Health Care Reform and the Patient-Physician Relationship

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HEALTH CARE REFORM AND THE PATIENT-PHYSICIAN RELATIONSHIP

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HEALTH CARE REFORM would greatly benefit the patient-physician relationship. With universal or near-universal coverage, many millions more patients would establish relationships with primary care physicians. As a result, these patients would have better access to preventive health measures. There also would be earlier detection of diseases like hypertension, diabetes, and cancer so that treatment could be instituted earlier with greater effectiveness and at a lower cost.

Nevertheless, health care reform also would pose important concerns for the patient-physician relationship. This Article will focus on these concerns. In Part I, the risk of greater discontinuities in the patient-physician relationship will be reviewed. With health care reform, patients’ primary relationships might be with their health care insurers rather than their physicians, making it more difficult for patients to maintain long-standing relationships with their physicians.

In Part II, threats to the traditional dedication of physicians to the needs of their patients are discussed. Health care reform would likely increase two of the conflicts of interest that physicians face with regard to their fiduciary duty of loyalty to their patients. Reform would accentuate the conflict between an individual patient’s needs and the needs of other patients. It also would accentuate the conflict between patient needs and the physician’s personal financial interests.
I. DISCONTINUITIES IN THE PATIENT-PHYSICIAN RELATIONSHIP

Before discussing how health care reform increases the likelihood of discontinuities in the patient-physician relationship, it is important to consider the reasons for concern from such discontinuities.

A. The Importance of Continuity in the Patient-Physician Relationship

Continuity in the patient-physician relationship has long been considered a hallmark of high quality medical care. According to the American Medical Association’s Code of Medical Ethics, “[t]he patient has the right to continuity of health care.” There are a number of benefits from long-standing patient-physician relationships. If physicians know their patients well, they can better evaluate the significance of the patients’ symptoms when the patients seek medical care. People react differently to illness; some are stoic, others are more sensitive to pain or discomfort. In addition, when a physician interprets a patient’s problems, the physician’s judgment will depend in part on the patient’s medical history. Chest discomfort in someone with previous heart disease must be viewed differently from chest discomfort in someone who has a history of heartburn. Finally, with long-standing relationships, patients are more likely to trust their physicians and feel comfortable seeking care. As a result, patients are more likely to consult their physician early in the course of an illness, before the illness becomes difficult to treat. Indeed, studies have shown that continuity of care leads to greater satisfaction by patients with their medical care and increases the likelihood that they will follow their medication regimens and keep their appointments with physicians.

2. See Ezekiel J. Emanuel & Allan S. Brett, Managed Competition and the Patient-Physician Relationship, 329 New Eng. J. Med. 879, 880 (1993) (discussing the important role of long-term interaction between patients and physicians to convey important individual nuances).
3. Allen J. Dietrich & Keith I. Marton, Does Continuous Care from a Physician Make a Difference?, 15 J. Fam. Pract. 929, 931 (1982); Gregory L. Weiss & Cornelia A.
There are gains in efficiency as well as quality from long-standing patient-physician relationships. For example, when patients change physicians, the new physician will have to undertake a full, initial medical history and physical examination to gain first-hand knowledge about the patient. While the patient's medical record will include another physician's description of a complete initial evaluation, relying on a second-hand account of the patient's medical history cannot provide as full an understanding of the patient to the physician. The patient may not only have to undergo a duplicative evaluation by the new physician, there also may be duplication of laboratory and other tests. The new physician will often experience delays in obtaining copies of the patient's medical record. Sometimes parts of the record will be in other cities; sometimes, they will be located in hospital records departments that are so backlogged with requests for copies that it takes days to weeks before they can fulfill a new request for copies. Consequently, the new physician may have to repeat blood tests, x-rays, and other diagnostic procedures to complete the initial evaluation of the patient.

B. The Threat to Continuity from Health Care Reform

Health care reform threatens continuity in the patient-physician relationship because it is driving the U.S. health care system more toward insurance provided by prepaid, comprehensive health plans like health maintenance organizations (HMOs) and away from insurance provided by traditional, fee-for-service plans like Blue Cross-Blue Shield. In doing so, re-
form is eliminating the independence of the patient’s choice of physician from the patient’s choice of insurance. With a traditional fee-for-service plan, the costs of care are covered no matter which physicians the patients see. With an HMO, the costs of care are covered only when the patients see one of the physicians whom the HMO employs or contracts with to provide services to the HMO’s subscribers. Consequently, when patients choose their HMOs, the patients are simultaneously choosing their physicians.

The linkage between patients’ choice of an HMO and their choice of physicians increases the likelihood of discontinuities in the patient-physician relationship for several reasons. First, when patients initially choose to receive care from an HMO, they may find that some or none of their current physicians are on the HMO’s panel. Consequently, patients may have to sever existing relationships with their physicians and receive their care from different physicians. Second, if patients become dissatisfied with their HMO and decide to switch to a different HMO, they also will have to switch to the new HMO’s panel of physicians. Third, patients may be satisfied with their choice of HMO and the physicians from whom they receive care but find that one or more of their physicians transfer to a competing HMO. The patients then must choose between following the physician(s) who move(s) or staying with the physician(s) who remain(s) with their current HMO. Fourth, patients may receive their health care as a benefit of employment and find that their employers no longer offer the current HMO as an option. To retain the employers’ contribu-

6. In some HMOs, if patients see a physician outside the HMO, the HMO will provide coverage but will cover a smaller percentage of the physician’s fees than when patients see a physician within the HMO. In emergency settings when it is not possible to receive care from HMO physicians, the plan also will cover the costs of care received from non-HMO physicians.

Although HMOs limit the physicians whose services will be covered, they typically cover more of the costs of physician services than do traditional fee-for-service plans. While fee-for-service plans might require patients to pay a copayment of 20% of the costs of physician services, HMOs might require no copayment or a copayment of $10.00, no matter how high the cost of physician visits.

7. If patients become dissatisfied with the HMO because of the care provided by the physicians, then the discontinuities in care are appropriate. However, patients may be happy with the care received from physicians but dissatisfied with other aspects of the HMO’s operations. For example, patients may dislike a requirement that they be seen by a nurse initially and by a physician only upon referral by the nurse.

8. Emanuel & Brett, supra note 2, at 880.
tion to the cost of the health insurance, patients may have to switch to other insurance plans.

In sum, to the extent that health care reform results in a shift in health insurance from fee-for-service plans to prepaid, comprehensive care plans, patients are more likely to find that they are unable to maintain long-standing relationships with their physicians. As a result, they will be unable to realize the benefits from such relationships.

C. Responding to the Risk of Discontinuities

How should society respond to the risk of greater discontinuities in patient-physician relationships from the shift toward prepaid, comprehensive health care plans? While some consider this risk an important argument in favor of a Canadian-style health care system in which patients are free to seek care from any physician and the government reimburses the physician for the care provided,9 the concern about discontinuities in the patient-physician relationship cannot alone settle the debate between managed competition and single-payer care given all of the other advantages and disadvantages of managed competition and single-payer systems. There are many ways within a system of HMO-style care in which discontinuities can be limited. For example, many HMOs allow patients to seek care from physicians outside of their panel as long as the patient pays a somewhat higher copayment for the outside physician services. Under such a system, patients could maintain some independence between their choice of insurers and their choice of physicians.

II. DIVISION OF THE PHYSICIAN'S FIDUCIARY DUTY OF LOYALTY

Health care reform also poses a serious threat to the physician's fiduciary duty of loyalty to the needs of patients. Again, before analyzing the threat from health care reform, it is important to consider the physician's duty of loyalty.

9. Id. at 881.
A. The Importance of the Physician’s Duty of Loyalty

Traditionally, the patient-physician relationship has been viewed as a fiduciary relationship in which the physician owes the patient a fundamental duty to place the patient’s interests first, above not only the physician’s personal interests but also the interests of other patients. This duty of loyalty arises primarily from the unequal relationship between patients and physicians.

Physicians are expected to place the interests of their patients foremost because they possess an inherent power over their patients. When suffering from an illness, people are in a most vulnerable state, both physically and psychologically. Sickness immediately interferes with physical activity and makes people feel apprehensive about their future. They worry that they might lose their ability to continue their careers, enjoy relationships with their family and friends, or pursue desired leisure activities.

Not only are patients unusually vulnerable, they are also unusually dependent. Patients not only lack medical knowledge, but, once disabled by illness, they also may be unable to undertake the research efforts necessary to educate themselves about their medical conditions. Several decisions may have to be made before the patients could gain sufficient understanding about their illnesses. Patients must ultimately rely on their physicians’ judgment when their health, and indeed their life, may rest in the balance. In order for patients to rely so heavily on their physicians when they are most vulnerable, patients must be able to trust deeply in their physicians’ dedication to their interests. Such deep trust would not be possible without assurances from the physicians that patients will not have their interests sacrificed in favor of the interests of their physicians or of other patients.

For generations, physicians have earned the trust of their patients by professing to place patient welfare before all other concerns. This tradition of elevating patient interests above other interests has endured through the ages as a guiding tenet.
of medical practice.\textsuperscript{11} The willingness of patients to turn to physicians for care, to speak openly about intimate and potentially embarrassing information, and to rely on their physicians' recommendations depends in large part on the ability of patients to trust that physicians are acting primarily to advance the interests of their patients.

The duty of loyalty underlies a wide range of ethical obligations of physicians. Physicians must maintain the confidentiality of their patients' disclosures,\textsuperscript{12} care for patients who are too poor to pay for their care,\textsuperscript{13} and care for the sick even when doing so exposes them to personal health risks.\textsuperscript{14}

To be sure, there have always been conflicts of interest that divide physicians' loyalty to patients. Fee-for-service medicine encourages physicians to order unnecessary tests or perform unnecessary operations that not only may cause economic harm to their patients, but also may cause physical harm if complications ensue.\textsuperscript{15} Similarly, when physicians assume responsibility for the care of multiple patients, they often may find that more than one patient requires attention at a given time. As a result, physicians may delay attending to one patient while providing care to another patient. Nevertheless, these conflicts have not seriously undermined patient trust in physicians. Indeed, surveys by the Gallup poll taken over the past fifteen years have consistently found that the public has greater trust in physicians than almost all other professionals.\textsuperscript{16}

B. The Threat to Physician Loyalty from Health Care Reform

While conflicts of interest that divide the physician's duty of loyalty are not new, they are likely to be accentuated under

\begin{enumerate}
\item \textit{Id.} at 24-26.
\item AMA Code of Ethics, \textit{supra} note 1, at § 5.05.
\item For example, during unnecessary surgery, the patient may die because of the anesthesiologist's negligent administration of anesthetic drugs.
\end{enumerate}
health care reform. Health care costs have risen dramatically over the past three decades; they now consume nearly 14% of the Gross Domestic Product (GDP). The need to restrain health care costs will place greater pressure on physicians to conserve resources when treating their patients, so that sufficient resources will be available to provide care for other patients. The physician's duty of loyalty to patients will be divided into a dual loyalty to patient and to society. In addition, as measures are being adopted to make physicians more conscious of costs, the dual loyalty is being converted into a triple loyalty; there is an increasing conflict between the personal financial interests of physicians and the needs of patients. For example, managed care plans typically pay physicians bonuses for keeping their spending on patient care low. Accordingly, by withholding potentially beneficial care from their patients, not only can physicians preserve scarce health care resources, but they also can increase their income.

1. Balancing the Needs of Individual Patients with the Needs of Other Patients

Specific aspects of health care reform will increasingly divide the physician's duty of loyalty, requiring physicians to balance the needs of individual patients with those of other patients and the needs of society. As efforts intensify to contain health care costs, there necessarily will be coverage for fewer medical services. Even if wasted health care spending could be eliminated, it still would not be possible to fund all useful medical care. Some treatments will provide so little benefit

18. Competition for resources will come not only from the health care needs of other patients but also from the need to fund other social goods. David M. Eddy, Health System Reform: Will Controlling Costs Require Rationing Services?, 272 JAMA 324, 324 (1994). Currently, there are pressing demands for funds to improve education and housing and to reduce crime.
19. PHYSICIAN PAYMENT REVIEW COMM'N, ANNUAL REPORT TO CONGRESS 275-81 (1989); Allan L. Hillman et al., HMO Managers' Views on Financial Incentives and Quality, HEALTH AFF., Winter 1991, at 207, 210-11 (examining the use of specific financial incentives among HMOs).
20. Eddy, supra note 18, at 328.
that their benefit will not justify their cost; other treatments will be so costly that their benefit also will not justify their cost. Accordingly, society needs to devise some methods for choosing when treatment will be covered and when it will not be covered.

Consider the following examples. When a patient suffers a heart attack, physicians could treat the patient with either tissue plasminogen activator (t-PA) or streptokinase to dissolve the blood clot that caused the heart attack, thereby increasing the patient's chance of surviving. T-PA costs $2000 more per patient than streptokinase, but it may lower the risk of death by an additional 1% beyond the diminution in risk achieved by using streptokinase. Is the 1% increase in survival worth $2000 in additional costs?

Similarly, when performing certain x-rays, CT scans, and other radiologic studies, physicians can use low osmolar contrast media rather than high osmolar contrast media, thereby reducing the risk to patients since the low osmolar media cause fewer adverse reactions. Should the low osmolar media be used even though they are many times more expensive than the high osmolar media?

Coronary artery bypass surgery also raises difficult cost-benefit questions. How much extra benefit over non-surgical

22. According to a recent study, the death rate for patients treated with streptokinase was 7.3%; with t-PA, the death rate was 6.3%. The GUSTO Investigators, An International Randomized Trial Comparing Four Thrombolytic Strategies for Acute Myocardial Infarction, 329 New Eng. J. Med. 673, 676-79 (1993); Valentin Fuster, Coronary Thrombolysis — A Perspective for the Practicing Physician, 329 New Eng. J. Med 723, 723 (1993).

23. If $2000 buys a one percent increase in survival, then $200,000 presumably buys an additional life. In fact, it is not quite that straightforward. Other studies have not found any difference in survival between the two drugs, Fuster, supra note 22, at 723, so there is some question whether the 1% difference between t-PA and streptokinase is a real difference. I am indebted to Professor Baruch A. Brady, Baylor College of Medicine, for this example.

24. Contrast media are liquid solutions that are given to a patient before certain kinds of x-rays, CT scans, or other radiologic studies so that the area being studied shows up more clearly on the x-ray or scan. The osmolarity of a medium refers to the extent to which solid substances are dissolved in the liquid solution. For example, if one tablespoon of salt is dissolved in one bottle of water and a teaspoon of salt is dissolved in another bottle of the same size, the first bottle will have a higher osmolarity.

25. Hitoshi Katayama et al., Adverse Reactions to Ionic and Nonionic Contrast Media: A Report from the Japanese Committee on the Safety of Contrast Media, 175 Radiology 621, 622 (1990). While the low osmolar media cause fewer non-fatal adverse reactions, there is no difference between the two contrast media in the risk that the patient will die from their use. Id.
treatment must we obtain from coronary artery bypass surgery to justify the higher cost? Is a year without chest pain sufficient benefit, or must there be at least one year longer survival? Would a two-year or even five-year longer survival be a sufficient benefit? How likely must it be that the extra benefit will be realized? Should there be a certainty of 10, 25, or 50%? These kinds of questions are prevalent and must be answered by society when it chooses how to allocate its limited health care resources.

During the health care debate in 1993-94, the legislative proposals for reform provided little guidance for resolving these questions. For example, among the reform proposals, the Clinton plan arguably provided the most detailed definition of covered benefits. The Clinton plan expressly included coverage for childhood vaccinations, and limited coverage for mental health treatment to thirty days per episode of inpatient care and thirty visits per year for outpatient care. However, for the most part, the bill did not address the rationing decisions that will have to be made. The bill offered comprehensive hospital and physician services, subject to only a few exclusions, and when the bill excluded care that is not medically necessary, it did so without indicating how it would be decided whether a particular treatment for a particular patient is or is not medically necessary.

Rationing decisions could be made by the individual health care plans. Currently, for example, health care insurers make decisions about the extent to which they will cover experimental treatments like bone marrow transplantation for metastatic breast cancer. However, these organizations, like the Clinton plan itself, could fail to address the bulk of rationing

27. Id. § 1115(c)(2)(C).
28. Id. § 1115(e)(2)(C).
29. Id. § 1101.
30. Id. § 1101(b).
31. See id. § 1141(a). The bill excluded care "that is not medically necessary or appropriate" or "that the National Health Board may determine is not medically necessary or appropriate." Id. The National Health Board would have been authorized to establish regulatory standards regarding medical necessity. Id. § 1154.
decisions, leaving the decisions by default to individual physicians. Physicians may be given the instruction to provide care only when it is medically necessary and then be expected to determine when care actually is medically necessary. When treating patients, physicians would have to consider whether additional treatment would provide sufficient benefit or whether the resources should be conserved for other patients.

Even if the government and health plans take an active role in resolving allocation questions, there will still be a good deal of decision making left for physicians. It will take some time to assess the value of a particular treatment and decide whether it should be covered. It took Oregon several years and millions of dollars to develop its rationing plan for Medicaid benefits, and even that rationing plan, despite its complexity, leaves many questions unanswered. While rationing guidelines are being developed, physicians will have to make rationing decisions without guidance from other potential decisionmakers. In addition, it simply is not possible to establish guidelines for all of the judgments that are required. The appropriateness of a particular test or treatment depends on the balancing of a number of factors, including the likelihood of benefit, degree of benefit, duration of benefit, and cost, and there is no formula that can tell physicians how to weigh a low likelihood of benefit against a high degree or duration of benefit. Finally, even if detailed guidelines could be developed,
they would likely become outdated by the time they were issued. Medical knowledge is constantly evolving, so only reasonably general guidelines can account for changes in information and technology. While the government and the medical specialty societies are issuing many practice guidelines for physicians, the guidelines will never be able to address the universe of rationing decisions that must be made, and society will have no choice but to leave many of these decisions to physicians.

Some have argued that physicians should make rationing decisions not simply because there is no other choice but because doctors are the appropriate decisionmakers. For example, E. Haavi Morreim argues that, if persons other than physicians make these decisions, then they will in effect be practicing medicine without a license, and physicians will not be practicing medicine, but will be carrying out medical decisions made by laypersons. While Morreim is correct that physicians should be making these decisions, it is not because these are medical decisions that can be decided simply by applying medical expertise. Rather, rationing decisions are ultimately value judgments about balancing benefits against costs and deciding when there is sufficient benefit to justify the use of society's limited health care resources. These are judgments that laypersons are as qualified as physicians to make.

Consider the following example that illustrates how medical judgments are no different in kind from other value judgments. As a general rule, obstetricians offer amniocentesis to check for Down syndrome in pregnant women without a family history of Down syndrome only if the women are at least thirty-five years old. This general rule reflects, in part, the fact that, when the woman is age thirty-five or over, the risk

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37. According to a recent report, the federal government's practice guidelines have had little effect in changing physicians' practices, in part because they are often too vague to give adequate guidance in specific situations. See Joe R. Neel, Guidelines Go Unheeded: A Government Effort to Change Doctors' Behavior Draws Apathy Instead, PHYSICIAN'S WKLY., Aug. 22, 1994, at 13 (discussing the lack of patient outcomes and targets in guidelines issued by the Agency for Health Care Policy and Research).


that the fetus will suffer from Down syndrome is equal to or
greater than the risk that the amniocentesis will inadvertently
abort the fetus. In other words, the medical community has
concluded that women should be offered amniocentesis only
when the likelihood of detecting a Down syndrome fetus equals
or exceeds the risk of aborting a normal fetus. This conclusion
may be a reasonable balance to draw between the benefits and
risks of an amniocentesis, but it is also the case that many
women may have very strong feelings about not having a Down
syndrome child and may therefore want to undergo amni-
ocentesis unless the risk of an abortion is five, ten, or even
twenty times that of the risk of a Down syndrome fetus. These
women might reason that they can always try to become preg-
nant again, but they cannot undo the birth of a child with
Down syndrome. In short, reasonable people can differ on the
appropriate place to draw the balance, and there is nothing
about medical expertise that helps us settle the question.

But if these decisions are ultimately value judgments for
which physicians have no special expertise, then why should
physicians have responsibility for making them? There are very
good reasons why we should prefer not to have physicians make
rationing decisions. First, physicians may overestimate the need
to conserve resources, thereby undertreating some of their pa-
tients, or they may overestimate the benefit from some treat-
ments, thereby overtreating other patients. Physicians cannot
possibly assimilate all of the information needed to make ra-
tioning decisions. They would need to know not only how much
benefit the patient might receive from treatment, how likely it
would be that the benefit be realized, and how much it would
cost for the treatment, but they also would have to know what
other social benefits would be realized if the funds were used
for other patients or other kinds of social services. Second,
there would be a good deal of inconsistency from physician to
physician. Some physicians will err in favor of conserving soci-
ety's limited resources; others will err in favor of treating the
patient before them. Whether patients will be treated, then,
may turn more on their particular physician's views than any

40. Susan P. Pauker & Stephen G. Pauker, Prenatal Diagnosis: Why Is 35 a Magic
and attitudes also should be factored into the testing decision).
PATIENT-PHYSICIAN RELATIONSHIP

The argument for relying on physicians to make rationing decisions, then, is that they are good decisionmakers, but that there is no better way to make rationing decisions and that there are important efficiencies in having physicians make these decisions. As discussed previously, it is not possible for other members of society to establish rationing guidelines that will resolve all rationing questions. Accordingly, physicians will frequently be faced with rationing decisions for which there are no clear answers. In theory, physicians could bring these decisions to another party, an administrative judge, perhaps, when the state is providing their patients' health care coverage, or a claims reviewer, perhaps, when patients subscribe to private insurance plan for coverage. However, given the tremendous number of decisions that must be made, it would be too cumbersome to bring each decision to a third party. On the other hand, if physicians make these decisions, it will be administratively very efficient. Physicians will know much of the information about the benefits, risks, and costs of treatment that is relevant to making the rationing decisions that are before them.

Because of the concerns about physician decision making, it is important that society issue rationing guidelines that are as specific as possible to lead physicians in the right direction. It is also essential to adopt safeguards to prevent physicians from

41. Even before rationing became a serious concern, physicians varied widely in their use of certain procedures. One study demonstrated that patients in Boston were much more likely than similar patients in New Haven to be hospitalized. John E. Wennberg et al., Are Hospital Services Rationed in New Haven or Over-utilised in Boston?, LANCET, May 23, 1987, at 1185. Another study found that some physicians at one hospital were twice as likely as their colleagues to perform cesarean sections, even after controlling for differences among the patients. See Gregory L. Goyert et al., The Physician Factor in Cesarean Birth Rates, 320 NEW ENG. J. MED. 706, 708 (1989). See also David Blumenthal, The Variation Phenomenon in 1994, 331 NEW ENG. J. MED. 1017, 1017-18 (1994) (discussing differences in the treatment received by similar patients in different places); David Orentlicher, The Illusion of Patient Choice in End-of-Life Decisions, 267 JAMA 2101, 2101-03 (1992) (discussing the primacy of physician values over patient preferences in decisions to withholding or withdraw life-sustaining treatment).
deviating from the spirit of those guidelines when they are applying them to decisions not clearly settled by the guidelines.

A number of unsatisfactory approaches have been suggested to guide physicians. E. Haavi Morreim has proposed that physicians test their proposed action by its generalizability. Morreim argues that, when physicians are considering a particular test or treatment and they are concerned about its affordability, they should ask themselves whether the patient's health care plan could afford to have physicians provide the proposed test or treatment every time the same situation arose.\(^4\) While Morreim articulates an excellent principle, it does not provide specific enough guidance for physicians. As already discussed, one of the major objections to physician decision making is the fact that each physician will draw the balance among different patients' needs differently, depending on the physician's own values and assessments of what the system can afford. Morreim's approach does not adequately address that problem.

Susan Wolf has suggested a sliding scale approach, with greater obligations to provide treatment when harm can be prevented than when benefit can be conferred. Specifically, Wolf argues that physicians have (a) the "strongest duty" to provide treatment when the treatment is likely to prevent "great harm" to the patient, (b) a "strong duty" to provide treatment when the treatment is likely to prevent "some harm," (c) a "duty" to provide treatment when the treatment is likely to confer "great benefit," and (d) a "weak duty" to provide treatment when treatment is likely to confer "some benefit."\(^4\) Wolf's basic point is an important one; the greater the need for treatment, the greater the obligation to provide it. Yet, her guidelines, too, lack sufficient specificity.

What will physicians do when faced with a situation for which there is a "weak duty" to provide care? Does this duty entail a presumption that the treatment should be provided but that the presumption should be overridden if there are countervailing circumstances? Which countervailing circumstances would count? Would the obligation to treat turn on the current

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42. Morreim, supra note 38, at 128.
balance sheet of the health plan or on whether there are other patients with more compelling needs vying for the physician's time?

Wolf's proposal also has some theoretical problems when it distinguishes preventing harm from conferring benefit. Why should there be the strongest duty to prevent great harm but only a simple duty to confer great benefit? What exactly is the distinction between preventing harm and conferring benefit? If a physician lowers a patient's risk of dying, is that preventing harm (avoiding death) or conferring benefit (prolonging life)?

2. Financial Incentives to Encourage Cost-Conscious Practices by Physicians

Recent legislative proposals have not informed us how physicians would be guided, but we can easily deduce how they would be guided from the emphasis on having health care provided by HMOs and other managed care plans. Managed care plans rely heavily on personal financial incentives for physicians to encourage greater cost consciousness among physicians when making treatment decisions.\(^4^4\) For example, the plans often compensate physicians with capitation fees or a salary. With a capitation fee, since the physicians earn a fixed amount of money per patient, physicians cannot increase their income by providing more services to their patients, as with fee-for-service care.\(^4^5\) Similarly, physicians paid by salary have no financial incentive to provide more services. Rather, when their income is fixed by capitation or salary, physicians have an incentive to provide fewer services and free up more time for leisure or other activities.

In addition to incentives for physicians to limit their own services, managed care plans typically employ incentives for physicians to limit their use of diagnostic tests, referrals to other physicians, hospital care, or other ancillary services.\(^4^6\)

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44. See generally Hillman et al., supra note 19, at 207 (examining the use of specific financial incentives among HMOs).
45. However, physicians can increase their income by assuming responsibility for the care of greater numbers of patients.
46. These incentives are needed to discourage physicians from circumventing cost controls by substituting ancillary services for their own services. If cost controls make it more difficult for physicians to provide additional care, physicians otherwise could avoid the cost controls by referring the patient to other physicians for care.
example, managed care plans often pay bonuses to physicians, with the amount of the bonus increasing as the plans’ expenditures for patient care decrease. Managed care plans often withhold a fixed percentage of physician compensation until the end of the year to cover any shortfalls in the funds budgeted for expenditures on patient care. If there is no shortfall, or the shortfall can be covered by part of the withheld fees, the remaining withheld fees are returned to the physicians.

Financial incentives may be common, but they are nevertheless controversial. They not only impel physicians to balance the needs of their patients with the needs of other patients, they also accentuate the conflict between patient needs and the personal financial interests of physicians. In other words, there is not only a dual loyalty but a triple loyalty.

The concerns with incentives to limit care are significant. Physicians may be tempted to cut corners or start viewing as elective those treatments that were previously considered necessary. Physicians also might delay or omit diagnostic tests or therapeutic procedures, or they might assume responsibility for care that should be referred to more expert and more expensive specialists. Even in the absence of actual physical harm to patients, incentives to limit care may compromise the trust that patients place in their physicians. If patients realize that their physicians are being pressured with financial rewards to economize on care, then patients will likely wonder whether treatment is being withheld because it is unnecessary or because their physicians have financial reasons to withhold the care. For example, patients with heart disease treated by drugs rather than surgery may start to worry that they are being denied surgery because of their physicians’ personal financial interests.

Financial incentives to withhold services are also problematic because their effects may not be apparent to patients. When physicians recommend an invasive diagnostic test, surgery, or some other course of action, patients may choose to seek a second opinion before undertaking the risks and costs of the action. However, when physicians do not offer an intervention, patients may have no idea that a diagnostic or treatment

47. In one study, more than half of HMOs used fee witholds as an incentive for their physicians to limit care. Hillman et al., supra note 19, at 211.
49. Id.
option was withheld and therefore not realize that a second opinion might be appropriate.\(^\text{50}\)

Nevertheless, there are several reasons why incentives to limit care may not compromise the quality of medical care. First, while physicians are motivated by financial concerns,\(^\text{51}\) they also are strongly devoted to other values and goals, in particular, to enhancing the health of their patients. Physicians clearly seek financial gain, but it is not clear that they would sacrifice the welfare of their patients to do so.

Second, the threat of malpractice liability provides a strong deterrent to the withholding of necessary care. Physicians already are prone to practice defensive medicine—their perception of the risk of a malpractice lawsuit is up to three times the actual risk of suit.\(^\text{52}\) Hospitals and health care plans are also at risk from physician malpractice and therefore have strong incentives to monitor quality of care and ensure that appropriate care is not withheld by physicians.

Third, it is possible that financial incentives to limit care will lead to care with fewer complications and more efficient utilization of health care resources. For example, because delays in intervention can allow a disease to develop or progress and become more costly to treat, incentives to limit care may actually result in more aggressive efforts to ensure that patients receive preventive and therapeutic services as early as possible. If physicians are penalized for high health care costs, they are more likely to try to prevent high costs from materializing. Indeed, many early proponents of HMOs encouraged their use because of their emphasis on preventive care, not simply as a means to contain health care costs. Studies have shown that HMO patients receive more preventive tests and examinations than patients who subscribe to traditional fee-for-service plans for their health care coverage.\(^\text{53}\)

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51. Future income plays an important role when medical students choose their fields of specialization. See Norman G. Levinsky, *Recruiting for Primary Care*, 328 NEW ENG. J. MED. 656, 658 (1993).


While there are theoretical arguments both in support of and in opposition to the claim that incentives to limit care will compromise physician decision making, the experience with incentives to expand services suggests that incentives to limit care will likely influence physician behavior. A number of studies have indicated that financial incentives to prescribe x-rays, physical therapy, or other medical services result in increased use of the services.\textsuperscript{4} If incentives to expand services result in greater use of those services and possibly overtreatment of patients,\textsuperscript{5} then it arguably follows that incentives to limit care will result in lower use of those services and possibly undertreatment.

It does not necessarily follow, however, that incentives to limit services will result in inadequate care. If, as many commentators believe, the harm to patient health is greater when necessary treatment is withheld than when unnecessary treat-
ment is provided, physicians are less likely to be influenced by incentives to limit care than by incentives to expand care. With incentives to limit care, physician concerns with patient welfare will be a stronger countervailing force. When physicians are uncertain whether to offer additional tests or treatments, concerns about protecting patient health may overcome the pull from any incentives to limit care and result in the physicians offering the extra tests or procedures.

Moreover, the existence of health care insurance makes it likely that physician practices have been affected more by incentives to expand care than they would be by incentives to limit care. The primary harm from excessive care is financial, but the current system of health care insurance dilutes the financial harm to patients from 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.

a. Empirical Studies of Incentives to Limit Care

A number of researchers have tried to examine the impact on quality of care from the use of financial incentives to limit care. There are two primary sources of data on the effects of incentives to limit care. First, studies have compared the health of patients treated under fee-for-service plans with the health of patients in prepaid health plans that typically employ financial incentives to limit care. If incentives to limit care result in patient harm, then these studies should find that patients in

56. When necessary treatment is withheld, a disease may worsen and become less responsive to later treatment. When unnecessary treatment is provided, patients suffer economic harm from the cost of the care. Patients also may be physically injured if one of the rare complications of the treatment occurs. For example, a patient undergoing unnecessary surgery may suffer a paralysis because the surgeon inadvertently cuts a nerve.

57. Measuring health is not the same as measuring quality of care. Some patients will do well even with poor quality care; other patients will do badly even with the best care. However, since it is more difficult to assess the quality of care than health status, researchers often look at health status on the assumption that over large numbers of patients, differences in health status will reflect differences in quality of care.
prepaid plans have a worsening of health relative to patients in fee-for-service plans.

Second, studies have compared both the health status and the quality of care for hospitalized patients under Medicare's earlier fee-for-service system of reimbursement with the health status and the quality of care for hospitalized patients under Medicare's current system of prospective reimbursement in which hospitals receive a fixed amount of compensation for each patient.\textsuperscript{58} If incentives to limit care cause harm to patients, then the patients should be doing worse from the time that Medicare changed its system of reimbursement.

i. Prepaid Health Plans. In one study, more than 1500 individuals were randomly assigned to receive health care either from an HMO or through a fee-for-service insurance plan. The HMO had lower costs than the fee-for-service plan, but, on average, there were no significant differences in health between individuals in the two plans three years after the study began.\textsuperscript{59} However, for individuals who were sick at the beginning of the study, different outcomes were found depending upon the individual's income. Among those sick patients who were in the top 40% of the income distribution, better health outcomes resulted for individuals in the HMO.\textsuperscript{60} Conversely, low-income, sick patients fared better with the fee-for-service system.\textsuperscript{61} In another study of chronically mentally ill patients who received their health coverage through Medicaid, the patients were randomly assigned to either fee-for-service care or prepaid health care. The researchers found no consistent evidence of harm to the health status of patients assigned to prepaid plans. On a few of the measurements used to assess health status, there

\textsuperscript{58} Medicare now reimburses under a system of capitated reimbursement which provides an incentive to limit care rather than a system of fee-for-service reimbursement which provides an incentive to expand care. While the amount of reimbursement is fixed, there are different reimbursement rates for different diseases, so that hospitals receive greater reimbursement when the patient has a disease that is expensive to treat. See Medicare Prospective Payment System, 42 U.S.C. § 1395ww (1988).

\textsuperscript{59} Elizabeth M. Sloss et al., \textit{Effect of a Health Maintenance Organization on Physiologic Health: Results from a Randomized Trial}, 106 ANNALS INTERNAL MED 130, 130 (1987) (finding that there were no differences in health status); John E. Ware et al., \textit{Comparison of Health Outcomes at a Health Maintenance Organisation with Those of Fee-for-service Care}, LANCET, May 3, 1986, at 1017.

\textsuperscript{60} Ware et al., \textit{supra} note 59, at 1021.

\textsuperscript{61} \textit{Id.}; John E. Ware et al., \textit{Health Outcomes for Adults in Prepaid and Fee-for-Service Systems of Care: Results from the Health Insurance Experiment}, at v-vi (Rand Paper No. R-3459-HHS, Oct. 1987).
were differences between patients in prepaid plans and those receiving fee-for-service care. However, there was no consistent pattern, with the fee-for-service patients sometimes doing better, other times not doing as well.\textsuperscript{62}

Other studies have yielded mixed results. In some early studies of care for obstetric patients or patients with rheumatoid arthritis, researchers found no difference in outcome between patients in prepaid plans and those in fee-for-service practices.\textsuperscript{68} However, in a recent study of elderly patients with chest pain or joint pain, researchers found that patients with joint pain were less likely to report an improvement in their pain when they received care from an HMO rather than under a fee-for-service insurance plan.\textsuperscript{64} In another recent study, on the other hand, researchers actually found a clear health benefit from prepaid health care. The study looked at patients with appendicitis, and the researchers found that patients enrolled in a prepaid health care plan were significantly less likely than patients receiving fee-for-service care to suffer a rupture of their appendix before their appendectomy.\textsuperscript{65} In other words, the fee-for-service patients were more likely to experience a delay between the development of their symptoms of appendicitis and the surgery to remove their appendix. The authors of the study

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\textsuperscript{62} Nicole Lurie et al., Does Capitation Affect the Health of the Chronically Mentally Ill?: Results from a Randomized Trial, 267 JAMA 3300, 3302 (1992).


\textsuperscript{64} Dolores G. Clement et al., Access and Outcomes of Elderly Patients Enrolled in Managed Care, 271 JAMA 1487, 1490 (1994). There were no differences in outcome between the HMO and fee-for-service patients with chest pain. Id. at 1491.

\textsuperscript{65} Paula Braveman et al., Insurance-related Differences in the Risk of Ruptured Appendix, 331 NEW ENG. J. MED. 444, 446-448 (1994) (comparing the adjusted risk of ruptured appendix according to type of insurance). If a patient with appendicitis suffers a rupture of the inflamed appendix before it is removed surgically, then the risk of death and other complications increases significantly.
\end{flushleft}
speculated that the higher deductibles and copayments in fee-for-service care may have discouraged the fee-for-service patients from seeking treatment as rapidly as their prepaid health care counterparts.

ii. Medicare's Prospective Payment System. Studies have also looked at the impact on health status and quality of care from the implementation of Medicare's Prospective Payment System (PPS) for hospital care. The studies compared Medicare patients who were treated before 1984, when Medicare reimbursed on a retrospective, fee-for-service basis, with patients who were treated after 1984, when Medicare started reimbursing on a prospective, fixed capitation basis. Although these studies involved hospital rather than physician reimbursement, they are likely to be informative. As hospitals are subjected to financial pressures to limit care, they will try to transmit those pressures to physicians because physicians largely control medical decision making.

Some small studies have shown mixed results from the implementation of Medicare's capitation system. In a study of patients who were treated in medical intensive care units in three community hospitals, researchers found no significant changes in the death rates of Medicare patients up to six months following discharge from the hospital. On the other hand, a study of elderly individuals in a single county found adverse effects on death rates from the implementation of capitated payments.

Another study of elderly patients with hip fractures found that

66. Fee-for-service insurance plans typically require the patient to pay a certain amount of health care costs each year, usually between $200 and $500 in an individual plan and more in a family plan, before the plan begins to pay for the patient's costs. Prepaid plans typically have no deductible.

67. Fee-for-service insurance plans generally require patients to pay a portion of each of their health care bills, often 20%, while prepaid plans typically have no copayments, or copayments of $5-10.

68. Braveman et al., supra note 65, at 448. See also supra text accompanying note 53 (discussing studies which have shown that HMO patients receive more preventive tests and examinations than patients who subscribe to traditional fee-for-service plans).


70. Gregory L. Lindberg et al., Health Care Cost Containment Measures and Mortality in Hennepin County's Medicaid Elderly and All Elderly, 79 AM. J PUB. HEALTH 1481, 1484-85 (1989) (reporting an increase in age-adjusted mortality rates among nursing home patients and the cessation of a downward trend in age-adjusted mortality rates among the elderly that occurred concurrently with the introduction of PPS).
Medicare patients were more likely to be in a nursing home one year after their fractures after the change to the capitated system.\footnote{71} Although these small studies indicate that patient welfare may have suffered from Medicare's adoption of capitated payments, a large, carefully conducted study has suggested the opposite result. In that study, researchers examined the care of nearly 17,000 patients in five states who were hospitalized for treatment of congestive heart failure, heart attack, pneumonia, stroke, or hip fracture.\footnote{72} The prospective system was introduced in 1984, and the researchers compared patient care in 1981-82 with care in 1985-86. For the patients in 1985-86, there was no increase in death rates, either during hospitalization or six months following admission of the patients to the hospital,\footnote{73} and the patients were more likely to receive good quality care during their hospitalizations.\footnote{74} Although patients were more likely to be unstable medically when discharged from the hospital,\footnote{75} that does not mean that there was harm to their health. It may be that although patients were discharged earlier under the new system, appropriate outpatient medical services were provided in lieu of hospital care to complete their course of treatment.

\footnote{71. John F. Fitzgerald et al., \textit{The Care of Elderly Patients with Hip Fracture: Changes Since Implementation of the Prospective Payment System}, 319 New Eng. J. Med. 1392, 1395 (1988) (finding that the rate of nursing home residence one year after hospitalization increased by 200\% after initiation of PPS).}

\footnote{72. Katherine L. Kahn et al., \textit{The Effects of the DRG-based Prospective Payment System on Quality of Care for Hospitalized Medicare Patients: An Introduction to the Series}, 264 JAMA 1953, 1954 (1990) (providing an overview of the study methods).}

\footnote{73. Katherine L. Kahn et al., \textit{Comparing Outcomes of Care Before and After Implementation of the DRG-based Prospective Payment System}, 264 JAMA 1984, 1985 (1990) (reporting similar survival curves before and after implementation of PPS for all five conditions).}

\footnote{74. Lisa V. Rubenstein et al., \textit{Changes in Quality of Care for Five Diseases Measured by Implicit Review, 1981 to 1986}, 264 JAMA 1974, 1977 (1990). The improvement in quality of care probably reflected factors other than the change in Medicare reimbursement. Joseph P. LoGerfo et al., \textit{The Prospective Payment System and Quality: No Skeletons in the Closet}, 264 JAMA 1995, 1995-96 (1990) (noting that professional ethics and changes in peer review organizations may serve to protect quality). For example, in the four-year period, there were the usual improvements in quality of care that occur over time.}

\footnote{75. Jacqueline Kosecoff et al., \textit{Prospective Payment System and Impairment at Discharge: The 'Quicker-and-Sicker' Story Revisited}, 264 JAMA 1980, 1982 (1990) (reporting a 22\% increase after implementation of PPS in the number of Medicare patients discharged unstable).}
While the data on instability need to be further investigated, the studies overall suggest that patient harm has not resulted from the inherent financial incentive for hospitals to limit care under Medicare's capitated payment system. Still, a decline in quality of care could have been hidden by manipulation of diagnoses. It may be that implementation of the capitated payment system encouraged physicians or hospital administrative staffs to assign more severe diagnoses to patients to assure higher Medicare reimbursement. If the patients had worse outcomes from poorer care under the capitated payment system, it would be erroneously attributed to their more severe diagnoses rather than to their poorer care. In addition, the impact of capitated payment on quality of care might have been more detrimental if hospitals were not able to engage in cost-shifting from Medicare patients to patients with private, fee-for-service insurance.

To date, the available data suggest that, in the aggregate, incentives to limit care are not significantly compromising patient care, but that some patients, particularly the poor, may be adversely affected. However, there are not sufficient empirical data to draw definitive conclusions about the effect on patient welfare from incentives to limit care. The studies also are not rigorous enough to exclude the possibility of undetected harmful consequences. Finally, much of the data was developed in the early stages of cost containment when there was more fat to cut out of health care spending and when private insurers tolerated more cost-shifting. Consequently, while the data may have reflected the impact of incentives to limit care at one time, they may no longer be valid.

C. Responding to the Divisions of Loyalty

Given the potential for harm to patient welfare and to the integrity of the patient-physician relationship, some commenta-
tors argue that financial incentives to limit care should be prohibited. Other commentators believe that the incentives should be allowed as long as they are regulated so that physicians are sensitive to costs when making treatment decisions but are not so concerned about protecting their income that they would compromise patient welfare.

1. Eliminate Financial Incentives that Have a High Potential for Abuse

Commentators have identified several characteristics of financial incentives that are important indicators of whether physicians are being given too strong an incentive to limit care. These characteristics include: (a) the amount of financial risk borne by the physicians, (b) whether incentives are tied to the performance of physicians individually or as a group, and (c) the length of time over which physician performance is measured.

a. Amount of Financial Risk Shifted

Health insurers may shift financial risk to physicians in a number of ways. A percentage of physician fees may be withheld until the end of the year to cover deficits in the fund for expenditures on diagnostic tests, referral services, hospital care, or other ancillary care. Withheld funds can be used to cover a narrow range of services like diagnostic tests and referrals to specialists or to cover the full range of ancillary services. As the breadth of services covered by the withheld funds increases, the amount of risk shifted to physicians increases. Risk also may be shifted by varying the fee paid for a particular service from month to month depending upon the extent to which services are utilized. For example, a physician who ordinarily receives $100 for a service may receive $80 one month, when utilization of services is high, and $120 in a month when utilization of services is low.

78. See, e.g., Wolf, supra note 43, at 37.
79. See, e.g., PHYSICIAN PAYMENT REVIEW COMM’N, supra note 19, at 292; Hillman et al., supra note 19, at 218.
80. PHYSICIAN PAYMENT REVIEW COMM’N, supra note 19, at 287-88; U.S. GENERAL ACCOUNTING OFFICE, MEDICARE: PHYSICIAN INCENTIVE PAYMENTS BY PREPAID HEALTH PLANS COULD LOWER QUALITY OF CARE, GAO/HRD-89-29, at 23 (Dec. 1988).
81. See U.S. GENERAL ACCOUNTING OFFICE, supra note 80, at 17.
To avoid the shifting of excessive risk to physicians, stop-loss protections are typically used by managed care plans. With stop-loss protections, a physician's financial responsibility may be limited to a specified amount per patient and/or a specified amount per year for all patients. The health care plan would assume responsibility for the costs of care that exceeded the ceiling amounts. In its proposed rules, the Health Care Financing Administration (HCFA) requires that health care plans place no more than 30% of a physician's compensation at risk. On the other hand, in a survey of HMO managers, most managers generally felt that placing 15% of a physician's income at risk is enough to make physicians sensitive to the costs of care without inducing physicians to make inappropriate treatment decisions.

b. Number of Physicians Sharing the Risk

If physician incentive payments are based solely on each physician's own treatment decisions, there is a strong incentive to limit services for each patient. Every additional medical service will have a direct effect on the physician's income. When payments are based on the performance of a group of physicians, on the other hand, the strength of the incentive is diminished. For example, when payments are based on the record of twenty physicians, a physician will feel only 5% of the impact of any one decision rather than its full impact. Consequently, while the physicians will still recognize that their failure to economize will reduce their income, they will not face as strong a conflict between the needs of their patients and their own financial interests.

Basing the incentives on a group of physicians is useful for two other reasons. First, when physicians are placed at risk together, they have a collective incentive to ensure that their colleagues are practicing in a cost-effective manner. Second, if incentive payments are based on a large group of physicians, the payments will necessarily be based on the costs incurred by

82. Id. at 28.
84. See Hillman et al., supra note 19, at 212-13.
85. Physician Payment Review Comm'n, supra note 19, at 287.
a large pool of patients. When the patient pool is small, there is a risk that treatment costs will be skewed by an unrepresentative group of patients that have unusually high needs for medical care. The larger the patient pool, the more likely that its treatment costs will not be skewed but will reflect average costs. 86

c. Length of Time for Measuring Performance

The strength of a financial incentive also varies with the frequency of incentive payments. If payments are made monthly rather than yearly, the physician receives rapid feedback on the economic consequences of treatment decisions and is therefore likely to be more sensitive to those consequences. When incentives are calculated monthly, there also is less of an opportunity for the costs of cases that are above average to be offset by the costs of cases that are below average. Accordingly, there is a stronger incentive not to incur unusually high expenses in any one case.

In its proposed rules, HCFA permits less of a physician's income to be put at risk if incentive payments are made more frequently than once a year. If payments are made once a year, up to 30% of a physician's income may be placed at risk; if payments are made more frequently than once a year, up to 20% of a physician's income may be placed at risk. 87

2. Eliminate the Incentives Entirely

Limiting the kinds of incentives that can be offered is an important step; however, some commentators argue that it is not sufficient just to eliminate only the most dangerous incentives. They observe that there is no objective method for defining "too dangerous" an incentive, and the definition chosen may fall short of that needed to protect patient welfare. While prohibiting the more serious incentives would lower the risk to patients, it would not eliminate the risk. Further, the risk to patient trust may depend as much on the existence of incentives to limit care and the divided loyalties they create as on

their magnitude. Even relatively moderate incentives can cause patients to question their physicians' commitment to patient needs. Accordingly, these commentators advocate the elimination of financial incentives to limit care entirely, on the grounds that they pose too great a threat to patient welfare and that alternative measures to contain costs can be utilized.  

There are several problems with this view. First, as to the argument that the risk to patient trust depends as much on the existence of incentives as on their magnitude, all compensation systems reward physicians either for providing too much care, as with fee-for-service, or for providing too little care, as with capitation fees or salary. As commentators have noted for decades, the traditional fee-for-service system leads to a good deal of unnecessary medical care, and such care can be not only economically injurious to patients but also detrimental to their health if one of the inherent risks of medical care materializes. Paying physicians on a salaried basis would remove their incentive to overserve their patients, but it would leave them with an incentive to underserve them. By seeing fewer patients, scheduling fewer follow-up visits, and performing fewer procedures, salaried physicians can free up more time for alternative activities, such as consulting, research, or leisure, without losing any income. It simply is not possible to have a compensation scheme that avoids all incentives for physicians to provide inappropriate care to their patients. It may be possible to reduce the magnitude of the conflict of interest between a physician's personal financial interests and patient welfare, but there will always be some conflict of interest. 

Second, as to the argument that costs can be controlled without using financial incentives to limit care, while prohibition of incentives to limit care would limit the risk to patient welfare, it is not clear that alternative measures to contain costs are sufficiently effective. For example, health care plans have used educational interventions to modify physician use of

88. See Mark Rodwin, Money, Morals and Ethics 232-33 (1994); Wolf, supra note 43, at 37.
89. For example, some patients who receive unnecessary coronary artery bypass surgery may die during surgery.
services. These interventions include efforts to improve physician awareness of the costs of and medical indications for tests, procedures, and treatments and to provide feedback to the physicians regarding their expenditures for patient care and the medical appropriateness of their practices. A number of studies have demonstrated the effectiveness of educational interventions at reducing the utilization of services.\(^{91}\) It also appears that the interventions can reduce overutilization of medical services without increasing underutilization.\(^{92}\) However, the effects of the interventions often disappear after the interventions have ended, and the administrative costs of the interventions may be so high that overall costs savings are small.\(^{93}\)

It is not surprising that educational efforts to instill greater cost consciousness among physicians have shown mixed results at best.\(^{94}\) There is substantial literature on the ineffectiveness of educational efforts in changing physician practices. This literature primarily deals with efforts to achieve higher quality care, but its lessons are nevertheless important for efforts to achieve lower cost care. In general, the studies have shown that simply developing and disseminating educational guidelines is not sufficient to change physician behavior, even

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91. See Donald M. Berwick & Kathryn L. Coltin, *Feedback Reduces Test Use in a Health Maintenance Organization*, 255 JAMA 1450, 1453 (1986) (finding that feedback on the cost of test ordering relative to peers resulted in a 14.2% decline in utilization of eleven tests); Albert R. Martin et al., *A Trial of Two Strategies to Modify the Test-ordering Behavior of Medical Residents*, 303 NEW ENG. J. MED. 1330, 1334 (1980) (finding that chart review resulted in greater reductions in lab testing than did financial incentives for residents); Joel M. Schectman et al., *Effect of Education and Feedback on Thyroid Function Testing Strategies of Primary Care Clinicians*, 151 ARCH. Intern. Med. 2163, 2165 (1991) (reporting improved compliance with test ordering guidelines after the circulation of an educational memo); William M. Tierney et al., *The Effect on Test Ordering of Informing Physicians of the Charges for Outpatient Diagnostic Tests*, 322 NEW ENG. J. MED. 1499, 1503 (1990) (finding that physicians ordered fewer tests when presented with test charges during the ordering process).


when there is widespread knowledge among physicians about the guidelines.

The failure of educational efforts is illustrated by the experience with efforts to reduce the frequency of cesarean sections. Commentators have observed that physicians perform too many cesarean sections. Between 1965 and 1986, the cesarean section rate steadily rose in this country from 4.5% to about 23%.\textsuperscript{95} Even though professional societies in medicine have tried to encourage more appropriate use of cesarean sections, the cesarean section rate has remained high both in the United States and Canada.\textsuperscript{96} For example, after Canada's Society of Obstetricians and Gynaecologists issued practice guidelines that delineated the circumstances that justify a cesarean section, roughly 90% of obstetricians reported that they knew about the guidelines, and more than 80% reported that they agreed with the guidelines.\textsuperscript{97} Yet, two years after the release of the practice guidelines, there was only a small decrease in the cesarean section rate. Even if that small decline multiplied over time, it would take more than thirty years for Canada's cesarean section rate to reach the medically desirable level.\textsuperscript{98} Similar results occurred in the U.S. following issuance by the National Institutes of Health (NIH) of a guideline for cesarean sections. Researchers found that the guideline showed little success in changing physician behavior.\textsuperscript{99}

The impact of other practice guidelines has been equally disappointing. In a study of NIH guidelines for the treatment of breast cancer and coronary artery bypass surgery, researchers found little evidence that physicians were incorporating the guidelines into their practices.\textsuperscript{100} Guidelines issued by the Agency for Health Care Policy Research have fared no better. In a recent report, the Physician Payment Review Commission


\textsuperscript{96} Id. (observing that the cesarean section rate in the United States essentially stayed the same from 1986 to 1991).


\textsuperscript{98} Id. at 1310.


\textsuperscript{100} Id. at 2712.
observed that physician practices were not being changed by the guidelines.\textsuperscript{101}

It is not surprising that physicians do not readily incorporate new guidelines into their practices. People in other professions act no differently. When sociologists have studied how innovations spread from their early proponents to the wider population, they reach the same conclusion, whether the innovation is in medicine, agriculture, or other contexts. The adoption of an innovation almost never occurs solely from the fact that potential users know about the innovation and have easy access to the innovation.\textsuperscript{102}

There are a number of reasons why physicians generally do not respond to educational efforts in the form of practice guidelines. Some studies have suggested that physicians may decide how to practice more on the basis of their personal experience in treating patients than on the recommendations of national panels of experts.\textsuperscript{103} In other words, physicians may be trusting their limited, anecdotal experience more than scientific data that have been interpreted in light of the experiences of many other physicians who are experts in their fields of specialization.\textsuperscript{104} These studies suggest that physicians are resisting practice guidelines as an unwarranted intrusion on their decision-making authority.\textsuperscript{105} There are at least two factors that may be underlying this resistance. First, American culture has traditionally valued and encouraged professional autonomy on the ground that society would benefit greatly if professionals were free to exercise their creativity.\textsuperscript{106} Second, physicians tend to distrust the pronouncements of researchers. In one study,

\begin{itemize}
\item \textsuperscript{101} Neel, \textit{supra} note 37, at 13.
\item \textsuperscript{102} JAMES C. COLEMAN ET AL., MEDICAL INNOVATION: A DIFFUSION STUDY 55 (1966).
\item \textsuperscript{104} Practice guidelines are developed by panels of medical experts who consider studies in the medical literature together with their own experiences in treating patients. John T. Kelly & James E. Swartwout, \textit{Development of Practice Parameters by Physician Organizations}, 16 QUALITY REV. BULL. 54, 56 (1990).
\item \textsuperscript{105} Greco & Eisenberg, \textit{supra} note 103, at 1272.
\end{itemize}
practicing physicians reported that they viewed researchers as biased by their personal interest in having their theories validated and their work published. As a result, the practitioners believed that scientific studies tend to exaggerate the value of a new test or treatment and that the initial promise of an innovation often does not hold up when the innovation is used more widely. Since the panels of experts that issue practice guidelines tend to include the researchers who have worked on the problem, distrust of researchers will likely carry over to distrust of practice guidelines.

Other factors underlying the resistance to change include personal interests and patient preferences. For example, with cesarean sections, physicians may continue performing unnecessary procedures for both of these reasons. They may believe that performing a cesarean section is in their interest because it will reduce their risk of malpractice liability. If a child is born with an injury, the jury might attribute the injury to the use of a vaginal delivery even when the injury actually occurred before labor commenced. Physicians also may be responding to financial and other personal incentives to perform cesarean sections—physicians are often paid more for cesarean sections than vaginal deliveries. In addition, less time is required for a cesarean section, thereby freeing up more time for other activities, such as sleeping (when the baby is born at night) or increasing income by seeing other patients. Physicians also may be responding to patient preferences for cesarean sections over a painful and prolonged delivery.


108. See id. This skepticism is hardly unwarranted. It is not difficult to find examples of new techniques or treatments that did not live up to their initial promise. For example, the use of drugs to dilate blood vessels, once widely prescribed for patients to counteract senile dementia, has no value for that purpose. Jerry Avorn et al., Scientific Versus Commercial Sources of Influence on the Prescribing Behavior of Physicians, 73 AM J MED. 4, 4 (1982).

109. Lomas et al., supra note 97, at 1310. The failure of practice guidelines to change behavior cannot be attributed simply to an inability of physicians to modify well-entrenched practices. There are a number of cases in which the medical profession has rapidly adapted to medical innovations, even without the issuance of practice guidelines. For example, within five years of its introduction in the United States, laparoscopic cholecystectomy has replaced more traditional surgical methods in roughly 80% of operations to remove the gall bladder. NIH Consensus Development Panel on Gallstones and
In some cases, physicians have readily incorporated new guidelines into their practices. These examples suggest that the dissemination of practice guidelines must be accompanied by mandates or financial incentives if they are to be successful.\footnote{110} When guidelines were developed for anesthesiologists to use when monitoring patients who are rendered unconscious by general anesthesia, their implementation resulted from a combination of mandates and financial incentives. Hospitals and a state licensing board required their use,\footnote{111} and malpractice insurers offered reductions in premiums to anesthesiologists who use the guidelines.\footnote{112}

New York State's experience with coronary artery bypass surgery provides an important example in which mandates ensured adherence to practice guidelines. In a study of coronary artery bypass surgery in New York, researchers found a very low rate of inappropriate operations. The authors of the study attributed the findings to the state government's careful regulation of bypass surgery, including the requirement that hospitals satisfy high standards of quality before they can be certified or recertified as centers for open heart surgery.\footnote{113}

Reimbursement policies of health care insurers have been an important example of how financial incentives can speed the adoption of practice guidelines. Before the American College of Cardiology and American Heart Association issued guidelines on cardiac pacemaker implantation,\footnote{114} data suggested that over

\begin{itemize}
\item In several cases, practice guidelines have been adopted by physicians when local "opinion leaders" (physicians whose opinions tend to be followed by other physicians in their community) have adopted the guidelines and encouraged their colleagues to do so as well. Orentlicher, \textit{supra} note 94, at 602-03. However, opinion leadership is not a complete answer. There is still the question of what leads opinion leaders to endorse new guidelines. Opinion leadership is more an explanation of how a change spreads through the medical profession rather than an explanation of why the change is adopted.\footnote{112}
\item Ellison C. Pierce, Jr., \textit{The Development of Anesthesia Guidelines and Standards}, 16 QUALITY REV. BULL. 61, 63 (1990).
\item Lucian L. Leape et al., \textit{The Appropriateness of Use of Coronary Artery Bypass Graft Surgery in New York State}, 269 JAMA 753, 859-60 (1993).\footnote{114}
\item Comm. on Pacemaker Implantation, American College of Cardiology/American Heart Ass'n Task Force on Assessment of Diagnostic & Therapeutic Cardiovascular
\end{itemize}
20% of pacemaker implantations were not warranted. Following the issuance of the guidelines, there was a 28% decline in the use of pacemakers in Medicare patients. The decline probably reflected the use of the pacemaker guidelines by Medicare in deciding when to reimburse physicians for implanting a pacemaker.

In short, efforts to educate physicians simply through the issuance of practice guidelines rarely are successful. Physicians often have countervailing incentives to maintain their existing practices. Consequently, additional measures, particularly financial incentives and/or credible threats or methods of enforcement, are needed to make educational efforts work.

3. Balancing Ethical Concerns with Cost Constraints

From the preceding discussion, two important lessons may be drawn. First, the need to contain health care costs will inevitably require physicians to exercise their own discretion to decide when potentially beneficial diagnostic tests or therapeutic procedures should be withheld from their patients. While to some extent decisions about which tests or procedures will be withheld from which patients can be made by the public, act-
ing through their government or their private health care plans, in many cases, society will have to rely on physician discretion. This is so for two reasons: developing rationing guidelines takes a good deal of time and money, and it simply is not possible to create guidelines for every medical decision that might arise. Although placing physicians in the role of rationers of health care divides their duty of loyalty to their patients, it is not possible to avoid dividing the loyalty. Accordingly, physicians will have to become more cost-conscious in their decision making.\footnote{118}

The second lesson drawn from the preceding discussion is that if society wishes to change physician behavior so that physicians become more cost-conscious in their decision making, it must employ mandates or financial incentives. Education alone does not work.\footnote{119}

These two lessons suggest that society should consider two important measures in its efforts to control health care costs. One of the measures is a personal financial incentive. The other is an external mandate. First, as already discussed, health care insurers can tie the compensation of physicians to the physicians’ success in containing health care costs. Physicians become more cost-conscious because every decision would have an impact on their income. The risk to patient welfare can be cabinéd by prohibiting financial incentives that carry a significant risk of abuse.\footnote{120}

\footnote{118. In theory, we also could make patients more cost-conscious. Patients should be able to receive whatever care they are willing to pay for. While relying on consumer choice can help contain costs, it is not a complete answer for the same reason that we cannot completely eliminate physician discretion in making rationing decisions. Under any kind of health care insurance plan, patients will receive a certain package of guaranteed benefits for their premium payments. It is possible to charge a smaller premium for fewer benefits, but ultimately it is not possible to specify with precision what benefits will be included in the insurance plan. Indeed, all insurance plans, whether traditional Blue Cross fee-for-service plans or HMOs, and virtually all legislative proposals for reform include a concept of a basic benefits plan that covers all medically necessary hospital and physician services. Yet, just as society cannot give detailed guidance to physicians about what will or will not be covered, health care plans cannot give detailed information to patients about what will or will not fall within the definition of medically necessary care.}

\footnote{119. Any personal incentive would do the trick, whether it takes the form of a financial interest or some non-financial gain. For example, academic physicians are motivated, in part, by personal recognition for their research discoveries or personal prestige for their academic titles. However, it is hard to see how physicians could be motivated to incorporate cost considerations in their decision making with non-financial, personal incentives.}

\footnote{120. Incentives that should be prohibited include incentives that place more than a small percentage of a physician’s income at risk, that are calculated on the basis of the costs for the individual physician’s patients or for only a small group of physicians’ pa-}
Second, health care plans could impose a fixed budget for health care costs and require physicians to operate within the budget. Physicians would become more cost-conscious because any resources used on one day would mean fewer resources for care in the future. This second approach is essentially the approach used in Great Britain where physicians are given a fixed budget that reflects much lower per capita health care expenditures than in the U.S. The physicians in Great Britain have adapted to a different, less costly standard of care than their U.S. counterparts. Indeed, in most cases, physicians in Great Britain appear to believe that they are providing a medically appropriate standard of care and that U.S. physicians provide a good deal of wasteful and unnecessary care.\(^2\)

4. Deciding Between Fixed Budgets and Personal Financial Incentives for Physicians

From an ethical standpoint, the fixed budget approach is preferable. Although it forces physicians to balance the needs of each patient against those of other patients, it does not create an additional conflict between patient needs and the physicians' personal interests. In other words, physicians have a dual loyalty, but not the triple loyalty that exists with financial incentives to limit care.

Fixed budgets have other important benefits. They force society to confront directly the fact that there are competing demands for its resources and that hard choices have to be made among those demands. The public is better served by an open process for deciding how many resources will be devoted to health care and how many to other social services.

Fixed budgets also assure physicians that, if they conserve resources when treating one patient, more resources will be available for other, more deserving patients. Conversely, if physicians do not conserve resources, fewer resources will be available for later, more deserving patients. Currently, many commentators argue that because there is no guarantee that resources saved on one patient will be available for other pa-

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tients or that spending resources on one patient will deplete the resources available for other patients, physicians must not withhold potentially beneficial care from one patient on the ground that the saved resources would be better used elsewhere.\(^{122}\) If we adopt a closed system with a fixed budget, it is inevitable that treating one patient will affect the resources available for other patients.

The primary objection to fixed budgets is that they are politically difficult to achieve. Medicare and Medicaid costs have far exceeded the levels projected when they were first enacted. Further, in the recent health care reform debate, the idea of budget caps did not survive very long. In Oregon, where the legislature has adopted a fixed budget, the funding level was so generous that little cost savings were realized.\(^{123}\) While fixed budgets arouse fierce political opposition, personal financial incentives for physicians are readily accepted politically and are already widespread.

**CONCLUSION**

Whether the result of legislation or private initiative, health care reform would pose serious threats to the patient-physician relationship. With its emphasis on managed care arrangements that link the patient's choice of insurer with the patient's choice of physicians, reform would increase the likelihood of discontinuities in patient care. With its greater responsibility for physicians to make individual rationing decisions, reform would also increasingly divide the loyalty of physicians to their patients.

There is no ideal solution to these problems. Linking the patients' choice of insurance to their choice of physicians is an important measure for containing health care costs. Similarly, while hard rationing decisions are also necessary if health care costs are to be contained, there is no way to remove all of those decisions from physicians.

Despite the lack of an ideal solution, the harmful effects of reform can be mitigated. If health care plans include an option


\(^{123}\) Janofsky, *supra* note 33, at 6.
for patients to use physicians outside of their plan at a higher cost, then there would not be as much disruption of patient-physician relationships.\textsuperscript{124} In addition, if fixed budgets rather than financial incentives were used to ensure that physicians limit their use of health care resources, then rationing decisions would be influenced much less by the physicians' personal financial interests.

\textsuperscript{124} Even this solution is problematic, for it is an option that would not be available to the indigent unless government subsidies to purchase insurance included funds to pay the extra costs.