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THE PATIENT-PHYSICIAN RELATIONSHIP IN AN ERA OF SCARCE RESOURCES: IS THERE A DUTY TO TREAT?

Maxwell J. Mehlman*

For the past twenty years, the dominant theme in American health care has been the need to control escalating costs. This concern has led to the development of new methods for delivering and financing care, such as employer-driven managed health care plans and the diagnosis-based payment system for Medicare. These approaches have sought to reduce costs by encouraging health care providers to alter their behavior, including decreasing hospital admissions, the length of stay in hospitals, and the performance of diagnostic and therapeutic...

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1. A managed health care plan is a health insurance program in which an administrative entity attempts to control patient access to health care providers and provider services in order to contain costs. For a lengthier description, see Stanley J. Reiser, Consumer Competence and the Reform of American Health Care, 267 JAMA 1511 (1992).

2. The diagnosis-based payment system for Medicare is a patient classification scheme which pays the hospital on the basis of the patient's diagnosis rather than on the basis of the services actually provided to the patient. The system is derived by classifying all possible diagnoses identified in the International Classification of Diseases, Ninth Revision, Clinical Modification ("ICD-9-CM") system into 23 major diagnostic categories ("MDCs") based on organ systems, and further organizing the diagnoses into 467 diagnosis-related groups ("DRGs"). Patients within the same DRG can be expected to evoke a set of clinical responses which, on a statistical average, will result in approximately equal use of hospital resources. Unlike the fee-for-service payment system that it replaced, the DRG system creates no incentive for the hospital to provide additional services to patients in order to increase revenue. See generally 42 U.S.C. § 1395ww (1988) (describing the DRG system for hospital payment under Medicare).

3. Since the inception of the diagnosis-based payment system, "the average length of stay is down 10% for patients 65 and over and 6.1% overall. Patient days are down 16% for those 65 and older and 17% overall. . . . [In addition,] more than 3% of United States hospital beds were filled in 1980, [while] less than ½ were occupied [by 1988]." Clay Mickel, Excess Capacity Becomes Center of Policy Debate, HOSPITALS, Sept. 5, 1989, at 38, 39.
procedures. Much of the pressure has been exerted on institutional providers, such as hospitals and health maintenance organizations ("HMOs"). Directly or indirectly, however, physicians increasingly feel the pressure as well.

Despite the increasing power of institutional providers and payers of health care, physicians continue to play the dominant role in determining the care that patients receive. Patients cannot be admitted or discharged from the hospital except on a physician’s orders. Diagnostic and therapeutic procedures are performed either by physicians or pursuant to their instructions. For the most part, only physicians can prescribe prescription drugs. If costs are to be controlled, it is generally recognized that physicians must be induced to change their practice.

4. John Wennberg has demonstrated variations in local practice patterns. Through a technique known as “small area analysis,” he and his associates have documented wide variations among different New England communities in the rates of performance of certain surgical procedures. For instance, the highest rate of tonsillectomies in those areas studied was six times the lowest rate, while the rate of hysterectomies displayed a four-fold variation between the highest and lowest areas. See John E. Wennberg et al., Will Payment Based on Diagnostic-Related Groups Control Hospital Costs?, 311 NEW ENG. J. MED. 295 (1984); John Wennberg & Alan Gittelsohn, Variations in Medical Care Among Small Areas, Sci. Am., Apr. 1982, at 120; John Wennberg & Alan Gittelsohn, Small Area Variations in Health Care Delivery, 182 SCIENCE 1002 (1973). Mark Hall notes that “if the existing legal standard is as broad as Wennberg’s evidence suggests, it can amply accommodate massive cutbacks in care within the tremendous variations in practice patterns that the established custom encompasses.” Mark A. Hall, The Malpractice Standard Under Health Care Cost Containment, 17 LAW MED. & HEALTH CARE 347, 348 (1989).

5. Hospitals and HMOs have felt the pressure to limit procedures due to the Medicare DRG system. Because they are paid according to the diagnosis rather than the services rendered, they are compelled to reduce services in order to reduce costs. See supra note 2. HMOs typically emphasize their relatively low costs. However, that advantage would likely be lost if they did not limit procedures and lengths of stay. See John A. Siliciano, Wealth, Equity, and the Unitary Medical Malpractice Standard, 77 Va. L. Rev. 439, 454 (1991).

6. However, some states permit non-physicians to engage in certain forms of medical practice. For example, Massachusetts, Tennessee, and Texas have laws which allow the practice of midwifery. See Leigh v. Board of Registration in Nursing, 481 N.E.2d 1347 (Mass. 1985) (mere practice of midwifery did not constitute the unauthorized practice of medicine; no statutory prohibition against the practice of midwifery by lay persons); Leggitt v. Tennessee Bd. of Nursing, 612 S.W.2d 476 (Tenn. Ct. App. 1980) (midwifery excluded from the practice of medicine by state statutes and regulations); Banti v. Texas, 289 S.W.2d 244 (Tex. Civ. App. 1956) (practice of midwifery by lay person is not unauthorized practice of medicine).

7. Some states permit non-physicians such as physicians’ assistants to prescribe some prescription drugs. See, e.g., Cook v. Workers’ Compensation Dept., 758 P.2d 854, 859 (Or. 1988) (en banc) (“Nurse practitioners also are eligible to apply for prescription privileges upon completion of an approved course of pharmacology.”); United States v. Composite State Bd. of Medical Examiners, 655 F.2d 131 (5th Cir. 1981) (allowing a Georgia physician’s assistant to prescribe and order routine medication). But see United States v. Jones, 816 F.2d 1483 (10th Cir. 1987) (stating that, notwithstanding valid medical reasons, an individual must be a physician registered with the DEA in order to prescribe medication).
patterns.
This recognition has led to cost control efforts aimed specifically at physicians. Third-party payers, such as government entitlement programs, insurers, and employers, are beginning to second-guess physicians' decisions by requiring prior approval before services are provided to patients or before the physicians' claims for reimbursement are paid. Physicians also are being given financial incentives to limit care. For example, a physician may have a portion of his fees withheld, to be returned to him at the end of a budget period only if he has successfully held down costs.8 Sometimes the pressures are less direct. For example, hospital administrators are reported to threaten physicians with sanctions, such as limiting or revoking their admitting privileges, if they exceed the lengths of stay prescribed by third-party payers.9

While these cost containment efforts may be designed to achieve a societal goal of reducing health care costs, they impact directly on patients by creating the risk that physicians will withhold beneficial medical services. For example, several cases have addressed allegations that, as a result of efforts by providers or third-party payers to contain costs, patients have lost limbs or have committed suicide because their physicians prematurely discharged them from the hospital.10 Cost containment may be desirable and even necessary, but is it appropriate to

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In a typical HMO, the insurer divides the premiums received from enrollees into several special-purpose “referral” funds to pay for the services of primary care physicians, those of specialists and hospitals, and outpatient laboratory testing. In addition, a percentage of the payment for primary care physicians is often withheld until the end of the year, when the status of the referral funds is determined. The amount withheld is returned to the physicians if there is a surplus in the referral funds, but not if there is a deficit. Primary care physicians who overspend the referral funds may incur additional penalties, and surpluses in the funds may be used to create bonuses for parsimonious physicians.

9. “Staff model” HMOs, in which physicians are salaried employees of the HMO, may refuse to renew the contracts of physicians who overuse services. See Paul Craig, Health Maintenance Organization Gatekeeping Policies: Potential Liability for Deterring Access to Emergency Medical Services, 23 J. HEALTH AND HOSP. L. 135, 136 (1989); see also Hillman et al., supra note 8, at 87 (providing additional examples of sanctions for a lack of cost control). Hospital administrators often issue quiet warnings or even threaten to revoke staff privileges of physicians whose patients cost the hospital too much money. See E. Haavi Morreim, Economic Disclosure and Economic Advocacy, New Duties in the Medical Standard of Care, 12 J. LEGAL MED. 275, 284 (1991). Because the doctor who is not cost conscious will pay a price professionally or financially, the physician is placed in a type of conflict of interest.

achieve it chiefly at the expense of patients? This question bears di-
rectly on the behavior of physicians in relation to patients and raises
the most difficult issue that physicians confront: As cost containment
efforts increasingly limit health care resources, to what extent are phy-
sicians required to furnish access to health care regardless of resource
constraints?

The answer might be sought within the principles of professional
ethics, but no ethical consensus on this issue has emerged. Some com-
mentators assert that the physician must maximize his patient's welfare
without concern for costs. For example, the Principles of Ethics of the
American Medical Association state that, notwithstanding the societal
interest in containing health care costs, "concern for the care the pa-
tient receives will be the physician's first consideration." Other ex-
erts argue that, in addition to his role as care-giver, the physician is a
gate-keeper who must subordinate the interests of an individual patient
if necessary to attain societal cost containment objectives.

In their relationship with patients, physicians are bound not only
by the ethics of their profession, but by rules of common law. The
physician owes the patient a legal duty to provide reasonable care. He
risks liability for malpractice and other sanctions if he fails to provide
the care to a patient that would be provided by a reasonable physician
under the same circumstances, even if he is prevented from doing so by
limited resources. The law also imposes a fiduciary duty on the physi-

11. Wickline and Wilson demonstrate that the detriment to the patient is not offset by a direct
reduction in her health insurance costs. The patient bears the full burden of the harm herself,
while the cost savings are spread across all insureds in the form of reduced premiums.

12. The answer to the question may depend on the nature of the resource constraint and on
the manner in which it affects the patient. Resource constraints can take different forms: the
patient can lack sufficient funds to pay for services; a third-party payer may provide only partial
coverage for a service or may refuse to provide coverage altogether; a provider may be pressured
to economize on the care provided to patients through mechanisms such as payment on a capi-
tated basis; or a geographic area may lack a type of facility or piece of equipment, such as a
pediatric intensive care unit or a magnetic resonance imaging ("MRI") device.

13. AMERICAN MEDICAL ASS'N, CODE OF MEDICAL ETHICS: CURRENT OPINIONS OF THE

Reimbursement, in PAYING THE DOCTOR: HEALTH POLICY AND PHYSICIAN REIMBURSEMENT 19,

15. In some respects the rules of common law which govern the patient-physician relationship
have been changed or supplemented by legislative enactment. However, most jurisdictions con-
tinue to rely on the rules of common law. For a discussion of statutory changes, see infra notes
123-26 and accompanying text.

16. See infra part II. For a discussion of civil sanctions which a state may impose upon a
delinquent physician, see Richard P. Kusserow et al., AN OVERVIEW OF STATE MEDICAL DISCIPLINE,
cian to act in his patient's best interests. The physician might be liable for punitive damages if he violates this duty in order to promote the interest of others in reducing health care costs.

From a legal standpoint, then, the question becomes: To what extent do the rules of common law governing the patient-physician relationship require that the physician provide access to health care regardless of resource constraints? If the physician withholds care and is sued by the patient for malpractice, can the physician assert that he acted reasonably in light of limited resources? Can the physician argue, for example, that he is not required to furnish the care because the patient's third-party payer refuses to pay and the patient herself cannot pay? Can a rural or inner-city physician defend himself by arguing that he is not required to furnish a certain type of care, such as state-of-the-art magnetic resonance diagnostic imaging, if the equipment necessary to render the care is not available in the area because it is too expensive? Can he assert as a defense that the scarce resources saved by denying care to one patient can be better spent on other patients, or that, by denying care to some patients, health care costs for other patients can be reduced? Finally, can the physician avoid liability by arguing that the patient agreed to receive care that fell below the standard of "reasonableness" because the physician agreed to charge her a lower price and she could not otherwise afford care?

This Article examines the three major areas of common law that govern the patient-physician relationship: contract law, tort law, and fiduciary law. It explores the definition of the patient-physician relationship within each doctrine and the extent to which physicians must furnish care to patients regardless of resource constraints. After concluding that the common law cannot ensure that individual patients receive access to needed health care services, the Article explores how the law might be changed to achieve this result.

I. THE ROLE OF CONTRACT

In order to determine whether a physician has a duty to render health care regardless of resource constraints, we will first look to the law of contract. If the patient-physician relationship were governed by a purely contractual approach, the answer would be rather simple. In a purely contractual relationship, the parties themselves establish the

17. See infra part III.
18. See infra note 73 and accompanying text.
terms of their relationship. Thus, they can agree to any arrangement that suits them regarding the performance to be expected from each other, including allowing services to be withheld under certain circumstances or to be rendered in a manner that would be substandard in the absence of a contractual agreement.

Application of a purely-contractual approach to the patient-physician relationship would require the physician to furnish the patient with only those services that he had agreed to provide. If third-party payers were unwilling to pay for necessary services, the physician could insist that the patient pay for the services out of her own pocket and could refuse to provide the services or terminate the relationship if she declined. If the patient wanted to ensure that she received services beyond those covered by her insurer, she could bargain with the physician and agree to pay the additional price, find another physician who was willing to provide the services at a lower price, or find another insurer who offered broader coverage. The patient could not sue the physician for failing to provide a service unless the physician had agreed to provide the service as part of the contract.

Similarly, the parties would be free to establish the performance standards within the relationship. The physician would only be held to a standard of "reasonable care" if the parties agreed upon that standard. The patient might prefer to bargain for a higher standard, such as "optimal care." If the patient did not wish to pay for a reasonable standard of care, she could agree to accept a lesser standard at a lower price.\(^{19}\) In theory, the parties could even decide that the physician did not owe the patient a fiduciary duty\(^{20}\) or could define that duty in whatever fashion they pleased.

A purely contractual approach to the patient-physician relationship is suggested by two divergent theories. One is neoclassic economic theory, which proposes that rational, self-interested individuals will bargain with each other to maximize their individual welfare until they

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19. A statement of this proposal is found in Richard A. Epstein, *Medical Malpractice: The Case for Contract*, 1976 AM. B. FOUND. RES. J. 87. See also Clark C. Havighurst, *Private Reform of Tort-Law Dogma: Market Opportunities and Legal Obstacles*, LAW & CONTEMP. PROBS., Spring 1986, at 143, 149 (suggesting that strong reasons exist to allow a provider to vary the extent of legal obligations incurred so that a more economical product can be provided for those consumers who wish to secure it); Richard A. Epstein, *Medical Malpractice: Imperfect Information, and the Contractual Foundation for Medical Services*, LAW & CONTEMP. PROBS., Spring 1986, at 201 [hereinafter Epstein, *Imperfect Information*] (suggesting that allowing private parties to contract for medical care will result in better care and more beneficial malpractice resolutions).

20. For discussion of a physician's fiduciary duty to his patient, see infra part III.
attain an equilibrium state, known as Pareto optimality, in which additional trades will not result in further mutual benefit. This state is deemed to be an optimal state for the parties which will produce an efficient allocation of resources within society. In terms of health care, patients would be expected to bargain for access to services and for standards of physician behavior that best suited their individual needs. The theory also holds that individual welfare-maximizing transactions, taken together, will result in an optimal societal allocation of health care resources relative to other desired goods and services.21

A contractual approach to the patient-physician relationship is also suggested by a development specifically related to health care: the movement to increase patient autonomy. This movement originated in the late 1960s as a response to physician paternalism and professional domination of the patient-physician relationship.22 The movement substituted for paternalism a model of shared decision making in which the physician is primarily a communicator and facilitator who assists the patient. The legal tool of the move toward patient autonomy is the principle of patient consent to treatment, which has been elevated from a technical requirement that the physician obtain the patient's consent to a touching to avoid being liable for battery,23 to a major obligation of the physician to transmit sufficient information about alternatives, risks, and benefits to the patient. This information enables the patient to make her own treatment decisions in consultation with the physician.24

The theoretical basis of the doctrine of informed consent has much


23. See Bang v. Charles T. Miller Hosp., 88 N.W.2d 186 (Minn. 1958) (where no emergency exists, a physician who can ascertain alternative situations prior to an operation should inform the patient of such alternatives); Mohr v. Williams, 104 N.W. 12 (Minn. 1905) (doctor found liable for battery for failure to secure patient's consent to an operation).

in common with the neoclassic economic approach described earlier. Both theories assume that only the patient can know her own preferences and aversion to risk; therefore, allowing her to make decisions for herself is the most efficient means to enable her to maximize her own welfare. Once the patient is allowed to make her own treatment decisions, it follows that she should be allowed to make other decisions regarding her relationship with her physician, such as determining what legal obligations to impose on him, and what costs or risks to bear herself. For example, after being informed by her physician about the risks and benefits of treatment alternatives, the patient might be said to assume the risk of harm if she chooses a treatment that the physician does not advocate, or one that his colleagues would reject as unreasonable.\(^{25}\) If the patient is adequately instructed regarding the trade-offs, why should she not be allowed to bargain with the physician over the dimensions of price, quantity, and quality? Should she not be permitted to agree to the level of care which the physician will provide in exchange for his fee and allow him to reduce the amount of care to conserve her scarce resources? Why should she not be free to hold the physician to a lesser standard of care in return for a lower price?\(^{26}\)

Despite the superficial appeal of a purely contractual approach and the supportive thrust of the doctrine of informed consent, the courts virtually without exception have rejected the proposition that patients and physicians should be allowed to bargain over the terms of their relationship. For example, courts have struck down the following types of patient-physician agreements: a patient’s release of the physician from liability for negligence,\(^{27}\) a limitation of the patient to

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25. See Schneider v. Rivici, 817 F.2d 987 (2d Cir. 1987) (allowing validity of such an express assumption of risk to be decided by jury in malpractice case rather than holding defense invalid as a matter of law).

26. Allowing a physician to provide the type and amount of information for which the patient bargained would constitute the ultimate marriage of contract theory and the informed consent doctrine. A patient who desired a significant amount of information would pay more than those patients who wanted less information. See Maxwell J. Mehlman, Fiduciary Contracting: Limitations on Bargaining Between Patients and Health Care Providers, 51 U. Pitt. L. Rev. 365, 374-88 (1990) (discussing why this approach is problematic due to the nature of the market for information).

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$15,000 in damages,28 and an acceptance of binding arbitration by the patient.29 In fact, courts have even refused to uphold agreements by the patient to pay a fee that the court deemed unreasonable.30 The only cases in which the courts have been willing to uphold agreements to limit the physician's liability have involved experimental or unconventional treatments that the patient agreed to try after being fully informed of the risks and benefits, only to claim later that the physician had acted unreasonably in failing to employ a more conventional approach. However, these cases can be distinguished on a public policy basis. It may be argued that failing to hold the patient to her agreement would render the physician strictly liable for any harm to the patient merely by virtue of employing an experimental modality, and, as a result, legitimate experimentation would be unduly discouraged.31 In refusing to uphold bargains between patients and physicians, the courts have not always provided a clear basis for their objections.32 The latent explanation for such objections is the inability of a purely contract-based relationship between patients and providers to achieve the efficiency goals of contract theory itself.

Contract theory, like the neoclassic economic theory upon which it is based, assumes that the parties possess equal bargaining power and

29. See Wheeler v. St. Joseph Hosp., 133 Cal. Rptr. 775 (Ct. App. 1976) (admission form which included arbitration agreement constituted contract of adhesion and was therefore unenforceable). But see Madden v. Kaiser, 552 P.2d 1178 (Cal. 1976) (patient held to binding arbitration which had been agreed to by bargaining agent acting on patient's behalf).
31. See Schneider v. Rivici, 817 F.2d 987 (2d Cir. 1987); Colton v. New York Hosp., 414 N.Y.S.2d 866 (Sup. Ct. 1979). Schneider's factual scenario is problematic in that the physician defendant was not engaged in legitimate research; rather, he was employing a technique to treat cancer that might be considered quackery. After a period of time, however, he allegedly advised his patient to discontinue the treatment because it had not proven effective. In any event, the court did not hold that the patient's release of the physician from liability was valid, but only that the validity of the agreement was an issue for the jury to decide. For a discussion of the legitimacy of subordinating a patient's protection to the interests of society, see infra notes 55-56 and accompanying text.
32. The most extensive analysis is presented in Tunkl v. Regents of Univ. of Cal., 383 P.2d 441 (Cal. 1963), which has been criticized as unpersuasive, incomplete, and inoperative. See Gardner v. Downtown Porsche Audi, 225 Cal. Rptr. 757, 759 (Ct. App. 1986) (criticizing Tunkl factors as not providing adequate guidance); Glen O. Robinson, Rethinking the Allocation of Medical Malpractice Risks Between Patients and Providers, LAW & CONTEMP. PROBS., Spring 1986, at 173, 184-85.
equal, if not complete, information about the nature and consequences of their transactions. Yet in terms of the patient-physician relationship, the physician possesses far greater bargaining power and far superior information. The physician's greater bargaining power stems from the following factors: his status as a professional; the patient's need for health care services and the lack of competition between health care providers, which limits the patient's choices to obtain care elsewhere; the physician's greater medical knowledge and expertise; and the "credence" nature of health care services, which makes it difficult for the patient to determine the quality of the services and therefore to determine what price to pay.

This imbalance undermines the assumption that a contractual arrangement between the patient and physician will produce an efficient result. In the first place, due to the lack of information about the relationship between quality and price of medical care, it is improbable that the parties will agree to a price that will yield the desired degree of quality (for example, imagine trying to arrive at a price for an automobile without knowing what brand or model was being purchased). Even if information about price and quality were available, the physician's training and expertise would make it more likely for him—as opposed to the patient—to possess the information or to obtain it.

33. See generally Cooter & Ulen, supra note 21, at 235.
34. See M. Traska, Home Health Care: Hospital's Activities Vary by Region Across the Nation, HOSPITALS, Feb. 5, 1986, at 54.
35. See Epstein, Imperfect Information, supra note 19, at 202; Robinson, supra note 32, at 188 (arguing that the information gap can be filled by requiring disclosure by the physician).
36. A "credence good" is one whose quality cannot be detected even after it is experienced. In contrast, the quality of a "search good" can be determined by the purchaser prior to purchase, while the purchaser of an "experience good" can determine quality by experiencing the good after it has been purchased. Health care is a "credence good" because patients typically cannot evaluate whether or not they have received high quality care from a clinical standpoint. A favorable result following an episode of care cannot necessarily be attributed to the care, since the patient's condition might have improved of its own accord. See Kenneth J. Arrow, Uncertainty and the Welfare Economics of Medical Care, 53 AM. ECON. REV. 941, 951-52 (1963); David Hemenway, Thinking About Quality: The Economic Perspective, 9 QUALITY REV. BULL. 321, 325 (1983).
37. Cooter and Freedman note that disloyalty could be controlled or prevented by contract if the parties to a fiduciary agreement possessed perfect information. However, they proceed to state that the parties in a fiduciary relationship are unable to foresee the conditions under which one act produces better results than another. See Robert Cooter & Bradley J. Freedman, The Fiduciary Relationship: Its Economic Character and Legal Consequences, 66 N.Y.U. L. REV. 1045, 1048 (1991). For more on the inefficiencies of such contracts, see Tamar Frankel, Fiduciary Law, 71 CAL. L. REV. 795 (1983); Deborah A. DeMott, Beyond Metaphor: An Analysis of Fiduciary Obligation, 1988 DUKE L.J. 879; Mehlman, supra note 26, at 388-91 (arguing that fiduciary contracting requires communication of information from the physician to the patient to ensure efficiency).
cheaply. Together with the patient's need for health care services—often a dire need—and the lack of meaningful alternatives, the physician's superior information may enable him to take advantage of the patient by appropriating surplus gains from trade for himself. The patient's only means to prevent such appropriation is to expend resources to monitor the physician's behavior. Due to her information deficits, however, the patient cannot determine the proper amount to expend on monitoring. Furthermore, monitoring a professional is expensive, particularly when the services delivered are of a credence type; only another professional of equal or greater expertise is likely to be able to detect a breach of the contract terms. Finally, the more the patient spends on monitoring the physician, the less she has left for purchasing health care.

In rejecting a purely contractual approach, the common law recognizes the power imbalance between the parties by protecting the patient from the risks of arm's-length bargaining. In its place, the law imposes a set of non-negotiable tort and fiduciary duties on the physi-

41. The patient could rely on external monitors such as professional disciplinary bodies or the government. However, the patient-physician relationship would no longer be purely a matter of private contract. Furthermore, it would become necessary to establish some preexisting standards in order to govern the behavior of the external monitors. Such monitoring of the monitor would create a sort of infinite regression.
42. One proposed solution is for the patient to rely on third-party payers to negotiate with providers on the patient's behalf. See Havighurst, supra note 22, at 1133 (by virtue of group organization, most consumers are now able to obtain expert assistance in choosing insurance packages); Havighurst, supra note 19, at 147 ("Although consumer ignorance had long been deemed to preclude a workably competitive market for health services, consumers of health care are encountering no appreciable difficulties in the emerging competitive environment because they have been able to rely upon sophisticated agents [such as employers and unions] to bargain with providers on their behalf."). Among other things, however, this solution assumes that third-party payers will endeavor to maximize the patient's welfare rather than their own or the welfare of a pool of patients. See Mehlman, supra note 26, at 375-77.
cian as the more powerful party. The duties that the courts impose may not always achieve optimal results, but the law assumes that externally imposed terms governing the relationship are more likely to lead to an efficient result than terms negotiated by the parties themselves.

However, there remains one critical respect in which the rules of contract control the terms of the patient-physician relationship under common law. The formation of the patient-physician relationship continues to be based upon the contractual doctrine of mutual assent. That is, the physician must agree to enter into a relationship with a patient before he is required to treat the patient and to fulfill the other duties externally imposed upon him. He cannot be forced to assume these obligations against his will. Contract retains a central role, but is one step removed from the interaction of the parties within their relationship: If the physician does not like the terms imposed upon the patient-physician relationship by the common law, he cannot vary them; however, he can decline to enter into the relationship with the patient in the first place. We will label this contract principle "Axiom 1" and return to it later.

In summary, an exploration of contract law provides only a partial answer to the question of whether the physician is required to provide access to services regardless of resource constraints. We have not identified those obligations imposed upon physicians within the relationship; we only know that the physician is not free to escape or to lessen them by negotiating with the patient. Axiom 1 tells us that the physician can refuse to enter into the relationship with the patient in the first place. This suggests that if the physician is required to treat patients regard-

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43. See infra parts II and III.
44. One might also argue that the law rejects a purely contractual approach because such an approach would yield unfair results for patients. However, contract's failure to render an efficient result makes this argument unnecessary.
45. For an older case exemplifying the common law approach, see Hurley v. Eddingfield, 59 N.E. 1058 (Ind. 1901) (finding no duty to aid person in peril).
46. See Siliciano, supra note 5, at 442.
47. By statute, the common law has been changed to a limited degree. The federal government requires hospitals and physicians receiving Medicare reimbursement to treat emergency patients in certain situations. The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), which took effect April 7, 1986, imposes three responsibilities on hospitals offering emergency medical care: the hospitals must examine all patients seeking emergency care; the hospital must stabilize the patient if an emergency exists, or transport the patient to a facility that can; and the hospital cannot transfer an unstable patient unless another facility can offer better treatment. See Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9121, 100 Stat. 82, 164 (1986) (codified at 42 U.S.C. § 1395dd (1988)).
less of resource constraints once he enters into the relationship, he can avoid the problem by not initiating the relationship. But we do not yet know if, or to what extent, this treatment obligation will be imposed on him, and therefore we cannot predict whether, or under what circumstances, he will take advantage of the escape route that Axiom 1 affords.

II. THE ROLE OF TORT

A second set of rules that the law imposes on the patient-physician relationship is the law of torts. Once the relationship is created by mutual assent, tort rules intervene to establish the standard of care owed by the physician. In tort terms, the problem of the physician’s role in the face of resource constraints translates into the following question: Does tort law prescribe a “unitary” standard of care, under which the physician must behave reasonably regardless of resource constraints, or does the law allow resource constraints to be taken into consideration in determining what is reasonable?

Many commentators urge that physicians must treat all patients alike regardless of their ability to pay, their health insurance coverage, or their area’s availability of state-of-the-art health care facilities or equipment. Any other approach, they contend, would legitimize a two-tiered system in which physicians would be free to deliver inferior care to the poor. According to this argument, resource considerations should not vary the standard of care.

Other commentators, such as Mark Hall, assert that the current

48. Tort rules also govern the standard of care for the patient by establishing the standard for contributory or comparative negligence.


50. See Paul Starr, Medical Care and the Pursuit of Equality in America, in 2 SECURING ACCESS TO HEALTH CARE 3 (President’s Comm’n for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research ed., 1983) (showing that hospitals provide less care or a lower quality of care to indigent patients); see also Jack Hadley et al., Comparison of Uninsured and Privately Insured Hospital Patients, Condition on Admission, Resource Use, and Outcome, 265 JAMA 374 (1991) (demonstrating that hospitals generally devote significantly fewer resources to uninsured patients).
standard is flexible enough to take resource constraints into account.\(^{51}\) Generally, the basic tort standard of what is "reasonable" is established by the medical profession.\(^{52}\) If the profession feels that it is being forced to render care without regard to resource constraints, it can simply reinterpret the standard to reflect those constraints. If physicians in rural areas lack state-of-the-art imaging machines, for example, the profession can adopt a standard of care under which use of the machines in rural areas is not required.\(^{53}\)

Haavi Morreim has argued that the current standard of reasonableness does not contain this degree of flexibility because courts possess the ability to set the standard of care regardless of where it is set by the custom of the profession.\(^{54}\) She maintains, however, that vesting judges with such authority is ill-advised. In her opinion, the law should be changed to reflect a bifurcated standard: Under this standard, physicians would be held to a standard of competence that ignores resource constraints. However, they would not be obligated to provide access beyond what the patient had contractually bargained for with the pro-

51. See Mark A. Hall, The Malpractice Standard Under Health Care Cost Containment, 17 LAW, MED. & HEALTH CARE 347 (1989). Siliciano makes a similar argument by analogy to products liability law. He contends, for example, that the driver who chooses to purchase a small car with few safety features and who is subsequently injured in an automobile accident would not be permitted to recover against the manufacturer on the basis that the car did not protect her as well as a more expensive model. See Siliciano, supra note 5, at 439.

52. While courts retain the power to reject the professional standard, see New England Coal & Coke Co. v. Northern Barge Corp. (In re Eastern Transp. Co.), 60 F.2d 737 (2d Cir. 1932) (owner of tugboat liable even though such tugs were universally not equipped with a radio to receive storm warnings), cert. denied, 287 U.S. 662 (1932); Helling v. Carey, 519 P.2d 981 (Wash. 1974) (universal practice of ophthalmologists not to administer glaucoma tests to patients under age 40 was negligent); Hall, supra note 51, at 349, they rarely do so.

53. Hall asserts that the argument that the standard of care can take resource limits into consideration is also supported by the courts' rejection of the strict locality rule. The purpose of moving to a national or "similar locality" standard, he argues, is to prevent the profession from relying too heavily on resource limits at the local level to escape liability for substandard care. See Hall, supra note 51, at 350. While this argument is clever, it ignores the fact that courts began to move away from the strict locality rule long before the issue of cost containment—and the resulting recognition of resource constraints—arose. See, e.g., Johns Hopkins Hosp. v. Genda, 258 A.2d 595, 598 (Md. 1969) (employing similar locality test); Lane v. Calvert, 138 A.2d 902, 905 (Md. 1958) (degree of skill required of physician is what is "ordinarily exercised by others in the profession generally"). The more likely explanation for the rejection of the strict locality rule is that the rule denies plaintiffs adequate access to expert witnesses.

54. See Morreim, supra note 9, at 317 ("[C]ourts are increasingly requiring . . . a national, basically uniform standard . . . "); E. Haavi Morreim, Cost Containment and the Standard of Medical Care, 75 CAL. L. REV. 1719, 1724 (1987) ("[A]s health resources become increasingly stratified, should the standard of care become similarly stratified? Currently, the law answers this question with an emphatic ‘no.’ "); see also cases cited supra note 52.
vider or with third-party payers. In any event, the outcome is the same under the approach of either Morreim or Hall. The physician would be entitled to assert resource constraints as a defense to a charge of substandard care so long as the physician met the standard of reasonable care under the circumstances.

Are these critics correct in arguing that the theory of tort law is compatible with a defense of limited resources to a charge of substandard care? The answer to this question lies in an understanding of what tort law means by "reasonableness." In essence, this is a standard designed to maximize social utility. Risks and resulting injuries can be imposed on victims without compensation so long as the person creating the risk acts in a manner that yields net societal gain. In short, the objective of tort law is utilitarian: the good of the individual can be sacrificed to increase the good of the whole.

Once the standard of reasonableness is understood as essentially utilitarian, it is not surprising that we find commentators like Hall and Morreim asserting that the standard of care should vary to reflect resource constraints. The only issue is whether a flexible standard—under which some patients appropriately may be denied treatment because of resource limits—is likely to achieve greater societal benefit than an inflexible standard. It is difficult to argue that denying treatments to a patient would never maximize social utility. Hence, a unitary standard may not be appropriate in all cases. For example, it is possible that,

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55. See George P. Fletcher, Fairness and Utility in Tort Theory, 85 HARV. L. REV. 537, 557 (1972). Fletcher notes that reasonableness provides a test for activities that should be encouraged and that reasonable men presumably seek to maximize utility. Thus, to ask what a reasonable man would do is to inquire into the justifiability of the risk. He proceeds to state that the paradigm of reasonableness

challenged the assumption that the issue of liability could be decided on the grounds of fairness to both victim and defendant without considering the impact on society at large. . . . [F]ault came to be an inquiry about the context and the reasonableness of the defendant's risk-creating conduct. . . . It provided the medium for tying . . . liability to maximization of social utility.

Id. at 557-58.

56. Fletcher further notes that reasonableness is determined by a straightforward balancing of costs and benefits. If the risk yields a net societal utility (benefit), it is reasonable and the victim is not entitled to recover from the risk creator; however, if the risk yields a net societal disutility (cost), it is not reasonable and the victim is entitled to recover. Id. at 542. Similarly, Henry Terry suggests that the test for justifying risks is a utilitarian comparison of the benefits and costs of the defendant's risk creating activity. See Henry T. Terry, Negligence, 29 HARV. L. REV. 40 (1915); see also Beatty v. Central Iowa Ry., 12 N.W. 332 (Iowa 1882) (employing cost benefit analysis to hold that railroad need not eliminate all risk when designing a grade crossing); Felske v. Detroit United Ry., 130 N.W. 676 (Mich. 1911) (defendant owner of a streetcar company not liable for injury caused by train jumping the tracks).
from a utilitarian standpoint, denying expensive lifesaving resources to one elderly patient so that many mothers can receive adequate prenatal care would produce a greater societal benefit.\textsuperscript{67} It may be difficult to determine if a particular level of access produces the maximum amount of societal benefit. Juries and judges may disagree over whether a physician in a particular case acted reasonably or not. Nothing in the doctrine of tort law, however, requires the standard to be held rigid despite resource limits.

Furthermore, it is necessary to bear in mind Axiom 1 from the discussion of contract law.\textsuperscript{68} The earlier discussion showed that the physician cannot vary the legal rules governing his relationship with the patient. Once he enters into the relationship, the rules of tort law dictate that the physician must act reasonably—that is, he must maximize societal welfare. The combined effect of tort and contract rules requires that, if the physician incorrectly estimates what constitutes reasonable behavior, he bears the risk of legal liability for malpractice and cannot shift that risk to the patient. However, Axiom 1 states that the physician can always refuse to enter into the relationship in the first place. Thus, as long as physicians retain such discretion, any rule that requires physicians to provide services regardless of resource constraints would simply cause physicians to refuse to initiate a relationship that would be likely to put them into this predicament.\textsuperscript{69}

\textsuperscript{57. See Daniel Callahan, What Kind of Life: The Limits of Medical Progress 28 (1990). Callahan asserts that a competent, but dying, patient has little right to vigorous life-extending treatment when such treatment is not likely to be efficacious. He feels that a patient has a right only to ask medicine to do that which is compatible with its proper goals and not to extend a life in the face of a wholly bleak medical prognosis. He also advocates a shift in priority from an individual-centered to a community-centered view of health and human welfare. To do this, he would focus upon the amounts and types of health needed to collectively and communally improve our society.

This argument was relied upon by the Oregon legislature in 1987 when it withdrew Medicaid funding for certain organ transplants in order to divert such funds to prenatal care programs. See Michael J. Garland, Setting Health Care Priorities in Oregon, 1 HEALTH MATRIX, J. LAW-MED. 139, 141 (1991).

\textsuperscript{58. See supra part I.}

\textsuperscript{59. Siliciano notes that physicians and hospitals are free, from a legal perspective (with limited exceptions), to decline treatment to those who cannot afford the cost of care. Thus, any theoretical defense of the current unitary standard must explain how tort law can achieve its goal of providing the same quality of care to all Americans when providers have the liability-free option of providing no care at all to whomever they choose. See Siliciano, supra note 5, at 443; see also John J. Howard, Medical Malpractice Liability and Cost Containment: Law and Economics in Conflict, 43 FOOD DRUG COSM. L.J. 309, 324 n.124 (1988) ("[M]edical malpractice law may fail to protect the poor . . . [because] it does not reach the major device used to withhold treatment from the poor, i.e., preventing the physician-patient relationship from coming into existence in the
It follows that, under the present state of the common law, the standard of care must be flexible enough to encourage physicians to enter into relationships with patients with marginal resources, such as patients who are unable to pay the physician’s usual fee or who live in rural or impoverished areas that lack expensive facilities and equipment. The patient herself benefits from a flexible standard since, by reducing the risk that the physician will be liable for malpractice for failing to provide a treatment because of resource constraints, physicians will be encouraged to enter into and remain in the patient-physician relationship. The patient arguably is better off with some care rather than none, even if, in the absence of resource limits, the care the patient receives would be regarded as “substandard.”

Yet this conclusion is problematic. For one thing, why would a physician ever need to assert a resource-based defense under a flexible approach to the standard of care? If the physician suspected that the patient’s resources would be inadequate, the physician simply would refuse to enter into a relationship with the patient in the first place. The purpose of the flexible-standard defense, then, must be to deal with cases in which the physician has misjudged either the available resources or the patient’s needs and has entered into a relationship that subsequently confronts the physician with insufficient resources. To the degree that the defense of limited resources is permitted, it allows the risk of making an erroneous resource assessment to be shifted to the patient and encourages the physician to enter into relationships with patients in uncertain cases—that is, where the physician is unsure whether the available resources will be sufficient.

However, if the physician is allowed to shift the risk of error to the patient as the price for agreeing to enter into the relationship, the physician is able to accomplish unilaterally what the common law of contract refused to allow him to accomplish with the patient’s consent. A flexible standard of care based on resource constraints seems at odds with the physician’s obligation to act in the patient’s best interests.

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first place.”); Morreim, supra note 9, at 278-79 (stating that physicians must consider economic matters when deciding which patients to treat).

60. Another possibility is that the physician declines to guess, perhaps because he thinks it is unethical to be concerned about the patient’s resources.

61. The existence of this defense helps to explain why courts regard the relationship as having formed only when the physician agrees to treat the patient for a specific condition. See Fought v. Solce, 821 S.W.2d 218 (Tex. Ct. App. 1991) (no physician-patient relationship by mere phone call to on-call physician); Lyons v. Grether, 239 S.E.2d 103 (Va. 1977) (relationship exists where doctor granted “appointment at designated time and place for the performance of a specific medical service”).
with the protection afforded patients by the common law's limitation upon the role of contract. The only difference is that under tort law, the courts in a malpractice action occasionally will second-guess the physician's decision in order to ensure a "reasonable"—i.e., socially efficient—result, while under contract law, the parties are presumed to achieve socially efficient results through their own private bargaining.

Our uneasiness with a flexible tort standard stems from an even more fundamental source, however. We have been looking in the wrong area of law for the answers, for we have yet to ask the right questions. To understand the problem with our inquiry to this point, we need to be more precise about the problem with which we are dealing. Thus far, we have defined the problem in general terms. That is, we have asked whether or not the standard of care should be flexible in light of resource constraints, and thus whether resource limits should be accepted as a defense to a charge of medical malpractice. But what does it mean to allow the standard of care to be flexible in light of resource constraints? What actual situations might it cover?

One scenario is represented by the following statement from a physician to his patient: "As a reasonable physician, I recommend that you receive treatment X. My fee for providing this treatment is $Y. Unless you can pay this fee, I will not provide the treatment." In this case, the physician and patient face a resource constraint in the form of the patient's willingness and ability to pay. If the standard of care did not vary according to resource constraints and the physician did not provide the patient with treatment X, the patient could hold the physician liable for malpractice if she was injured as a result. Conversely, if the standard were allowed to reflect resource constraints, the physician might successfully defend the suit on the basis of the patient's inability to pay.

Seen this way, the issue is no longer simply one of whether to recognize a resource-dependent standard of care—or, in terms of the objectives of the tort system, whether such a standard is likely to yield the greatest net societal benefit. Instead, the issue is whether to allow

62. See Ricks v. Budge, 64 P.2d 208 (Utah 1937) (physician undertaking an operation or other treatment must, in absence of an agreement limiting service, continue service so long as patient requires attention).

63. When a patient agrees to enter into a relationship with a physician, the patient undertakes certain duties, one of which is to pay the physician's reasonable fee. The thrust of the principle of a unitary standard of care and cases like Ricks, however, is that the patient's failure to pay may not entitle the physician to terminate the relationship or withhold services. Instead, the physician may be relegated to an action for quantum meruit against the patient.
the physician to refuse to provide medically necessary services because of the physician's own self-interest in being compensated. The law must resolve not only the conflict between the patient's self-interest and the greater good, but also the conflict of interest between the physician and the patient. Relaxing the standard of care under these circumstances affects not only the physician's duty of care, but his duty of loyalty. To understand the implications of this realization, we need to look beyond the area of tort law and to apply a set of legal rules specially designed to deal with conflicts of interest of this nature: the rules of fiduciary law.

III. THE ROLE OF FIDUCIARY LAW

While there is some lingering debate over whether the patient-physician relationship is properly termed a fiduciary relationship, most courts and commentators now agree that it is. Like contractual agreements, fiduciary rules are designed to allow the parties to gain from trade. However, these rules stem from the same concerns that led the courts to reject direct contracting between parties for medical care: un-

64. The term "medically necessary" is used to indicate that the patient will suffer some significant detriment in health status if the services are not rendered.

65. A number of commentators characterize it instead as a confidential relationship. See 1 Austin W. Scott & William F. Fratcher, The Law of Trusts § 2.5, at 43 (4th ed. 1987) ("A confidential relation may exist although there is no fiduciary relation; it is particularly likely to exist where there is a family relationship or such a relation of confidence as that which arises between physician and patient or priest and penitent."); see also E. Haavi Morreim, Conflicts of Interest, Profits and Problems in Physician Referrals, 262 JAMA 390, 391 (1989) ("Only some courts and commentators declare that physicians are fiduciaries in the full sense of the term ....").

equal bargaining power between the parties resulting from the high cost of patient monitoring of physician performance, due to information asymmetries and the “credence” nature of the physician’s services. 67 Some of these factors are present in other types of transactions and have led courts to reject the contract model in particular instances—for example, by declaring certain agreements unconscionable. 68 In some relationships, however, the disparity of bargaining power between the parties is so great and so embedded in the nature of the relationship that the law not only rejects the contract model, but also imposes fiduciary duties on the stronger party. 69

Fiduciary rules respond to disparities of bargaining power in a number of ways. First, they limit the fiduciary’s freedom of action by prohibiting him from using his superior power to take advantage of the principal 70 and by requiring him to act in the principal’s interest. The physician may avoid tort liability merely by acting reasonably, 71 but he may still be liable for breach of his fiduciary duty if he fails to act loyally. Fiduciary rules address the disparity between the parties in other ways as well. Where the entrustor challenges her contractual agreement or other transaction with the fiduciary, the burden of justification is shifted from the challenging party to the fiduciary. 72 Further-

67. See supra notes 33-41 and accompanying text; see also Mehlman, supra note 26, at 366-77.
68. See RESTATEMENT (SECOND) OF CONTRACTS § 153 (1981); id. at § 208 (“[i]f a contract or term thereof is unconscionable at the time the contract is made a court may refuse to enforce the contract”). See generally Williams v. Walker Thomas Furniture Co., 350 F.2d 445 (D.C. Cir. 1965) (absence of meaningful choice in entering into unconscionable contract for the purchase of furniture due to inequality of bargaining power); Friedrich Kessler, Contracts of Adhesion—Some Thoughts About Freedom of Contract, 43 COLUM. L. REV. 629 (1943).
69. See Cooter & Freedman, supra note 37, at 1064-74; DeMott, supra note 37, at 908-15; Frankel, supra note 37, at 800-01; Healey & Dowling, supra note 66, at 1001. These authors contend that fiduciary law has evolved in response to the recognition that there are certain legal relationships where the conduct of the more powerful party should be subject to a higher standard than those found in the law of contracts or torts. It is also important to note that the fiduciary concept reflects a relationship of trust in which one party is especially vulnerable. As a matter of public policy, the law is willing to impose further protective measures for the benefit of that party.
70. See Healey & Dowling, supra note 66, at 1003. Henley and Dowling state that the fiduciary receives his power from the entrustor and is expected to act in place of, or on behalf of, the entrustor. In addition, the power is vested for the well-being of the entrustor and not for the use or benefit of the fiduciary in his personal role.
71. See supra part II.
72. See Cooter & Freedman, supra note 37, at 1048 (once the appearance of disloyalty is established, the burden shifts to the fiduciary to prove his innocence). DeMott explains that the presence of a fiduciary obligation significantly affects the conduct of litigation through its allocation of the burden of proof. If a suit challenges a transaction between a fiduciary and a beneficiary, the fiduciary has the burden of proving that he dealt candidly and fairly with the benefi-
more, the fiduciary may be required to do more than merely compensate the patient for the loss she suffers as a result of a breach of fiduciary duty; punitive damages may be imposed upon the fiduciary. This stems from the fact that the information disparity between the parties lowers the probability that a breach of fiduciary duty will be detected. Health care delivery is so complex that it is difficult for a patient to identify when a physician is acting disloyally. Fiduciary rules respond by increasing the severity of the sanction to deter a breach of fiduciary duty.

The overall effect of these rules is to permit the patient to entrust her welfare to a party with greater knowledge and expertise, while at the same time minimizing the need to monitor the physician's behavior to ensure that the physician acts in the patient's interest. As a result, patients are able to expend more of their scarce resources on the purchase of health care rather than on the surveillance and sanctioning of physicians. The patient at the margin is encouraged to seek physician services rather than forego treatment because of the risk of physician misfeasance.

Fiduciary rules reduce the costs of monitoring and encourage patients to obtain care by inducing the patient to "trust" the physician. Trust correlates to the patient's uncertainty regarding the physician's behavior. Faced with uncertainty, the patient has three choices. She can expend resources to monitor the physician's performance (either directly or through third parties such as state medical boards and gov-

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73. See Cooter & Freedman, supra note 37, at 1048 ("If disloyalty is actually proved rather than inferred, it may be appropriate for fiduciary law to increase the sanction to include punishment, not just disgorgement of the appropriated asset."). For a detailed discussion of fiduciary remedies, see J.C. SHEPARD, THE LAW OF FIDUCIARIES 75, 82, 116-21 (1981). See also Hospital Auth. of Gwinnett County v. Jones, 409 S.E.2d 501 (Ga. 1991) (punitive damage award sustained where patient's injuries were exacerbated by hospital's transfer policy), cert. denied, 112 S. Ct. 1175 (1992).

74. See Cooter & Freedman, supra note 37, at 1049. Detecting a breach of fiduciary duty is also complicated by the fact that the breach of duty may appear to be merely a lack of competent performance. If a patient suffers a poor outcome as a result of something the physician did or did not do, it is difficult for the patient to distinguish whether the physician lacked the requisite skill or placed his own interests above those of the patient. The patient's difficulty in detecting a breach of fiduciary duty is underscored by how rarely patients detect a lack of competent performance. A recent study showed that only 1 in every 7.6 of all adverse events due to negligence resulted in malpractice claims. See A. Russell Localio et al., Relation Between Malpractice Claims and Adverse Events Due to Negligence, 325 NEW ENG. J. MED. 245, 248 (1991).
ernment regulators); she can expend resources to reduce the uncertainty, such as by learning enough about her medical condition to make choices for herself,75 or she can ignore the uncertainty and behave as if she were confident that the physician would not betray her.76 The third alternative constitutes "trusting"-the physician and is embodied in fiduciary doctrine because it entails the least expenditure of the patient's resources.77

A fiduciary analysis of how physicians should deal with resource constraints addresses the effect of the denial of treatment on patient trust. As a fiduciary, a physician is required to act in the patient's interest. When a patient is denied treatment, however, the patient's interest is being subordinated to someone else's. According to fiduciary theory, this could cause the patient to distrust the physician, thereby leading the patient to expend excessive resources on monitoring physician behavior or to incur the costs of illness rather than obtaining the physician's services. In that case, the law might respond by declaring the denial of treatment to be a breach of the physician's fiduciary duty to his patient.

The response of the law could depend upon who possesses those interests to which the patient's interests are subordinated. A distinction might be drawn between sacrificing the patient's interests for the personal gain of the physician and sacrificing the patient's interests for the benefit of other patients or society. The law might be more tolerant of the latter because the effect on patient trust might be perceived as being slight or because other concerns were deemed to outweigh the loss of patient trust. In order to understand the application of fiduciary doctrine under conditions of constrained resources, we must first identify

75. Reducing uncertainty is a primary objective of informed consent. In the extreme, the patient attempts to become a "lay doctor." See Susan P. Shapiro, The Social Control of Interpersonal Trust, 93 Am. J. Soc. 623, 630 (1987). By becoming more informed, the patient reduces the disparity between herself and the physician, which may deter the physician from taking advantage of her. However, obtaining information does not necessarily promote trust; rather, it decreases the need for trust. See J. David Lewis & Andrew Weigert, Trust as a Social Reality, 63 Soc. Forces 967, 970 (1985) ("[I]f one were omniscient, actions could be undertaken with complete certainty, leaving no need, or even possibility, for trust to develop .... Although some prior experience with the object of trust is a necessary condition for establishing the cognitive element in trust, such experience only opens the door to trust without actually constituting it.").

76. The connection between trust and uncertainty has been explored by German sociologist Niklas Luhmann, who states that trust "increases the 'tolerance of uncertainty.'" See Niklas Luhmann, Trust and Power 15 (1979).

77. In effect, the patient decides that it is advantageous to accept a risk of being harmed by the physician rather than expending greater resources to prevent the harm or incurring the certain harm of foregoing the physician's services.
whose interest is being enhanced at the patient’s expense and then address whether any circumstances justify the patient’s sacrifice.

A. Conflict Between Patient and Physician

In denying a patient access to care, a physician may face a conflict between his own interests and those of the patient. Subordinating the patient’s interests to his own might seem to constitute the cardinal sin of fiduciary misbehavior and to result in clear liability for the physician. The issues are not that simple, however. For example, the physician certainly is permitted to accept a fee from the patient. Yet the patient would arguably be better off if she could obtain the care for free. By charging a fee, the physician might be said to be placing his own interests above those of the patient. However, this does not necessarily constitute a violation of his fiduciary duty.

If we assume that the physician would not willingly harm his patient unless he derived some benefit, we identify the following possibilities in terms of the effect of the physician’s behavior on his and his patient’s welfare:

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<th>Change in Welfare</th>
<th>Legal Rule</th>
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<td>Patient</td>
<td>Physician</td>
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<td>(1) Decreased</td>
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<td>(2) Unchanged</td>
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<td>(3) Increased</td>
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<td>(4) Increased</td>
<td>Unchanged</td>
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<td>(5) Increased</td>
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The essence of the fiduciary principle is that alternative (1) is prohibited: The fiduciary cannot advance his own interests to the detriment of the principal. A physician cannot refuse to provide a patient with a necessary service, for example, in order to increase the physician’s earnings. Some payment systems—such as so-called capitated systems in which the physician receives a fixed amount per patient, per month, regardless of the services the patient receives—reward physicians financially if they reduce care to their patients. If the patient can show that care was denied solely to leave more money for the physician at the end of the month, the physician will be liable for breach of his
fiduciary duty to his patient.78

Arguably, alternative (2) is also prohibited: Insofar as the purpose of the relationship is to benefit the patient, the physician should not be permitted to use the relationship for his gain, even if doing so produces no direct loss to the patient. One way of looking at alternative (2) is that the physician has appropriated an opportunity for gain to himself, rather than giving it to the patient. The case of Moore v. Regents of the University of California,79 in which the California Supreme Court held that a physician breached his fiduciary duty to his patient by commercializing the patient's cells without permission and without allowing the patient to receive any of the financial benefit, suggests that alternative (2) would violate the physician's fiduciary duty.80

The remaining alternatives, (3) through (5), are all arguably permitted—that is, the physician can act in these ways without necessarily violating his fiduciary duty to his patient. The only controversial alternative is (3). Some might think that the physician's fiduciary duty prohibits him from benefitting at all. Yet, as mentioned earlier, this is clearly erroneous: the physician is allowed to charge the patient a fee for his services.

To answer the question of whether the physician can refuse to provide services to the patient if the patient cannot pay the physician's fee, it helps to rank the permissible alternatives in the order in which they would be preferred by the physician. The order is probably descending: the physician would most prefer to gain along with the patient — alternative (3). For example, the physician would prefer to receive payment in return for any health benefit provided to the patient. The physician would be less interested in alternative (4), where the patient gains but not the physician. For example, the physician would prefer to treat the patient himself than to refer the patient to a specialist and lose his

78. See Bush v. Dake, No. 86-25767 (Mich. Cir. Ct. Apr. 27, 1989) (HMO's capitation and risk pool arrangement delayed plaintiff's referral to specialist for pap smear test and consequent diagnosis of cancer); Hughes v. Blue Cross of N. Cal., 245 Cal. Rptr. 273 (Ct. App. 1988) (utilization review decisions used to achieve cost control constituted bad faith because they were significantly more restrictive than community standards); Joanne Wojcik, Health Plans Urged to Assess Liability, Bus. Ins., June 25, 1990, at 12 (noting that HMOs are increasingly being held liable for injuries resulting from reduced care).

79. 793 P.2d 479 (Cal. 1990).

80. See id. at 483. While the facts suggest that the patient was made to suffer expense and discomfort in order to enable the physician to profit, the opinion premises the breach of fiduciary duty on the physician's personal interests, unrelated to the patient's health, that may affect the physician's professional judgment, rather than on the patient's cost of the physician's behavior.
fee. The physician would least prefer alternative (5), in which the patient gains at the physician's expense. For example, the physician would not like to provide care for free because he would suffer an opportunity cost of being unable to treat other patients. The physician's worst scenario under alternative (5) would require him to pay the costs of the patient's care out of his own pocket, such as by having to pay for the patient's hospital care to avoid a premature discharge.

The progression from alternative (3) to (5) involves the patient's preferences as well as those of the physician. The farther down the list the physician is required to go to fulfill his fiduciary duty to his patient, the more the patient is benefitted at the physician's expense and the more reason she has to trust the physician. This reduces the amount that the patient must spend on monitoring the physician to insure that the physician does not act in his own self-interest at the patient's expense.

The fact that, as the patient and the physician move down the list, the patient's welfare increases relative to the physician's, suggests that alternatives (3) to (5) in the preceding table must be viewed as a continuum rather than as a set of clearly distinguished options. The question of whether the physician must treat the patient regardless of resource constraints then becomes: How far down the list must the physician be willing to go in order to fulfill his fiduciary duty to the patient?

Based on existing case law, the answer, at present, is unclear. The question usually arises when the patient complains that the physician caused her harm by prematurely terminating the relationship. This practice is known as "abandoning" the patient. On the one hand, the law permits the physician to terminate the relationship by giving the

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81. In some respects, the physician may gain by the referral. Although he forgoes his fee for this particular patient (since fee-splitting and kickbacks are illegal), the specialist may reciprocate by referring other patients to the physician in the future. Moreover, the physician who fails to refer a patient to a specialist risks liability for malpractice if the patient is harmed as a result. A rational physician who decides not to refer the patient must calculate that the risk of liability and the loss of goodwill from the specialist is outweighed by other factors. Potential factors include the patient's benefit of continued care from the primary physician and the physician's benefit of future fees from that particular patient (which would be lost if the patient never returned to the physician after referral to the specialist).

82. These cases typically are brought as malpractice cases and do not expressly address whether the physician has breached his fiduciary duty. However, by delineating the bounds to which the physician must go to avoid mistreating the patient, they provide a lower limit to the requirements of fiduciary doctrine.
patient notice and a reasonable opportunity to obtain care elsewhere.\textsuperscript{83} If, as some cases have suggested, a "reasonable opportunity" is defined merely as giving the patient a list of other physicians in the area and a reasonable amount of time in which to contact them,\textsuperscript{84} the physician would seem to be able to avoid treating a nonpaying patient by terminating the relationship. On the other hand, other cases, together with the doctrine known as the "continuous treatment" rule,\textsuperscript{85} suggest that a physician who agrees to treat a patient may have to provide necessary treatment whether or not the patient can pay for it.\textsuperscript{86} In terms of giving the patient who needs treatment a reasonable opportunity to obtain the care elsewhere, we might say that the physician cannot terminate the relationship unless he can find another physician who is willing to treat the patient without payment, since otherwise the patient simply does not have a reasonable opportunity to obtain care elsewhere. This might require the physician to absorb the cost of the patient's care himself if need be.

One way to determine the extent of the physician's duty to provide treatment is to consider the effect of the physician's behavior on patient trust. Assuming that an increase in the physician's willingness to sacrifice his own interests for his patient's will yield greater patient trust, we might wish to tighten the physician's fiduciary obligations if we perceived a need to enhance trust, or to relax those obligations if we felt that the degree of trust was greater than necessary.\textsuperscript{87}

Numerous surveys and commentators have noted that trust between patients and physicians has deteriorated.\textsuperscript{88} Patients report that


\textsuperscript{84}See Payton, 182 Cal. Rptr. at 227.

\textsuperscript{85}The continuous treatment rule states that a physician must continue to treat a patient until the patient no longer requires care for the affliction that led her to initiate the relationship with the physician, or until the relationship is otherwise terminated. See Johnson v. Vaughn, 370 S.W.2d 591, 596 (Ky. 1963); see also C.T. Drechsler, Annotation, Liability of Physician Who Abandons Case, 57 A.L.R.2d 432, 439 (1958) (discussing physician's right of withdrawal). However, the rule is not clear as to whether a patient's inability to pay terminates the relationship.

\textsuperscript{86}See Wilson v. Blue Cross of S. Cal., 271 Cal. Rptr. 876 (Ct. App. 1990); Wickline v. California, 239 Cal. Rptr. 810 (Ct. App. 1986); Ricks v. Budge, 64 P.2d 208 (Utah 1937).

\textsuperscript{87}By virtue of Axiom 1, one of the costs of excessive trust would be a decrease in access. See infra notes 116-18 and accompanying text.

\textsuperscript{88}See Edmund D. Pellegrino, Trust and Distrust in Professional Ethics, in ETHICS, TRUST AND THE PROFESSIONS: PHILOSOPHICAL AND CULTURAL ASPECTS 77 (Edmund D. Pellegrino et al. eds., 1991); Bill Stokes, An Uneasy Alliance: Suspicion, Skepticism and an Army of Outsiders Threaten the Doctor-Patient Relationship — But the Condition Is Being Monitored, CHI. TRIB.,
doctors are more interested in making money than in helping patients. Together with concerns over malpractice liability, the deterioration of trust between patient and physician has significantly demoralized physicians. Applications to medical schools have declined. The absence of trust makes physicians long for a bygone era. As one surgeon writes, "I have come face to face with the disheartening fact that we don't see such simple trust in our patients' eyes as often as we used to." One commentator goes so far as to state that "the position of the physician in society has taken a 180-degree turn, from respect to contempt."

Given the deterioration in trust between patients and physicians, patients are likely to be devoting an excessive amount of resources to monitoring physician behavior. It is difficult to measure directly how much patients spend on monitoring physicians in attempting to detect and prevent breaches of fiduciary duty. However, if we assume that there is a link between malpractice actions and patient trust, in that


89. See Kolata, supra note 88, at 1.

90. See Skelly, supra note 88, at 28.

91. See Leigh Page, Medical Schools 'Enlarge Their Vision,' Embrace Humanities, AM. MED. NEWS, Jan. 5, 1990, at 28 (medical school applications at an all-time low of 1.6 applicants for every place available). But see Leigh Page, Hike in Medical School Applicants May Boost Standards, AM. MED. NEWS, May 18, 1992, at 15 (applications appear to be increasing once again).


93. Wassersug, supra note 88, at 23.

94. One reason is that, as noted earlier, it is extremely difficult to distinguish a breach of fiduciary duty from a lack of competent performance. See supra note 74 and accompanying text. If a physician denies treatment to a patient, the patient may not be able to determine whether her subsequent condition is the result of the physician's behavior or the inevitable progression of her underlying disease or condition. Furthermore, even if the patient realizes that she has suffered a poor outcome due to the physician's failure to render necessary care, she may not be able to determine whether the physician has sacrificed her interests for his own. Disentangling the effect of the patient's illness or condition from the patient's health outcome following an episode of medical care is the objective of the new science of outcome measurement. While progress has been made, much work remains to be done before the results can be used to evaluate the quality of health care services. See generally Maxwell J. Mehlman, Assuring the Quality of Medical Care: The Impact of Outcome Measurement and Practice Standards, 18 LAW, MED. & HEALTH CARE 368 (1990).

95. See William Y. Rial, I Have A Concern For Thee, 248 JAMA 1069, 1070 (1982) (active cultivation of patient trust is one of the best ways to prevent malpractice suits); William B. Applegate, Physician Management of Patients With Adverse Outcomes, 146 ARCHIVES INTERNAL MED.
patients are more inclined to attempt to detect and remedy poor outcomes if they distrust their physicians, the widely noted increase in the severity of malpractice actions, along with calls for reforms to reduce the number of suits and the costs of the system, support the proposition.

If patients are spending too much on monitoring physicians, a more efficient system could be achieved by increasing trust. In terms of the obligation to treat patients at the physician’s expense, the physician may have to go to “heroic” lengths to provide treatment when resources are constrained. The physician may be required to submit to one or more of the following: treat the patient without charge, lower his fee to cover only his “cost,” accept whatever the patient can afford to pay, or allow the patient to pay the fee over an extended period. If the physician terminates treatment without offering the patient these alternatives and thereby harms the patient, the physician might be open to the charge that he breached his fiduciary duty by placing his own interests above his patient’s. 97

96. Barry Furrow calls this a “duty to rescue.” Barry Furrow, Forcing Rescue: The Landscape of Health Care Provider Obligations to Treat Patients, 3 HEALTH MATRIX, J. LAW-MED. (forthcoming 1993). However, the rules of tort law regarding this duty suggest that it does not require the actor to expose himself to personal risk. See RESTATEMENT (SECOND) OF TORTS § 324 cmt. d (1965). Thus, since a fiduciary may have to risk a loss of compensation to fulfill his duty to his patient, it is preferable to describe the physician’s duty as “heroism” rather than as “rescue” behavior.

97. It might be questioned whether patient trust would in fact be enhanced by tightening fiduciary rules for physicians. Patients might discount physician behavior on the basis that the physicians’ actions were the result of a fear of legal sanctions rather than a desire to promote their patients’ interests.

Several commentators appear to suggest that legal rules are a functional substitute for trust in professionals, in that both allow patients to reduce their monitoring costs. Shapiro calls this “impersonal trust.” See Shapiro supra note 75, at 634 (in impersonal trust, reliance is placed on “guardians” and on their monitoring and control mechanisms). According to this approach, patients turn to legal regulation to sustain their relationships with physicians when they feel that trust in the physicians themselves is no longer warranted. For example, Bernard Barber states that, in relation to trust, law is an “alternative and complementary mechanism of social control,” adding that “we need to discover and continually rediscover how to foster trust and make it more effective . . . . [P]aradoxically, this goal can be achieved in part by making its social control alternatives and complements more extensive and more effective.” BERNARD BARBER, THE LOGIC AND LIMITS OF TRUSTS 22, 170 (1983). Similarly, Mark Granovetter states that institutional ar-
The heroic behavior demanded of the physician in fulfilling his fiduciary duty assumes a different appearance if the source of resource constraints is another party rather than the physician himself. Even if the physician agrees to waive his fee, a hospital may not be willing to admit a patient who is uninsured, a specialist may not be willing to accept a referral, or a piece of necessary medical equipment may not be found in the area. In these situations, we might say that the physician has done all that is required once he agrees to waive his fees. To increase trust, however, the physician may need to go further by serving as an advocate for his patient. In Wickline v. State, for example, the court suggested that the physician had a responsibility to protest a

arrangements that make it too costly to malfeas "do not produce trust but instead are a functional substitute for it." Mark Granovetter, Economic Action and Social Structure: The Problem of Embeddedness, 91 Am. J. Soc. 481, 489 (1985). In contrast, Shapiro argues that the mechanisms of impersonal trust enhance trust in agents, and that only those strategies that "virtually eliminate agency and uncertainty are functional substitutes for trust." See Shapiro, supra note 75, at 636 n.18.

However, some commentators are concerned that reliance on legal rules may impair the patient-physician relationship. For example, philosopher Annette Baier states: "Where the truster relies on his threat advantage to keep the trust relation going, or where the trusted relies on concealment, something is morally rotten in the trust relationship." Annette Baier, Trust and Antitrust, 96 Ethics 231, 255 (1986).

Furthermore, those who claim that reliance on the threat of the law is a functional equivalent to trust ignore the fact that parties turn to legal controls only when trust has deteriorated. Thus, reliance on the threat of sanctions constitutes a reflection of distrust rather than an equivalent to trust: the greater the role of this threat in facilitating a relationship, the greater the breakdown of trust and the level of distrust between the parties.

Barber appears to accept the relationship between reliance on legal sanctions and distrust when he endorses the principle of "rational distrust," which he describes as "rationally based expectations that technically competent performance and/or fiduciary obligation and responsibility will not be forthcoming." Barber, supra, at 166. According to Barber, this type of distrust is not destructive, but instead is "another, and in a sense functionally equivalent, instrument for maintaining social order." Id. As a reflection of distrust, however, the threat of legal sanction may erode trust in much the same way that distrust breeds distrust. Pellegrino observes that parties embrace "ethical minimalism" when they rely upon law: "Patients must seek strict contractual relationships with their doctors. Professionals will tend to limit themselves to the precise letter of agreement." Pellegrino, supra note 88, at 79. This in turn gives rise to an "ethics of distrust," in which "professionals and those who seek their help assume primarily a self-protective stance." Id.

The concern that reliance on legal rules produces distrust is based on the notion that the function of legal rules is to punish misbehavior and that physicians will act upon fear rather than concern for patients. However, the law can play a more positive role: uncertainty may be reduced by reflecting a consensus on the standards of physician behavior. This consensus can be reached through a process that includes input from public and private groups, particularly from the medical profession itself. In this light, the law becomes more a code of conduct than a mere threat of punishment, with trust enhanced rather than destroyed.

98. 228 Cal. Rptr. 661 (Ct. App. 1986).
third-party payer's refusal to pay for additional days of hospitalization for his patient. Morreim similarly has argued that "under current economic conditions, [a patient's] needs also encompass economic advocacy. . . . The patient . . . needs the physician's vigorous lobbying efforts, such as to persuade recalcitrant utilization reviewers of the necessity of treatment." Where resources are lacking in a geographic area, the physician's fiduciary duty may require him to lobby providers and payers to secure the resources; likewise, a rural physician may be obligated to try to convince a legislature or state health department to build a clinic in his area or to fund regional access to an advanced medical technology such as magnetic resonance imaging. At a minimum, the physician must alert the patient to the need for the resource.

A physician incurs numerous costs in trying to eliminate barriers to treatment created by third parties. Lobbying takes time away from his practice. In addition, a physician who pressures a third party such as a payer or hospital on behalf of his patient is likely to be unpopular with that party. A hospital or HMO may take administrative action against the physician, such as attempting to revoke his hospital staff privileges or to exclude him from the HMOs panel of physicians. Nonetheless, the physician might be obligated to undertake an advocacy role on behalf of his patients despite these risks.

B. Conflict Between Patients

Thus far, we have only considered the conflict between the physician's self-interest and the interests of his patient. However, resource constraints may also affect physician behavior when one patient's interests are pitted against those of another patient, a group of patients, or society as a whole.

An example of one patient's interests being pitted against those of another is cost shifting. This occurs when a physician increases the charges for one patient or group of patients to cover the costs of treating other patients who are indigent or lack health insurance, or whose insurance pays less than the physician's fee.

99. Id. at 670. The court noted that a physician cannot avoid ultimate responsibility for his patient's care by simply complying without protest with limitations imposed by a third-party payer when the physician's medical judgment dictates otherwise. Id. at 671. Thus, the court concluded that Wickline's physician should have attempted to prolong her hospital stay beyond the authorized time period if he determined that such additional care was in her best interest. Id.

100. Morreim, supra note 9, at 292.

101. See Siliciano, supra note 5, at 446 ("[H]ospitals and physicians routinely overcharged some patients to finance the care of other patients . . . ."); Gerard F. Anderson, All-Payer
tort law, we might say that the physician is entitled to shift costs so long as he maximizes societal welfare, and he may even be required to do so in order to act "reasonably." Cost shifting is comparable to spreading the costs of accidents, a primary function of tort liability and one that is generally agreed to be desirable. In terms of the physician's fiduciary duties to his patients, the physician might be deemed to be acting heroically by providing services to those who otherwise would not receive them because of resource constraints. At the same time, however, the physician is sacrificing the interests of one group of patients for those of another. It is unclear whether this is consistent with the physician's common law duties.

As a practical matter, cost shifting might not be problematic if the burden on those who are made to pay is hidden or small. However, difficulties arise if the effect is to deny treatment to the patients who must absorb the costs. This consequence is bound to occur at the margin. As the loss of benefit to the patients who must bear the cost increases and becomes more visible, the physician would likely be subject to greater risk of liability for violating his fiduciary duty to those patients who were denied services because the resources necessary to provide those services were diverted to other patients.

Yet as John Siliciano points out, this issue is becoming moot. Third-party payers increasingly are refusing to absorb the costs of providing health care services to patients who are not their enrollees.

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103. The common law does not seem to provide a clear answer to the physician's dilemma. There are no cases in the health law area that illuminate the issue. However, it is interesting to note that the recent Oregon Medicaid legislation contains a provision that immunizes physicians from legal liability for denying patients medically necessary services when those services are not covered by the state plan. See infra note 126 and accompanying text. Under the Oregon plan, certain services are denied coverage in order to expand the number of persons eligible for Medicaid benefits. Thus, the plan resembles cost shifting by denying some services to some patients so that other services can be provided to other patients within the resource constraints set by the legislature. The fact that the legislature added the immunization provision suggests that physicians might otherwise be liable at common law if they denied services to some of their patients in order to benefit others.

104. See Siliciano, supra note 5, at 453-57. Siliciano states:

Because DRG reimbursement payments are set simply by category of diagnosis, there is
Soon, physicians will no longer be able to discharge their duty to act heroically by simply shifting costs. Instead, they will have to sacrifice their own interests to benefit their patients—such as by waiving their fees.

Thus, we find ourselves back at the point where the physician’s interests conflict with the patient’s. Once again, if the objective is to increase patient trust, the physician may be expected to perform heroically by sacrificing his own interests for those of his patients.

Conflicts between patients competing for scarce resources can occur in ways that do not so clearly involve the physician’s own self-interest. One type of case is “absolute scarcity,” in which there is an immediate shortage of resources that cannot be alleviated by allocating additional funds or by reallocating existing resources. For example, when a single transplant organ becomes available and there is more than one patient on the waiting list, some method must be used to decide who will receive the organ. The interests of the patients denied the organ will necessarily be sacrificed to the interests of the patient who receives it. Another illustration of absolute scarcity is triage, in which an accident or battle creates more persons in need of emergency treatment than can be treated by the physicians available. As in the transplant example, some method must be used to determine priority of treatment. The triage physician and the transplant surgeon who has more than one patient on a waiting list might be accused of violating

no possibility of assessing surplus charges against some patients in order to subsidize the care of others who are not similarly covered by some form of health insurance. . . .

[IIJ]ittle or no portion of the DRG payment under most systems represents an allocation for the free treatment of indigent patients.

Id. at 453-54. He further states that the health care system’s ability to provide uncompensated care is also undercut by HMOs and the remaining potential subsidizers who are less willing, under current market conditions, to accept the charges assessed by a health care provider attempting to finance care for the indigent. Id. at 454-55.

105. To the extent that physicians shift costs in order to continue to receive their fees, cost shifting pits patients against the physician’s self-interest as well as against each other. Unless costs are shifted to obtain resources to enable the patient to receive care from another provider after the physician has already acted heroically by reducing or waiving his fee, the practice of cost shifting may be said to contain an inherent conflict between physicians and patients.

106. For a general discussion of this issue, see Maxwell J. Mehlman, Rationing Expensive Medical Treatments, 1985 Wis. L. Rev. 239. Absolute scarcity results in an absolute shortage at the micro level due to the necessity of a short-term allocation decision. However, the shortage may be alleviated for the long term through a reallocation of resources at the macro level. For example, more transplant organs might be available if donors received payment, a transaction currently prohibited under federal law. See National Organ Transplant Act, 42 U.S.C. § 274e (1988). Similarly, triage might be avoided if more physicians were available in the first place.
their fiduciary duty to the patients who are denied treatment. However, the circumstances compel the physician to make a choice. The only alternative to that choice is to permit all the battlefield casualties and accident victims to die, or to allow the organ to go to waste.

It would hardly seem appropriate for the common law to subject a physician to automatic liability for breach of his fiduciary duty if he treats patients under conditions of absolute scarcity. However, the common law provides little guidance on how he should decide which patients to treat. Some commentators have suggested that patients be selected on the basis of social worth criteria. That is, priority would be given to those expected to make the greatest contribution to society. This approach actually was employed to allocate access to kidney dialysis in the 1960s, but was widely condemned. Another method would give the physician wide discretion and protect him from liability as long as he did not act in an arbitrary, capricious, or discriminatory fashion. For example, the physician might use medical criteria to select patients on the basis of which patient was in worse condition or which patient stood the best chance of survival. This resembles a sort of “business judgment rule” that is sometimes used to insulate corporate directors from liability to shareholders for breach of fiduciary duty.

107. For this reason, as well as to avoid biased decisions, the government has established a system for selecting transplant organ recipients that does not involve the patients' physicians in the decision-making process. First, all potential recipients must be listed on the United Network for Organ Sharing ("UNOS") waiting list. Then, a point system is utilized to determine the allocation of organs. Points are received in accordance with such factors as time spent on the waiting list, quality of match to the donor's organ, existence of certain antibodies, medical urgency, and ease and rapidity of performance of the transplant. See generally ORGAN TRANSPLANT POLICY: ISSUES AND PROSPECTS (James F. Blumstein & Frank A. Sloan eds., 1989).

108. See, e.g., Leo Shatin, Medical Care and the Social Worth of a Man, 36 AM. J. ORTHOPSYCHIATRY 96, 98 (1966) (criteria should include economic productivity, age, history of antisocial behavior, and contributions to humanity).


110. The best known criticism was that of Sanders and Dukeminier, who stated that the policies of the Seattle Artificial Kidney Center, which selected patients in part on the basis of social worth, ruled out "creative nonconformists, who rub the bourgeoisie the wrong way but who historically have contributed so much to the making of America. The Pacific Northwest is no place for a Henry David Thoreau with bad kidneys." Id. at 378.

111. These two alternatives do not lead to the same patients being selected or to the same results in terms of success. When one hospital changed its method of allocating access to beds in the intensive care unit from favoring those patients in the most critical condition to those patients who had the best chance of surviving, the mortality rate dropped from 80% to 20%. See Note, SCARCE MEDICAL RESOURCES, 69 COLUM. L. REV. 620, 655-56 & n.188 (1969).

112. The most extreme example in the corporate law field is Johnston v. Greene, 121 A.2d 919 (Del. 1956). In that case, a shareholder claimed that a director who served on multiple corporate
Another approach would ignore differences between patients and allocate scarce resources randomly, such as by casting lots. In contrast to employing medical criteria, random selection is arbitrary and might lead to odd, non-utilitarian results, such as providing a scarce resource to a convicted criminal rather than to a head of state. However, by tending to ignore differences between patients based on social status or wealth, both medically based and random decision making might be less likely to erode patient trust than allocating resources based on social worth.

In other situations involving conflicts between patients, the lack of resources may not be absolute, and the physician may actually be able to provide treatment to competing patients. Under such conditions, the physician's decision not to provide treatment to a patient may be termed a case of "relative scarcity": health care for an individual patient is limited by the desire to devote resources to other patients or to societal uses other than health care. For example, the physician may decide that the benefit of treatment to patient A is greater than the benefit to patient B. He may further determine that the treatment should only be given to A in order to conserve societal resources and thereby ensure that patients like A received the treatment in the future. This approach is advocated by some commentators as a partial remedy for skyrocketing health care costs.

In many instances of "relative scarcity," the physician will be act-
ing at least in part out of his own self-interest. For example, he may decide to provide care to one patient who is willing to pay more than another potential recipient of care. Likewise, he may deny treatment to a patient in order to appease a third-party payer who is concerned about costs. In these situations, the physician might be deemed to be violating his fiduciary duty to the patient denied treatment; the fact that the physician’s self-interest coincided with the interests of other patients or of society should not excuse him from behaving heroically on behalf of all of his patients.

However, it is also possible that a denial of treatment will not promote the physician’s self-interest. The physician may feel that it is his duty to society, or to the beneficiaries of an insurance or entitlement plan such as Medicare, to refrain from providing expensive treatments to certain patients because the resources are needed for other patients or for non-health purposes. Indeed, in denying the treatment, the physician may in fact be sacrificing his own self-interest by foregoing his fee. The physician’s behavior seems selfless. He may believe that he is acting reasonably because, by saving money, he is maximizing the efficient use of scarce resources. Yet is he acting consistently with his fiduciary duties to his patients?\textsuperscript{115} The answer depends on whether or not the physician’s behavior erodes patient trust and encourages patients to devote excessive resources to monitor the physician’s behavior, resulting in an inefficient patient-physician relationship. It seems likely that a patient denied necessary medical treatment for the benefit of another patient or a third-party payer will feel betrayed. Patient trust can be enhanced, therefore, by prohibiting this type of behavior as a breach of the physician’s fiduciary duty.

In summary, the goal of fiduciary doctrine is to reduce monitoring costs by promoting trust. To promote trust, fiduciary rules require the

\textsuperscript{115} One analogy arises in the case of corporate directors who divert corporate earnings from shareholders to non-shareholder constituencies. The well-known case of Dodge v. Ford Motor Co., 170 N.W. 668 (Mich. 1919), held that such diversion did not necessarily violate the directors’ fiduciary duty to shareholders, although it was ultra vires under the articles of incorporation in question. Approximately 28 states have enacted so-called “other constituency” statutes which permit a diversion of corporate earnings if the interests promoted by the diversion bear some beneficial relationship to the interests of shareholders. See generally Charles Hansen, \textit{Other Constituency Statutes: A Search for Perspective}, 46 Bus. Law. 1355 (1991).

Another analogy arises in trust law when a trustee distributes trust assets to selected beneficiaries where such distribution is not specifically authorized by the trust instrument. While the law is very murky on this issue, it appears that the trustee must secure the consent of the disadvantaged beneficiaries in order to avoid liability. See George T. Bogert, \textit{Trusts} § 110 (6th ed. 1987).
physician to further his patients' interests. The rules significantly con­strain the physician's ability to act on his own behalf or to sacrifice the welfare of individual patients for benefits to other patients or other constituencies. It is generally acknowledged that trust between patients and physicians has eroded; this translates into a corresponding increase in monitoring costs. This condition suggests that, in order to enhance trust and reduce monitoring costs, fiduciary rules in the patient-physician relationship should be applied vigorously, interpreted strictly, or both.

Yet we have not taken into account Axiom 1. Axiom 1 gives physicians the freedom to decide when to enter into relationships with patients. The more that physicians are constrained by fiduciary obligations from acting in their own self-interest, and the more that they feel caught between their fiduciary obligations to specific patients and their perceived obligations to other constituencies, the less willing they may be to enter into relationships with those patients who are likely to create these sorts of conflicts, or the more they will insist on being paid. Increasing trust therefore may decrease access, particularly for those patients who are likely to consume significant amounts of health care resources or to have fewer resources available to them by virtue of their poverty, their location in underserved areas, or their lack of health insurance. Fiduciary rules create a tension between trust and access. The fact that we impose fiduciary rules on a relationship means that we are willing to sacrifice access to some degree in order to increase the value of the relationship to the weaker party: fiduciary rules only protect those patients fortunate enough to find physicians willing to treat them.

This would not be a problem if patients enjoyed an abundance of access. In that case, if we felt that the amount of trust between patients and physicians was suboptimal, we could tighten fiduciary rules and not worry about a decrease in access. Yet access is a critical problem for many Americans without health insurance, and an increasing problem for insured persons whose coverage is shrinking relative to insurance costs. Similarly, our dilemma would be alleviated if we were not concerned about health care costs. We could increase trust by imposing higher duties on providers and compensating them for the increased value of the relationship to patients. Yet cost containment has become a social imperative. The question, then, is: Can we tighten fiduciary

116. See supra part I.
117. Some commentators maintain that we can afford to spend even more on health care than is currently spent. See, e.g., Eli Ginzberg, High Tech Medicine and Rising Health Care Costs,
IV. CHANGING THE COMMON LAW

Axiom 1 poses a threat to patient access by allowing physicians to refuse to enter into a relationship with those prospective patients to whom the physician may be required to provide services without compensation or at the physician’s expense. One way to eliminate the threat from Axiom 1 is to change the common law to make it illegal for the physician to refuse to enter into a relationship with a patient. This would shift the role of contract a further step away from the direct interaction between patients and physicians: contract rules—which are not allowed to govern the terms of the relationship under current law—would no longer be permitted to govern the formation of the relationship. A role for contract would remain, however: contract would still govern entry into the profession. While a physician could not refuse to treat a patient, a person could refuse to become a physician, perhaps because he disliked the coercive regime under which he would be forced to practice.

In the extreme, a physician who rejected a potential patient could be subjected to criminal penalties or disciplinary action—perhaps including the loss of his license to practice. A less severe approach would make the physician liable in tort for actual damages sustained by the patient as the result of not being treated. A middle ground would permit the patient to recover punitive as well as actual damages on the theory that the physician breached his fiduciary duty to the patient by

263 JAMA 1820, 1822 (1990) (“There is nothing inherently bad about the expenditure of $620 billion on health care services by a $5 trillion economy. Nor is there any reason a $6 to $7 trillion economy should not spend $1 trillion or even more for its health care.”).

118. It might be objected that the degree of fiduciary duty imposed by the law should not affect access. In the absence or relaxation of fiduciary rules, patients would need to expend greater resources on monitoring physicians to prevent overcharging, and these resources would not be available to purchase access. Conversely, increasing fiduciary obligations may allow patients to divert resources from monitoring physicians to purchasing additional services, but it also encourages physicians to demand more for their services or to avoid entering into conflict-laden or less remunerative relationships. Either approach would threaten access.

However, it has already been noted that the excessive cost of monitoring the behavior of a party with greater bargaining power provides the justification for creating a fiduciary relationship. See supra notes 67-77 and accompanying text. Accordingly, it is cheaper to promote trust than to monitor physician behavior. Thus, assuming that the patient-physician relationship is formed, reducing monitoring costs by promoting trust is likely to be more efficient than promoting access by relaxing fiduciary rules (and thereby increasing monitoring costs).
not entering into the relationship; in effect, this would extend the physician’s tort and fiduciary obligations beyond the confines of the relationship to precede its formation.119

As a result, the physician’s cost of refusing to enter into the relationship would be increased by the degree of the sanction multiplied by the probability that it will be imposed. Ideally, this cost would be set slightly higher than the cost to the physician of fulfilling his fiduciary responsibilities to his patients. A sanction consisting of punishment by the government—either through criminal penalties or disciplinary action by state medical boards—would amount to the physician being coerced into treating patients. The same effect would be achieved if the sanction took the form of a civil remedy for injured patients, although the appearance of coercion would be diminished.

This approach draws a number of criticisms. The common law generally resists forcing people to provide services to others.120 The concern is that the provider of services will respond by degrading his performance. If we hold price constant by refusing to increase payment to physicians in return for strict fulfillment of their fiduciary responsibilities, such as by making it impossible for them to shift costs, and if at the same time we make it prohibitively expensive for them to refuse to provide services at all by sanctioning them if they do so, the only remaining variable to manipulate is the quality of their services. The result is that patients may indeed obtain access, but to a lower quality of care. Avoiding this result would require additional monitoring of physicians (for example, additional malpractice actions) at an additional cost. Such monitoring might be particularly expensive because of the inherent difficulty in distinguishing between poor-quality care that results from lack of competent performance (for which the physician is only liable for compensatory damages) and poor-quality care that results from the physician’s resistance to coercion (for which the physi-

119. The nature and severity of the penalty would depend on the difficulty of detecting and processing misbehavior. Criminal penalties might be preferred over civil penalties if the government could monitor and respond to physician misbehavior more cheaply than patients could. Likewise, a more severe penalty might be desired to maintain an adequate level of deterrence if violations were difficult to detect and punish.

120. The court in Hutchinson Gas & Fuel Co. v. Wichita Natural Gas Co., 267 F. 35 (8th Cir. 1920), set forth the “general rule that specific performance of a contract will not ordinarily be decreed by a court . . . in favor of a party against whom that court cannot efficiently compel its performance.” Id. at 39. Similarly, the court in Bickford v. Davis, 11 F. 549 (C.C.D.N.H. 1882), rejected specific performance when the defendant contracted to use his skill and machinery to manufacture exclusively for the plaintiff a certain article in quantities plaintiff should order, due to the impossibility of the defendant’s compliance and the one-sidedness of the contract.
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cian may be additionally subjected to punitive damages, disciplinary
action, or criminal punishment). 121

Another problem raised by forcing physicians to treat patients is
ensuring that the burden of limited resources is spread fairly among all
practitioners. Physicians who practice in areas with fewer resources or
poorer patient populations would bear a disproportionate share of the
burden unless some method were employed to keep track of the provi-
sion of “coerced” care and to reappportion the burden more evenly. 122

Despite its problems, this approach has been adopted by the fed-
eral government. Legislation enacted in 1989 prohibits physicians (and
hospitals) from turning patients away from emergency rooms unless the
patient is stable or another hospital has agreed to accept a transfer of
the patient. 123 A Texas physician was recently convicted of violating
this statute and was fined $20,000. 124

Thus far, coercive legislation has been limited to emergency situa-
tions. The theory may be that quality is a lesser concern in these cases
because in an emergency any care is better than no care at all. How-
ever, several states are considering requiring physicians to treat Medi-
care and Medicaid patients even in non-emergency circumstances. 125

121. See Cooter & Freedman, supra note 37, at 1052-53 (observing that punitive damages are
necessary to deter adequately violations of fiduciary duties).

122. This coercive approach must go further. Even if the law prohibited a doctor from refus-
ing to treat Medicare or Medicaid patients, the physician could escape this prohibition by opening
his practice in an affluent area where there would be few or none of these patients. To solve this
problem, British Columbia initiated a policy to issue billing numbers to physicians. This policy
was designed to permit the province to control both the total number of physicians able to bill the
Medical Service Plan of British Columbia and their geographic location. For example, newly
graduating physicians trained in British Columbia would be required to apply for privileges. Once
privileges were gained, the applicants would receive a geographically restricted billing number.
See Morris L. Barer, Regulating Physician Supply: The Evolution of British Columbia's Bill 41,

123. See supra note 47.

124. See Sullivan v. Burditt, 934 F.2d 1362 (5th Cir. 1991) (holding that a failure to weigh
medical risks and benefits before ordering transfer of severely hypertensive woman in active labor
violated the statute).

125. A new California Act would require all doctors to accept 15 Medicare and Medicaid
patients for every 100 in their care. See California Health Care Crisis Spawns Initiatives, Pro-
posals, 19 Pens. Rep. (BNA) No. 15, at 634 (Apr. 13, 1992). In addition, the Minnesota House
of Representatives proposed a health care bill requiring doctors to treat Medicare patients if they
accept patients from other government programs. See Rogers Worthington, Minnesota Pushing
Health Coverage For All, Chi. Trib., Apr. 5, 1992, at C1. In Massachusetts, the Foundation
Health Corporation contracted to administer a new Medicaid program. Under this program, each
Medicaid recipient will be assigned a primary care doctor, and all HMOs that write health insur-
ance will be required to accept Medicaid business. See Mike Pulley, Foundation Steams Ahead
Given the problems with a coercive approach, we might search for other ways to eliminate the impact of scarce resources on the patient-physician relationship. Instead of placing the responsibility on the individual physician to provide access despite resource constraints, the responsibility might be shifted to the state. Access would no longer be an issue to be resolved by physicians at the micro level, but a problem to be addressed at the macro level through government decision making. The government, rather than the physician, would determine the services to which patients were entitled, either directly through a government program such as Medicare or a national health care financing system as in Britain or Canada, or indirectly by specifying those health benefits that must be included in private insurance plans.

A thorough discussion of the merits of providing access through government health care programs is beyond the scope of this Article. A few comments are in order, however, concerning the effect that shifting the responsibility for access from the micro to the macro level would have on patient trust.

In the first place, it is not clear that relying on government to determine the access to which the patient was entitled would relieve the physician of his fiduciary duty to his patient and the corresponding risk of liability. If the government merely established those costs for which it (or private insurers) would pay, the approach would resemble payment limits imposed by a third-party payer. Just as the refusal of payment by a third-party payer does not relieve the physician of his obligation to act on his patient's behalf, the physician facing payment limits imposed by the state might still be expected to act heroically on behalf of his patient, such as by providing noncovered services for free or by pressuring the government or other third-party payers to pay for the services in marginal cases. To avoid this, the physician might invoke his privilege under Axiom 1 to refuse to treat patients who are likely to create this type of problem, once again creating the access problem that government intervention was designed to solve.

To avoid this result, it would be necessary to insulate the physician from liability for refusing to provide services to a patient when the services were not covered by the government program. This approach was taken by the legislature in Oregon. Under the Oregon plan, a priority ranking of medical services was constructed by a state commission. The state legislature then decided how far down the list it could afford to go in order to provide some degree of health care to all persons with incomes below the federal poverty level. To avoid the Axiom 1 problem,
the legislation included a provision immunizing physicians from liability for failing to provide services that are not funded by the legislature. As a result, the Oregon approach permits the physician to shift his loyalty from the patient to the state. The patient in turn shifts his trust from the physician to the state.

In terms of effect upon monitoring costs, it cannot be taken for granted that placing the responsibility for access in government will reduce such costs. Surveys show that people distrust government—probably much more than they distrust physicians. Even if government functions in accordance with the law, people may fear that government will sacrifice individual interests for societal objectives in much the same way as tort rules. Monitoring governmental activity might take different forms than monitoring the behavior of individual physicians—such as lobbying legislators, learning how to work the administrative process, and so on—but it may not be cheaper. Furthermore, patients are likely to continue to monitor physicians—for example, to ensure that the physician is providing all the treatment that the government has authorized, or that the physician is not furthering his own interest at the expense of the patient’s. The costs of monitoring

126. See OR. REV. STAT. § 414.745 (Supp. 1992) (“Any health care provider or plan contracting to provide services to the eligible population under [this Act] shall not be subject to criminal prosecution, civil liability or professional disciplinary action for failing to provide a service which the Legislative Assembly has not funded . . . .”). For a general discussion of the Oregon plan, see OFFICE OF TECHNOLOGY ASSESSMENT, U.S. CONGRESS, EVALUATION OF THE OREGON MEDICAID PROPOSAL (1992); The “Oregon Plan”: A Symposium, 1 HEALTH MATRIX, J. LAW-MED. 135 (1991). It is not clear that physicians will take advantage of the immunity provided by the legislature. Fears have been expressed that physicians in Oregon will attempt to provide uncovered services to their patients by characterizing the services as “above the line” covered services.

127. There is a basic distrust of government in this country. A majority of citizens would prefer that the government provide care only for those unable to afford it. See Christine Woolsey, Health Care Reform Plans; Most Americans Want Private Sector to Continue Control Over Medical Care, BUS. INS., June 8, 1992, at 1. Public opinion surveys around the nation have also registered distrust and disgust at the process by which lawmakers are elected and govern, see Nancy Gibbs, Keep the Bums In, TIME, Nov. 19, 1990, at 32, particularly with respect to the government’s ability to spend money wisely. See Jeffrey A. Perlman, Watchdogs Vie to Oversee ‘M’ Funds, L.A. TIMES, Nov. 13, 1990, at B1 (voter approval of Citizens’ Oversight Committee to monitor government spending of tax money raised for transportation projects).

128. See supra notes 55-56 and accompanying text.

129. The manner in which the physician might take advantage of the patient under a government program would depend, among other things, on how the physician was compensated. A physician who was paid a set amount per patient regardless of the services he rendered would have an incentive to provide as few services as possible to keep his costs down relative to his revenue. A physician on salary would have an incentive to shirk. A physician paid a set amount on a fee-for-service basis would have an incentive to deny services if their costs were high relative to the
physicians would be incurred in addition to the costs of monitoring the
government, and together they could increase the overall costs of the
system.

Even if monitoring costs do not increase, the more that govern­
ment is entrusted with the task of assuring access to health care and
allowed to usurp the fiduciary functions of the medical profession, the
more that the professional role of physicians will diminish. Instead of
professionals, they will become bureaucrats, mere administrators of
government programs.

To avoid this, physicians must resort to enhancing their status as
members of a group of professionals. If the profession collectively un­
dertakes to ensure that the needs of patients are met at the same time
that costs are contained, both access and trust might be enhanced.
Trust in the profession as a whole would help replace trust in individual
practitioners. Indeed, an effective collective response by the profession
to the problems of access, cost, and trust could obviate the need for
extensive governmental intervention in the patient-physician relation­
ship. An approach at the level of the profession as a whole also would
be consistent with the effort to eliminate Axiom 1. The profession
would define rules for itself, and people would be free to refuse to be­
come members of the profession if they felt unable to live by those
rules. Contract would still govern entry into the profession.

The organized medical profession has taken some strides in this
direction. The American Medical Association ("AMA") has aban­
donned its unwillingness to consider government financing of health care
and has begun to explore government-supported methods of expanding
access.130 The AMA also participated in the development of the new
payment system for physicians under Medicare that reallocates pay­
ment among different groups within the profession in ways that might
reduce physician payment for the patient's benefit.131 Organized

amount of payment and to provide profitable services of little or no net benefit to the patient in
order to inflate his net revenue.

130. See James S. Todd et al., Health Access America—Strengthening the U.S. Health Care
System, 265 JAMA 2503 (1991); AMA, Health Access America: Refinements, Report to
the Bd. of Trustees, Chicago, Ill. (1991); see also George D. Lundberg, National Health

131. The Resource Based Relative Value System ("RBRVS") was developed by the AMA
and a Harvard group to create a better fee system. See Victor Cohn, Deciding What Doctors Are
Worth, Wash. Post, Feb. 25, 1992, at Z9; AMA Bd. of Trustees, AMA Policy on the Resource­
Based Relative Value Scale and Related Issues, 261 JAMA 2386 (1989). Once the specifics of
the RBRVS program were determined there was much dissent in the medical field. Many physi­
cian groups opposed the plan and its acceptance by the AMA, thereby causing a split between the
medicine must now accept the need for physicians to sacrifice their own individual self-interest for the interests of patients and press for a just approach to allocating available health care resources. If the profession as a whole is to retain its role as a profession, it must act boldly and quickly in this direction.

AMA and those groups. Due to this split, the AMA has changed its view and now criticizes the RBRVS proposal. The AMA said that it would withdraw its support of RBRVS-based payments for physicians if there were not appropriate adjustments to the dollar conversion factor. See Rep. Stark Urging Compromise on Medicare Payment Conversion Factor, THE GRAY SHEET (F.D.C. Reports, Inc.), July 1, 1991, at 23. As a result of the criticism levied against the RBRVS proposal, Medicare expects to spend seven billion more dollars on its program. See Joanne M. Judge, A Path Through the Mine Field, 45 HEALTH CARE FIN. MGMT. 10 (1991).

It has been asserted that professional groups (including physicians) should improve the status and prestige of their profession by engaging in work for the public interest. See George D. Lundberg & Laurence Bodine, Fifty Hours for the Poor, 262 JAMA 3045 (1989) (caring for the poor is a duty of the medical profession and all physicians should give at least fifty hours of uncompensated work to the poor each year); George D. Lundberg, National Health Care Reform: The Aura of Inevitability Intensifies, 267 JAMA 2521, 2524 (1992) ("[T]rue professionalism means self governance, self-determination, and ethical behavior in the public interest."); ELIOT FREIDSON, DOCTORING TOGETHER: A STUDY OF PROFESSIONAL SOCIAL CONTROL (1976).