos Community Hosp.,\(^{125}\) a hospital denied reappointment to a staff physician after the doctor’s peers on a utilization review committee determined that a pattern of excessive use of lung scans, medications, tests, pacemakers and pulmonary angiograms existed, and that the excessive testing resulted in both poor quality care and in 30 percent higher costs to the institution. The staff privilege cases often reflect peer sensitivity to the cost-quality interface in the evaluation of peer conduct within institutions. Studies have shown the importance of physicians and administrators working together in the decision-making process, in order to bring together concerns for both costs and quality.\(^{126}\) Greater physician involvement in hospital decisionmaking has been linked to lower costs . . . and higher quality of care.\(^{127}\) The more

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123. The Joint Commission on the Accreditation of Hospitals (JCAH) accredits eighty percent of the hospitals in the United States. See supra note 107, at 345. It establishes standards for the conduct and organization of the accredited hospital’s medical staff. See The Accreditation Manual of the Joint Commission on Accreditation, Medical Staff, Standard 10.1 (1986).

124. The PRO statute is 42 U.S.C.A. §§ 1320c-1320c-12. For a good discussion, with portions of a PRO contract, see Health Law, supra note 107, at 420-35.


127. Shortell, Physician Involvement in Hospital Decision Making, in The
aware physicians are of the decisionmaking process within a health care institution, and its performance generally, the lower the costs in specific medical departments. Schroeder summarizes studies during the 1980’s which concluded that “greater physician participation in hospital decision making is positively associated with higher quality of care, as measured by such indicators as severity-adjusted death rates and postsurgical complication rates.” Shared collaborative decision-making models within the hospital hold out promise for improving both efficiency and quality. Clinical participation in bureaucratic decisionmaking does not come easy to physicians who are used to a perpetual state of hostility with administrators. Consideration of administrative and cost concerns is equally disquieting. But the evidence, even though tentative, suggests that collaboration may reduce rather than intensify the ethical dilemmas feared by clinicians. The goal is enhanced physician consciousness of how health care is delivered within the institution. Any principle of beneficence requires full awareness of what works for the patient, how it works, and what it costs compared to other approaches.

4. Clinical Applications — The Physician as Advocate.

Strategies one through three may minimize or avoid the ethical dilemmas posed early in this article. They present the physician as citizen, as specialist, and as peer collaborating in hospital decisions, through existing committees and other arrangements. Strategy four places the physician in the clinic, testing the limits of the strong beneficence principle in the face of bureaucratic medicine. The physician as clinical advocate has several audiences: peers, patients, and the bureaucracy (now also increasingly made up of peers).

Such advocacy forces acknowledgement of the conflicts in medical practice, rather than trying to conceal the conflicts by moving them to other levels of decisionmaking. Physician motivation in a patient-centered model may be conflicting, but the conflict is better out in the open for examination and discussion. The flaw in the model of strong beneficence is the assumption that clinical medicine is improved by putting blinders on the doctor. The evidence — from studies of in-

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128. Id. at 91.
129. Id.
formed consent, the diffusion of medical practice variation — is that the physician may practice better medicine, even if his anxiety level is higher, by facing all of the uncertainties and conflicts inherent in modern bureaucratic medicine. At least the fight is out in the open.

B. The Principle of Advocacy Beneficence

The Wickline case presents the tension between beneficence and justice most sharply. To what extent is it the duty of the physician to the society of which he is a member to consider the effect of his decisions on social resources? The case places us in the middle of a microallocation problem. A routine procedure (as compared to an experimental one) is performed, and the allocation issue is solely length of hospitalization. Over large numbers of patients, excess hospitalization drains resources away from other uses. Should the doctor be able to argue cost constraints in this case? Should he keep the costs of excess hospital use in mind as he evaluates a treatment decision for a specific patient? It is preferable, as Veatch has argued, not to ask the physician to directly trade off patient welfare and social resource use. However, the four strategies I have proposed avoid this direct trade-off whenever possible. The macroallocation issues are handled at the political level, with the physician as lobbyist advocating his perspective. The cost-efficacy issues are handled at the specialty level, through more systematic protocol setting. The treatment alternatives are handled at the institutional level, with a collaborative decisionmaking model allowing doctors and administrators to advocate their interests and justify their positions. The cost issues at the bedside will remain, but if the physician as lobbyist, specialist and committee member has been involved in standard setting, then he may be better able to live with the treatment choices. If not, he is the clinician as advocate, aware of the reimbursement structure and

133. See Fried, supra note 54, for the argument that the professional, whether lawyer or doctor, must focus only on his client's, or patient's, interests.
134. Veatch, supra note 41, at 38.
capable of energetically advocating his client's interests, in contrast to Dr. Polonsky's failure to advocate Ms. Wickline's. A spirit of advocacy replaces the physician passivity described in *Wickline*, if the doctor learns to acknowledge that he is part of the whole apparatus of health care delivery, and not the solitary and autonomous clinical decisionmaker.

Consider the facts of *Wickline*. The patient is qualified to receive reimbursement, as an eligible Medi-Cal patient. The doctor faces uncertainty in treatment, after the second operation, and would like the patient to spend extra time in the hospital. Consider the following hypothetical encounter between physician and patient.

"Ms. Wickline, your leg seems to be okay now, but we can never be sure with these cases. It's important that we keep an eye on it for possible infection, impairment of blood flow, or other problems. Unfortunately, your Medi-Cal benefits are up tomorrow, and after that you have to stay in the hospital at your expense."

"Dr. Polonsky, what should I do?"

What choices can Dr. Polonsky now offer Ms. Wickline? First, he must be her advocate, as Donabedian suggests, helping her search for every form of payment within her grasp if he feels strongly that further observation is needed. He must therefore practice bureaucratic medicine, learning the byways of reimbursement politics and the mechanisms by which he can push the system in a problem case. But this does not mean simply manipulating or gaming the system. It means working collaboratively, following strategy three, to convince others to change policies that have placed him in the present dilemma. He must advocate, convince, before he can prevail. Second, he can further the principle of autonomy by discussing the risks fully with her. Katz' interactive model of informed consent would require Dr. Polonsky to share medical uncertainty with Ms. Wickline. Dr. Polonsky in *Wickline* was practicing statistical medicine, in which Ms. Wickline stood a low probability chance of a complication, given her stormy recovery. If he is really up against the cold stone wall of reimbursement cutoff, it may be that she will herself try to pay for extended hospitalization. He may teach her to observe her own condition and learn the signs and symptoms of a developing problem. Or he can help to arrange for a cheaper home health care arrangement to follow up her problem.\(^{135}\)

\(^{135}\) Patient choice can be advanced through a variety of mechanisms...
We can still imagine cases in which the doctor as advocate fails to convince the payer that the extra care was necessary; the patient is unable to pay for it out of pocket; no alternatives are available; and the patient suffers. If the standard of medical practice supported the doctor’s position, then the payer was at fault, acting in a fashion flawed both ethically and legally. If the doctor was practicing aggressive medicine, wanting to do all that was possible, even though his peers would have taken the small chance of adverse side effects by doing nothing, then it is not clear that the institution has violated the principle of beneficence by tying his hands. The doctor in this case may have to live with statistical medicine, recognizing that conservative (and lower cost) approaches may sometimes produce bad results. But so may too much medical intervention.136

CONCLUSION

Beneficence requires a far more complicated look at the nature of medical practice, its costs and benefits, and more active involvement by physicians in the process of setting both medical and reimbursement standards. The principle of beneficence remains as the cornerstone of the doctor-patient relationship, as it should. We must however be careful not to confuse an eroding concept of medical autonomy, the clinician in splendid isolation with the patient, with legitimate justifications of beneficence. Beneficence means helping the patient, and the version of advocacy beneficence presented here requires more peer involvement and bureaucratic collaboration than older versions of the principle allow. And yet, as the world of health care delivery changes, so must the principle of beneficence. It may be that the patients will come out of the transition to bureaucratic medicine better off than we have expected, if physicians are willing advocates for their patients and collaborators with the bureaucracy of which they are, after all, an essential part.
