A Cure for What Ails? Why the Medical Advocate is Not the Answer to Problems in the Doctor-Patient Relationship

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A CURE FOR WHAT AILS?
WHY THE MEDICAL ADVOCATE IS NOT THE ANSWER TO PROBLEMS IN THE DOCTOR-PATIENT RELATIONSHIP

SUSAN L. GOLDBERG

I. INTRODUCTION

The idealized view of the doctor-patient relationship consisted of a beneficent doctor in a longstanding relationship with a single patient. Financial considerations, third-party payors, resource allocation issues, and conflicting obligations did not exist. The doctor practiced medicine to the best of his ability, in furtherance of the best interests of his patients, according to the Hippocratic oath. There is certainly doubt as to whether this dream version of medical practice ever actually existed.

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1. Emanuel and Dubler have written about the ideal physician-patient relationship as the culmination of six elements: "[c]hoice, competence, communication, compassion, continuity, and (no) conflict of interest." Ezekiel J. Emanuel & Nancy N. Dubler, Preserving the Physician-Patient Relationship in the Era of Managed Care, 273 JAMA 323, 323 (1995). They use these criteria to assess the changes which have been developing in the U.S. health care system. Since approximately 37 million Americans are currently uninsured, for some Americans, managed care holds the potential for improving the physician-patient relationship by allowing them greater access to physicians. Id. at 323.

2. Physicians must keep patient confidentiality, avoid mischief, and give no harmful or death causing remedies. See Ethical Issues in Managed Care, 273 JAMA 330, 331 (1995). In its report on Ethical Issues in Managed Care, the Council on Ethical and Judicial Affairs, American Medical Association points out that in the Hippocratic Oath "trust is a central element in almost all the ethical obligations of physicians." Id. at 331. However, medical practice under Hippocrates also condoned concealing information from the patient. See RUTH MACKLIN, ENEMIES OF PATIENTS 7 (1993).

3. See Barry R. Furrow, The Ethics of Cost-Containment: Bureaucratic Medicine and the Doctor as Patient Advocate, 3 J. L. ETHICS & PUB. POL’Y 187, 191-93 (1988). Financial conflicts of interest existed under fee for service payment plans, and physicians had incentives to over-utilize testing in order to maximize reimbursement. Carolyn M. Clancy & Howard Brody, Comment, Managed Care: Jekyll or Hyde?, 273 JAMA 338 (1995). Under fee for service plans, many individuals were uninsured and did not have access to medical care. One estimate put the number of uninsured Americans at 36.6 million in 1991. Number of Uninsured Persons Increases to 36.6 Million in 1991, 7 DAILY LAB. REP.
However, today's medical practice has become increasingly complex and for many patients radically departs from earlier visions of the benevolent solo practitioner. Medical advancements have led to a variety of diagnostic and treatment options which have made medicine appear to be increasingly technical in its practice. The structure of medical practice is also drastically changing. Spiraling costs have led to a dramatic increase in the number of managed care plans. Proposals for universal health care and other health care reforms occupied the national agenda for a time during the last congressional term, bringing issues of health care to the nation's attention. Although no

(BNA) ¶ A-11 (1993). The "old" view of physician practice also gave rise to abuses of discretion such as withholding of diagnosis. See Macklin, supra note 2, at 7.

4. See SHERWIN NULAND, HOW WE DIE: REFLECTIONS ON LIFE'S FINAL CHAPTER 10 (1994). Sherwin Nuland eloquently describes some of the changes technology has brought to the inevitable process of dying. Nuland also notes that despite technological advancements, medicine is still not an exact science. Id.


6. See Clancy & Brody, supra note 3, at 338. Emanuel & Dubler, supra note 1, at 323. Holleman et al., identified a variety of third party payors, including employers, the government via public assistance programs, and schools. Holleman et al., supra note 5, at 113.

Almost 14% of the gross national product went toward health care costs in 1992, resulting in expenditures of more than 800 billion in 1992. Lawrence O. Gostin, Health Care Reform in the United States, 21 J.L. MED. & ETHICS 6,7 (1993). If current projections are correct, by the year 2000 health care costs will exceed 1.6 trillion dollars. Id.

reform bills were passed, many changes in physician practice have occurred, in part, as a result of the congressional focus on health care matters. These changes in physician practice and the delivery of health care have led to an increased attention to perceived conflicts of interest between the physician and the patient. Proposals to eliminate conflicts which may undermine quality patient care have been developed by a number of authors.

II. CONFLICTS OF INTERESTS

In reality, conflicts of interests between the doctor and patient are not new. Under traditional fee for service plans, doctors had incentives to over-test and over-treat, because payment was based on the number of services provided. Doctors, paid by patients on the basis of office visits

8. Emanuel & Dubler, supra note 1, at 326. However, these changes are not by the decision of medical practitioners, but by employers seeking to reduce the costs of health care. Id.

9. Clancy and Brody have divided managed care into two types, Jekyll Care and Hyde Care. The former enhances physician-patient relationships and good management of health care costs. The latter is used to identify plans which use methods which undermine doctor patient relationships and quality care. Clancy & Brody, supra note 3, at 338. Clancy and Brody include cost controls achieved by exclusion of sick patients, "rationing by inconvenience" over intensive review of treatment decisions and "perverse incentives" among the tools of Hyde Care. Id.

10. See, e.g., Ethical Issues in Managed Care, supra note 2, at 3. In order to prevent self-referrals to physician owned laboratories, a number of states are trying to address the problems of self referrals. See Carol Michna, Note, The Patient Has Not Been Informed: A Proposal for a Physician Conflict of Interest Law, 27 VAL. U. L. REV. 495, 506 (1993).

One report concluded that physicians must place patient welfare first, and in order to protect patients, all relevant financial inducements and restrictions on physicians created by their contracts had to be disclosed if they could affect the delivery of health care to patients. Ethical Issues in Managed Care, supra note 2, at 333 (discussing a variety of conflicts and presents guidelines for physician practice). The Report notes that "by creating conflicting loyalties for the physician, some of the techniques of managed care can undermine the physician's fundamental obligation to serve as patient advocate." Id. at 331.


12. See Ethical Issues in Managed Care, supra note 2, at 333. "[F]inancial conflicts are inherent in the practice of medicine, regardless of the system of delivery, and physicians generally have been able to maintain their duty to patient welfare despite those conflicts. However, incentives to limit care are more problematic than incentives to provide care." Id.
and tests performed, had direct financial incentives to have patients return for additional office visits and tests. Doctors’ fear of malpractice claims have also been a driving force of over-utilization of services as doctors increasingly practice defensive medicine, order every conceivable test, and abandon high risk specialties altogether.13

In addition to conflicts of interest created by financial reimbursement systems, other conflicts of interest have long been a part of our medical service delivery structure. Some doctors held financial interests in laboratories which led them to refer patients to particular facilities and may have led to over-utilization of diagnostic testing.14 Doctors have always had obligations to society at-large concerning public health, and sometimes these obligations could be viewed as conflicting with patients’ interests. For example, mandated reporting of some sexually transmitted diseases overrides patient confidentiality but is required by state laws.15 Scarcity of resources has always existed in medicine, whether the resource in question was a hospital bed in the critical care unit, an organ needed by more than one matching potential recipient, or the limited number of medical personnel available in the emergency room.16 Some of these scarcities are based on irremediable shortages unrelated to financial decisions, but many are the result of a decision to allocate funds (limited


14. See generally RODWIN, supra note 11, at 67-71 (discussing the risks and problems inherent in physician investment and self referral).

15. MACKLIN, supra note 2, at 22. However, as Macklin correctly observes, these reporting obligations stem from the duty to protect public health and safety, while conflicts today are often derived from more ambiguous obligations to society, which do not necessarily have the promotion of public health or safety at their core. Id. at 22-23. Holleman et al., include family members and employers as the sources of additional intrusions into the doctor patient relationship. Holleman et al., supra note 5, at 113.

16. MACKLIN, supra note 2, at 116, 153. Macklin observes that: [It is a common mistake to confuse expensive resources with genuinely scarce resources. The motivation for seeking a fair means of allocating scarce resources is to achieve justice in distribution. The motivation for controlling the use of expensive resources is to limit costs. If money saved by rationing costly services actually succeeded in being reallocated to other patients in greater need, that could be justified by a principle of fair allocation of resources. But the way our health care system is structured, such reallocations simply do not occur. Id. at 155. I am not sure that I totally agree with Macklin’s pessimistic conclusion. In many health maintenance organizations, expensive treatments may be "rationed" or excluded from coverage as a trade-off for expanded preventive care.
resources in and of themselves) in a certain way. Holleman, Edwards and Matson have called some of these other obligations held by physicians "concomitant obligations" rather than conflicts of interest. In their view, physicians' legitimate obligations to others do not necessarily detract from patient care and need to be balanced with patient interests.

Haavi Morreim, in writing of changes in the health care system, argues that third party payors "are not 'intruders' into the health care relationship. They are intimately a part of it. If the physician-patient relationship was once a simple dyad, this was only because the times, and medicine itself, were simpler." 

17. Holleman et al., supra note 5, at 114. See also Ethical Issues in Managed Care, supra note 2. "Physicians make cost benefit judgements every day as a part of their professional responsibility in treating patients. It is unethical to knowingly provide unnecessary care or to be wasteful in providing needed care." Id. at 332. However, the focus on costs mandated by managed care has complicated the physician's role as de facto gatekeeper. The Council of Ethical Judicial Affairs of the AMA quotes Edmund Pellegrino, who believes the view of the doctor as a gatekeeper is an inappropriate physician role because of the conflict it creates between the doctor's obligations to the patient and to society at large. Id. at 332 (citing E. Pellegrino, Rationing Health Care: The Ethics of Medical Gatekeeping, 2 J. CONT. HEALTH L. & POL'Y 23 (1986)). The Council report accepts the doctor's role in conserving societal resources as legitimate and important, but cautions that the primary responsibility of the physician must be to the patient. Ethical Issues in Managed Health Care, supra note 2, at 332.

18. Holleman et al., supra note 5, at 116. The authors determine whether the demands of third parties are legitimate by examining these factors: 1) is the integrity of the medical profession at risk; 2) are budgetary considerations being examined with human values in mind; 3) are there gender, race, or age biases involved; 4) are employment fitness related questions directed to physicians accompanied by legitimate job criteria upon which physicians can make valid assessments; and finally 5) do the third parties force doctors to make judgements based on economics instead of upon good medicine? Id.


In the past, insurance companies generously reimbursed for medically necessary treatment without applying any independent judgement of what care was appropriate under the circumstances. Haavi Morreim describes three kinds of institutional payors of health care: private insurance companies, governmental entities and businesses. MORREIM, supra, at 24-26. These payors contract with an increasing variety of service entities to provide health care to insured individuals. Institutional providers include hospitals, HMOs (which also act as business payors as well) and independent practice corporations. Under this latter formulation, physicians incorporate and contract with insurance companies to provide services for fixed fees. Preferred Provider Organizations broker services provided by physicians to insurers and other purchasers. Id. at 28.
As practice patterns have changed, powerful new potential conflicts have arisen, and the nature and pervasiveness of the current conflicts of interest make it difficult to ignore their potential impact on patient care. As a result of changes in practice affiliations, many physicians now feel pressures from their employers to limit referrals, reduce expensive diagnostic testing and refrain from utilizing costly treatment modalities. At times, direct economic benefits from reducing care are built into the physician payment system as incentives. These financial incentives are tied both to the physician's compensation and to the financial well being of the organization. These direct economic incentives have led to allegations that doctors face financial conflicts which may cause them to inappropriately limit care. Doctors may limit care in a number of ways. Doctors may adopt a "wait and see" approach before initiating diagnostic testing in an effort to preserve financial incentives. They may recommend less costly modes of treatment which may be less effective or may have greater risks or side effects. Primary care doctors may defer referral to specialists in an effort to keep costs down. More subtly, the existence of financial incentives may serve to undermine physician credibility by raising patient doubts about physician motivations, thereby reducing patient trust in the physician.


Managed Care Plans constrain the costs of participating physician practices in several ways: [they] may restrict the ability of physicians to perform certain procedures or to order certain medications or diagnostic tests . . . and Managed Care Plans aggressively use programs of utilization review to detect what they consider medically inappropriate or unnecessarily costly practice patterns. *Id.* at 330.

21. Some plans withhold a percentage of physician salary and allocate this percentage based on how well she restricts access to expensive treatment. *Ethical Issues in Managed Care*, supra note 2, at 331.

Bonus money may be tied to the reduction in use of expensive diagnostic testing, with "the amount of the bonus increasing as the plans' expenditures for patient care decrease." *Id.* For a discussion of physician obligations to patients and the issues raised by health care reforms, Wolf, *supra* note 11.

22. *Ethical Issues in Managed Care*, supra note 2, at 333.

23. *Id.* at 331. "Moreover, in their zeal to control utilization, managed care plans may withhold appropriate diagnostic procedures or treatment modalities for patients. Indeed, the US Department of Health and Human Services recently expressed concerns about practices at a major HMO after receiving eight allegations of insufficient patient care." *Id.*

24. See *id.* at 333.

25. *Id.*
Indirect incentives also exist which may affect the physician's practice patterns.\textsuperscript{26} When hospital privileges, continued employment, and bonuses are based on the doctor's success as a fiscal gatekeeper, these indirect pressures may be powerful. The conflicts physicians face vis-a-vis their other patients have also become starker under some managed care plans as physicians realize that one referral for expensive treatment might preclude another such referral in the future, because only a fixed number of referrals are available.\textsuperscript{27} Incentives to limit care are particularly problematic, because the patient often lacks the medical expertise to recognize that particular alternatives were not explored or offered.\textsuperscript{28} Under the fee for service payment system, over-utilization of services had financial ramifications resulting in additional fees generated by unnecessary services rendered. Pressures to reduce services under managed care may have an effect on patient health instead of finances.\textsuperscript{29} As a result, increased attention is directed toward minimizing, if not eliminating, the conflicts which may compromise patient care.

### III. THE MEDICAL ADVOCATE PROPOSAL

\textsuperscript{26} Indirect incentives include employers limiting the raises or promotions of physicians who fail to act in furtherance of the institution's interests. \textit{Rodwin, supra} note 11, at 137. Rodwin notes that indirect incentives are pervasive, difficult to uncover and assess, and nearly impossible to eliminate. \textit{Id.}

\textsuperscript{27} \textit{Ethical Issues in Managed Care, supra} note 2, at 331. To protect patients, the Council report urges that doctors not engage in bedside rationing. \textit{Id.} at 332. To that end, the report recommends that allocation decisions be made at the policy level via the development of guidelines. \textit{Id.} Then, in representing individual patients, doctors could look to the guidelines, and advocate on a patient's behalf "in any case in which material benefit to a particular patient would result." \textit{Id.}

\textsuperscript{28} \textit{Ethical Issues in Managed Care, supra} note 2, at 333.

\textsuperscript{29} \textit{See} David Orentlicher, \textit{Health Care Reform and the Patient-Physician Relationship}, 5 J.L. \& MED. 141, 161 (1995).

The primary harm from excessive care is financial, but the current system of health care insurance dilutes the financial harm to patients of overuse of services. Since patients do not pay the full cost of excessive care, they do not have a strong incentive to ensure that they do not receive unnecessary care. As a result, physicians and patients may not be very sensitive to the harm of financial incentives to expand care. However, if necessary care is withheld, the primary harm is physical, and patients will feel the harm fully and directly. Accordingly, physicians and patients are likely to be very sensitive to the potential harm from incentives to limit care.

\textit{Id.}
Max Mehlman believes that a new, independent profession of medical advocates hired by patients is necessary to ensure that adequate representation and assistance are available for patients. He envisions teams of advocates, coming from different disciplines, that would be licensed to serve as patient representatives in order to make the system work as well as possible for the individual patient. In addition to assisting patients by providing information, advocates could help determine available benefits, review treatment alternatives, review records, accompany the patient for testing and office visits if necessary, and advocate on the patient's behalf in order to obtain maximum allowable benefits. Under certain circumstances, Mehlman would allow the medical advocate to act on the patient's behalf, even when the patient is not present. After care is provided, the advocate could review records to


31. Maxwell J. Mehlman, The Patient-Physician Relationship in an Era of Scarce Resources: Is There a Duty to Treat?, 25 CONN. L. REV. 349 (1993). Mehlman recognizes that patient advocates have existed within health care systems in the forms of social workers and ombudsmen, but he believes that these actors can no longer effectively protect patients because they are either subject to conflicts of interests themselves, or are relatively powerless actors within the system who are ineffective in representing patients in the face of bureaucratic denials of care.

In a 1989 commentary appearing in Journal of the American Medical Association, Dr. Condict Moore proposed a patient advocacy system which would utilize senior physicians to provide expertise in their particular fields of medicine. Condict Moore, Need for a Patient Advocate, 262 JAMA 259 (1989). The advocate would consult only with the patient for a limited time and would be "committed to advising patients how to receive the best medical care available with their particular personal desires, with the resources and facilities open to them." In Moore's view, the advocate would not "pose a threat to the family physician's relation with the patient." Moore advocated a modest hourly fee, without involvement of third party payors. In his view, the establishment of a physician advocate recognizes the existence of conflicts of interest, protects patients and ensures the continuation of the primary physician's pivotal role in American medicine. Id. at 260. While Moore's proposal does not avoid all of the pitfalls of Mehlman's independent medical advocate profession, his proposal addresses some concerns. The educational focus of Moore's proposal is meant to strengthen the patient's faith in his physician rather than to foster distrust, and the limited nature of the consultation appears to ensure that the concerns raised in parts IV, a-h, infra are minimized.

32. Mehlman, Medical Advocates, supra note 30, at 321. In some respects the team oriented approach to patient care mirrors the process of team assignments currently being adopted in many hospitals. Doctors, nurses, social workers, and lawyers are among the professionals Mehlman envisions as suitable for medical advocates.

33. Id.
ensure the treatment meets acceptable levels of care.34 If the medical care was not acceptable to the patient, the medical advocate could pursue administrative remedies available through governmental review bodies. If the advocate perceived that there had been under-service or malpractice, the patient would be told of the problems,35 and the advocate could suggest an attorney if the patient wished to file a malpractice suit.36

According to Mehlman, advocates could be paid either fixed or hourly rates for their services. In order to pay for the services of a medical advocate, patients could join organizations and pay dues which would entitle them to the services of an advocate if the need arose.37 Indigent patients could be represented by medical advocates funded under a system like legal services. According to Mehlman, if funding is not available from the government, "there is still no reason why the profession should not be formed to provide services to those who can pay for them, any more than the fact that legal services are not available equally to all should prevent there from being lawyers for those who can afford them."38

IV. WHY THE MEDICAL ADVOCATE IS NOT THE ANSWER TO DOCTOR-PATIENT CONFLICTS

In light of the pervasive nature of pressures on physicians to act as gatekeepers in reducing care, the economic incentives and disincentives they face, the increasingly complex nature of medical technology, and the ever expanding bureaucracy involved in managed care, the idea of an independent patient advocate is initially appealing. The patient appears to have been lost in the struggle to contain costs. The loss of autonomy suffered by the doctor pales in comparison to the potential effects on

34. Id.
35. Id.
36. Id. If attorneys were part of the advocacy team, the "referral" might actually be to another member of the group, which could create conflicts of interest and problems associated with self-referrals in medical testing and treatment.
37. The model for this type of association might be AAA, where payment of the annual fee entitles members to certain roadside services, towing, maps, and other travel planning services.
38. Mehlman notes that the lack of advocates for the poor could result in resources allocated to the poor being taken by those who have advocates to fight for additional care. While health care plans for the poor remain separate, this does not seem as likely to occur as if health care programs for the poor and wealthy were combined. Mehlman, Medical Advocates, supra note 30, at 322.
patient care. The patient seems to have become a pawn in the managed care plans’ quests for profits, and patient care (and potentially the patient herself) seems to be expendable. However, in spite of the initial appeal of the proposal for a medical advocate, there are a number of concerns about the establishment of a new profession of medical advocates. While the problems in medical care delivery have been exacerbated by changes in the structure of the delivery system, adding another actor to the system whose sole role is to advocate on behalf of a solitary patient is not the solution.

A. Legitimizing Conflicts and Abdicating Responsibilities

By introducing a third party, we implicitly accept that the doctor cannot maintain the duty of loyalty to the patient and, in essence, we communicate that it is no longer critical that a physician try to avoid conflicts. Instead of taking the moral high road by requiring patient primacy, the existence of the medical advocate would allow the physician to abdicate the responsibility to avoid conflicts. The advocate would become the fiduciary to the patient, sending the message that the physician has been absolved of this obligation.39 Creating a new profession will have the effect of legitimizing conflicts of interest which should not be accepted in medical practice.40 If the system has deteriorated to this point, then it is unworkable, because doctors would be no longer treating patients according to acceptable norms of care. While all is not well in the medical delivery system, we have not reached this crisis point yet. Doctors still view themselves as advocates for patients, and are motivated by patients’ best interests.

However, we do need to have a more realistic view of the doctor-patient relationship to acknowledge that "insurers" may place limits on what doctors can provide.41 Doctors, according to E. Haavi Morreim,

39. E. Haavi Morreim, Gaming the System: Dodging the Rules, Ruling the Dodgers, 151 ARCHIVES INTERNAL MED. 443, 446 (1991). This would result, in part, because of the role of the "advocate". Id.

40. MACKLIN, supra note 2, at 3. Macklin points out that physicians have traditionally been trained to act as patient advocates. In discussing how incentives can undermine informed consent, Rodwin states, "suspicion alone weakens the informed consent process, for it requires communication, cooperation, and trust between patient and physician. If patients doubt the neutrality of their doctors, that process is impaired." RODWIN, supra note 11, at 153.

owe a duty of loyalty, care, and competence. These are the skills which patients seek in physicians and which physicians have the ability and obligation to provide. However, it is wrong to expect that doctors will be able to deliver that which is not theirs, the resources of care which are controlled by the managed care provider and which are allocated according to the contractual relationship with each patient. Doctors should discuss the economic ramifications of treatment decisions with patients and should advocate to appeals boards if coverage the doctor believes is beneficial is denied. It is not necessarily a conflict of interest on the part of the physician to be unable to provide these resources to the patient.

Doctors do have an obligation to act on behalf of their patients and to advocate for them. According to Susan Wolf, doctors may be the most appropriate advocate for the patient because the physician knows the patient’s medical background and wishes, thus enabling the doctor to explain to others why a particular treatment is appropriate under the circumstances. The patient places trust in the doctor, upon whose expertise the patient relies. This creates fiduciary obligations which include the responsibility to act as the patient’s advocate.

B. Institutionalizing Adversarial Roles

Creating an independent medical advocate may have the effect of making all doctor-patient relationships adversarial from their inception. The term advocate sometimes carries an adversarial connotation.

42. Morreim, supra note 39, at 446.
43. Id. at 446.
44. Id. at 445-46. Morreim notes that a physician’s inclination to "correct" the contract between patient and insurer solely because he personally has judged it to be inadequate "is misguided and has the effect of undermining contractual relationships" and is "an invitation to economic anarchy." Id. See also Ethical Issues in Managed Care, supra note 2, at 344.
45. Id. at 446. Morreim argues that in the past, physicians controlled access to their own skills, and costs were generally ignored because third party reimbursement was substantial. Now, however, in this era of cost consciousness, physicians and patients must recognize that third party payors make the doctor-patient relationship possible and have legitimate interests which must be respected. Id. According to Morreim, "advocacy is an important part of the physician’s job, but it is distinguishable from any obligation to 'commandeer' the resources controlled by others." Id. at 446-47.
46. Wolf, supra note 11, at 36.
47. The Oxford English Dictionary defines an advocate as "one who pleads, intercedes or speaks for, or on behalf of, another." Morreim, supra note 39, at 446 (citing
Webster's dictionary defines an advocate as "one that pleads the cause of another . . . one that defends . . . or espouses a cause." Medical advocates, whose only role would be to represent the client, would be required to represent their client's interests under all circumstances, even if what the client seeks is not reasonable, just, or fair. As a hired gun, the independent advocate would not be obliged to recognize competing interests and might foster unrealistic expectations on the part of the patient.

While health care professionals have long viewed themselves as patient advocates, they also have other roles to play within the health care delivery system. These other roles give rise to potential conflicts on one hand and ensure perspective and balance on the other. If physicians are supplanted in their advocacy role based on fears of conflicts, this valuable ability to see all facets of the system and patient may be lost. Creating such a position introduces another actor into the system before conflicts have occurred. By analogy, establishing a medical advocate position would be equivalent to recommending that independent attorneys be hired by individuals utilizing lawyers in order to monitor and assess the lawyer's activities.

Treating every relationship as the rare case which ultimately results in malpractice or breach of fiduciary obligations undermines all such

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The Oxford English Dictionary (2d ed. 1989). Ann Bird, in writing of the nurse's role as a patient advocate, states that advocacy comes from the legal profession where a lawyer is hired to defend individual interests. Ann W. Bird, Enhancing Patient Well-Being: Advocacy or Negotiation, 20 J. Med. Ethics 152 (1994). According to Bird, advocacy involves "pleading for the cause of one's client: the intercession for, or the defence of, someone." Id. at 152. It means "defending someone, even if they are wrong, and are known to be wrong." Id. It is this defining characteristic of Mehlman's medical advocate that is most troubling. The medical advocate, because of his or her role, has no perspective other than the client's and, as a result, may act in ways which undermine the system as a whole.

Bird ultimately adopts the view that empowerment of the patient rather than advocacy on behalf of the patient is the appropriate role for nursing staff. "Empowerment to act against injustice or incompetence is what is needed, rather than advocacy with its unnecessary and perhaps immoral baggage." Id. at 154. Bird believes that if the multi-disciplinary care team meets its responsibilities to act in a patient's best interests by providing care and avoiding harm, "advocates" will be unnecessary. Id. at 153. Bird's view is sound as it is relevant to Mehlman's proposal for a medical advocate, even though external forces affecting the health care delivery system are exerting pressures which may be undermining the ability of health care professionals to keep patients primary.

relationships, is extremely costly, and in reality, does little to protect the client. The doctor-patient relationship must still be based on trust, a trust which leads patients to divulge personal, intimate information to the physician as part of the treatment process.\textsuperscript{49} If the medical advocate position is established, the seeds of doubt will be planted in the doctor-patient relationship, regardless of whether the patient is seeking assistance for relatively minor ailments or whether the illness is life threatening.\textsuperscript{50} As a result, patients may be less than forthcoming to their physicians. Creating this adversarial approach to health care will not ultimately be advantageous to patients, as doctors may subconsciously seek to distance themselves from their adversaries.\textsuperscript{51}

\textit{C. Physician as Mere Technician}

Physicians, through training and experience, develop expertise which is more than just technical knowledge.\textsuperscript{52} Medicine is still as much art as it is science.\textsuperscript{53} Patients do not go to their doctors with the same expectations with which they purchase consumer goods in arms-length transactions, where each party is responsible for ensuring her needs and interests are met during the purchase of a fungible product.\textsuperscript{54} The essence of a fiduciary relationship is precisely this trust and reliance on a doctor's expertise, where one party is charged with ensuring the primacy of the other's interests.

If the medical advocate profession is established to supplant physicians as protectors of patient interests, in a sense, we may be moving toward Robert Veatch's third model of the physician as an engineer or body mechanic.\textsuperscript{55} However, in an effort to bring back the primacy of the

\begin{itemize}
\item \textsuperscript{49} Ethical Issues in Managed Care, supra note 2, at 331.
\item \textsuperscript{50} Id.
\item \textsuperscript{51} According to Dubler and Emanuel, communication is essential to the doctor-patient relationship, as is the avoidance of conflicts. Emanuel & Dubler, supra note 1, at 324.
\item \textsuperscript{52} Often the technical knowledge derived from lab tests provides only the starting place (or the confirmation) of what physicians learn from knowledge of a patient and medical practice. See SHERWIN NULAND, HOW WE DIE 36 (Alfred A. Knopf ed., 1994).
\item \textsuperscript{53} NULAND, supra note 52, at 10. Nuland notes that the Greeks believed medicine was an art; this philosophy remains unchanged. Id.
\item \textsuperscript{54} Ethical Issues in Managed Care, supra note 2 at 331.
\item \textsuperscript{55} Robert Veatch, Models of Ethical Medicine in a Revolutionary Age, reprinted in MORAL PROBLEMS IN MEDICINE 78-82 (Samuel Gorovitz et al. eds., 2d ed. 1983). Veatch's other models are the priestly model, the collegial model, and the contractual model. Veatch believes the engineer model is inappropriate because in this model the physician
patient in the equation, we are inverting the relationship. Under the medical advocate system, instead of the doctor viewing the patient as an object to be worked on to produce the desired healing effect, the patient is objectifying the doctor as a provider of technical skills rather than as a fiduciary with knowledge of the patient, technical skills, and knowledge of the health care delivery system, whose judgement is sought and trusted. In essence, this new view of the physician may transform the profession from a combination of art and science to a more formulaic view of the doctor as an interchangeable scientific technician delivering a prescribed set of treatments. We appear to be moving in that direction by adopting practice parameters and computer models as diagnostic tools, but we still trust doctors to use their expertise to benefit the patient, and practice guidelines have not yet become rigid requirements to be followed without question.

If television is a mirror of our view of physicians, the latest Star Trek incarnation does not bode well for physicians. Unlike Victor Fuchs' vision of the doctor as captain of the ship, in the latest edition of the Star Trek series, the sick bay doctor, a programmed hologram, is nameless and appears only at the touch of a switch. He is limited in the range of services he can provide. As a result, he needs reprogramming for the unplanned extension of the voyage of the ship. He complains that the crew does not respect him and treats him as a machine, turning him on and off according to its convenience without regard to what he is objectifies the patient, making the doctor into a "body mechanic" who makes necessary repairs without interaction with the "system" undergoing the repairs. Id. at 79.

Veatch believed the contractual approach was best suited to the physician patient dynamic, because the relationship involves equality in obligations and duties. See also MACKLIN, supra note 2, at 112-15.

56. VICTOR FUCHS, WHO SHALL LIVE?: HEALTH AND ECONOMICS AND SOCIAL CHOICE 56 (1974). Fuchs attributes the primacy of the physician to the fact that for much of history the physician was the health care provider. Id. He notes that at the turn of the century two of every three case workers was a physician. Id.

57. STAR TREK: FOUR GENERATIONS, T.V. GUIDE COLLECTOR'S EDITION 39 (1995). Although the doctor has tremendous technical abilities as a result of being programmed with the knowledge of forty-seven of Starfleet's most respected physicians, he believes he is not accorded the deference which is due him. Id.

58. Id. The holographic doctor eventually receives a name: Doc Zimmerman. STAR TREK: FOUR GENERATIONS, supra note 57. Even T.V. Guide has noted the irony of a holograph as a physician: "Doc Zimmerman may know everything there is to know as a physician, but if he becomes annoying or troublesome, he can be disposed of with three words: 'computer end program'." Id. at 39. The actor who plays the doctor characterizes this as "the ultimate patient empowerment experience." Id.
doing at the time. To the doctor, the fact that he has no name is indicative of the lack of respect the crew has for him. Conversely, according to complaints lodged by crew members, the doctor's reprogramming should include interpersonal skills because he is insensitive to patient needs and has rote, scientific responses to their concerns.  

Computer models and practice guidelines currently being developed are designed to assist physicians in diagnosis and treatment, but the computer program is not intended to supplant the physician. If the medical advocate position is established, societal views of the doctor-patient relationship may begin to move toward that fantasy world articulated by the Star Trek episodes.

D. Fiscal Problems of the Medical Advocate Position

The fiscal problems attendant to the establishment of a medical advocate profession may also outweigh benefits which might be derived from having an independent advocate for patients. Introducing a new independent profession may well raise the costs of care to all patients, and may do so at the expense of patient care because it ignores the reality of corporate based health care delivery systems. The medical advocate position may deplete resources that could otherwise be devoted to providing medical services, because managed care providers will allocate resources to defend against the medical advocates' positions.

In addition, to stave off claims, managed care providers are likely to create incredibly detailed contracts to explicitly govern services provided. If the advocate is successful in obtaining treatment which

59. Id.
60. Id.
61. Even if, as Mehlman contends, the medical advocate can be paid for out of pocket by the wealthy, through consumer groups, or through welfare agencies, the dollars spent to fund the position would add to the already staggering percentage of the gross domestic product spent on health care in this country. See Orentlicher, supra note 29, at 149.
62. A study conducted by Woolhander and Himmelstein found that almost 25% of all dollars spent on health care go toward administrative costs. Macklin, supra note 2, at 156. By comparison, Canada devotes approximately 11% of its total health care expenditures to administration. Id. at 156. For a comprehensive examination of liability insurance arrangements and malpractice suits in Canada as compared to the United States, see Joan M. Gilmour, Overview of Medical Malpractice Law in Canada, 3 Annals. Health L. 179 (1994).
63. If some form of health care reform legislation is revived, it is likely to contain a basic minimum package of covered services. However, services above and beyond the
had initially been unavailable, individual patients may be victorious. But these "victories" may result in cutbacks of care to other, less empowered patients.64 Those patients who will bear the burden may be those unable to afford an advocate. The legal services system Mehlem proposes as a funding source for the advocate position for the poor is already financially strapped and will be unable to take on this additional role in any meaningful sense.65

As a society, we have yet to agree on financing universal health care coverage,66 and at a minimum, this must occur before we provide

minimum might be the subject of competition among health care providers.

64. Assuming that health care providers work within fixed budgets, a zero sum game exists, and benefits to one patient could result in losses to another as insurers fix their profits and allocate other expenditures accordingly. See Cost Containment, supra note 41, at 22-23.


66. See supra note 7. Some of the problems encountered in the reform debate may be the result of the way the debate was framed and the language we use to identify and discuss medical care, costs and coverage. George Annas, in an essay in the New England Journal of Medicine, discusses the metaphors which have shaped the way Americans look at health care. George Annas, Reframing the Debate on Health Care Reform by Replacing our Metaphors, 332 NEW ENG. J. MED. 744 (1995). Annas articulates the consequences of using a military metaphor which focuses on the physical and uses control as the linchpin to waging war on illness and disease. Id.

The military metaphor leads us to over-mobilize and to think of medicine in terms that have become dysfunctional. For example, this perspective encourages us to ignore costs and prompts hospitals and physicians to engage in medical arms races in the belief that all problems can be solved with more sophisticated technology. Id. at 745.

The other common metaphor is health care as marketing to consumers. "The market metaphor leads us to think about medicine in already familiar ways: emphasis is placed on efficiency, profit maximization, customer satisfaction, the ability to pay, planning, entrepreneurship, and competitive models. The ideology of medicine is displaced by the ideology of the marketplace. Trust is replaced by caveat emptor." Id. In Annas' view, we need to create a new metaphor for health care in order to focus debate about reform in a way which allows us to balance competing interests and accept that there must be some limitations on expenditures. "The ecologic metaphor could, for example, help us confront and accept limits (both on expectations about the length of our lives and on the expenditure of resources we think reasonable to prolong longevity)[.] value nature and
advocates for those who are already receiving care. The wealthy, who already have access to superior care, most likely will be able to afford superior medical advocates, but these additional services are likely to increase the overall costs of medical care. As with other professions, quality of services may, in part, be dependent on the fees paid by the patient, resulting in further stratification of the quality of health care available to patients. The existence of a medical advocate might exacerbate the fact that the wealthy generally receive more and better quality health care than the poor. However, the existence of a health care advocate would not alter the fact that health care coverage is limited under some managed care plans, that referrals must pass through a gatekeeper, and that experimental treatment is often explicitly excluded from coverage.\textsuperscript{67}

As a practical matter, the medical advocate could increase the health care gap because insurers would look for ways to recoup resources spent on those with effective advocates. The medical advocate approach to solving conflicts is untenable since it perpetuates and intensifies inequities in access to care and the level of care provided.

E. Bureaucratic Problems

Introducing yet another actor into the already bureaucratic health care system may diminish the quality of care provided if patients are reluctant to trust their doctors and fully communicate their symptoms. Some commentators have written on the expanding bureaucracy in medical practice. Adding another actor (or as Mehlman proposes, a team of actors) further expands the bureaucracy rather than reduces it. Adding an official ally for the patient to the flow chart may not radically change the structure of the system, but it may further distance the patient from the providers of care.\textsuperscript{68} The potential filtering of communications between

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emphasize the quality of life." \textit{Id.} at 746.
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\textsuperscript{67} One of the premises of managed care is that the primary physician’s role as gatekeeper reduces expenditures. While courts have been willing to construe contract language against the insurance companies when ambiguities in coverage exists, when the language is clear and the exclusion is explicit, the focus shifts to whether a given treatment is still considered experimental, or has quickly become the standard therapy for a given disease. \textit{See} Morreim, supra note 39, at 23.

\textsuperscript{68} If the medical advocate takes on the role of protector, facilitator, and provider of information to the patient, a patient’s natural inclination might be to allow the advocate to become the patient’s mouthpiece. After all, the job of the advocate is to act on the patient’s behalf, in dealings with all aspects of the patient’s medical care. There are
the hired emissary and the health care provider may have results similar to the children's game "telephone" (aka "whisper down the lane"), where initial communications are distorted to the point where the first comment becomes nearly unrecognizable as it is transformed by various actors in the system. While in the child's game the changes are humorous, in the health care delivery system, this filtering may harm the patient-physician relationship.

F. Patient Passivity

A hired mouthpiece may lull patients into more passive roles. This reliance on the medical advocate might undermine the goals of patient autonomy advocated by the medical consumerism movement. Under the theory that medical care is a service, the medical consumerism movement puts the patient in the role of consumer. Information, education, and choice are supposed to ensure the provision of quality medical care.

In theory, a medical advocate could promote the goals of the medical consumer movement by ensuring patient education and by maximizing the chances that patient choices will be respected. However, reality may not bear this out. The shortcomings of the movement result from the complexities inherent in medical decision-making. The medical advocate may not be able to reduce these problems, but the existence of the advocate might result in a shifting of reliance from the physician to the advocate. This does not empower the patient and may not result in additional protections for the patient.

While in theory the medical advocate would possess the expertise to assist the patient and could act as an objective advocate to protect the

dangers in over-reliance on one person. Doctors may de-personalize their patients even more since most contact will be through the patient advocate. In addition, misunderstandings increase as more actors become involved.

69. The medical consumerism movement will not solve all ills in the doctor patient relationship because patients themselves lack expertise, cannot assess quality of services delivered and are entering the system when they are most vulnerable. See Marc A. Rodwin, Patient Accountability and Quality of Care: Lessons from Medical Consumerism and the Patient's Rights, Women's Health and Disability Rights Movements, 20 AM. J.L. & MED. 147, 155 (1994).

70. Id. at 153, 155-57 (describing some patient-centered approaches to the delivery of medical services which have developed in the past few years).

71. Id. at 153.

72. Id.
patient, the reality might actually leave patients worse off. If patient advocates are culled from various fields, they may lack the necessary expertise and training to effectively assist patients. If patient advocate teams are assembled, as Mehlman proposes, the same bureaucratic forces at work in health care systems might delay and undermine care.

G. Conflicts of Interests

Once established, the medical advocate might be subject to some of the same conflicts of interests faced by physicians. Actors in a system seek to perpetuate their own roles, and in order to earn their keep, advocates may ultimately undermine patient autonomy by ensuring the perpetuation of their institutional existence. If medical advocates act as members of a multi-disciplinary team as envisioned by Mehlman, and advocates have ownership interests in their firm, referring clients to other team members could result in a situation similar to physicians with ownership interests in testing facilities referring patients to those facilities. Just as "personal interests and divisions in loyalty can compromise a physician's commitment to patient welfare," so too could the patient advocate position be inimical to patient interests if the business arrangement encourages additional referral and fees to another member of the team.

In addition, when long term actors within the system have interests in protecting ongoing relationships, conflicts of interest between maintaining the relationship for future dealings and advocating the interests of the individual can arise. While the interests of the advocate and health care delivery system might not always be the same, common institutional concerns about maintaining credibility and making tradeoffs between multiple clients would no doubt develop and may conflict with individual patient interests. In this sense, the medical advocate position may duplicate doctors' difficulties with ongoing relationships with hospitals.

H. Undermining Just Resource Allocation

Perhaps the most detrimental aspect of the medical advocate as individual emissary is the potential that the advocate could promote unrealistic expectations on the part of the patient which would erode legitimate allocation decisions made at the policy level. Escalating

73. RODWIN, supra note 11, at 9.
74. See id.
75. Holleman, Edwards and Matson point out the problems with undifferentiated advocacy regarding the physician as advocate.
costs, expanding medical technologies, the lack of health care coverage for millions of Americans, and the growth of managed care plans have led to what has been perceived as a crisis in our health care system.\textsuperscript{76} Efforts to introduce cost containment and managed care have focused primarily on ensuring the efficient use of health care dollars.\textsuperscript{77} Managed care plans focus on creating economic efficiencies and reducing waste of resources.\textsuperscript{78} Fairness and justice require consistency and equality in the distribution of resources. By definition, the advocate seeks to place his client in the best position without regard to considerations of money, scarce resources, or fairness.\textsuperscript{79} Cost containment measures and distributive justice would be undermined by advocacy on an ad hoc basis and resource allocation decisions subverted by individual advocacy positions.\textsuperscript{80}

Given the exponential increase in health care costs, it is imperative that, as a society, we begin to make hard choices about health care expenditures and resource allocations. To some authors, access to health care holds special moral importance based on "social obligations to protect equal opportunity."\textsuperscript{81} However, under these theories of equality of access,
there are times when care must be denied to one person in order to ensure care for others. The latest Report of the Council on Ethical and Judicial Affairs of the American Medical Association expresses the view that patient autonomy does not entitle patients to carte blanche access to all health care services.\(^82\) Autonomy requires responsibility,\(^83\) and issues such as funding and futility must be addressed.\(^84\) In order to ensure that basic health care is provided in an equitable manner, "[s]ome limits on personal freedom are inevitable."\(^85\) The hired advocate is likely to foster the idea that all resources should be expended on one individual client without regard to the impact on society. As the Council on Ethical and Judicial Affairs Report articulates, "patient autonomy entails patient responsibility, including a responsibility to abide by societal decisions to conserve health care and to make an individual effort to use resources wisely . . . "\(^86\) Individual challenges to resource allocations made by health care payors can have the effect of undermining the equitable distribution of resources or the decision to focus more resources on primary care.\(^87\)

V. EXISTING ALTERNATIVES TO THE MEDICAL ADVOCATE

If the medical advocate position proposed by Professor Mehlman is unworkable for the reasons described,\(^88\) other potential alternatives to address the real problem of conflicts of interest must be examined. Existing remedies might provide appropriate solutions, particularly if they are explicitly applied to today's problems and strengthened to meet current challenges.

A. Fiduciary Laws

In the past, fiduciary obligations and physician vows of service were thought to be sufficient protection to ensure that patient interests were

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82. *Ethical Issues in Managed Care*, supra note 2, at 334.
83. *Id.*
84. *See Macklin*, supra note 2, at 166-86.
85. *Ethical Issues in Managed Care*, supra note 2, at 334.
86. *Id.*
87. *See supra* notes 75 & 76 and accompanying text.
88. *See supra* notes 39-87 and accompanying text.
preeminent. While the old fee for service system (like the current managed care practice) was created by a contractual relationship, the relationship was not viewed as a typical "arms length" transaction. Instead, as a result of the doctor's superior knowledge, experience and expertise, and the patient's vulnerable position as a sick person, fiduciary obligations were imposed on the physician. 89

The fiduciary responsibility requires the physician to act in good faith. 90 The patient relies on the doctor's judgment and expects the physician to use his skills and knowledge to provide care to the patient. 91 Many of the medical oaths subscribed to by physicians entering practice invoke fiduciary obligations in the treatment of patients. 92 These fiduciary responsibilities require physicians to act in the best interests of the patient. 93 Fiduciary principles require loyalty and the elimination or

89. See Cobbs v. Grant, 502 P.2d 1 (Cal. 1972). In Cobbs, the court examined the nature and scope of the physician's obligation to his patient. The court recognized that the doctor had greater knowledge than the patient, which created the fiduciary obligation. Id. Because competent adults have the right to autonomy and control of their course of treatment, physicians must disclose "the available choices with respect to proposed therapy and of the dangers inherently and potentially involved in each." Id. at 242. See also Ethical Issues in Managed Care, supra note 2, at 331.

90. See Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972). In Canterbury, the physician failed to explain all of the risks associated with the surgery he advocated, and did not fully explain the alternative treatments available. Id. at 776-78. These two obligations imposed on the physician are separate, but are obviously closely linked in most situations. See also Yates v. El-Deiry, 513 N.E.2d 519, 522 (Ill. App. 3d 1987) ("[The] patient places a trust and confidence in the doctor to act in his best interest."); Max Mehlman, The Patient-Physician Relationship in an Era of Scarce Resources: Is There a Duty to Treat?, 25 CONN. L. REV. 349, 367-71 (1993) (discussing the role of fiduciary law in regulating physician obligations to patients); supra note 75.

91. See Black v. Littlejohn, 325 S.E.2d 469, 482 (N.C. 1985).

92. Id.


94. Maxwell J. Mehlman, The Legal Implications of Health Care Cost Containment, 36 CASE W. RES. L. REV. 778, 852-53 (1986). One commentator has argued that the application of fiduciary obligations to physicians is new. Eileen Scallen, Broken Promises v. Promises Betrayed: Metaphor, Analogy and the New Fiduciary Principle, 1993 U. ILL. L. REV. 897, 968-69 (1993). Scallen acknowledges that the court in Canterbury applied fiduciary principles to the doctor-patient relationship. Id. at 969 n.332. Scallen notes that the patient "confer[s] power over his physical well-being to his physicians. Needless to say, once a patient has entrusted this power to the physician, the patient is powerless to protect himself in case the physician breaches. . . . Physicians are well aware of the
limitation of self-dealing which can create conflict of interests. The most recent AMA Council on Ethical and Judicial Affairs Report confirms that under fiduciary principles, the doctor's primary duty is to act for the patient, including acting as an advocate when necessary.

Although fiduciary obligations have not always been explicitly articulated, should the physician fail to adhere to the obligations of the fiduciary position, legal remedies may be available. Fiduciary obligations need to be clarified and strengthened to ensure that self dealing is eliminated or limited and to reduce the impact economic incentives may have on decision-making. Doctors already view themselves as patient advocates with duties of loyalty to the patient, and this should be the

patient's vulnerability and dependence and accept it." Id.

95. See generally Scallen, supra note 94. Fiduciary obligations imposed on other professionals also require good faith, fairness and loyalty. See, e.g., DEL. CODE ANN. tit. 8, § 144 (1991). If an officer of the corporation has any interest which might affect his judgement, either personal or financial in nature, the officer must disclose the interest to the shareholders and receive approval from the shareholders prior to further involvement on behalf of the corporation. Id. By analogy, physicians with financial interests should, at a minimum, be forced to disclose those interests and receive informed consent from the patient prior to continuing treatment. See Moore v. Regents of Cal., 793 P.2d 479 (Cal. 1990), cert. denied, 499 U.S. 936 (1991). Lawyers are also under the obligation to act in the interests of their clients. The American Bar Association's Model Rules of Professional Conduct state that an attorney shall not represent a client without first fully disclosing any possible conflict and receiving consent. In addition, the attorney must be confident that his professional judgement will not be compromised by these personal interests. MODEL RULES OF PROFESSIONAL CONDUCT Rule 1.7 (1994).

96. Ethical Issues in Managed Care, supra note 2, at 334. See also MORREIM, supra note 19, at 88, 93-95.

97. See Moore v. Regents of Cal., 793 P.2d 479 (1988). In Moore, physicians failed to disclose to the patient the fact that they had created a cell line from cells cultured from the patient's spleen. Id. Because the doctors did not disclose their economic and research interests in his blood and tissues, Moore had stated a cause of action for breach of fiduciary duties. The court found that the physicians had an obligation to disclose those financial interests which affected the patient's treatment. Id. This information might have been material to the patient's decisions concerning follow up treatment, and as a result, the physicians may have violated their obligations to provide informed consent and breached their fiduciary obligations to the patient. The court was more concerned that the physicians' interests were clouding their professional judgement concerning treatment, rather than with the patient's financial interests in the sale of the cell line. "The possibility that an interest extraneous to the patient's health has affected the physician's judgement is something that a reasonable patient would want to know in deciding whether to consent to a proposed course of treatment." Id. at 151.

98. RODWIN, supra note 11, at 232-41.
standard of practice required of all physicians.99 Patient primacy should include the obligation of the physician to advocate on behalf of the patient,100 but this advocacy should not be equated with the use of all conceivable technologies.101

Marc Rodwin has examined how conflict of interest laws and rules governing the behavior of fiduciaries has developed to govern behavior in the fields of law and government.102 Rodwin notes that both lawyers and physicians have dual roles as advisors and providers of services, and this duality can lead to conflicts.103 Rules to prevent the development of conflicts, and supervision of fiduciaries via regulations and sanctions for breaches of obligations are remedies Rodwin analyzes as potential means of minimizing conflicts of interests.104 Further examination of these fields is appropriate to examine fiduciary obligations imposed on actors in those fields,105 and make explicit the rules which should govern physician behavior.

B. Informed Consent

The informed consent doctrine requires that patients be told of the various treatments available, the risks and benefits of each option, and the

99. MACKLIN, supra note 2, at 3. See also Ethical Issues in Managed Care, supra note 2, at 331. Orentlicher points out that while physicians respond to financial incentives, money is not their only motivation. Physicians "also are strongly devoted to other values and goals, in particular, to enhance the health of their patients." Orentlicher, supra note 29, at 159. David Frankford discusses physicians' beliefs about their perceptions of their work, and how these values conflict with the goals of financial inducements to "manage care". David Frankford, Managing Medical Clinicians Work Through the Use of Financial Incentives, 29 WAKE FOREST L. REV. 71 (1994). Frankford believes that the use of financial incentives undermines the conception of the professional physician and as such, should be eliminated.

100. See Ethical Issues in Managed Care, supra note 2, at 332; Cost Containment, supra note 41, at 24-25.

101. The requirement of disclosure of relevant information concerning diagnosis, treatment alternatives, risks and benefits has also been incorporated into "The Patient's Bill of Rights" promulgated by the American Hospital Association. The Bill of Rights explicitly discusses informed consent. MACKLIN, supra note 2, at 9; See also MORREIM, supra note 19 (discussing the limits of physician obligations to patients); Cost Containment, supra note 41, at 24.

102. See RODWIN, supra note 11, at 179-211.

103. Id. at 205-06.

104. Id. at 207-09.

105. RODWIN, supra note 11, at 179-211.
consequences of inaction. Informed consent requirements are based on the patient's right of self-determination in decisionmaking. Early legal decisions focused on bodily autonomy, while later cases have defined what constitutes informed decisionmaking. "True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each." Failure to fully explain alternatives and risks, including failure to disclose conflicts of interest which may prevent a physician from fully articulating each of the alternatives, could result in a lawsuit. Informed consent principles are derived in part from the view that individuals have the right to determine their course of treatment.

The AMA Council on Ethical and Judicial Affairs Report expresses the view that informed consent principles mandate disclosure of all treatment alternatives, including options not covered by an individual's insurance plan. While doctors cannot provide services unavailable under an individual's insurance contract, if these services constitute reasonable alternative treatments, they should be discussed with the patient to ensure any decisions made by the patient are done so with full knowledge of the range of treatment modalities. In this way patients can make the judgment whether to pursue a non-covered option, to appeal the denial of

106. MACKLIN, supra note 2, at 9. See also Ethical Issues in Managed Care, supra note 2, at 332. For an in-depth examination of the development of the theory and legal doctrine of informed consent, see RUTH FADEN ET AL., A HISTORY AND THEORY OF INFORMED CONSENT (Oxford U. Press 1986).

107. See Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92 (N.Y. 1914). In Schloendorff, Justice Cardozo wrote, "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages." Id. at 128. See also Cobbs v. Grant, 502 P.2d 1 (Cal. 1972).

108. See, e.g., Schloendorff, 105 N.E. at 92.


110. Canterbury, 464 F.2d at 780.


112. See RUTH FADEN ET AL., supra note 106, at 123, 133-34 (discussing the impact of some of the seminal informed consent cases).

113. Ethical Issues in Managed Care, supra note 2, at 332 ("[P]hysicians should discuss all available treatment alternatives, including those potentially beneficial treatments that are not offered under the terms of the plan.").

114. Id.
coverage, or to avail themselves of other, covered treatments.115

C. Negligence

When physicians have failed to provide adequate care for the particular medical circumstances involved, courts have found liability for the injuries sustained.116 The implicit threat of a lawsuit arising from negligent care may be a powerful reason for physicians to ensure necessary care is provided.117 Common law negligence suits for failure to meet the standard of care in the community have, in part, fueled the defensive medicine practices which have led to runaway costs.118 The standard of care is increasingly being determined with reference to uniform, national norms rather than to localized practice areas,119 which may have had the effect of increasing damage awards.

In cases brought by managed care plan patients denied services, doctors have not been absolved of liability by invoking the higher authority denial defense.120 Instead, courts have expressed the belief that doctors are obligated to advocate for their patients even in the face of administrative denials of coverage and care.121 In Wickline v. State of California,122 the court addressed the responsibilities of the physician and third party payor in a situation where adverse outcomes resulted from plan denial of physician requests for extended hospitalization for a patient.123 The court found that the physician is not absolved of his medical obligations

115. Ethical Issues in Managed Care, supra note 2, at 332.
117. Orentlicher, supra note 29, at 159. Orentlicher notes that physicians perceive their risk of being sued for malpractice at three times the actual rate. Id. (citing Ann G. Lawthers et al., Physicians Perceptions of the Risk of Being Sued, 17 J. HEALTH POL. POL’Y & L. 463, 468-69 (1992)).
118. See MORREIM, supra note 19, at 12.
119. Id. at 114. According to Morreim, current malpractice standards "fail to recognize current economic realities" by invoking a "uniform standard". Id. at 115. Standards of Medical Expertise (SME) covers the physician's obligation to act with skill and care while Standard of Resource Use (SRU) addresses allocations issues. Id. at 89.
120. See Wickline v. Medi-Cal, 239 Cal. Rptr. 810 (Ct. App. 2d 1986).
123. Id. at 810.
to his patient when the insurer denies coverage.\textsuperscript{124}

The physician's fiduciary role obligates him to act as an advocate on behalf of his patient.\textsuperscript{125} In \textit{Wickline}, the State was absolved from liability by a statutory grant of immunity.\textsuperscript{126} However, "third party payors of health services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms."\textsuperscript{127} While the court did not find Medi-Cal liable in \textit{Wickline}, the case has paved the way for insurer liability if physicians' judgements are overly restricted. \textit{Wickline} was followed by \textit{Wilson v. Blue Cross of California},\textsuperscript{128} which overturned a summary judgement motion granted to the defendant insurance company and raised the possibility that liability would shift to the insurer if a physician's medical judgement is overridden by cost containment measures. At least in the initial cases heard by the courts, fiduciary obligations owed by physicians have been reaffirmed.

In \textit{Wilson v. Chesapeake Health Plan, Inc.},\textsuperscript{129} a lower court concluded that a physician's fiduciary obligation included the duty to inform the patient about resources and alternatives available to the patient to assist in determining the scope of insurance coverage and the existence of alternative sources of funding. This expansion of a physician's obligations to include "non-medical" referrals for ensuring funding of medical care appears to reinforce and even to expand the physician's fiduciary obligations.

When clearly delineated in insurance contracts, coverage exclusions are likely to be upheld unless they violate public policy or legislatively

\begin{itemize}
  \item \textsuperscript{124} \textit{Id.}
  \item \textsuperscript{125} \textit{Id.}
  \item \textsuperscript{126} \textit{Id.} at 818.
  \item \textsuperscript{127} \textit{Id.}
  \item \textsuperscript{128} \textit{Wilson v. Blue Cross of Cal., 271 Cal. Rptr. 876 (Ct. App. 1990).} In \textit{Wilson}, a patient suffering from severe depression was denied coverage for additional hospitalization. \textit{Id.} at 877. Because the patient could not afford to pay for additional care on his own, he was discharged and committed suicide a few days later. \textit{Id.} at 877-78. The insurer was liable for the patient's death. \textit{Id.} at 885. The \textit{Wilson} court rejected the \textit{Wickline} interpretation that the treating physician was solely responsible for decisions to discharge a patient. \textit{Id.} at 880. One commentator views the shift from \textit{Wickline} to \textit{Wilson} as attenuating the fiduciary obligations of the physician to act on behalf of the patient. Stilling, \textit{supra} note 121, at 295. However, it appears that the obligation of the physician to advocate on behalf of the patient remains intact. How far a physician must go to advocate in the face of administrative denial of coverage remains an open question.
  \item \textsuperscript{129} \textit{Wilson v. Chesapeake Health Plan, Circuit Court, Baltimore, MD No. 88019032/ca 76201.}
\end{itemize}
mandated benefits packages, but these exclusions do not absolve the physician of the obligation of fully informing his patient. Contract exclusions do not seem amenable to advocacy by a medical advocate if the language is clear. However, when language interpretation becomes the issue, litigation is likely. While insurance plans often exclude "experimental" treatment, what constitutes experimental care is open to interpretation. If the issue is coverage, the conflict of interest is not between the physician and the patient. If managed care plans driven by profit motives reduce coverage to levels below accepted standards of care, liability may ensue.

Managed care plans may find themselves subject to liability for the negligence of participating physicians under agency theories. Although plans may attempt to structure their arrangements with participating doctors in a manner which they hope invokes independent contractor relationships, courts may interpret patient awareness and choice to require application of agency laws. The Restatement (Second) of Agency, Section 267 states:

One who represents that another is his servant or other agent and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent is subject to liability to the third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he were such.

In Boyd v. Albert Einstein, the trial court had ordered summary


131. Id. at 49.

132. See Wilson, 271 Cal. Rptr. at 876; Wickline, 239 Cal. Rptr. at 810. See also Mariner, supra note 130, at 53-55.


134. Id. at 1232.

135. Naviera Despina, Inc. v. Cooper Shipping Co. Inc., 676 F. Supp. 1134, 1141 (1987). When one party allows another to be in control, and consents to the actions of the person in control, agency theory applies. In Naviera Despina, Inc. v. Cooper Shipping Co. Inc., the court held that "agency was a fiduciary relationship that resulted from one person's consent to another that the other shall act on his behalf and subject to his control . . . ." Id. A conflict of interest arises when an agent attempts to serve two principles with different interests. Id. But cf. Menzie v. Windham Community Memorial Hosp., 774 F. Supp 91, 94 (D. Conn. 1991)(Independent contractor is not under the control of the employer, therefore, no agency theory can be applied.).

judgement in favor of Health Maintenance Organization (HMO) of Pennsylvania. In reversing the summary judgement order, the Superior Court noted that changes in patient relationships with physicians, hospitals, and managed care organizations could result in agency liability being imposed on HMOs. The court looked to the Restatement (Second) of Agency, Comment A, to establish the test for agency: "[T]he rule normally applies where the plaintiff has submitted himself to the care or protection of an apparent servant in response to an invitation from the defendant to enter into such relations with such servant."

VI. SHARING RESPONSIBILITIES TO ENSURE QUALITY HEALTH CARE

Traditional fiduciary obligations and common law remedies alone will not ensure that the physician-patient relationship remains protected. All actors within the system have obligations to ensure that forces detrimental to maintaining quality care are minimized.

A. Responsibilities of the Payor

Insurance companies must disclose to potential participants plan limitations on coverage, incentives to physicians creating conflicts regarding referrals or treatment, and bureaucratic deterrents to the utilization of services. Consumers can then choose not to join plans.

137. Id. at 1234 (citing RESTATEMENT (SECOND) OF AGENCY § 267 cmt. a (1958)).
138. Id.
139. RESTATEMENT (SECOND) OF AGENCY § 267 cmt. a (1958), cited in Boyd, 547 A.2d at 1234.
140. In a recent article in the Hastings Center Report, Alice Herb wrote of the obligations of hospital attorneys to act on behalf of patients dying of AIDS. Alice Herb, The Hospital Based Attorney as Patient Advocate, 25 HASTINGS CENTER REP. 13 (1995). Herb believes that the provision of legal services, while non-medical in nature, meets patient needs and should be incorporated into the institutional framework of provision of services. She compares attorneys to other non-medical hospital providers, including social workers and psychologists, who do not necessarily provide direct medical care, but who do comprise part of the care giving team. Id. at 16. In order to avoid conflicts of interests, Herb recommends that patient advocate attorneys be individuals who do not directly represent institutional concerns. Id. at 18. She notes, however, that since most of the attorney advocates in the program she is involved with represent the personal issues of patients, conflicts with institutional concerns were unlikely. Id.
141. See Boyd, 547 A.2d at 1229. In Boyd, the Structure of the HMO was typical of many managed care plans. Patients selected primary caregivers from an approved list.
or can urge their employer to switch from plans which risk patient health in their pursuit of cost containment and profits.\textsuperscript{142} As an employer, the managed care plan also has the duty to contract with competent doctors, and to ensure that medical practices are conducted in a competent manner.\textsuperscript{143} Managed care providers must also create the structure and maintain standards to govern the provision of quality care.\textsuperscript{144} Quality assessment measures, implemented by managed care providers, must focus not just on cost controls, but also on consumer satisfaction, outcomes, and performance reviews by colleagues.\textsuperscript{145} Susan Wolf has argued that health care organizations have ethical obligations to patients and physicians. She believes that quality assurance monitoring encompasses not just medical practice but should ensure ethical practice as well.\textsuperscript{146}

A number of authors have argued that health care organizations should be proscribed from utilizing financial incentives which encourage physicians to withhold potentially beneficial treatment that is authorized under the plan.\textsuperscript{147} David Orentlicher believes that economic incentives motivate physicians in ways that education about costs and treatment modalities alone does not, and therefore proposes that incentives be acceptable within certain parameters.\textsuperscript{148} If incentives are indirect, limited in scope, and based on patient-centered criteria (such as quality of care indices, good outcomes, and time spent with patients) they will be less objectionable to plan members than if rewards and penalties focus solely

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Fees were paid to the company, not to the physicians. The Plan also required patients to seek approval from the primary physician before being referred to a specialist. MORREIM, supra note 19, at 109-10.

142. See RODWIN, supra note 11, at 216-17 (discussing the limitations of consumer education movements).


144. McClellan, 604 A.2d at 1057-59.

145. See Mariner, supra note 13O, at 37 (discussing various types of outcomes assessments and the potential beneficial and negative uses of these tools); Wolf, supra note 46, at 38.

146. Wolf, supra note 46, at 38.

147. See, e.g., RODWIN, supra note 11, at 232-33; Wolf, supra note 46, at 37.

148. Orentlicher, supra note 29, at 169-70. According to Orentlicher, incentives which "have a high potential for abuse" should be eliminated. Id. at 167. Factors that can establish whether incentives pose unacceptable risks include how much financial risk is shifted to physicians, the length of time used to measure compliance with utilization directives and whether assessments of utilization compliance are based on individual physician activities or upon the practice patterns of a group of physicians. Id. 167-69.
on cost containment. The Council on Ethical and Judicial Affairs Report urges that quality assessments be central to incentives. Several indicia might be useful in these judgements including objective outcomes data, adherence to standards of practice, patient satisfaction, and peer evaluations.

The development of practice guidelines may also be beneficial in ensuring that the prevailing standard of care is met by managed care practitioners. Orentlicher points out that practice guidelines are of limited utility because practitioners are slow to incorporate guidelines into their practices. However, when guidelines are combined with employer mandates and incentives are incorporated, compliance may be more likely. Some authors fear that guidelines may be set too low or that they will be used by payors to limit services. The fact that standards of care have developed through community and national practices will, in all likelihood, prevent this problematic use of practice guidelines. Courts have not always absolved practitioners who adhere to an unconscionably low level of care when the technology exists to provide greater levels of protection. In addition, the standard of care

149. Ethical Issues in Managed Care, supra note 2, at 333. Patient incentives should also be developed to make health care consumers accept responsibility for the effects of their own behavior on health care costs. Id. at 334. Some managed care plans have incorporated subsidies for members' health club memberships on the theory that encouraging members to exercise is, in fact, a form of preventative care within the control of the individual plan member.

150. Id. at 333.

151. Id. at 333-34. Dubler also suggests that certain types of incentives be proscribed, that incentives be indirect, and that good medical practice be rewarded rather than punished. See generally Emanuel and Dubler, supra note 1.

152. Mariner, supra note 130, at 38. Mariner identifies six potential uses for outcome assessment data, including: (1) quality assurance; (2) cost control; (3) patient decision making; (4) defining benefits; (5) individual care; and (6) dispute resolution. Id. at 39. Marc Rodwin discusses a number of approaches which have been taken to measure quality assessment: "[a]ccreditation, license or certification . . . patient guidelines and protocols for medical treatment; systems that prompt physicians, check for certain problems or justify decisions, analysis of physician and institution performance by assessing how frequently particular services are used and the mortality, morbidity and complication rates . . . patient assessment of medical care received. . . ." are all encompassed within the drive to assess and ensure quality care. Rodwin, supra note 69, at 147.

153. Orentlicher, supra note 29, at 172-75.

154. Id. at 175.

155. Mariner, supra note 130, at 39.

referenced in tort actions has increasingly become a uniform one, which will hold doctors and plans accountable for failing to meet the levels of practice throughout the country.\textsuperscript{157}

With the obligation of ensuring quality care, the payor has the right to make policy determinations regarding coverage.\textsuperscript{158} Individual health plan guidelines determined at the company's policy level, with input from physicians and other relevant actors in the system, should have the effect of being comprehensive, consistent, and equitably applied. Doctors then do not have to "ration at the bedside" in a standard manner, which creates conflicts between doctor and patient.\textsuperscript{159}

Clear appeals processes must be established and information explaining how to appeal a coverage denial must be disseminated to both doctors and patients.\textsuperscript{160} Ethics committees should be established to assist in educational efforts, to formulate policy, to review difficult cases, and to

\textsuperscript{157} See MORREIM, supra note 19, at 114.

\textsuperscript{158} Ethical Issues in Managed Care, supra note 2, at 332. See also Wolf, supra note 46, at 38. As Mariner discusses, common practice in insurance contracts is to list exclusions from coverage rather than to define covered benefits. Mariner, supra note 130, at 46-47.

\textsuperscript{159} Ethical Issues in Managed Care, supra note 2, at 334. Macklin believes bedside rationing is inappropriate because it undermines physician advocacy roles and creates conflicts for the physician which are permanent and structural in nature. MACKLIN, supra note 2, at 160-61. In addition, fairness issues are raised by bedside rationing. Inconsistent decisions are likely to be made by individual doctors and these inequitable results will undermine fairness as a component of justice. \textit{Id.} at 161. Macklin notes that the elderly, the vulnerable, and the incapacitated are likely to become the first targets of bedside rationing. \textit{Id.} Macklin rejects bedside rationing for a third reason, she believes it will not result in the desired financial savings to free up resources to be utilized in other areas. According to Macklin, rationing by physicians is likely to undermine the doctor-patient relationship. Doctors may be less forthcoming with patients, and patients are less likely to trust their physicians. MACKLIN, supra note 2, at 162-63. The final set of reasons Macklin introduces to support the argument that front line, ad hoc rationing by physicians, is inappropriate stems from the physicians' lack of knowledge of relevant areas of information necessary for just allocations. Doctors frequently lack sufficient information concerning financial aspects of treatment, costs and billing, and are unable to quantify probabilities in any meaningful way. \textit{Id.} at 163. But see Clancy & Brody, supra note 3, at 339. Clancy and Brody believe that "bedside rationing" is inevitable if medical care is to remain based on personal interaction between doctors and patients. \textit{Id.} In their view, a doctor should focus his inquiry on how to make such decisions ethically. \textit{Id.} The AMA Council's recommendations that policy making be done at a different level from individual clinical encounters is, in their view, a good first step. \textit{Id.}

\textsuperscript{160} Ethical Issues in Managed Care, supra note 2, at 332. See also Wolf, supra note 46, at 38.
address resource distribution. After the Matter of Quinlan case was decided in the early seventies, hospitals and nursing homes nationwide began to establish ethics committees. The roles of ethics committees range from policy development and education to retrospective or concurrent case review. While some authors argue that an ethics committee established by the managed care provider faces an inherent conflict which will preclude it from functioning effectively, committees can offer a "systematic framework for ethical decisionmaking and ... engage[e] in thorough and reflective deliberations." These discussions can help to ensure equitable distribution of resources and provide for input from a variety of representatives.

B. Patient Responsibilities

Autonomy requires responsibility. Education of consumers and involvement in allocation decisions should be a national priority in order to ensure that patients understand the ramifications of their decisions. One discount retailer has adopted the quote, "[a]n educated consumer is our best customer," presumably on the theory that education ensures that customers will know quality merchandise and good prices. Consumers should likewise become part of the policy-making process for health care. The Council on Ethical and Judicial Affairs Report recommends that "some mechanism for taking into account the preferences and values of the people whom the rationing decisions will most directly affect" be developed. The Council on Ethical and


164. MACKLIN, supra note 2, at 208.

165. Id. at 226-28.

166. MORREIM, supra note 19, at 136. See also Lance Stell, Review Essay, Herding Cats and Reforming the American Health Care System, 22 J.L. MED. & ETHICS 72, 78 (1994). Stell notes that Morreim's treatment of patient autonomy as requiring individuals to incorporate "public moral legislation" into their decisionmaking, rather than allowing "subjective preference" to predominate decision making, echoes Kantian philosophy. Id.


168. See id. Mariner notes that educated consumers "are less likely to mistake more care for better care." Mariner, supra note 130, at 44.

169. Ethical Issues in Managed Care, supra note 2, at 332. The report notes that patient
Judicial Affairs Report offers the possibility of using the "town meeting" for subscribers to voice their opinions about covered services or to "vote" on what treatments should be included in their benefits package.\textsuperscript{170}

Marc Rodwin, writing on patient accountability and quality of care, believes that:

\begin{quote}
[\textit{m}]edical consumerism shows that market forces and patient perspectives can serve as powerful and constructive tools to make medical care institutions more responsive to the needs and wishes of patients. The challenge is finding ways to promote consumer consciousness in the public and to make it easier for medical consumers to organize and communicate their wishes.\textsuperscript{171}
\end{quote}

If individuals understood the costs and resources of the health care system, they could make informed choices regarding coverage, and as a result, insurance decisions would not appear arbitrary.\textsuperscript{172} Patient satisfaction measures should be publicly released as part of surveys of managed care plans, and this additional information may shape health plans based on consumer choices in the future.\textsuperscript{173} Rodwin has advocated that additional information on patient grievances be released as part of an effort to ensure that managed care plans are responsive to patient concerns.\textsuperscript{174}

However, patient satisfaction is not always a complete or accurate indication of quality of care. Patients may focus on surface factors, such as "visible amenities and personal relations," instead of on quality and "appropriateness of medical services."\textsuperscript{175} Despite limitations in their utility as a component of indices used to ensure quality service, these factors may provide additional useful measures of performance.

Haavi Morreim believes that as long as patients perceive their health care to be "free", they have no incentive to be conscious consumers of health care.\textsuperscript{176} According to Morreim, a number of options are available

\begin{enumerate}
\item \textsuperscript{170} Id. at 332.
\item \textsuperscript{171} Rodwin, \textit{supra} note 69, at 157.
\item \textsuperscript{172} \textit{Ethical Issues in Managed Care}, \textit{supra} note 2, at 334. The Report emphasizes the need for ensuring patients are informed, and suggests that legislation to protect the right to be informed is essential. Obviously, some of the responsibility to become informed must be borne by the consumers of care. \textit{Id.}
\item \textsuperscript{173} \textit{PHILA. INQUIRER}, \textit{supra} note 167. \textit{See} \textit{Mariner}, \textit{supra} note 130, at 46.
\item \textsuperscript{174} \textit{See generally} \textit{RODWIN}, \textit{supra} note 11, at 153-57.
\item \textsuperscript{175} Arnold S. Relman, \textit{Medical Practice Under the Clinton Health Plan}, 329 \textit{NEW ENG. J. MED.} 1574, 1574-76 (1993). \textit{See also} \textit{Ethical Issues in Managed Care}, \textit{supra} note 2, at 331.
\item \textsuperscript{176} E. Haavi Morreim, \textit{Diverse and Perverse Incentives of Managed Care: Bringing}
to create incentives for patients to manage their health care in ways which responsibly utilize resources. Companies can institute higher co-payments to ensure that patients do not seek care frivolously. However, instituting additional co-payments may create access barriers to care for those with limited resources. Morreim believes that medical savings accounts and variations adapted for use in managed care plans provide a better vehicle for bringing patients into the system. Under this approach, tax-free accounts could be established and funded to cover medical services under the amounts specified in high deductible catastrophic care policies. Incentives to reduce health care spending are created because money in these tax-free accounts which was not spent on health care would then be available to the patient for other purposes.

A variant on the medical savings account creates a point system for patients in managed care organizations. Care and testing might cost a patient points, while preventative care and healthy behaviors might earn points. At the end of the year, the organization could provide cash or prizes for the points remaining in an individual’s account. Morreim also explores the possibility of a system of stock options for patients in managed care organizations under the theory that people with a stake in the financial well-being of the company will be more cost-conscious in the care they utilize and will be more likely to remain in the same plan for longer periods of time.

Another option to ensure patients have a stake in their health care delivery systems involves the appointment of patient representatives to boards established by all plans to create and review policies governing

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178. Id. at 105-06.
179. Id. at 106
180. These catastrophic care policies would cover only major expenditures. Id. The money in the MSA would be used to pay for routine care. Id. Although Morreim is somewhat sketchy on how these accounts would be funded, she writes that employers and the government could help fund the accounts. Id.
181. Id.
182. Id. at 108.
183. Id. at 108-09.
184. Id. at 109.
185. Id. On a variation of this approach, Morreim also suggests a system under which plan members can earn rights to greater input in policy making as they remain members of this plan for longer periods of time. Id.
resource distribution.\textsuperscript{186} Other members of the policy-making board should be independent physicians, staff members, and other actors in the system. Physicians should have the opportunity to contribute to the development of allocation guidelines.\textsuperscript{187} As patients become more educated about the issues involved in distributing resources, they may be more likely to accept that trade-offs must be made in order to equitably distribute resources.

The Council on Ethical and Judicial Affairs recommends that "[a]dequate appellate mechanisms for both patients and physicians should be in place to address disputes regarding medically necessary care."\textsuperscript{188} Some commentators advocate that the review board be independent of the managed care plan.\textsuperscript{189} This board, like some ethics committees, could review individual cases and also conduct educational forums for members of the plan. These forums could be designed to educate members about the plan, discuss ethical issues, provide seminars on treatment alternatives for particular illnesses, and act as a conduit between management and members. If an issue could not be resolved by the review board, perhaps the board could invoke a referral to an independent regional review board.

C. Physician Responsibilities

Physicians have the obligation to inform patients of all treatment alternatives, even those which are not covered under the plan.\textsuperscript{190} Susan

\textsuperscript{186} Emanuel & Dubler, \textit{supra} note 1, at 328. The Council Report also suggests that there be "public participation in the formulation of benefits packages." Ethical Issues in Managed Care, \textit{supra} note 2, at 334.

\textsuperscript{187} Id. at 334.

\textsuperscript{188} Id. See also Ethical Issues in Managed Care, \textit{supra} note 2, at 334.

\textsuperscript{189} Id.

\textsuperscript{190} MORREIM, \textit{supra} note 19, at 112-14, 117.

If the physician fails to inform because a beneficial treatment is politically (economically) unavailable, he has deceived the patient by implying a medical decision, not a political decision, has been made. The physician has violated his fiduciary relationship with the patient. This contractual relationship acknowledges
Wolf urges that physicians have the responsibility to discuss all "potentially beneficial treatment" in order to form a "therapeutic alliance with the patient."\textsuperscript{191} Informed consent cannot be accomplished by a rote incantation of diagnosis, prognosis, and alternative treatment. As Jay Katz eloquently states in his revisitation of the meaning of informed consent, "[d]octors' authority resides in the medical knowledge they possess, in their capacity to diagnose and treat, in their ability to evaluate what can be diagnosed and what cannot, what is treatable and what is not. . . ."\textsuperscript{192} Katz believes that informed consent can only occur when the relationship between doctors and patients includes recognition of physicians' limitations,\textsuperscript{193} and efforts by physicians "to sort out with the patient the choice to be made."\textsuperscript{194} According to Katz, until informed consent principles recognize patient autonomy based on joint decisionmaking, the doctrine of informed consent will remain a fairy tale.\textsuperscript{195}

Steven Miles, M.D., believes that there must be a recognition that concepts of beneficence must include physicians' obligations to provide access to all who need medical care.\textsuperscript{196} According to Miles, "[t]he nature of the modern health care system means that health care professionals have a moral duty of stewardship that informs, advocates for, and constrains our duties to individual patients."\textsuperscript{197} This stewardship obligation involves the responsibility of defining the duties of health care personnel and the infrastructure of the health delivery system.\textsuperscript{198}

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that the partners have unequal information and skill. However, the partner with superior knowledge agrees to use it on behalf of the less knowledgeable partner to an agreement. Thus, the physician agrees to use his skill on behalf of the patient.


\textsuperscript{191} Wolf, supra note 46, at 35.


\textsuperscript{193} \textit{Id.} "Physicians must learn to face up to and acknowledge the tragic limitations of their own professional knowledge, their inability to impart all their insights to all patients, and their own personal incapacities - at times more pronounced than others - to devote themselves fully to the needs of their patients." \textit{Id.} at 89-90.

\textsuperscript{194} Katz, \textit{supra} note 192, at 90.

\textsuperscript{195} \textit{Id.} at 90-91. Katz does not assess the impact of cost containment measures on autonomous decisionmaking. \textit{See id.} at 90.


\textsuperscript{197} \textit{Id.}

\textsuperscript{198} \textit{Id.} at 256-57.
Physicians have the obligation to act as patient advocates in practicing medicine according to mandates of their training and experience. In addition, physicians have the duty to act as "economic advocates" in order to ensure that patients understand the financial consequences of their decisions and to assist them in examining alternative funding if necessary. Fiduciary obligations should guide doctors in their dealings with patients.

The physician should have the obligation to initiate appeals processes for the patient if plan exclusions are inappropriate or if exclusions of coverage are ambiguous. Wolf points out that an evaluation must be made of "patient need for a physician advisor and advocate in complex health care organizations, whether we want a system committing the physician to advocacy, and what limits to that advocacy we will accept." These "broad social determinations of what is fair, and what we most value" should be made by legislatures, commissions, and other branches of government.

199. See, e.g., MACKLIN, supra note 2, at 3; Holleman et al., supra note 5, at 116. See also Thomas Boyd, Cost Containment and the Physician’s Fiduciary Duty to the Patient, 39 DEPAUL L. REV. 131 (1989) (discussing another aspect of the physician’s fiduciary obligations to patients). Boyd advocates that physicians carefully examine the contractual relationships they enter into with insurers to ensure that the contracts do not limit their ability to provide proper care to patients. Id. at 141-46. "Very simply, physicians have the affirmative responsibility by virtue of their fiduciary duty to ensure that neither hospital policy nor health insurance agreements will inhibit their ability to provide the proper quality of care for all patients." Id. at 157.

200. MORREIM, supra note 96, at 2, 88-90. As Morreim points out, this duty is no longer just a moral obligation as courts are imposing legal obligations upon physicians. Id. at 90.

201. Ethical Issues in Managed Care, supra note 2, at 333.

202. See Wolf, supra note 46, at 35 fig. 1. As Barry Furrow points out in the context of utilization review:

[A] physician is expected to be a patient’s advocate, trying to squeeze out of tightfisted payors 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 judgement when reimbursement was denied, he risks liability for malpractice.


203. Wolf, supra note 46, at 34.

204. Id.
VII. CONCLUSION

As Ruth Macklin pointed out in *The Enemies of Patients*,205 we need to develop ways to promote alliances between doctors and patients rather than turning physicians into adversaries.206 Doctors and patients are feeling pressures imposed by third-party payors concerned with cost containment, resource allocation, and profits.

Introducing a new actor to "advocate" on behalf of patients would further undermine the fiduciary obligations and trust which are central to the doctor-patient relationship. All actors in the system have obligations to act as patient advocates within their spheres of expertise. To attempt to supplant the care givers' advocacy role would have the effect of intensifying the conflicts between doctors, patients, and payors and might cause chasms which cannot be bridged.

By promoting the common interests physicians and their patients share, strengthening protective measures designed to limit the direct influences the third-party payor has on health care decisionmaking, and involving consumers in discussions about resource limitations and allocations, the role of the medical advocate should become unnecessary and the goal of providing equitable health care is more likely to be achieved.

205. MACKLIN, supra note 2.
206. Id. at 3.