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Resuscitating Professionalism: Self-Regulation in the Medical Marketplace

Gail B. Agrawal*

"Conventional wisdom says that traditional professionalism is dead and gone."¹

The health care delivery system has shifted from a physician-dominated professional model to a market paradigm in an effort to address the skyrocketing costs of health care. Cost containment through controls on the use of health care resources has become a mainstay of the new delivery system. Even an economic model, however, must rely on physicians, as caregivers and as medical managers, to make the decisions that require clinical knowledge and judgment. Effective cost control, therefore, will require physician cooperation. The market has attempted to secure physician participation by devising financial incentives to limit health care services to patients, causing dire pronouncements of the demise of medical professionalism. In the market model, physician self-regulation as a system of social control has been viewed as a dysfunctional anachronism of a discarded paradigm, unworthy of serious attention. In this Article, I contend that market failures and the inherent limitations of an economic model to regulate health care delivery warrant a reexamination of physician self-regulation as a means to address the necessity of and concerns about health care spending controls.² Although physicians, like all market participants, will respond to economic incentives, the standards for professional conduct adopted through self-regulatory mechanisms are an additional, important, and overlooked determinant of physician conduct. They can be used to achieve results that evade both market forces and command-and-control legislation. These standards, however, have not kept up-to-date with the new market demands on physicians. If physicians are to fulfill the tasks assigned to them in a cost-constrained health care delivery system, professional standards will have to be reexamined and modified to provide substantive guidance to physicians making medical decisions under financial restraints.

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2. I use the term "regulate" throughout this Article in a general sense to mean to direct or intentionally influence conduct—market forces, ethical dictates, common law, statutes, and regulations regulate physician conduct. Cf. Ted Schneyer, Legal Process Scholarship and the Regulation of Lawyers, 65 FORDHAM L. Rev. 33, 35-37 (1996) (stating that the market for legal services, law firms, journalists, the American Bar Association, and even liability insurers all may be said to regulate lawyers).
I. INTRODUCTION

An inherent and unavoidable tension exists between public goals to control health care spending and individuals' interests in meeting their needs and desires for health care services. The health care delivery system must respond to both public goals and individual needs, and therefore, it faces the inevitable, if unenviable, task of balancing the competing and conflicting demands on health care resources.

The managed care industry developed in direct response to public and private calls for health care spending controls; it was the instrument of the so-called revolution in the health care delivery system from the professional to the market paradigm. Managed care organizations made cost control their special mission and relied on market mechanisms to advance that purpose. As the managed care industry's market presence expanded, however, suspicions arose that the methods it adopted to cure the problems of excessive health care spending might well be worse than the disease.

The national debate soon shifted its focus from the high costs of health care to the perceived excesses of the methods used by managed care organizations to control health care spending. The usual methods of responding to these public concerns so far have been unavailing. The recent onslaught of litigation against managed care organizations, on theories ranging from racketeering to medical malpractice and consumer fraud, provides persuasive evidence of public mistrust of market solutions driven by competitive forces. Congressional responses have

3. When I speak of health care spending in this Article, I refer generally to spending by third-party payers—state and federal governments, insurers, managed care organizations, and self-insured employers. In a market economy, individuals should be free to spend as much of their discretionary income on health care, or any other consumer good or service, as they wish.

4. Sociologists would characterize the current managed care system as a bureaucratic model, rather than a market model. The ideal type bureaucratic model is one that is hierarchically organized and controlled by organizations and their executives who decide which products and services will be made, by whom, and how they will be offered to consumers. In contrast, an ideal type market model is one in which consumer demand and free competition determine what work will be done, by whom, and under what conditions. See ELIOT FREIDSON, PROFESSIONALISM REBORN: THEORY, PROPHECY, AND POLICY 187-90 (1994) (discussing market, professional, and bureaucratic models to organize health care delivery).


6. See, e.g., Maio v. Aetna, 221 F.3d 472, 482-83 (3d Cir. 2000) (plaintiffs lack standing to pursue a claim under the Racketeer Influenced and Corrupt Organizations Act against a health maintenance organization ("HMO"); In re U.S. Healthcare, Inc., 193 F.3d 151, 162-65 (3d Cir. 1999) (claims of vicarious liability for malpractice, negligent adoption of hospital discharge policy, reckless indifference, and negligent selection of
been equally unsatisfactory, addressing the lightning-rod issues of the day without affecting comprehensive reform. The states have found their efforts stymied by the preemptive effects of federal law. Even federal courts have confronted limits on the legal remedies available to redress harms alleged to have resulted from the health care rationing that has become the trademark of the managed care industry.

The dispute over cost-control methods soon degenerated into an ideological dichotomy between free market forces and command-and-control style government regulation. The dichotomy engendered by the current debate, however, is a false one. It ignores a third option: reconsidering and restructuring professional self-regulation to address physicians’ behavior as medical managers, as well as caregivers, in a newly cost-constrained environment. This lack of attention to physician self-regulation was probably not inadvertent. Professional self-regulation has been viewed as a remnant of the largely discredited physician-dominated professional model for health care delivery. The values reflected in self-regulatory standards have been blamed for the escalation in health care spending. In addition, commentators have pronounced professional self-regulation ineffective in policing its own ranks, prone more to self-aggrandizement and self-interest than to public protection.

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7. Congress enacted legislation prohibiting payers from requiring mothers and newborns to be discharged from the hospital within twenty-four hours of a normal vaginal birth and from requiring that mastectomies be done on an outpatient basis. See Newborn & Mothers’ Health Protection Act of 1996, Pub. L. No. 104-204, 110 Stat. 2935 (codified at 29 U.S.C. § 1185, 42 U.S.C. §§ 300gg-4 to -51 (1994)). Congress failed to enact President Clinton’s reform package and has to date failed to agree on a patient bill of rights. See also GEORGE J. ANNAS, SOME CHOICE 32 (1998) (noting that the problems with market-driven medicine cannot be resolved by legislation that addresses single aspects of medical care or single reasons for hospitalization).


10. See Troyen A. Brennan, An Ethical Perspective on Health Care Insurance Reform, 19 AM. J.L. & MED. 37, 37-38 (1993) (noting the “emphasis on economics and politics” and arguing for inclusion of “social and moral” terms and values); William M. Sage, Physicians as Advocates, 35 Hous. L. Rev. 1529, 1552-59 (1999).

11. Professor Stanley Gross in his seminal work on professional licensure opined that “[p]rofessional licensure as the solution ... has become worse than the problem,” arguing that self-regulation “serves to protect and enhance income, security, status, and privilege” of physicians. STANLEY J. GROSS, OF FOXES AND HEN HOUSES 5 (1984).
Its rejection, therefore, might be characterized as an implicit, and resounding, vote of no confidence in the utility of professional self-regulation in a market-based system.

In this Article, I take issue with those who condemn professional self-regulation. Professionalism and self-regulation developed in response to deviations from market conditions that are inherent in medicine and that persist in the managed care system that has evolved under the market paradigm. I contend that professional standards retain viability as a means to address intractable problems in the market for medical services. Drawing on insights from law-and-norm theory, I argue that self-regulatory standards are a powerful determinant of physician conduct. The failures of physician self-regulation, therefore, argue not for dispensing with self-regulation as an institution of social control, but rather for strategic intervention to improve its functioning. Using precepts developed in comparative institutional analysis, I maintain that a self-regulatory system is well suited to oversee the kinds of decisions that are involved in efforts to control health care spending by limiting the use of health care services. The paradox, which this Article begins to consider, is how professional norms and self-regulation can address the problems created under the auspices of the professional paradigm, as well as the real and potential market abuses mediated by professionals under the market paradigm. In short, the question is whether medicine can heal not only itself but also the institutions that responded to the problems created under its watch.

The central premise of this Article is that the market, law, and professional self-regulation all must be brought to bear on society's endeavor to control health care spending. Where one fails, the other two must compensate. Because professional self-regulation is the neglected member of the troika, my aim with this Article is to initiate a dialogue about its potential role in the current market paradigm and to suggest how it might be made more responsive to social needs.

Although self-regulatory responses could focus on managed care organizations, physicians warrant an independent focus. They are the constant in health care; regardless of the system of delivery or the method of financing health care services, in a medico-technological environment, physicians will...
make most of the health care decisions that determine how much, and on whom, health care dollars will be spent. In the present-day managed care system, physicians implement cost-containment initiatives and take on the role of medical manager and payer, as well as that of caregiver; to the extent that their behavior is affected by factors in addition to economic incentives, those factors deserve an independent review.\footnote{In a body of scholarly work, Professor Mark Hall established that among the possible decision-makers for health care rationing decisions, physicians were preferable. \textit{See} Mark A. Hall, \textit{Making Medical Spending Decisions} 113-69 (1997). In an earlier work reviewing that book, I agreed with Professor Hall's central premise. I also expressed some disappointment that he did not discuss how physicians were to evolve from the traditional role of caregiver, focused on medical benefit largely to the exclusion of cost, to the dual role that he envisioned. \textit{See} Gail B. Agrawal, \textit{Chicago Hope Meets the Chicago School}, 96 Mich. L. Rev. 1793, 1795 (1998). In this Article, I suggest that professional self-regulation must be a key component if that evolution is to occur.}

The economic model has underestimated the importance of professional norms and their influence on physician conduct. Current market incentives encourage conduct that existing self-regulatory standards seemingly forbid. The failure to acknowledge physicians' actual roles in allocating health care resources and the conflicts they present has stymied the development of meaningful standards to guide physicians in fulfilling these responsibilities. Moreover, the public disavowal that managed care delivery systems necessarily entail physician allocation of health care resources prevents participatory dialogue about societal expectations for physician conduct in a market-based system. These are conditions precedent to the evolution of professional norms that respond to societal needs, just as the evolution of professional norms is a necessary condition to achieving meaningful health care cost control.

This Article has six parts. Part II is a primer on health care cost containment. In it, I address the systemic factors that led to the escalation in health care spending and the methods used by managed care organizations, with the direct involvement of physicians, to control that spending. This Part highlights the changing role of the physician in the evolving medical marketplace and explores the response of the self-regulatory system to market initiatives. Part III identifies the risks of controlling health care spending by limiting the use of health care services to permit an analysis of how well the market model has responded to those risks and to identify opportunities for response through self-regulatory mechanisms. Part IV turns to the examination, and rejection, of the contention that market forces alone will address the risks of controlling spending by limiting use. Part V discusses self-regulation and considers the promise, as well as the perils, of professional self-regulation in...
health care. Part VI offers some preliminary thoughts on the means to influence the development of professional norms to respond to the need for health care spending controls.

II. WHAT GOES UP DOESN’T ALWAYS COME DOWN

A. The Story of Health Care Spending

For much of this century, the health care delivery system in the United States was based on a professional model, with its focus on highly skilled professionals making technical, scientific decisions on their patients’ behalf. Physicians made these decisions largely unfettered by market forces and guided only by their own ethical dictates. Isolated medical errors were addressed through the tort system, and incompetent physicians were handled quietly within their own ranks. The last twenty years have seen a reformation as health care delivery evolved into a market model, with consumers selecting medical services as one of a market basket of consumer goods.

The causes for the reformation of the health care delivery system are complex and varied, including public distrust of both the professional elite and big government, and the increasing spheres of influence of large corporate purchasers. But the principal culprit was seemingly uncontrollable increases in medical spending.

Many factors contributed to the high levels of spending on health care in twentieth century America. Dramatic increases in scientific knowledge and concomitant improvement in the effectiveness of medical interventions have characterized the second half of this century—a process that promises to continue. With enhanced results came increasing use, and with heightened utilization came increasing costs. The 1940s saw the rise of private health insurance. In 1965, the federal government created the Medicare program to provide public insurance to individuals from the age of sixty-five and to those with certain disabilities, and joined with the states under the auspices of the Medicaid program to extend health care coverage to those considered categorically or medically needy.

The existence of third-party payers made health care affordable to more Americans, thereby increasing the use of and spending on health care services.

The 1970s saw a dramatic rise in complex medical technology, which continues through the present date. This new technology frequently supplemented, rather than supplanted, the prior technology, with the predictable outcome: more available services lead to more spending. The last twenty years have seen the effects of an aging population and a dramatic increase in the efficacy, and the cost, of pharmaceuticals, both of which promise to continue. Between 1980 and 1993, health care spending increased from 8.9% of gross domestic product to 13.5% of gross domestic product. Despite the high levels of health care spending in the United States, major health indices revealed little difference from other industrialized nations with significantly lower levels of spending on medical services.

As medical spending increased, the cost of health care coverage increased, as well. Higher premiums led inevitably to higher numbers of uninsured individuals, as small employers elected not to offer coverage to their employees and increasing numbers of individuals were unable to afford to purchase health care coverage on their own. Even large employers were affected. Excessive spending on health care coverage adversely affected their global competitiveness, as American employers outspent their international competitors, raising the overall cost of their products. High levels of government spending on health care affected the amounts of money available for other important goods and services, including those like safe highways and adequately funded public schools that contribute significantly to the overall health and welfare of the population.

The blame for the increasing levels of health care spending was placed on the combined effects of the physician-dominated professional model for health care delivery, fee-for-service reimbursement for medical services, and indemnity insurance, although an analysis reveals that other powerful forces were at least equally culpable. Traditional medical ethics, dominated by the twin principles

22. New EBRI Research: National Health Care Costs Expected to Keep Going Up, PR NEWSWIRE, Aug. 4, 2000, available at LEXIS, Nexis Library, PR Newswire file. The rate stayed steady between 1993 and 1998, but is expected to rise to 13.9% when expenditures for 1999 are calculated. Id.
23. Many factors in addition to health care services affect health care outcomes, including lifestyle factors like diet and exercise, and also genetic makeup. Research on citizens' satisfaction with the health care system in ten developed nations shows that only ten percent of Americans thought that only "minor changes" were needed in their health care system, compared with fifty-six percent of Canadians, forty-one percent of Germans, and twenty-six percent of British citizens. See R. J. Blendon et al., Satisfaction with Health Systems in Ten Nations, 9 HEALTH AFFAIRS 185, 185-92 (1990).
of beneficence and non-malfeasance, were interpreted to require that physicians "put the patient first" and subordinate all other concerns, whether personal to the physician or external to the patient-physician relationship. Fee-for-service reimbursement coupled with indemnity insurance reinforced this ethical principle by giving physicians financial incentives to provide as much beneficial care as possible. Insured patients' inattention to the costs of that care eased any ethical pangs that their physicians might have had about high charges for these services. Although some physicians undoubtedly responded to those incentives and provided wasteful and even harmful care, even ethical physicians lacked any financial incentive or professional directive to evaluate the cost effectiveness of their medical spending decisions. With the evolution of the bioethics movement, the sole limitation on the physician's largess was the patient's right to refuse to give consent to the physician's recommendations.

Insured patients suffered from the same infirmity as physicians: the lack of any personal or financial incentive to control health care spending. Third-party payers sheltered insured individuals from the economic effects of health care treatment decisions. Most patients lacked the ability to dictate health care spending limits, even if they were inclined to do so; patients who were not clinically trained were uninformed about which, or how much, medical services would be appropriate. Accordingly, patients relied on their physicians' judgments about medical services. This reliance allowed physicians to influence both the supply and the demand sides of the health care marketplace. Market forces had little effect in a health care delivery system based on a professional model where physician-as-seller and patient-as-purchaser did not confront the economic effects of their behavior.

25. In familiar terms, these principles are captured by the charge "first, do no harm."


27. Paradoxically, health insurance, itself, was made feasible by physicians' ethical commitments to provide only beneficial care. Without the limits imposed by that fundamental ethic, there would have been no reasoned way to protect insurers from paying for useless or harmful medical services that might be demanded by patients or provided by unscrupulous physicians. See Elhauge, supra note 1, at 1540 (discussing physicians' ethics and health insurance).

28. High charges to insured patients were used to supplement charity care to indigent patients.

29. If physicians were perfect agents for their patients, they would have no incentive to control health care spending, even if they had no personal financial incentive to increase spending.

30. Bioethics shifted the focus of physician ethics from beneficence, which was criticized for its paternalistic roots, to patient autonomy. See THOMAS A. MAPPE & JANE S. ZEMBATY, BIOMEDICAL ETHICS 44-45 (1981).
The legal system was not silent in the face of increasing health care costs, although its response was of limited utility. Congress enacted prohibitions on payments for referrals of Medicare and Medicaid patients and on physician referrals to entities with which physicians have financial relationships to counteract the financial incentives for over-utilization of health care services, which were inherent in the fee-for-service system. Many states passed similar statutes with broader applicability. Eventually, the ethical guidelines promulgated by the American Medical Association (“AMA”) and other professional associations came to mirror these legal restrictions on physician financial conduct.

In 1983, Congress modified the reimbursement system for hospitals that provided treatment to Medicare patients. The prospective-payment system provided a fixed payment for hospital services provided to Medicare beneficiaries based on the patient’s diagnosis-related group. In theory, this change should have increased the incentive for hospitals to control health care spending decisions by physicians, because the hospital would receive the same payment regardless of the type and amount of services ordered by the physician. But Congress’ response sent a mixed message. While seemingly giving hospitals incentives to control costs, Congress inhibited the hospitals’ ability to

31. Some evidence suggests that the legal system will fall into step with the prevailing paradigm. In an influential article published in 1988, Professor Mark Hall maintained that the legal system supported the professional paradigm to the detriment of cost-control efforts. See Mark A. Hall, Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment, 137 U. PA. L. REV. 431, 474-502 (1988). Slightly more than a decade later, Professor Peter Jacobson showed that the legal system had shifted to support the market paradigm. See Peter D. Jacobson, Legal Challenges to Managed Care Cost Containment Programs: An Initial Assessment, HEALTH AFFAIRS, July-Aug. 1999, at 80-81.


33. See, e.g., FLA. STAT. ANN. § 455.654 (West 1991); LA. REV. STAT. ANN. § 1745 (West 2000).

34. See discussion infra notes 81-94 and accompanying text. This shift in professional standards following a change in legal requirements provides empirical evidence of the effect of law on social norms.


36. Hospitals historically reinforced the professional paradigm of health care delivery through their reliance on organized medical staffs to oversee the quality of care provided in the hospital as well as to determine, through its influence on admissions to the medical staff, by whom that care would be provided. Because hospitals relied on physicians and their admissions of patients for revenues, hospitals also lacked any incentive to control health care spending by imposing limits on the use of health care services.
effect physician behavior by including a prohibition on hospital actions intended to influence physicians to reduce health care services to Medicare beneficiaries.\textsuperscript{37} Organized medicine followed this lead as well, acknowledging in its ethical standards that cost was a concern while rejecting physician rationing and failing to adopt standards to assist physicians with their inevitable role in controlling health care spending.\textsuperscript{38} Physician-dominated state boards of medicine, charged with physician licensure and discipline, also turned a blind eye to physician cost-containment efforts, beyond the prohibition of fraud and restraints of market practices that were perceived as weakening physicians’ market power.\textsuperscript{39} The response by Congress and organized medicine signaled a conflict that permeates the current spending crisis: a desire to control spending on health care services coupled with a refusal to acknowledge the inevitability of limiting the use of health care services. The unwillingness to confront this conflict has slowed legislative and professional responses to current market incentives to underutilize medical services.

With physicians, patients, and hospitals disinclined or disabled to act as cost-control agents and legal authorities out-of-step with market-based cost-containment activities, only payers were left to effect health care spending controls.\textsuperscript{40} Employers, the source of health care coverage for the majority of Americans under the age of sixty-five, began to cast about for ways to control their health care coverage costs. Encouraged by national and state legislative developments encouraging the formation of alternative delivery models, the market responded accordingly.\textsuperscript{41} Increasingly, employers chose health care benefit plan designs that included mechanisms to control spending on health care services. These control mechanisms placed spending authority in the hands of those who paid for health care services, generally commercial insurers, managed care organizations, and self-insured employers. It remained for private payers to bring physician conduct into alignment with public desires to control health care spending. The marketplace quickly embraced that which Congress and organized medicine had forbidden, creating economic incentives for physicians to limit the use of health care services in the commercial marketplace, leaving physicians to reconcile the seemingly irreconcilable on their individual terms.\textsuperscript{42}

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\textsuperscript{38} See discussion infra notes 81-94 and accompanying text.
\textsuperscript{40} Payers for health care services are commercial insurers, self-insured employers, managed care organizations, and the state and federal government.
\textsuperscript{41} See Gail B. Agrawal, Managing the Managers, in THE CHALLENGE OF REGULATING MANAGED CARE (John Billi & Gail Agrawal eds., forthcoming 2001) (manuscript on file with author) (discussing the role of legislation in encouraging the development of the managed care industry).
\textsuperscript{42} See discussion infra notes 73-80 and accompanying text.
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B. The Managed Care Solution

"Managed care" is simply a shorthand term for a range of diverse health care benefit designs that combine health care services with payment for those services, giving the payer substantial control over both the provision of services and the amount that will be paid for the services provided. This Article defines as managed care organizations any legal entity that sells or administers these benefit designs. Managed care organizations have a wide variety of means to effect health care spending. Because of the implications for physician regulation, this Article will address only on those cost-control methods that depend on the medical expertise of physicians.

1. Physician-Managers

Managed care organizations frequently base decisions about whether to pay for recommended treatment on whether the treatment is required to treat the patient’s symptoms or to make a diagnosis of the patient’s ailment. Physicians

43. Entities that sell managed care benefit designs include commercial insurers, HMOs, and physician-sponsored organizations. These entities and other third party administrators also manage the managed care benefit designs used by self-insured employers to provide coverage to their employees. In the former case, the managed care organization bears the ultimate insurance risk and is the payer; in the latter, the self-insured employer retains the risk and is the payer.

44. For example, like indemnity insurers, managed care organizations specify the types of services that will be eligible for reimbursement. They impose conditions under which covered services will be reimbursed, for example, requiring a patient to make co-payments to receive services, to obtain a referral to receive treatment from a specialist, and to receive services from designated caregivers. They control the cost of services, and less directly the utilization of services, by contracting with caregivers who agree to accept the contract price in exchange for their services, by monitoring their financial performance, and by influencing through reimbursement mechanisms and coverage decisions the care that they provide.

45. An example of a cost-control method that does not require any physician involvement includes designing benefits to exclude certain high-cost medical or surgical procedures. Some payers, for example, exclude from coverage high dose chemotherapy with autologous bone marrow transplant or specified solid organ transplants. See, e.g., Fuja v. Benefit Trust Life Ins. Co., 18 F.3d 1405, 1409-10 (7th Cir. 1994) (excluding high dose chemotherapy with autologous bone marrow transplant from coverage).

46. This process is not unprecedented. The managed care industry adopted and refined methods that were used by other types of third-party payers to control spending on health care services. Blue Cross plans and indemnity insurers frequently relied on committees of physicians to review and evaluate retrospectively the necessity of hospital admissions and lengths of stay to determine whether they would provide reimbursement for services rendered to insureds. In 1972, Congress created Professional Standards Review Organizations to perform a similar function for government-sponsored health care programs. A decade later, Congress replaced those organizations with private

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employed by or under contract with the managed care organization are responsible for making these decisions, which serve as coverage determinations based on medical judgments about reasonable medical treatment. Coverage decisions may be made before any services are rendered (prospective review) or during an ongoing course of treatment (concurrent review). For example, a managed care organization's contract may provide payment for medical services related to problems of the spine, but payment will be made for surgery on the spine only if that surgery is deemed "medically necessary" for an individual patient.

Although the term "medical necessity" may convey little more than "doctor's orders" to a layperson, in this context "medical necessity" is a defined term in the contract between the managed care organization and its customer, typically an employer. Because the definition is determined by agreement between private parties, the term in its application lacks uniformity. Some entities that were engaged to perform utilization review and authorized both to deny claims for payment and to impose sanctions on caregivers who provided unnecessary or inappropriate care or care of inadequate quality to government beneficiaries. For a full discussion, see Jeffrey E. Shuren, Legal Accountability for Utilization Review in ERISA Health Plans, 77 N.C. L. Rev. 731, 745-53 (1999).

47. See Pegram v. Herdrich, 530 U.S. 211, 228-31 (2000) (classifying coverage decisions that are based on physicians' judgments as "mixed eligibility and treatment decisions" or simply "mixed eligibility decisions").

48. The prospective utilization review process is based on a telephone, paper, or an electronic system; it does not include face-to-face contact with the patient or the treating physician. The typical pre-certification process involves an initial review of a physician's treatment or testing request by a registered nurse who gathers medical information about the patient and compares it with clinical criteria adopted by the managed care organization. The nurse-reviewer will consider the timing of the service: whether less costly methods have been exhausted when a highly technological procedure is recommended, for example. The nurse-reviewer also will consider the site of services: will the service be provided in the least intensive, and therefore least costly, location? If an inpatient hospital stay is requested, the reviewer will consider the length of that stay. If the reviewer determines that the criteria that have been adopted by the managed care organization are satisfied, the recommended service is pre-authorized for payment. If the criteria are not satisfied, the nurse-reviewer refers the request to a physician for a decision whether to approve or deny pre-authorization for payment.

49. The concurrent review process is similar to that for prospective review. It occurs after a patient is admitted to a hospital or has otherwise begun an extensive treatment regime. Medical personnel review the treating physician's planned course of treatment, including the intended length of inpatient stay and the use of ancillary services. If the initial reviewer cannot approve the treatment plan, a physician is called in to review the course of treatment to make the final decision about payment for the recommended course of treatment.

50. This example is not hypothetical. See Long v. Great W. Life & Annuity Ins. Co., 957 P.2d 823 (Wyo. 1998); see also discussion infra notes 104-08 and accompanying text.
common elements to the contractual definition might be counter-intuitive to the average patient. Medically necessary services may be defined as those that are "essential," not merely useful or appropriate, and that are "consistent with accepted standards of medical practice," as determined by the [payer], rather than by the treating physician. While the information about the process of determining medical necessity provided to individual enrollees highlights the managed care organization's desire to avoid "outdated" or "unnecessary" treatments, the process is intended not only to eliminate the provision of medical services that are not likely to provide medical benefits to a patient, but also to introduce an element of cost effectiveness into coverage policy. The failure to acknowledge and explain the dual purpose contributes to public suspicion about utilization management practices.

The adoption of utilization review practices introduced a new category of physicians: those who review the medical recommendations of their practicing peers to determine whether the managed care organization will pay for the proposed treatment. These physician-managers have maintained that they are exempt from the dictates of medical ethics and the oversight of state boards of medicine, because their decisions concern cost not medicine. Organized


53. Friends Hosp., 9 F. Supp. 2d at 530; see, e.g., McGrav, 137 F.3d at 1256.

54. See, e.g., Long, 957 P.2d at 830 (referring to physicians and nurses who will review a treatment plan to protect insureds from "outdated" and "unnecessary" treatment).

55. The extent to which medical necessity determinations result in cost containment is open to debate. One study found that some medical necessity definitions incorporate cost-effectiveness analysis, but that respondents were divided about its efficacy, with administrators favoring its use and clinicians viewing it as an intrusion into clinical autonomy. See Peter D. Jacobson et al., Defining and Implementing Medical Necessity in Washington State and Oregon, INQUIRY, Summer 1997, at 147. A recent California study found that only a few medical necessity contractual definitions included cost-effectiveness, but that private managed care plans and medical directors nonetheless mentioned cost-effectiveness as a prominent criterion for decision-making. See Sara J. Singer & Linda A. Berghold, Prospects for Improved Decision Making About Medical Necessity, HEALTH AFFAIRS, Jan.-Feb. 2001, at 202. This study suggests a gap between what plans actually do and what they state publicly. Id.; see Maio v. Actna Inc., No. 99-1969, 1999 U.S. Dist. LEXIS 15056, at *5 (E.D. Pa. Sept. 29, 1999), aff'd, 221 F.3d 472 (3d Cir. 2000) (defendant Actna classified its public statements about quality of care offered through its managed care plans as "mere puffery").

56. See David S. Shimm & Roy G. Spece, Jr., Discovering the Ethical Requirements of Physicians' Roles in the Service of Conflicting Interests as Healers and as Citizens, in CONFLICTS OF INTEREST IN CLINICAL PRACTICE AND RESEARCH 61 & n.62 (Roy G. Spece et al. eds., 1996) (quoting an HMO medical director stating that his duty was solely to the payer); Murphy v. Bd. of Med. Exam'rs of Ariz., 949 P.2d 530, 533
medicine has disagreed, while the law has been equivocal on the role of the physician-manager. In its first pronouncement on the subject, issued in 1992, the AMA opined that physicians in administrative positions were subject to the requirement of the Hippocratic Oath to “put the needs of patients first.”\(^7\) Seven years later, the AMA addressed the specific ethical obligations of physician-managers.\(^5\) Again, the AMA maintained that the patient-primacy directive governed physician-managers who were not engaged in direct patient-physician relationships when their activities involved the use of professional knowledge or values gained through medical education, training, or practice and their decisions affected individual or group patient care.\(^5\) Medical necessity determinations fulfilled both criteria.\(^6\)

The law seemed less certain than organized medicine about its role in overseeing these new market actors. In 1997, the Arizona Court of Appeals became the first court to hold that physician-managers were subject to the jurisdiction of the state board of medicine and to disciplinary action on the basis of their clinically based coverage decisions.\(^6\) Three years later, thirteen states had enacted legislation requiring state licensure of all medical directors, while legislatures in eight states had rejected similar bills.\(^6\) In the absence of specific legislation, some state attorneys general ruled that the state board of medicine did not have jurisdiction over physician-managers’ medical necessity decisions.\(^6\) Whether physician-managers will be subject to the same professional and legal constraints as practicing physicians remains an open question.\(^6\)


\(^{59}\) Id.; see also, E. Haavi Morreim, Playing Doctor: Corporate Medical Practice and Medical Malpractice, 32 MICH. J.L. REF. 939, 953-56 (1999) (discussing whether HMOs practice medicine).

\(^{60}\) In addition to compliance with the patient-primacy ethic, physician-managers were directed to apply coverage rules equally to all patients and to use fair and just criteria in making any determinations related to medical care. See discussion supra notes 46-55 and accompanying text.

\(^{61}\) See Murphy, 949 P.2d at 530; discussion infra notes 271-76 and accompanying text.

\(^{62}\) See Linda O. Prager, Texas Board Attempts to Discipline Medical Director, AM. MED. NEWS, May 8, 2000 (listing states and discussing opinion of the Ohio attorney general that the state board of medicine does not have jurisdiction over physician-managers).


\(^{64}\) See discussion infra notes 261-69 and accompanying text.
The adoption of utilization management techniques also had an effect on physicians who remained in traditional treatment roles. It eliminated the ability of practicing physicians to prescribe without regard to cost. Practicing physicians saw the process as an impingement on their professional autonomy and a potential occasion for ethical missteps. In contrast to its uncertainty about physician-managers, however, the law clearly supported utilization controls and was largely unsympathetic to physicians' objections.

Regulations promulgated pursuant to the Federal Health Maintenance Organization Act of 1974 mandated that federally qualified HMOs have "effective procedures to monitor utilization and control cost," thereby envisioning economic constraints on clinical conduct. State statutes mirrored this authorization. Thus, public policy evolved to reflect economic reality: if health care spending was to be controlled, physicians could not continue to be shielded from the economic consequences of their clinical decisions. When physicians challenged the expanded role of payers in the clinical relationship, courts declined to deviate from that legislative directive. In one oft-cited case, Varol v. Blue Cross & Blue Shield of Michigan, a district court judge rejected a challenge brought by a group of psychiatrists to a utilization review program.

65. Circumstances in which a patient has the financial resources and willingness to remit payment from personal funds are an exception.

66. The closest ethical dictates come to offering direction to physicians who are subject to financial risk for their patients' care is to urge them to engage in self-help in assessing reimbursement arrangements to avoid the occasion of improper influence and to reject financial arrangements that could lead to withholding medically necessary care. See, e.g., AMA Principles of Med. Ethics, Conflicts of Interest Under Capitation, Op. 8.051 (1998), in MEDICAL ETHICS, supra note 57, at 37-38 (urging evaluation of financial adequacy of the proposed arrangement and stop-loss insurance to protect against catastrophic expenses); AMA Principles of Med. Ethics, Managed Care, Op. 8.13 (1996), in MEDICAL ETHICS, supra note 57, at 41 (permitting financial incentives that promote the cost-effective delivery of care but not the withholding of medically necessary care); Am. Acad. of Neurology Code of Prof'l Conduct 5.2 (1993), reprinted in MEDICAL ETHICS, supra note 57, at 376 ("neurologist must avoid... financial arrangements that would, solely because of personal gain, influence decisions in the care of patients"); Am. Acad. of Ophthalmology, Advisory Opinion of the Code of Ethics: Ethical Obligations in a Managed Care Environment (1997), reprinted in MEDICAL ETHICS, supra note 57, at 546 (capitated physician groups must provide patients with the care they need even at a financial loss); Am. Urological Ass'n, Policy Principles on Health Care Reform (1997), reprinted in MEDICAL ETHICS, supra note 57, at 1011-12 (opposing reimbursement systems that put the primary care referring physician at financial risk for referral to specialty care).


adopted by General Motors. The program gave personnel employed by Blue Cross and Blue Shield the authority to withhold payment approval for mental health treatment. The psychiatrists maintained that that authority gave the payer the right to determine methods of diagnosis and treatment and resulted in the unauthorized practice of medicine. The court rejected the argument, noting that the psychiatrists' ethical obligations required them to provide appropriate care and treatment without regard to the advance payment decision. Varol foreshadowed the dilemma between traditional medical ethical standards and methods adopted in the health care marketplace as society has attempted to effect health care spending controls. The law was prepared to rely on physicians' ethics to protect against market excesses, while those who promulgated ethical standards were equally prepared to overlook the changes that market innovations wreaked on medical practice.

2. Physician Incentives

Physicians influence or control approximately seventy-five percent of health care spending through their practice patterns. A careful review by physician-managers of each of the myriad clinical decisions that physicians make each day is not feasible. Meaningful cost control, therefore, would remain elusive as long as practicing physicians were permitted to insulate themselves from economic considerations. Accordingly, managed care organizations began to devise methods to enhance practicing physicians' awareness of the financial consequences of their treatment practices. Rather than directly confronting the conflict between market practices to control spending and ethical dictates to make cost a secondary (or tertiary) concern for physicians, many managed care organizations adopted business practices designed to shift responsibility for controlling utilization to practicing physicians. This change in the locus of decision-making resulted in practicing physicians taking on an unacknowledged role in allocating, or rationing, health care services, a role for which neither the market nor medical ethics prepared them.

70. Id. at 831-34.
71. Id. at 832-33.
72. Id. at 833 (characterizing as "strange stuff indeed from which to fashion a legal argument" an assertion that the psychiatrists would be affected in their treatment decisions by the payer's payment decision).
74. United Healthcare decided to abandon utilization review mechanisms due to their cost and the relatively small number of recommended treatments that were found to be inappropriate. See Penelope Lemov, The HMO Laid Low, GOVERNING MAG., June 2000, available at http://www.lexis.com (noting that United HealthCare has limited its use of utilization management finding that it was not cost effective).
75. See discussion infra notes 84-93 and accompanying text.
Managed care organizations adopted a variety of different kinds of direct and indirect incentives to facilitate this shift. They attempted to identify and contract with those physicians whose practice styles were already cost conscious, monitoring the caregivers’ practice patterns over time to identify those practitioners whose costs of care exceeded the managed care organizations’ expectations. High-cost caregivers could be counseled in ways to improve their financial or clinical performance, or their contracts could be terminated or not renewed after the initial term. These selective contracting and monitoring measures, however, were inexact, because managed care organizations often lacked sophisticated methods and the data necessary to account for differences in severity of disease across caregivers. A reviewer could not tell if a physician’s average cost-of-care per case was high because she ordered more care than was necessary, or because her patients were sicker and required more care than the patients of other physicians. Despite the method’s imperfections, the fear of “deselection” served as a powerful self-policing mechanism to physicians seeking to avoid that consequence by controlling their practice patterns.76

Managed care organizations also attempted to shift the locus of utilization control from payer to caregiver by structuring payment arrangements in a manner that required physicians to make cost-conscious clinical recommendations or risk adverse personal financial consequences. These methods ranged from withholding certain amounts from the contract payment rate to creating bonus pools and conditioning additional payment on achieving utilization targets for referrals, hospitalization, or prescriptions. Managed care organizations also abandoned fee-for-service reimbursement, with its inherent incentives to “do more,” in favor of a capitated method of reimbursement, which provided a fixed per member-per month payment. Under the least complex capitation payment arrangement, a managed care organization would pay a primary care physician a fixed sum regardless of the amount or type of care that the physician provided to the patient. Medical services that were not provided by the capitated physician were reimbursed by the managed care organization under separate arrangements. The capitated physician was at financial risk only for her own services.

Over time, managed care organizations diversified capitation methods. More complex capitation payment arrangements included services that were not provided personally by the capitated physician such as referrals to other physicians and the services ordered by them. Under these arrangements, a capitated physician would be required to pay other caregivers for services required by the patients that were subject to the capitation arrangement.

primary care physician who referred a patient to a cardiologist, for example, would have to make arrangements to pay the cardiologist from the capitation payment. It was a short step from including under the capitation umbrella all services that the capitated physician provided or controlled to all medical services that the patient required. Physicians were soon bearing substantial amounts of financial risks associated with their patients’ medical needs.

Having contracted physicians assume responsibility for utilization of health care services offered a number of benefits to managed care organizations. It helped with the public relations problems that invariably occurred when payers said “no” to requests to treat terminally ill patients, children, or other especially sympathetic individuals. Shifting responsibility to physicians might have also allowed managed care organizations to avoid legal liability for harm to individual patients that might result from rationing health care services.

The return of control over utilization to physicians had positive effects for them as well, permitting the recapture of their professional autonomy in a market-based system. The physician regained the ability to make medical decisions unfettered by managed care physician-managers. Professional autonomy, however, came at a price. If the cost of the services required by the designated group of enrollees exceeded the contract amount paid by the managed care organization, the costs were required to be borne by the capitated physician or physician organization out of funds otherwise available to it.

Although market incentives could affect day-to-day clinical decision-making more effectively than limited review by physician-managers, market


78. Managed care organizations avoid liability under respondeat superior because physicians are usually independent contractors, rather than employees. While they may be held liable on other agency theories, they can take steps to deny an apparent agency relationship. Until the decision of the United States Court of Appeals for the Third Circuit in Dukes v. U.S. Healthcare, 57 F.3d 350 (3d Cir. 1996), managed care organizations successfully had defended against claims of vicarious liability on grounds of ERISA preemption. Id. at 351-52. But see Kuhl v. Lincoln Nat’l Health Plan of Kan. City, Inc., 999 F.2d 298, 302 (8th Cir. 1993), cert. denied, 510 U.S. 1045 (1994) (holding that ERISA preempted claims of vicarious liability against managed care organizations).

79. Because the physician organization bore the financial risk of care, the managed care organization typically would delegate to the capitated entity a wide-range of administrative duties. These duties included the rights to select and credential the caregivers to provide services to managed care enrollees and to decide which covered services would be reimbursed.

80. Physicians could avoid large out-of-pocket losses by the purchase of reinsurance. If a physician is at substantial financial risk for the cost of services provided to Medicare patients that the physician does not provide personally, federal regulations require the purchase of reinsurance, as well as other safeguards. See 42 C.F.R. § 417.479 (2000).
incentives were not designed with enough specificity to reward or deter based on the quality of the trade-off decision. As Professor Einer Elhauge has observed, current managed care methods may result in care that is denied as a means to control costs when the denial will go "unnoticed or unprotested." Financial rewards also could be achieved by avoiding high-users of medical services. Within broad parameters, reducing cost was rewarded by market incentives without careful examination of the medical outcome of each cost-constrained clinical decision or of how cost reductions were achieved.

C. The Self-Regulatory Response

The legal system looks to physicians’ ethical standards to counteract market incentives to act in ways contrary to their patients’ interests. A review of current medical ethical standards shows a dearth of direction on responding to managed care practices. The juxtaposition of medical ethics and market realities reveals that modern-day physicians confront an inescapable dilemma: professional norms forbid that which certain market incentives would seem to demand. Thus, the law and organized medicine seem to be engaged in a child’s game of “see no evil, hear no evil, and speak no evil”; each has failed to consider and address the effects of the changed environment on medical practice.

The medical profession does not speak with one voice; thus, there is no single code of ethical conduct to consult. No fewer than twenty-six physician groups purport to provide ethical guidance to physicians. Despite this myriad of voices and the wide-ranging changes in the organization of health care delivery and methods of financing health care services that have occurred since the mid-nineteenth century, the predominant ethical themes have changed little during the more than 150 years since the AMA’s first codified version. The patient’s interest remains the physician’s overriding concern. Each physician is

81. Deterrence was left to the tort system and medical malpractice litigation against the practicing physician.
82. See Elhauge, supra note 1, at 1535.
83. This point was not lost on physicians who argued that financial incentives should be related to quality of care, not simply cost of care. Quality of care, however, is notoriously difficult to define and measure. Even if meaningful measures of quality could be developed, the question would remain whether their use to formulate incentives would be administratively and economically feasible.
84. See Pegram v. Herdrich, 530 U.S. 211, 218 (2000) (“The check on this [economic] incentive is a physician’s obligation to exercise reasonable medical skill and judgment in the patient’s interest.”).
85. The American Medical Association (“AMA”) produced the first national code of conduct for physicians in 1847. Since that time, medical and surgical specialty associations have also developed codes of ethical conduct or issued statements of ethical guidance for their members. For a compilation of ethical standards, see MEDICAL ETHICS, supra note 57.
directed to "do all that he or she can for the benefit of the individual patient." Physicians are given neither permission to nor guidance about allocating health care resources across a population of patients.

Scholars assert that current ethical precepts direct modern-day physicians to ignore the cost of care in treating individual patients. But this characterization of medical ethics is inaccurate. Physician associations acknowledge cost constraints, while varying in the degree of directness with which they address the role of cost in clinical decision-making. The AMA is equivocal, stating only "[w]hile physicians should be conscious of costs and not provide or prescribe unnecessary services, concern for the quality of care . . . should be the physician's first consideration." Other medical associations are more willing to acknowledge that cost is an inescapable concern. The American College of Emergency Physicians, for example, acknowledges that the "financial resources of our society are finite" and accepts "dual obligations to steward resources prudently while honoring the primacy of the patient's best medical interests." The American Academy of Orthopaedic Surgeons states unequivocally "it is ethical . . . to consider cost as one factor in determining appropriateness of care," recognizing an "ethical responsibility to consider the health of the public, particularly regarding the allocation of scarce societal resources." The dilemma, then, lies not in legitimizing concern for cost in clinical decision-making. Cost consciousness is not only permitted; current ethical standards seem to require it. Rather, the oversight gap is in the failure

86. AMA Principles of Med. Ethics, Allocation of Limited Medical Resources, Op. 2.03 (1994), in MEDICAL ETHICS, supra note 57, at 9-10. Other medical organizations offer slightly different versions of this directive. Obstetricians and gynecologists are told to "focus on their primary goal of providing quality care." Am. Coll. of Obstetricians and Gynecologists Comm. on Practice Mgmt., Cost Containment in Medical Care (1996), reprinted in MEDICAL ETHICS, supra note 57, at 422. The American Academy of Physical Medicine and Rehabilitation, whose members frequently care for profoundly incapacitated patients, are advised that the physiatrist has a "significant responsibility for the welfare, well being, and betterment of the patient . . . [which] responsibility should take precedence over all other aspects of professional practice." Am. Acad. of Physical Medicine and Rehabilitation Code of Conduct (1995), reprinted in MEDICAL ETHICS, supra note 57, at 733.

87. See, e.g., HALL, supra note 15, at 114-17.


91. Going further to recognize a duty not only to the public but also to payers, the American College of Ophthalmology Code of Conduct opines charging fees for services for which there is not some substantial benefit exploits patients and payers. Both of these

http://scholarship.law.missouri.edu/mlr/vol66/iss2/3
to acknowledge and provide guidance in responding to conflicts between the physician's obligation to an individual patient and her obligations to the public.

Ethical guidelines continue to reject a role for physicians in allocating health care resources across populations of patients in clinical encounters with individual patients. The AMA, for example, states bluntly "treating physician[s] . . . should not make allocation decisions." Perhaps in an attempt to eliminate potential confusion or forestall arguments that published standards are unintentionally outdated, several codes of conduct include a general proposition that neither the existence of managed care arrangements or of


92. The guidelines state: Health care resources . . . should be used on the basis of individual patient needs . . . Diagnostic and therapeutic decisions should be made on the basis of potential risks and benefits of alternative treatments . . . The emergency physician has the obligation to diagnose and treat patients in a cost-effective manner and must be knowledgeable about cost-effective strategies; but, under the principle of nonmaleficence, the physician should not allow cost containment to impede proper medical treatment of the patient. Am. Coll. of Emergency Physicians, Code of Ethics for Emergency Physicians (1997), reprinted in MEDICAL ETHICS, supra note 57, at 224.

93. Both the AMA and medical specialty associations uniformly urge that rationing decisions be made in a public forum, rather than at the bedside of individual patients. AMA Principles of Med. Ethics, The Provision of Adequate Health Care, Op. 2.095 (1994), in MEDICAL ETHICS, supra note 57, at 14 ("Ethical principles require that a just process be used to determine the adequate level of health care"); the process should include "(1) democratic decision making with broad public input . . ., (2) monitoring for variations in care . . . with special attention to evidence of discriminatory impact on historically disadvantaged groups, and (3) adjustment . . . over time to ensure continued and broad public acceptance."); see, e.g., Am. Coll. of Obstetricians and Gynecologists Comm. on Ethics, Physician Responsibility Under Managed Care: Patient Advocacy in a Changing Health Care Environment (1996), reprinted in MEDICAL ETHICS, supra note 57, at 425 ("decisions to ration community health care resources for the purpose of just allocation should be made explicitly within a public forum" and "the needs of all patients, not financial loss or gain, should be the primary basis of allocation decisions"); Am. Acad. of Pediatrics Comm. on Bioethics, Policy Statement: Ethics and the Care of Critically Ill Infants and Children (1996), reprinted in MEDICAL ETHICS, supra note 57, at 650 ("judgments about which diagnostic categories of patients should receive or be denied intensive care based on considerations of resource use are social policy deliberations and should be made after considerable public discussion, not ad hoc at the bedside").
recently developed financial incentives justifies deviations from standard principles.\textsuperscript{94}

The universal ethical proscription on physicians' participation in decisions to allocate medical resources largely ignores present reality. Simple denial cannot change facts. Physician-managers are charged with allocating medical care by managing the expenditure of the total premium revenues between individual patients and the population of enrolled patients, frequently against the backdrop of the corporate directive to maximize shareholder value.\textsuperscript{95}

Incentivized physicians, who bear the financial risk of caring for a population of patients, confront the necessity of a similar trade-off, against the backdrop of their own financial well-being. Both physician-managers who make medical necessity decisions and physicians who bear financial risk for their patients' medical needs must make determinations, directly or indirectly, about resources that will be expended on the individual patients and those that will be available to the patient population. The failure of ethical dictates to acknowledge and to provide physicians with guidance about this key element of contemporary medical practice is a serious one. As managed care organizations developed means to align payers' and physicians' financial incentives to control health care spending, the juxtaposition of the traditional aspirational method of self-regulation and the current market paradigm created a health care delivery system at war with itself.

\textbf{III. IS THE CURE WORSE THAN THE DISEASE?}

Reliance on ethical standards that fail to address market practices would not be troubling if the risks that were presented by physicians as cost-control agents were remote or inconsequential. In this Part, I identify the public and private concerns that have been expressed about controlling health care spending by physician-directed limitations on the use of medical services. Although these

\textsuperscript{94} Am. Coll. of Emergency Physicians, \textit{Policy Summaries: Managed Care} (1997), reprinted in \textit{Medical Ethics, supra} note 57, at 227-28 ("The ethical obligations of emergency physicians do not change when practicing in a managed care or any other environment."); \textit{see also} Am. Coll. of Obstetricians and Gynecologists Comm. on Practice Mgmt., \textit{Cost Containment in Medical Care} (1996), reprinted in \textit{Medical Ethics, supra} note 57, at 422 ("[w]hile striving to contain costs, obstetricians-gynecologists must focus on their primary goal of providing quality care"); Am. Acad. of Pediatrics Comm. on Child Health Financing, \textit{Policy Statement: Principles of Child Health Care Financing} (1998), reprinted in \textit{Medical Ethics, supra} note 57, at 626 ("cost containment is essential but must not impair the quality of care delivered").

\textsuperscript{95} Even the language adopted by the managed care industry makes it clear that the trade-off between spending money on medical care and the corporate bottom line is all too apparent: the percentage of premium spent on providing medical care to patients is referred to as the "medical loss ratio"; that amount of the premium dollar that is "lost" to covering insured risks.
concerns do not justify abandoning market-based reforms, they do warrant an examination of methods by which these concerns might be addressed.

A major area of concern presents problems of agency, the potential for harm to a patient due to the under-use or misuse of medical treatment that results from economic incentives to limit care. Either may occur as a result of incompetence or action based on a conflict of interest. The typical methods of assessing medical competency are not in place for many physician-managers. In contrast to practicing physicians, many states do not require physician-managers to hold a license to practice medicine in the state in order to make clinically based coverage decisions that affect the medical treatment of state residents. In an era characterized by increased medical specialization, the health care delivery system has relied on institutional peer review to ensure that licensed physicians’ professional activities are limited to areas in which they have training and expertise. While most practicing physicians are subject to peer review by hospitals or managed care organizations to ensure that they do not exceed the limits of their expertise, such safeguards are rare for physician-managers. Many managed care organizations do not subject their physician-managers to periodic credentialing to assess their general competence. Moreover, they do not restrict physician-managers medical review activities to areas in which they have clinical training or expertise. In contrast to the specialization that characterizes medical practice, physician-managers remain generalists making clinically based coverage decisions across a wide spectrum of specialty areas in which they may lack training or expertise.

This risk is demonstrated by a review of the facts of Pappas v. Asbel. In Pappas, an emergency room physician, and the neurologist and neurosurgeon he consulted, concluded that Mr. Pappas was suffering from an epidural abscess that was pressing on his spinal cord and that required immediate transfer to a university hospital with capacity and capability to treat the condition. The health maintenance organization’s (“HMO’s”) physician-manager refused to

96. Risks associated with the competency of the physician are not, of course, limited to the cost-control context. Medical treatment generally presents risks of overtreatment, under-treatment, inexpertly delivered treatment, and incorrect treatment. These problems can be addressed by market forces with patients’ shunning incompetent practitioners; laws of general applicability like tort and contract; and self-regulation and discipline. These mechanisms have more limited application to physician-managers. See discussion infra notes 259-68 and accompanying text.

97. See discussion supra notes 62-63 and accompanying text.


100. See Pappas, 768 A.2d 1089, 1091.
authorize the transfer to the recommended university hospital, although he agreed to permit the patient's transfer to either of two other hospitals that were under contract with the HMO; he also declined to speak directly with the emergency room physician. Mr. Pappas's transfer was delayed by several hours while the emergency room staff attempted to locate a hospital that had a contract with Mr. Pappas's HMO and the capability to treat Mr. Pappas's medical condition. Mr. Pappas alleged that the delay caused permanent quadriplegia from the compression of the spine by the abscess. The physician-manager was trained in pediatrics. As a practicing pediatrician, it is unlikely that he would have been permitted by a hospital or a managed care organization to undertake, or to consult on, a treatment of an adult patient with a neurological diagnosis. As a physician-manager, his coverage decision effectively controlled the patient's treatment.

The concern about physician-manager competence is not limited to decisions about payment, because physician-managers do not always limit themselves to a "yes" or "no" response to questions about coverage. On occasion, when recommended treatment is not approved for payment, a physician-manager will make her own treatment recommendations. For example, in Long v. Great West Life & Annuity Insurance Co., an insurer denied pre-authorization for back surgery, which had been recommended by Mr. Long's attending physician. A physician-manager associated with the insurer's utilization review agent recommended instead a course of steroid injections. Mr. Long's physician disagreed, and the consulting physician refused to administer the injections on the ground that "the injections would be of no physical benefit ... and could involve some risk." Thereafter, the physician-manager recommended to Mr. Long's treating physician that Mr. Long should have physical therapy in lieu of the surgery. As his condition worsened, Mr. Long decided to have the surgery without pre-authorization. The risk, in cases like Mr. Long's, is that a patient might not receive the care she needs if the physician-manager recommends inappropriate treatment. The patient might be influenced by the physician-manager's medical recommendation made in the

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102. The merits of Mr. Pappas's medical malpractice claim have not been adjudicated. See Pappas, 675 A.2d at 711.
103. The district court in Pappas noted that the record did not "reveal the field of specialization" of the physician-manager. Id. at 713 n.1. My assertion that the physician-manager in this case was trained in pediatrics is based on personal knowledge, verified by representatives of the successor organization to the defendant HMO.
104. 957 P.2d 823 (Wyo. 1998).
105. Id. at 824-25.
106. Id. at 825.
107. Id. at 825-26. The reported opinion did not reach the merits of the plaintiff's claims.
108. Id. at 826.
context of a coverage decision, or she simply might be unable to afford care when payment is not authorized.109

Concerns about physician-managers are worsened by their disavowal that they owe any duty to the patients whose care their coverage decisions affect.110 With no clearly defined legal or ethical duty to offset an obligation to the employer, a suspicious public fears that physician-managers might be influenced to make coverage decisions that are not consistent with acceptable medical practice.

Relying on physicians with personal incentives to withhold care raises similar concerns. Just as physician-managers might be inclined to make coverage decisions in areas in which they lack clinical competence, practicing physicians might provide care in areas beyond their expertise when they have financial incentives to minimize referrals to other physicians.111 A practicing physician's decision not to refer a patient to a specialist for treatment when the patient's condition is beyond his expertise poses an additional risk not present when a physician-manager decides not to pre-authorize treatment for payment: the patient is unlikely to be aware that a decision to withhold care had been made, eliminating the possibility of appeal or other recourse.112 This conflict is heightened when incentivized physicians do not disclose their personal incentives; that nondisclosure, in effect, eliminates the possibility that a patient might resort to market mechanisms to protect herself by requesting a second opinion or seeking additional care at her own expense.113

109. It should be apparent that this is a risk akin to medical malpractice by a treating physician, but current law is not amenable to malpractice suits against physician-managers. Many such claims are deemed preempted by ERISA when the patient is covered under an employee benefit plan. See discussion infra notes 259-68 and accompanying text. State laws or rulings that medical necessity decisions are not the practice of medicine shield others. See discussion supra notes 62-64 and accompanying text.

110. For example, in Hand v. Tavera, 864 S.W.2d 678, 679 (Tex. Ct. App. 1993), Lewis Hand sued Dr. Robert Tavera, the physician responsible for authorizing admissions of patients insured by Mr. Hand's managed care plan, for failing to authorize Hand's admission to the hospital from the emergency room. Dr. Tavera defended against the claim of malpractice on the ground that he owed Mr. Hand no duty because the two had never had a patient-physician relationship. Id. The court disagreed, holding that the Humana Health Plan contract established the patient-physician relationship. Id. at 681.

111. Unlike physician-managers, however, treating physicians can be held liable under state law for medical negligence for omissions that fall below the standard of care. Practicing physicians are also subject to state licensure laws and oversight by the state board of medicine.

112. A full discussion of the nature and scope of these conflicts of interest is beyond the scope of this Article. For an excellent discussion of the conflicts of interest and ethical dilemmas created for practicing physicians by managed care organizations' reimbursement methods, see Rodwin, supra note 18.

113. See, e.g., Shea v. Esensten, 107 F.3d 625 (8th Cir.), cert. denied, 522 U.S. 914
The absence of ethical standards to guide physician conduct in a market-based system presents systemic concerns, as well. Physicians' bedside allocation decisions have been criticized for undermining patients' trust in their physicians and in the integrity of the medical profession as an institution. Similarly, reliance on physician-managers to oversee treatment recommendations of practicing physicians has been blamed for a loss of consumer confidence and trust in the managed care system. Silence has fueled this mistrust. By now, more than ten years into the shift to a market paradigm for medicine, the public is generally aware that some physicians have personal incentives to withhold care. They are also aware that managed care organizations deny coverage based on their assessment of clinical need. The medical profession has failed to provide professional guidance or public disclosure about the manner in which physicians make the required trade-offs. Managed care organizations have elected to provide little information about the process by or the substance upon which coverage determinations are made.114 The resultant mistrust undermines the ability of the medical profession and the managed care industry to be responsive to societal needs to conserve health care resources.

IV. CAN THE MARKET CURE ITSELF?

The shift to a market model alleviated financial incentives that contributed significantly to the escalation of health care spending and brought market discipline to the formerly unfettered physician-dominated professional model. The methods used to accomplish these tasks, however, brought with them their own risks, as well as heightened public skepticism. The debate about those risks—and in recent years, about health care reform generally—has been artificially circumscribed by the pervasiveness of market analysis.115 My aim in

(1997). Patrick Shea was a forty-year-old man with a family history of heart disease experiencing severe chest pains and shortness of breath. Id. at 626. He was enrolled in an HMO, and he asked his primary care physician for a referral to a cardiologist. His physician declined. Several months later, Mr. Shea died of heart failure. Id. The HMO in which Mr. Shea was enrolled used physician financial incentives to minimize specialist referrals. Id. at 627. Mr. Shea was not advised of that fact, nor was he advised whether his physician's clinical decision was affected by his enrollment in an HMO. Id. Mrs. Shea alleged that disclosure of the financial incentive would have been enough to cause Mr. Shea to visit a specialist. Id. The court agreed, holding that the HMO had a fiduciary duty under ERISA to disclose incentives to limit care. Id. at 629. But see Ehlmann v. Kaiser Found. Health Plan, 198 F.3d 552, 556 (5th Cir. 2000) (distinguishing Shea as a case of "special circumstance" based on a specific request, and holding that ERISA does not impose a fiduciary duty to disclose financial incentives to limit care). See also Pegram v. Herdrich, 530 U.S. 211, 228 n.8 (declining to address the question).

114. See discussion infra notes 137-45 and accompanying text.

this Article is to expand the dialogue beyond the limited confines of neoclassical economics." To advance that initiative, this Part highlights some shortcomings of market analysis in health care.

A. Market Ideals

Market theory rests on the assumption that the self-interested behavior of economic actors in the marketplace will yield a socially desirable result: that result is typically characterized as consumer sovereignty. In independent transactions in a competitive market, self-interested consumers will purchase the products that they most value, and profit-oriented producers will produce only those goods and services that consumers desire to purchase and will do so in the least costly manner possible. Products of inferior quality will be rejected in law.

116. For a discussion of non-economic values that should be considered in health reform, see Margaret G. Farrell, The Need for a Process Theory: Formulating Health Policy Through Adjudication, 8 J.L. & HEALTH 201, 211 (1993-94) (discussing equity and distributive justice).

117. The absence of a perfectly functioning market, of course, is not conclusive given the almost certain absence of a utopian choice of an oversight mechanism. See generally NEIL K. KOMESAR, IMPERFECT ALTERNATIVES: CHOOSING INSTITUTIONS IN LAW, ECONOMICS AND PUBLIC POLICY (1994). Identification of shortcomings in the economic model also may suggest opportunities for the operation of other models to compensate for or correct market failures. See Martin Gaynor & William B. Vogt, What Does Economics Have To Say About Health Policy Anyway? A Comment and Correction on Evans and Rice, 22 J. HEALTH POL., POL'Y & L. 475, 477 (1997) ("If a market is not textbook competitive, there is no implication about what the optimal organization of exchange might be. It might be pure government activity, it might be pure market activity, or it might be a mixture of the two.").

118. Self-interested behavior is one of the cornerstones of economic analysis, while the professional model demands that the professional resist self-interested behavior when it would conflict with ethical responsibilities. See George H. Cohen, When Law and Economics Met Professional Responsibility, 67 FORDHAM L. REV. 273, 275 (1998).

119. See Cass R. Sunstein, Television and the Public Interest, 88 CAL. L. REV. 499, 514 (2000) ("According to the economic model, a well-functioning . . . market would promote the ideal of consumer sovereignty."). Consumer sovereignty as an end converts private preference into national policy. See id. at 591 (making this point about private preferences for programming in the broadcast market). Private preferences of corporate purchasers would seem a weak foundation upon which to base national health care policy.

120. The Coase Theorem, which posits that individual exchanges in a competitive market will allocate society's scarce resources to their most highly valued uses, is a principal tenet of the Chicago School that dominates the law and economics movement. The theorem was developed in Ronald Coase, The Problem of Social Cost, 3 J.L. & ECON. 1 (1960). I use it here, although the approach I take in this Article is institutional; I view the market as one possible approach rather than the single ideal approach. See
favor of better products, and the quality-cost trade-off will occur as a result of self-interested transactions in the market.

An economic model, implemented through the unfettered functioning of a competitive market, would seem particularly well suited to the oversight of utilization-based cost-control processes. The methods used to control utilization of health care services developed during the shift from a professional to a market paradigm for health care delivery; relying on the same market forces that led to the development of utilization control to shape its functioning is intuitively appealing. Moreover, the purpose of utilization management—efficient allocation of premium dollars—is consistent with the larger resource allocation goal of an economic model. Finally, reliance on market forces as a means of oversight adds less cost to the health care system than does additional formal regulation; adding oversight costs to the health care system exacerbates the high cost of health care that utilization controls were developed to alleviate.

An analysis reveals, however, that the market has limited regulatory potential as a means of addressing the risks of utilization-based controls.

Under current market practices for health care coverage, individual consumers, or the purchasers who act on their behalf, are not given the opportunity to select the individual physician-manager who makes the medical necessity decision or to direct the incentives that each treating physician is offered. That choice is embodied in their selection of a payer and a health benefit design. Accordingly, problems associated with the substance of the individual cost-constrained clinical decisions, whether in the context of a medical necessity decision or an incentivized treatment decision, are addressed in the current market for insurance coverage only indirectly—by consumers' rejection of an unsatisfactory managed care organization or benefit design and choice of a replacement plan. In the market for health care coverage, consumers' choices among a range of coverage options would determine the


121. The methods used to control the utilization of health care services depend upon the type of health insurance coverage purchased by, or on behalf of, health care consumers. For a discussion of the shortcomings of market forces in controlling the substantive decisions of professionals, see Ameringer, *supra* note 39, at 124-27.

122. While consumer-patients remain free to select their own physicians from the list of participating physicians provided by the managed care organization, they typically are not provided information about different physicians' philosophies toward cost control through clinical decisions to make informed choices. Consumers also would be required to know a great deal more than most do about clinical medicine to comprehend the trade-offs. See infra text accompanying notes 137-45 (regarding the role of information in the economic model).

123. For individual consumers to select individual physician decision-makers as caregivers and as monitors would require significant dismantling of the group insurance model.
trade-off between premium cost and restrictions on the use of medical services, the utilization control processes used by market participants, and the preferred mix of those control processes.  

The extent to which the market produces the economic ideal of consumer sovereignty, however, depends upon the pattern of market participation. Inefficient outcomes—deviations from consumer sovereignty—in an economic model result from imperfections in market operation, commonly called market failures. It is axiomatic that the markets for health care services and health care coverage are rife with imperfections. In the next section, I discuss four market failures that affect consumer preferences about managed care and the methods adopted by managed care organizations to control utilization of health care services.

**B. Four Market Failures**

In the market for health insurance coverage, little functions as the economic model predicts. The purchaser is typically not the ultimate consumer. If purchasers do not reflect the desires of consumers, at least most of the time, then purchasing decisions might not reflect consumers’ preferences among health care coverage products. Sellers, managed care organizations and insurers, are not equally happy to sell to anyone who will pay for their product and are affirmatively anxious to avoid some potential consumers; they are unlikely to compete for or develop products that are desired by these undesirable consumers.

126. *See David A. Hyman, Regulating Managed Care: What’s Wrong with a Patient Bill of Rights, 73 S. Cal. L. Rev. 221, 233 (2000)* (“It is elementary health economics that there are a variety of imperfections in the markets for health care coverage and delivery. These imperfections affect virtually every aspect of the relationships between providers, payers, and consumers.”).
127. The use of an economic model also has normative shortcomings. An economic model presupposes that efficient allocation of resources, measured in the aggregate, is the single desired end project. Efficiency as an end disregards whether the current distribution of wealth and opportunity is a desirable beginning. It should be apparent that even a perfectly functioning market would fail to meet the needs of patients without economic means, including the uninsured and the medically indigent. The question of how to allocate health care resources, therefore, has an inescapable moral element that must take into account factors that transcend market efficiency. For a discussion of normative shortcomings of market analysis in health care, see M. GREGG BLOCHE, MEDICAL CARE AND THE ENIGMA OF EFFICIENCY (1999) (Georgetown University Law Center, Business, Economics, and Regulatory Law Working Paper No. 184275), available at http://www.ssm.com (discussing the shortcomings of economic efficiency as a goal for allocating health care resources); Thomas Rice, *Can Markets Give Us the Health System We Want?*, 22 J. Health Pol., Pol’y & L. 383, 386-88 (1997) (discussing Pareto optimality).
Information, especially about the methods of cost control used by third-party
payers, is sparse, leaving consumers uninformed about their options and the
trade-offs embodied in them. Finally, the ability of consumers to take action,
whether on the basis of experience or information, to abandon unsatisfactory
sellers and select more responsive ones is limited.

1. Limitations of Agency

In making decisions about health care coverage, employers act as
purchasing agents for their employees and agents-once-removed for their
employees' dependents.128 Under traditional common law principles of agency,
the employer would not be considered a bona fide agent. Traditional notions of
agency define an agent as one who is directed to act in the interest of and by the
principal, who retains the authority to control the agent's conduct.129 Employees
do not direct employers in their choice of health plans, although they may be able
to influence that decision directly through collective bargaining in unionized
workplaces or indirectly as potential employers compete for skilled workers.
Moreover, agents are prohibited from having interests that conflict with those of
the principal; employers have an element of self-interest, as well as a legal duty
to shareholders to maximize corporate value. In purchasing a health benefit plan
for employees, therefore, a corporate employer might be expected to focus more
on the cost of the premium than the quality of the care or coverage provided to
the employees by the plan.130 Unlike traditional agents, employers who act as
purchasing agents for their employees cannot act solely in their interest and are
not subject to their direct control.131

Despite this limitation, employer-based insurance also has the potential to
enhance consumer sovereignty. Corporate purchasers, particularly those with
large numbers of employees, have significant leverage with which they can
establish and demand compliance with performance standards.132 Thus,

128. Some scholars are willing to accept, at least for purposes of argument, that the
employer is an appropriate agent for its employees. See, e.g., Russell Korobkin, The
Efficiency of Managed Care "Patient Protection" Laws: Incomplete Contracts, Founded
Rationality, and Market Failure, 85 CORNELL L. REV. 1 (1999). Others frankly state that
employers are “at best, imperfect agents.” See Hyman, supra note 126, at 233.
129. See RESTATEMENT (SECOND) OF AGENCY § 1 (1957).
130. See Erica Worth Harris, The Regulation of Managed Care: Conquering
Individualism and Cynicism in America, 6 VA. J. SOC. POL’Y & L. 315, 363-64 (1999)
(discussing agency problems of third-party purchasers and payers); Hyman, supra note
126, at 247 (noting that employees are also concerned about premium cost).
131. ERISA permits employers to act as other than fiduciaries in selecting the
132. Although smaller employers have less direct leverage because the purchasers' power is based on the ability to deliver volume, in the managed care marketplace, private accrediting agencies can leverage the market pressure of small and larger purchasers to
corporate purchasers have market power that no individual consumer possesses. Staff members who are responsible for employee benefits can be expected to pay closer attention to the specific terms of coverage and the trade-offs between coverage and cost than the typical individual, thus increasing the likelihood of a rational purchasing decision. 133

Corporate purchasers might be expected to mirror the concerns of corporate employees and, therefore, to reflect their employees’ purchasing preferences. As a theoretical matter, the corporate executives who make coverage purchasing decisions on behalf of employers should be entitled to receive the same quantity and quality of medical benefits as other employees. Corporate decision-makers, therefore, should be expected to share other employees’ personal concerns, and to reflect those concerns in their decisions. In practice, however, the matter is not so clear. Corporate decision-makers might not be subject to the same rules or have those rules applied in the same fashion as the vast majority of the employees they represent. For example, corporate executives who make health care purchasing decisions have greater influence than other employees over the payer they are charged with selecting; therefore, they reasonably could expect to receive more favorable responses to their requests for coverage for health care services for themselves or their dependents than might be afforded to employees who are not in a position to influence the employer’s purchasing decision. 134 Furthermore, managed care organizations are willing to provide different benefit designs for senior executives, and for rank and file employees. When this occurs, there is less reason to assume that a corporate decision-maker, who is subject to different and likely fewer spending restraints, would be a good agent for rank-and-file corporate employees.

Employers also might be expected to strive to reflect their employees’ purchasing preferences because they have to compete for employees. This is especially true in a marketplace with low unemployment figures or in a market segment of highly skilled workers. Because the employee benefit package is an important factor in that competition, employers should be expected to strive for a benefit package that satisfies current and attracts potential employees. In addition, because employers benefit from healthy workforces, they should have a strong financial incentive to purchase a health benefit plan that meets their employees’ medical needs in order to maintain worker productivity. But here too there are countervailing considerations. Employers might have a financial disincentive to attract potential employees (or retain current employees) who require an inordinate amount of health care services either for themselves or for

affect supplier conduct. See O’Kane, supra note 13.

133. Individuals making decisions about health care coverage suffer from “bounded rationality.” See Korobkin, supra note 128, at 44-51.

134. My personal experience as a practicing lawyer representing managed care organizations strongly suggests that this is the case.
their dependents. Employers that are self-insured directly bear the costs of that care, and those who purchase health care coverage bear the cost indirectly through increased premiums. This disincentive detracts from the effectiveness of employers as agents, at least for the disfavored employees. Moreover, the desire to avoid such individuals might deter employers from adopting health benefit plans that are more generous than their competitors so as not to attract an inordinate number of “high users.” In short, employers’ purchasing preferences can be expected to mirror those of some of their employees some of the time. This inevitability of imperfect agency in the current market configuration for health care coverage undermines a fundamental assumption of market analysis.

2. Lack of Information

In the fable of the emperor’s new clothes, it is left to a young child to announce what all could see but none would admit. In a similar show of candor, the United States Supreme Court recently stated that health care rationing is an immutable characteristic of managed care organizations. Despite the increasing amounts of information required by state and federal law, as well as by private accreditation standards of the National Committee on Quality Assurance, admissions that managed care organizations ration health care services and information about how that rationing occurs remain scarce. Both

135. Employees who, or whose dependents, require significant health care services also might be expected to place a high value on quality of or access to care. It is not uncommon for employers to inquire about which employees or employees’ dependents incur the highest expenses for health care services. See Doe v. Southeastern Pa. Transp. Auth., 72 F.3d 1133, 1135 (3d Cir. 1995) (chief administrative officer examined reports of employees who had purchased more prescription drugs at a cost in excess of $100 a month and discovered that an employee suffered from AIDS).

136. These categories of employees and potential employees might include the aged, the chronically ill, and individuals with disabilities, as well as those with serious acute illnesses. Many of these individuals would be protected from job discrimination under federal laws.

137. See Pegram v. Herdrich, 530 U.S. 211, 220-21 (2000) (“whatever the HMO, there must be rationing and inducement to ration”).


139. In a series of recently filed class action suits against managed care organizations, there are allegations that managed care organizations engaged in systematic efforts to mislead consumers about the methods used to control health care utilization. See, e.g., In re Humana, Inc., No. 00-1334-MD-Moreno (S.D. Fla. Miami Div.) (on file with author) (managed Care Litigation); see also National Class Action Filed in Conjunction with Action Filed by Connecticut Attorney General, PR NEWSWIRE, Sept. 8, 2000, available at LEXIS, Nexis Library, PR Newswire file (federal class action suit alleging that managed care-organization-defendants, inter alia, used undisclosed and
factors are important to a consumer's informed choice of a health care benefit design.

The participation of informed consumers is a central concept of the market model. To fulfill its role in market analysis, information, relevant to a consumer's choice, must be comprehensible and readily available. The information of concern in this context is not information about the need for or proper choice among alternative medical services, but information about the means used to control the utilization of medical services. For example, if a pre-authorization and concurrent review process is used to control spending on and use of health care services, the consumer might wish to know the qualifications of the decision-maker; the criteria on which the decision will be based; the right, and processes by which, to challenge a decision; and the rates of initial denial or pre-authorization for payment and sustained denial after appeal. If, in contrast (or in addition), the payer relies on physician incentive mechanisms, the consumer might find information about the existence and type of incentive, the medical services to which the incentive is tied, and the consequences to the caregiver of failing to satisfy the utilization targets helpful in making a decision. To enable consumers to make an informed choice, this information should be detailed enough for a consumer to understand the managed care organization's methods, as well as to make meaningful comparisons among

arbitrary guidelines to deny coverage and provided enrollees with confusing and contradictory information).

The inability of most consumers to comprehend complex medical information is frequently cited as a partial explanation for physician dominance of health care delivery. Consumers cannot make informed choices about their health care needs even when information is available, because they lack clinical insights upon which to base those decisions. Therefore, they must rely on the judgment of trained clinicians. Professional ethics and the social contract they form dictate that physician decision-makers act in the best interests of the patient.


142. Information about the occurrence and rate of undesirable events resulting from utilization control decisions, such as worsening of medical conditions or deaths from lack of treatment, would provide a measure of the quality of the utilization decision.

143. Some employees do not have a meaningful choice to make. See infra notes 146-50 and accompanying text. Nonetheless, information would allow employees to exercise a medical version of caveat emptor to inquire about the basis for treatment or coverage decisions.
managed care organizations and between managed care options and any other coverage type that might be available. This information is not intrinsically difficult to understand, although some care will be required to disclose the information in a meaningful way.

Such information, however, is not readily available to individual consumers. In a study published in 1998 by the General Accounting Office ("GAO"), the GAO found that the information that managed care organizations made available to enrollees did not provide explanations of physician compensation arrangements or even reveal that physicians were given incentives to limit care. In the absence of comprehensive information about the methods used to control cost by limiting use, reliance on consumer choice to reflect actual consumer preferences is misplaced.

3. Restrictions on Choice

To achieve the economic ideal of consumer sovereignty, informed consumers must have choices. Consumer choice is affected by the number of competitors in the marketplace, consumer access to those competitors, and the diversity of product offerings. While managed care remains a competitive enterprise, the number of competitors in the marketplace is decreasing as a result of industry mergers and consolidations. Even as the number of existing competitors decreases, the cost of entry for new competitors has increased as managed care has evolved from a local to a regional or national enterprise. Major stakeholders in the health care industry, including purchasers and caregivers, have expressed concern about the effects of the decreasing number

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145. Id. My own review of materials provided in 1998 to enrollees and potential enrollees of the HMOs listed in this footnote, supports the GAO’s findings, which were based on an earlier review. I reviewed materials submitted by Blue Cross and Blue Shield of North Carolina; BlueChoice Health Plan and the Blue Choice Option offered by Blue Cross and Blue Shield of Georgia; CIGNA HealthCare; Doctors Health Plan of Durham, North Carolina; Kaiser Permanente Health Choice of Raleigh, North Carolina; Optimum Choice of the Carolinas, Inc.; Prudential HealthCare offered in the Atlanta, Georgia, metropolitan area and Prudential HealthCare HMO in North Carolina; QualChoice of North Carolina; United Healthcare of Georgia, Inc., and United Healthcare of North Carolina, Inc.; and Wellpath Community Health Plans (all on file with author).
and increasing market share of the major managed care organizations. Industry consolidation has lessened competition and reduced consumer choice. 

Even without a reduction in the number of competitors participating in the managed care marketplace, the scope of consumer choice is affected by the decisions of employer-purchasers. Many employers do not provide options for health care coverage to their employees. Eighty percent of employed Americans are enrolled in health benefit plans that utilize managed care benefit designs. Less than forty-one percent of employed workers have a choice of more than one plan, and even fewer have a choice of a traditional indemnity plan that does not rely on utilization controls. An employee without an opportunity to choose among competing plans is faced with a Hobson's choice between accepting the health care coverage selected by her employer or rejecting any employer-provided coverage. Accepting the coverage offered says little about the consumer's preference of health care benefit design or the related methods of utilization control.

The final element affecting consumer choice is the diversity of the product offerings of market competitors. The extent of the diversity among managed care benefit designs is important in determining the scope of consumer choice. The extent of the diversity among managed care benefit designs is important in determining the scope of consumer choice.

146. In Georgia, the state medical association expressed concern that two pending mergers would give the new combined companies a market share of nearly sixty percent in two health care benefit designs. MAG Opposes Healthcare Insurance Mergers, PR NEWSWIRE, Oct. 21, 1999, available at LEXIS, Nexis Library, PR Newsire file. Similar concerns were expressed by a business alliance in Florida. Mike Stobbe, Aetna Buys 1st Place in Healthcare, TAMPA TRIB., Dec. 11, 1998, Finance at 1, available at LEXIS, Nexis Library, Major Newspapers file.

147. See Managed Care, Politics and Policy, AM. HEALTH LINE, July 6, 1998, available at LEXIS, Nexis Library, American Health Line file (quoting Paul Ellwood, a developer of the concept of managed care, expressing his "disappointment" with managed care and the focus on price competition to the exclusion of quality-based competition).

148. See supra notes 128-36 and accompanying text.


150. High-income employees, earning more than $60,000 annually, are more likely than lower-income employees, earning $20,000 or less, to be offered a choice of plans. Id. And employers with fewer than five hundred workers are less likely than larger employers to offer their employees a choice of plans. Id.

151. Health insurance can be purchased individually, although individual coverage is usually more expensive and less extensive than group coverage. Some individuals, particularly those with a past history of serious illness, a disability, or a chronic disease, are likely to have difficulty in purchasing affordable health care coverage, because extensive questioning of health history is typical.

152. Although a wide-range of managed care benefit designs are available in the marketplace, including HMOs, preferred provider options, and point of service plans, the differences within each design type, for example among HMOs, in the methods used to
care benefit designs will be affected by the insurers' desire to avoid adverse selection. Individuals who are high-users of medical services are not desirable consumers. Managed care organizations, therefore, have an economic incentive to offer products that are no more generous than their competitors' products, because more generous products would be more attractive to undesirable customers. Similarly, if a managed care organization offers benefit designs that are less generous than its competitors, it risks a shift of its younger and healthier enrollees into that product, leaving the product design of average generosity with a higher-than-predicted percentage of individuals with current illness or greater likelihood of illness. The resulting rush to conformance lessens diversity among products and, therefore, consumer choice.

4. Barriers to Exit

An economic model exercises oversight of market participants through the process of exit: dissatisfied consumers must have the ability to take their dollars elsewhere as a means to ensure that disfavored practices will be abandoned. Sellers that fail to respond face loss of valued customers and, if enough customers exit, elimination as market competitors. As with choice, if an employer does not offer options for health care coverage, then a consumer has little meaningful opportunity to exit; the sole alternative is individual coverage. The ability to exit is limited even for those consumers whose employers offer a choice among benefit plans. Employees are usually given the opportunity to select a health benefit plan at the time of their employment. Thereafter, employers typically conduct an annual enrollment process that enables control utilization of services are difficult to discern as a result of the lack of detailed information made available to consumers.

153. Adverse selection occurs when individuals who believe they are likely to require a particular insurance coverage are more likely to purchase that coverage than those who see their risk as remote. When adverse selection occurs, the insurer will incur insurance losses that exceed the actuarial estimates and, therefore, will earn less than anticipated profits or suffer a loss. See Wortham, supra note 120, at 844.

154. A comparison of managed care organizations lists of covered benefits will prove this point.

155. When coupled with employers' economic incentives to avoid health care benefit designs that are especially attractive to high users of health care services, this rush to conformance takes on elements of a classic race to the bottom.

156. Exit as a regulatory mechanism is not at its most powerful in the managed care marketplace. Because some consumers are not profitable to insure, their exit, due to dissatisfaction with managed care practices, would not prompt a managed care organization to change its practices. Self-interested behavior would suggest that managed care organizations intentionally would adopt practices to discourage enrollment by high-users and to encourage individuals who develop conditions leading to their becoming high-users to disenroll, at least until the point where this behavior resulted in the loss of desirable customers.
employees to make a once-a-year selection of a health care benefit plan. Exit at other times is possible only through a change of employment to an employer that offers another health benefit option or through the individual purchase of health care coverage. Each alternative imposes significant burdens on the consumer.

An unregulated competitive market should not be expected to result in the optimal mix of health care benefit designs as measured by consumer preferences, due to the existence of market imperfections in information, choice, and the ability to exit. Accordingly, singular reliance on market forces to ensure that clinical practices accurately reflect consumer preferences for cost-quality trade-offs is misplaced. Moreover, market mechanisms simply cannot facilitate the nuanced clinical decision-making that is necessary if a cost-conscious medical system is to restrict medical care based on the likelihood of producing health benefits rather than that of avoiding active protest. For that, we must look elsewhere.

My suggestion is a modest one. I do not suggest that we abandon the market paradigm for health care, and its contributions to addressing the economic incentives that result from a third-party payer system. Rather, I recommend that we consider supplementing the market system with a revitalized self-regulatory system based on professional norms that charge physicians with making responsible cost-quality trade-offs and that establish guidelines for mediating between patient primacy and group responsibility.

V. SELF-REGULATION IN MEDICINE

Self-regulation is the means by which a profession establishes the standards that govern its behavior and the conduct of its individual members. Those standards serve as powerful professional norms that can be used to explain and influence the conduct of the individual professional, as well as inform patient and public expectations about physicians’ behavior. Effective health care cost control will require evolution of professional norms to legitimize cost conscious clinical decisions and cost-quality trade-offs in the context of individual patient encounters and to establish guidelines to direct this activity. If professional norms can be influenced to adapt to changed market conditions and the actual roles physicians undertake in a managed care system, self-regulation will offer comparative advantages over market mechanisms and legislative directives to achieve effective health care spending controls.

Self-regulation holds out the promise of professionalism, institutional memory, and ethical restraints. But it also raises the specter of self-

157. If a consumer is ill at the time she wishes to exit her current insurer, she may have difficulty with the health screens that accompany the purchase of individual health care coverage.

protectionism and unrestrained spending, which have produced widespread skepticism about self-regulatory mechanisms. To achieve the benefits offered by a responsible self-regulatory system, means will have to be devised to ensure that it serves public needs. In this Part, I define self-regulation and examine both its promises and its perils. Later, I offer some preliminary thoughts on creating a responsive self-regulatory system.

A. The Definition of Self-Regulation

A threshold question is definitional: What is self-regulation? In practice, it has taken many guises, each of which can be classified according to the source of power for self-regulatory activity and the degree of government involvement in or influence on the self-regulatory system. "Self" refers to the common calling or endeavor among the regulators and the regulated. The term "regulation" refers to deliberate attempts to influence conduct. It entails four key functions: rule making, policing, adjudicating, and providing notice. In its purest sense, "self-regulation" refers to entirely voluntary conduct. Membership in a self-defined group entails an agreement to accept and comply with group norms that are codified in a code of conduct. In this sense, codes of conduct adopted by professional associations are examples of self-regulation. Their standards are aspirations, rather than mandates. The policing function is informal, and the formal sanctions that result from the adjudicatory processes are limited to expulsion from the group. This is not to say, however, that this type of self-regulatory activity is without legal effect. Codes of conduct create and limit expectations about another's behavior. The publication of a private code of conduct to the general public may give rise to a legally cognizable right to rely

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159. Professional self-regulation addresses entry into the profession, adoption and enforcement of standards of conduct, and discipline for violations of those standards. See William T. Gallagher, Ideologies of Professionalism and the Politics of Self-Regulation in the California State Bar, 22 PEPP. L. REV. 485, 488 n.2 (1995) (noting the aspects of professional self-regulation of lawyers). This Article is principally concerned with adoption and enforcement of standards of conduct as they relate to utilization and cost control.


161. See, e.g., Am. Acad. of Physical Medicine and Rehabilitation Code of Conduct (1995), reprinted in MEDICAL ETHICS, supra note 57, at 733 (describing the code as "a statement of ideals, commitments, and responsibilities . . . to patients, their families, other health professionals, society and to [physicians] themselves").

162. See AMA Principles of Med. Ethics, Discipline and Medicine, Op. 9.04 (1994), in MEDICAL ETHICS, supra note 57, at 47 ("Expulsion from membership is the maximum penalty that may be imposed by a medical society upon a physician who violates the ethical standards.").

http://scholarship.law.missouri.edu/mlr/vol66/iss2/3
on a commitment to the published standards in an individual case. In addition, the standards set out in ethical codes may be used as evidence of the duty owed, and breaches of the code of conduct as evidence of a violation of a legal duty. Courts also have relied on ethical dictates to find the requisite knowledge of wrongfulness to satisfy intent-based statutes.

Self-regulatory activity need not be entirely voluntary. It may be encouraged, sanctioned, or required by government action. Legislatures may elect to rely on self-regulation to capitalize on existing systems, to achieve financial economies, or to avoid the need to develop bureaucratic expertise. Government agencies may retain the right to direct, to perform, or to oversee some, or all, regulatory functions. Such regulatory arrangements retain self-directedness by the involvement of members of the regulated group, although the voluntary nature of the activity is moderated by government involvement. The regulatory standards adopted by the government agency may, but need not, be those adopted by the profession itself. When medicine and law are classified as self-regulating professions, reference is made to both voluntary self-regulation through professional associations and government-mandated regulation that relies on state agencies dominated by members of the profession.

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165. See, e.g., United States v. Jain, 93 F.3d 436 (8th Cir. 1996) (physician's conduct is "knowing and willful" within the meaning of the Medicare anti-kickback statute when he knows that it is unethical under professional standards).


167. Depending on the degree of government involvement, due process requirements may be imposed and legal sanctions may be available for violations of regulatory standards.

168. Most states have adopted some version of the Model Rules of Professional Conduct promulgated by the American Bar Association. State boards of medicine may adopt AMA standards in whole or in part, although it is more common for state boards to refer to AMA standards as one factor in determining whether a physician has violated a professional obligation. See, e.g., Gladieux v. Ohio State Med. Bd., 728 N.E.2d 459, 462-63 (Ohio Ct. App. 1999) (ethical principles provide sufficient notice of prohibited conduct to satisfy due process requirement when state board of medicine sanctions a physician for failing to conform to "minimal standards of conduct").

169. AMERINGER, supra note 39, at 25 (noting that states enacted legislation to
That self-regulation exists in multiple forms evinces the mutability of existing mechanisms. Self-regulatory methods and standards, like law and the market, are not static. The possibility of government involvement and, therefore, of democratic processes suggests that self-regulation can be made responsive to societal needs. The potential for government direction and oversight offers a means to address self-interested standards and lax enforcement.

B. The Case for Self-Regulation

To understand why self-regulation offers important benefits in a market-based system, the initial focus must be on the function that physician-promulgated standards fulfill for the medical profession and the health care delivery system, rather than on the current content or enforcement of those standards. Content and enforcement become important only after self-regulation is embraced as a viable mode of oversight.

Self-restrained behavior is a method to compensate for long-recognized factors that interfere with the functioning of a market model in medicine. In a managed care system, self-regulatory standards offer a means to avoid a race to the bottom that could result from financial incentives to do less, especially when those incentives are coupled with the elimination of a legal floor by federal preemption of state laws. In addition, self-regulation provides the professional norms for medicine that are a powerful determinant of physician conduct.

establish medical boards in the late 1800s); David B. Wilkins, Who Should Regulate Lawyers?, 105 HARV. L. REV. 799, 801 (1992) (noting that disciplinary agencies under the auspices of state supreme courts have had the primary responsibility for regulation of lawyers). Modern-day state medical boards frequently include lay members, although physicians retain a majority. Id. (discussing the evolution of the modern state medical board). There are many other examples of government-influenced self-regulation in medicine. With the Federal Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101-11152 (1994), Congress encouraged existing peer review systems by bestowing a benefit in exchange for fair review processes and reporting of the actions found to endanger patients. In establishing peer review organizations to review the necessity for and reasonableness of medical services provided to Medicare beneficiaries, the federal government utilized a system of audited self-regulation. For a discussion of audited self-regulation generally and as part of the Medicare program, see Douglas C. Michael, Federal Agency Use of Audited Self-Regulation as a Regulatory Technique, 47 ADMIN. L. REV. 171, 174-78 (1995).

170. See infra notes 179-92 and accompanying text.

171. Managed care organizations are shielded from the effects of state laws that relate to private-sponsored health benefit plans by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 (1994). If the managed care enrollee is not a beneficiary of a private-employer sponsored health benefit plan, state laws will be available to pursue complaints against the managed care organization. See infra notes 259-68 and accompanying text.

172. See infra notes 193-235 and accompanying text.
Professional norms, therefore, can either facilitate or impede efforts to control health care spending. Professional norms are also part of a social contract between the medical profession and the public. If physicians are acting as cost-control agents, that role and the standards that guide it should be reflected in the public commitments to medicine. Finally, a system for regulating medicine that is based on cooperative self-regulation can facilitate voluntary conduct when deviant conduct would go undetected by market forces and by command-and-control regulation.

Although the promise of self-regulation based on professional standards has been largely ignored in the present-day market model, as originally envisioned the market-based system was not intended to displace physician leadership and self-regulation. Rather, professional values were intended to guide a revamped delivery and financing system that employed economic incentives to reward preventive care and to control the use of high-cost medical services. In ignoring or implicitly rejecting this precept, current market participants have created a system that is fundamentally flawed and at odds with its theoretical underpinnings.

The ideal medical market has been characterized as an integrative model based on mutual recognition and acceptance by patients and physicians of rights and responsibilities, which are enforced by traditional professional values, as well as market incentives and government regulation. Paul Ellwood and Alain Enthoven, who provided the intellectual underpinnings for managed care, acknowledged that physicians were key to the success of any cost-control system. They envisioned that physicians would make all medical decisions, and would share financial risk and determine premiums for coverage in conjunction with insurers based on the covered population’s medical needs. Thus, Professors Ellwood and Enthoven concluded that managed care, as a system to control spending, could not succeed without “the loyalty, commitment and responsible participation of doctors.” In 1982, health care economist Victor Fuchs agreed that “physician-centered control of, and responsibility for the total health care...
"bill" was a key feature of a system to control health care spending. More than a decade later, Professor Fuchs cited as "one of the greatest errors of health policy-makers" the assumption that "market competition or government regulation are the only instruments to control health care." Rather, he called for a "revitalization of professional norms" as an instrument of control. Even as they argued for a larger role for market forces in health care delivery, health care analysts recognized that physician self-regulation would remain both desirable and necessary in a market-based health care delivery system. Self-regulation fulfills an important function even in a market-based system, although the changed paradigm would necessitate changes in the content of professional standards.

1. Self-Regulation: A Traditional Rationale with Contemporary Validity

Professional self-regulation is not an historical accident: the health care system adopted a professional paradigm in response to information asymmetries between patients and physicians, the necessity of honesty and trust in the treatment relationship, and the benefits of professional cooperation to patients and to medicine. More than a century ago, the United States Supreme Court implicitly acknowledged that regulation of the health care industry was required to compensate for market failures and that self-regulation was an appropriate means to accomplish the required oversight. More recently, the Court reiterated that self-regulation and professional standards are a necessary counterweight to economic incentives. The factors that contributed to the

178. Id.
179. See Kenneth Arrow, Uncertainty and the Welfare Economics of Medical Care, 53 AM. ECON. REV. 941, 950-60 (1963). This is a classic article in the field and has generated much discussion and controversy, perhaps most prominently from Paul Starr in his influential work, The Social Transformation of American Medicine, in which he argues that professionalism, itself, may cause market failure. This chicken-and-egg problem need not be resolved for present purposes. Here, I am not arguing for a return to the professional paradigm; I am merely pointing out that there are sound reasons for professionalism and self-regulation in a market paradigm.
180. In Dent v. West Virginia, 129 U.S. 114 (1889), the Court held that a state could fulfill its obligation to protect the public health by delegating licensure authority to members of the medical profession. Id. at 122 ("Reliance must be placed upon the assurance given by [a physician's] license, issued by an authority competent to judge in that respect, that [the physician] possesses the requisite qualifications.").
181. Pegram v. Herdrich, 530 U.S. 211, 218 (2000) ("The check on this incentive is a physician's obligation to exercise reasonable medical skill and judgment in the
adoption of a professional paradigm will continue to exist regardless of the
method of delivery or financing of health care services. Contemporary managed
care financial incentives heighten the need for professional restraints. A self-
regulatory system that influences physician conduct to compensate for
differences between medical care and other market commodities, therefore, is
socially beneficial even in a market-based model.

An information gap exists between physician and patient that is unlikely to
be addressed by regulatory intervention or availability of information in the
marketplace. The complexity of medical information and the rapidity at which
technology changes renders clinical medicine inaccessible for all but a small
percentage of potential patients. This observation is not intended to impugn the
intelligence of the vast majority of the population who is not clinically trained.
It is rather an acknowledgment of the natural tendency of individuals to invest
their time in pursuits other than acquiring medical information when they are in
good health and not in need of medical attention. When an individual is ill,
physical manifestations of illness and emotional issues distract her from a search
for the information that might create an informed medical consumer. Even
consumers who take advantage of newly available medical information from
web-based sources lack the clinical expertise to assess the accuracy of the
information and to make informed judgments about their treatment options.
Moreover, patients, including those who seek out information about their medical
conditions, may choose to rely on physicians and other clinically trained
caregivers to provide information, identify options, and recommend a course of
treatment.

Professor Carl Schneider’s work on how patients make medical decisions
during a time of serious illness demonstrates that a majority prefers to rely on
trusted physicians to provide information and make recommendations about
care.\footnote{182} Many patients do not wish to be consumers in a medical marketplace.
In the language of economics, a patient’s informed choice to rely on her
physician’s superior knowledge and medical judgment and to expend her
personal resources on other pursuits can be an efficient one. This option is a
viable one because of ethical standards that demand physician dedication to
patient interests.

Physicians’ acceptance of these ethical standards constitutes a moral
commitment to patients under their care.\footnote{183} This moral commitment facilitates

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\footnote{182} See generally CARL E. SCHNEIDER, THE PRACTICE OF AUTONOMY: PATIENTS,

\footnote{183} See Robert Cooter, Do Good Laws Make Good Citizens? An Economic
Analysis of Internalized Norms, 86 VA. L. REV. 1577, 1593 (2001) (noting that
internalizing a social norm is a moral commitment that leads to more trust in the morally
committed person).
patient trust. And, patient trust can serve as a replacement for the caveat-emptor mentality of the marketplace. 184

Trust serves therapeutic goals, as well as providing a partial substitute for fully informed consumer choice. 185 A patient’s trust in her physician aids in the process of diagnosis, because a patient is more inclined to be frank in her discussions with a trusted caregiver. Open discourse assists the physician in formulating treatment recommendations that are consistent with a patient’s lifestyle and values. 186 A patient’s ability to draw strength and comfort from a trusted caregiver enhances compliance with treatment recommendations and is a source of therapeutic benefit. 187

Trust is not the only alternative to a fully informed consumer choice. In a market model, an alternative to trust is monitoring. When consumers cannot trust sellers to offer high-quality goods and services, and they lack the information necessary to protect themselves from unscrupulous sellers, they engage monitors to ensure that supplier commitments are met. 188 When patients mistrust their

184. See Ezekiel J. Emanuel & Linda L. Emanuel, Preserving Community in Health Care, 22 J. HEALTH POL’Y & L. 147, 153 (1997) (“Because the physician is primarily dedicated to the patient’s well-being, the patient can be a trusting recipient of the physician’s care, rather than a wary consumer in the marketplace.”). If a physician fails to fulfill these obligations, patients have legal recourse on a variety of different theories. They also have the ability to report the physician to the state board of medicine.

185. The intra-professional trust that results from professional values of consultation and cooperation offer patient and societal benefits, as well. The ethical standard for professional cooperation serves individual patient’s medical interests by requiring consultation and referral to obtain professional assistance when a physician cannot meet a patient’s medical needs. The standards of cooperation and consultation also compensate for the limitations of market competition as a means to achieve social goals related to the creation and dissemination of scientific information. See infra notes 256-58 and accompanying text. Where market forces would foster competition for paying patients as a means to enhance financial well-being and require payment in exchange for sharing a valuable resource, professional standards require cooperation and consultation and condemn fee splitting and other economically motivated behavior. In this instance, the law supports the professional ethic by prohibiting the payment of referral fees. Tort law also encourages consultation when a physician might be incompetent to provide the care a patient requires.


188. In fact, if consumers trusted managed care organizations, they might be willing to rely on physician-managers to monitor treating physicians. It takes little more than reading the daily newspaper or popular news magazines to conclude that trust does not characterize that relationship. In a forthcoming article, Professor William M. Sage proposes incorporating medical professionalism into health insurance contracts as a means to capture the benefits of medical professionalism in a medical marketplace. See
physicians—whether because of the physician’s own suspect behavior or for reasons that are systemic to the health care industry—they could seek additional medical care to monitor their physicians’ conduct and recommendations. Monitoring, however, incurs additional costs. In a market model, consumer trust, which results from the ethical dictates of loyalty and service, compensates for an inherent imperfection caused by uninformed consumers, while avoiding the costs associated with ongoing monitoring.189

Individual patients are not alone in their reliance on physicians’ compliance with ethical dictates. The managed care system also depends on physicians to behave in ways that are not strictly in their economic self-interest. Managed care benefit designs were intended to capture financial motivation as a regulating device. Proponents saw financial motivation as a means to improve quality and distribution by eliminating services that were not medically beneficial and those that were not cost effective. But achieving those results requires more than a change in economic incentives. Physicians have to conduct themselves as careful, responsible clinicians. If physicians acted solely as market suppliers, their profits easily could be increased by avoiding ill patients altogether rather than by carefully monitoring the care provided to them. Physicians also could achieve financial gains by withholding treatment from patients who were not likely to notice or to complain, rather than by thoughtfully weighing potential medical benefit with the cost of achieving that benefit. Their clinical decisions could be based not on whether a treatment was medically necessary for a patient, but on whether providing that treatment was economically tolerable for the physician.

In market theory, managed care organizations could monitor to prevent these practices, but the industry already has acknowledged that extensive monitoring is not practical.190 Alternatively, informed consumers would eliminate these practices from the marketplace by switching doctors or managed care plans.191 But, the system also has exacerbated the difficulties of consumer


189. See Harris, supra note 130, at 360 & n.230.

190. See Lemov, supra note 81 (noting the decision by United HealthCare to eliminate utilization review because “micromanaging was not cost effective”).

191. In theory, costs associated with poor quality care, resulting either from withholding of payment for medical services or from cost constrained clinical decisions that result in harm to patients, would be borne by the managed care organization through greater costs incurred as a result of worsening medical conditions. The desire to avoid loss of business and higher health care costs later should lead managed care organizations to use only those cost-control mechanisms that are acceptable and avoid unreasonable risks of harm to consumers. The managed care revolution was based on this theoretical principle. It has not, however, proved accurate in practice. Data reveal that employers make frequent changes in their offerings of managed care organizations to their employees. In addition, dissatisfied enrollees are likely to change managed care
choice, by increasing the concentration of economic resources into the hands of relatively few payers and their large corporate customers, as well as patient ignorance, by shielding from public view the mechanisms used to control health care spending. Responsive markets depend on the ability of a dissatisfied consumer to shop for a new health plan or a new health care provider. The lack of competition for high-users of medical services, coupled with the limited consumer knowledge and the restrictions on the consumer's ability to act on that knowledge, however, renders the market remedy largely illusory. Thus, standards developed under the professional paradigm are a method of moderating the behavior of physicians in ways that compensate for the risks inherent in a medical marketplace.

2. Self-Regulation: The Evolution of Social Norms

Professional standards established through self-regulatory mechanisms form the social norms of medicine. Professional norms, like social norms generally, can explain professional conduct. For example, Professor Einer Elhauge traced the continuous development of new medical technology, as physicians strive to develop improved means to provide care that offers medical benefit without regard to cost, to the patient-primacy directive. Even in circumstances when the patient-primacy directive is not consonant with personal financial interests, physicians are expected to conform their behavior to the ethical precept. Group norms, and the law, condemn a physician who allows her...
financial interests to take precedence over her patient's medical needs.\textsuperscript{196} Because norms can be used to explain conduct, they also can be used to predict and to influence behavior in circumscribed conditions. Those who advocate a pure market model for health care, therefore, underrate two major sources of ordering professional conduct: internal and group enforcement of professional norms, including those that embody non-economic values.\textsuperscript{197}

Social norm scholarship is flourishing, yet scholars have not applied their insights to the medical profession. Because this section draws on those insights, the reasons for that apparent inattention warrant examination. One possible explanation for the lack of scholarly attention to professional standards as social norms is definitional. In the broadest sense, norms are expectations that govern behavior, which are enforced by private, rather than public, actors. Some scholars view decentralized norm formulation as an essential element defining social norms. Professor Eric Posner, for example, excludes from his analysis of social norms rules formulated and issued by private institutions. Accordingly, he would not consider standards formally promulgated by organized medicine as social norms.\textsuperscript{198} Professor Melvin Eisenberg takes a similar approach reasoning that “organizational rules” are similar to legal rules because they can be enforced by formal sanctions.\textsuperscript{199} Others disagree and include in their definition and analysis of social norms rules created by formal private legal systems in a centralized manner.\textsuperscript{200} Sociologists agree, viewing self-regulation as the means by which professionals commit to social norms of excellence and service.\textsuperscript{201}

\begin{itemize}
\item \textsuperscript{198} See Eric A. Posner, Law, Economics, and Inefficient Norms, 144 U. PA. L. REV. 1697, 1700 (1996). His definition would exclude professional norms adopted through a self-regulatory process, because they are formulated and conveyed by professional associations and government agencies dominated by physicians. Id.
\item \textsuperscript{199} See Melvin A. Eisenberg, Corporate Law and Social Norms, 99 COLUM. L. REV. 1253, 1255 (1999).
\item \textsuperscript{200} E.g., Lisa Bernstein, Merchant Law in a Merchant Court: Rethinking the Code's Search for Inmanent Business Norms, 144 U. PA. L. REV. 1765, 1767-71 (1996).
\item \textsuperscript{201} See FREIDSON, supra note 4, at 173-78.
\end{itemize}
Definitional exclusions are not the only reason that scholars have not devoted significant attention to professional self-regulation as a means of social control. Critics contend that professional standards are suspect because the physicians who promulgate them are motivated by self-interest.202 Social norm scholars may shun the study of professional norms because of suspicions about their formation or content. Neither definition nor motivation, however, is an adequate ground to eschew the insights of social norm theorists in considering the benefits of self-regulation and professional norms.

Professional standards are a hybrid of legal rules and social norms, exhibiting characteristics of each. The common characteristics of professional standards and social norms, however, are the ones most relevant to the present analysis. Social norms are created through group consensus without formal means of formulation or change. Professional norms are also built upon group consensus, but they are created through institutions based on formal mechanisms. The intentional formation of professional norms, while differentiating them from a narrow definition of social norms, also might make them more subject to external influence and intentional change to reflect new social demands. Like social norms generally, professional norms evolve over time in response to changes in the external environment. Professional norms, for example, have evolved in response to changes in the law. After the enactment of the Ethics in Patient Referral Act, which prohibited physician referrals to certain facilities with which the physician had a financial relationship, professional standards condemned such referrals, as well.203 They also have evolved to acknowledge the validity of cost considerations in clinical decision-making, although, to date, they have not evolved to address societal allocation decisions based on cost of care.204

Unlike social norms, however, some professional standards can be enforced formally through legal sanctions, as well as informally through praise and shame. The theoretical possibility of formal enforcement is largely irrelevant to the role that professional norms assume for the medical profession. The formal sanctions available to professional medical associations are limited in scope and effect to exclusion from membership. Because fewer than thirty-three percent of physicians belong to the largest medical organization, the AMA, it is reasonable to conclude that if physicians comply with ethical dictates it is more from a sense

203. Compare Ethics in Patient Referral Act, amended by 42 U.S.C. § 1395nn (1994) (prohibiting referrals to entities with which a physician has a financial relationship, with some exceptions), with AMA Principles of Med. Ethics, Conflicts of Interest: Health Facility Ownership by a Physician, Op. 8.032 (1994), in MEDICAL ETHICS, supra note 57, at 36 (“physicians should not refer patients to a health care facility which is outside their office practice . . . when they have an investment interest in that facility”).
204. See discussion supra notes 86-94 and accompanying text.
Disciplinary actions by state boards of medicine, likewise, affect few physicians. As Professor David Orentlicher explains, the principal activity of medical associations and state boards of medicine is standard setting, not enforcement. Moreover, professional standards serve a function analogous to other groups' social norms. They foster group consciousness and integration as a means to inculcate group values, and they impart a sense of obligation and responsibility that leads to internalization and compliance.

Self-interested motivation in the formation of professional norms does not provide a valid justification to ignore them as a determinant of physician conduct in a market-based system. This is not to say that economic incentives are irrelevant to the formation of professional norms, or to the behavior of economically rational physician actors. None of the alternatives for guiding physician conduct, however, is free of self-interested actors. The market paradigm depends on the actions of self-interested actors motivated to increase personal utility, generally defined in terms of wealth maximization. A legislative paradigm depends on the decisions made by elected officials who are influenced by special interest groups, including among them both organized medicine and the managed care industry. Yet society does not reject either the market or law as valid means to direct and constrain conduct. When the question is which institutional method, or what combination of institutions, to use to achieve a goal, the motives of individual actors are subsumed in the process of institutional decision-making and the character of the institution.

Professional norms are developed through processes of self-regulation. Self-regulation involves a collective engagement in developing, enacting, and enforcing professional standards, which are embodied in the rules of professional conduct or accepted clinical standards. Engaging in the process of self-regulation fosters moral decision-making. Moral decision-making, in turn, enables the decision-maker to resist demands to deviate from accepted group norms. In

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208. See Herbert Swick, Academic Medicine Must Deal with the Clash of Business and Professional Values, 73 ACAD. MED. 751, 751-53 (1998) (arguing the importance of professional values to health care delivery).
209. For a discussion of the role of motive in a comparative institutional analysis, see KOMESAR, supra note 117, at 58-65.
210. A profession or other shared enterprise has at least three reasons voluntarily to engage in self-regulation: self-protection, avoidance of government regulation, and development of shared social norms.
211. Cf. Wilkins, supra note 169, at 852 (1992) (recounting commentators')
other contexts, social norm scholars have demonstrated that discussion among members of a group increases group identity and raises the level of cooperative behavior by as much as eighty-five percent. Similar results can be observed in medicine. In organ transplantation, shared clinical measures are used to dictate a patient's position on the list that establishes the priority to receive an organ. Transplant surgeons have both economic and personal motives to favor their own patients: economic motives because when a transplant is performed, the transplant surgeon receives a fee; personal motives because of the long-term relationship between patient and physician that is usually fostered during a serious illness of this type. Despite personal motivations to the contrary, transplant surgeons are expected to report accurately on their patients' status as measured against the agreed-upon criteria, and to resist the temptation to misstate a patient's medical condition to secure a preferred position. And, as a general rule, they do so. This example also demonstrates the application of two other principles of social norm theory. Once formed, group norms substitute for independent evaluations of each choice with which a group member is confronted. Internalization of professional standards facilitates decision-making when decisions cannot be mechanized because of their complexity, the requirement to exercise judgment, and, in the organ transplant example, the potential for disagreement about the relative weight of various factors. Self-regulation in medicine, therefore, can lead to cooperative behavior, resistance to demands contrary to accepted standards, and consistent decisions in complex situations.

The degree to which these results are achieved will depend upon physician internalization of professional norms. The concept of internally enforced norms posits that actors follow social norms that are inconsistent with wealth-seeking/cost-avoiding incentives because they internalize the social norms of their communities. Scholars believe that internalization of professional standards occurs if the individuals to whom the standards apply are socialized through professional education to embrace professional norms; if they are active

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213. This example is based on my personal experience as counsel for a statewide organ procurement organization. For at least five years, I attended every board meeting at which these matters were discussed. During this period, only two instances of false reporting were uncovered. The other transplant surgeons dealt swiftly and harshly with each.


participants in a strong professional culture, subject to peer pressure to encourage compliance; and if they receive relatively high status and reward from their membership in the profession. Physicians satisfy each condition. Individual physicians, beginning in their medical education and throughout their professional lives, are socialized to internalize professional standards and values. Peer review is the preferred method of physician oversight in the institutions in which physicians practice and is also encouraged and relied upon by the federal government. Moreover, medicine is generally rated as one of the highest status occupations in public surveys. Thus, physicians may be expected to internalize professional norms established through self-regulation in much the same way that members of other closely-knit communities embrace the social norms that define acceptable and unacceptable behavior in their communities. When professional standards are internalized, physicians may be predicted to take pride in fulfilling them, and to suffer guilt and shame at falling short of them, creating an internal enforcement mechanism for professional norms.

The medical community serves as an external enforcer of professional norms through rewards of professional esteem and enhanced reputation and punishment through professional condemnation. Professional esteem and reputation are powerful determinants in medicine. Physicians as a group are keenly concerned about the place of the medical profession in the societal hierarchy. The individual counterpart of that group concern is intra-professional standing determined by peer evaluation. In economic terms, individual compliance with professional standards provides a non-monetary subsidy in the form of positive esteem that exceeds the cost of the foregone

216. See id. at 1242.

217. See, e.g., Robert L. Cruess & Sylvia R. Cruess, Teaching Medicine as Profession in the Service of Healing, 72 ACAD. MED. 941, 949-50 (1997) (arguing that the objective of medical education is to ensure that all physicians understand professionalism and accept its obligations).


219. Physicians generally enjoy an above-average income, enabling them to resist self-interested economic influences more readily than those who are significantly less affluent. Cf. Mansbridge, supra note 212, at 255-60 (discussing the "luxury" theory of altruism).

220. See Orentlicher, supra note 206, at 538.

221. See Eiliot Freidson, Profession of Medicine: A Study of the Sociology of Applied Knowledge 5 (1988) ("If we consider the profession of medicine today, it is clear that its major characteristic is preeminence," with respect to prestige, as well as expertise.).
financial incentive, while noncompliance imposes a non-monetary tax through loss of esteem. Social norms have been cited by scholars to explain a wide-range of individual conduct, from why individuals voluntarily contribute to public radio, to why they refrain from littering or return items to lost-and-found. Given the importance of professional esteem to physicians and the benefits that flow from enhanced professional reputation, professional norms should have a powerful effect on physician behavior. Although there is little empirical evidence to test this hypothesis, commonly observed behavior when physicians act contrary to a wealth-maximizing model suggests that it is an accurate prediction.

If professional esteem and self-regard did not compensate for financial reward, one would predict that physicians in a marketplace that financially rewards providing fewer services would seek out healthy patients who do not require medical intervention. Physicians also would seek the highest paying positions and would not put themselves in harm’s way without (and perhaps even with) significant economic reward. Professional standards, however, impose a rule of rescue, and the professional community provides recognition and psychic rewards to the professional who undertakes the complex task of caring for patients with difficult conditions or who fail to respond to traditional therapies.

That physicians seek positions with teaching institutions and multi-specialty


224. Scholars have shown that social norms are at their most powerful when participants engage in repeated, readily observable interactions and have similar values and interests. See ROBERT C. ELLICKSON, ORDER WITHOUT LAW: HOW NEIGHBORS SETTLE DISPUTES 156-66 (1991). While physicians share similar values, they engage in a wide-variety of complex tasks; however, the practice of peer review makes those transactions observable to a subset of other physicians.

225. Some empirical work has been done with corporate actors and individual executives. The results indicate that loss of reputation and adverse publicity are powerful deterrents. For a discussion, see BRENT FISSE & JOHN BRAITHWAITE, THE IMPACT OF PUBLICITY ON CORPORATE OFFENDERS (1983). Professor Robert Cooter notes in a recent article that another group of professionals, lawyers, act contrary to wealth maximization in abandoning lucrative private practices for the bench. See Robert Cooter, Do Good Laws Make Good Citizens? An Economic Analysis of Internalized Norms, 86 VA. L. REV. 1577, 1578 (2000).

226. This is much like insurers behave in seeking to avoid high-risk patients. Certainly, some physicians do behave in this manner, just as some physicians were motivated by the incentives inherent in fee-for-service medicine to provide medical services that provided no medical benefit. Norm compliance, like legal compliance, will always be less than one hundred percent.

227. See FREIDSON, supra note 4, at 176-78.
group practices, like the Mayo Clinic, which offer lower compensation than other occupational choices, is evidence that professional prestige matters. That physicians donate their time, even without any compensation, to treat certain “difficult” and therefore “interesting” cases provides further evidence. And it would be difficult to conceive of an economic incentive large enough to motivate a physician to confront a ward full of patients suffering from the Ebola virus or other highly contagious diseases; yet many have done and continue to do so. Professional norms of service and altruism can be used to explain why physicians render some medical services without expectation of payment, why physicians render medical services to strangers in emergency situations, and why physicians are willing to expose themselves to infectious agents in the care of their patients. None of these observed behaviors can be attributed to a desire to maximize personal wealth, and some are counter to that goal.

Social norm theorists have shown that individuals will ignore or attempt to circumvent efforts to influence their conduct when they consider those efforts illegitimate or philosophically inconsistent with their beliefs and values. Behavior consistent with this prediction can be observed in medicine. Economic

228. See Paul Roberts, Profile of Mayo Clinic, NAT'L POST, Apr. 1, 1999, at C12 (noting that Mayo physicians are salaried).

229. After the Oklahoma City bombing, for example, a New York dermatologist who was an expert in the surgical use of lasers to remove powder burn scars donated his services to treat bombing victims. See Karen Klinka, New York Expert Joins City Doctor To Fix Bomb Scars, DAILY OKLAHOMAN, Oct. 9, 1995, at A1.

230. For an anecdotal account of one medical student’s introduction to the expectations of a physician in an emergency situation, see MELVIN KONNER, BECOMING A DOCTOR: A JOURNEY OF INITIATION IN MEDICAL SCHOOL (1987) (author describes being chastised by his physician-preceptor for his failure to identify himself as a second-year medical student in response to an airline pilot’s inquiry whether there was a doctor on board). If you question the power of this ethical dictate, observe the number of call buttons that are pushed the next time you travel by airplane and the pilot asks physicians on board to identify themselves. I saw many examples of the internalization of the professional ethic to render medical services in an emergency in my own legal practice representing physicians. One of the more poignant occurred in an airport terminal where I was seated next to my physician-client who appeared to be asleep after a particularly long day. When an announcement was made seeking a physician who spoke Spanish to respond to a medical emergency, I watched my physician client, whom I had not known spoke Spanish, awake instantly and hurry across the crowded terminal to the designated spot. I observed several other people making the same trek. A quick discussion of specialties yielded the identification of the most appropriate caregiver.

231. Not every physician is moved to respond to these professional norms in every instance, but enough physicians are in a sufficient number of instances to suggest the overall successful inculcation of the expectations that arise from these shared professional norms.

incentives to limit care are contrary to prevailing norms with the predictable result of obstructionist conduct. Recent survey data suggest that a sizeable minority of physicians collude with their patients to obtain reimbursement from third-party payers by exaggerating the severity of a patient’s condition, reporting signs or symptoms that the patient did not exhibit, or misstating a patient’s diagnosis. Physicians who admit to engaging in such conduct justify their conduct on the ground that the patient-primacy directive demands it. Although the validity of that justification is highly doubtful and the economic incentives for the conduct should not be overlooked, these findings indicate a need for both norm change and attention to means of securing compliance with society’s efforts to control health care spending.

The argument that professional standards function as social norms for medicine is a pragmatic one. I do not maintain that all existing professional standards are socially efficient. Nor must I prove that professional standards do not externalize costs. The point is merely that professional standards do, and should be expected to, influence physician behavior. Regulatory systems that run counter to strongly held values should anticipate evasive, manipulative conduct as actors attempt to get around the system. Self-regulation, therefore,

233. See Mathew K. Wynia et al., Physician Manipulation of Reimbursement Rules for Patients: Between a Rock and a Hard Place, 283 JAMA 1858, 1861 (2000). Such reasoning ignores that this practice harms the population of patients covered by a particular payer by reducing the funds that are available to care for the group. It also ignores that such conduct is likely unlawful if it leads to the submission of false claims for payment from third-party payers. Finally, surreptitious conduct is likely to disguise any possible flaws in coverage policy or design that might be brought to light if coverage denials were confronted on the merits.

234. See Posner, supra note 198, at 1706 (discussing an argument that people in closely-knit communities have an incentive to choose norms that maximize joint welfare). Physicians, like members of closely-knit groups generally, have an incentive to adopt professional standards that maximize their joint welfare. For example, by adopting the patient-primacy rule, physicians maximized their personal income as long as patients were able to pay for their services whether through insurance or personal financial resources. They also gained status within society by portraying the profession as altruistic and other-serving.

235. See Posner, supra note 198, at 1723. Physicians, again like other communities, have an incentive to adopt professional standards that externalize costs. Thus, they have to date formally rejected responsibility for allocating scarce resources. The rejection of that task is efficient for the group because it shields them from the loss of public esteem that has accompanied those who attempt to allocate health care resources. Nonetheless, that professional standard is not desirable for society as a whole, because attempts at allocation will fail without physician cooperation.

236. That some physicians fail to follow ethical precepts is no more a reason for rejecting professional self-regulation than is the observation that some individuals fail to comply with the law a reason for rejecting legal regulation.

237. See FREIDSON, supra note 221, at 442 (referring to empirical studies showing that individuals do not passively obey systems to which they feel no loyalty).
must figure into a system of control when cooperative physician behavior is essential to achieving a social goal. Until the centrality of social norms is recognized, the complex task of influencing professional standards to be responsive to social needs cannot begin. The task of those who would use professional standards to initiate a professional response to societal desires to control health care spending is to determine how to influence norm change, a topic to which I turn in Part VI.

3. Self-Regulation: Comparative Institutional Advantages

Examining the physician behavior that will be required to address health care spending further illuminates why self-regulation as a system of oversight is well positioned to respond to the need to control health care spending by controlling the use of health care services. Health care spending control, based on limiting use of health care services, depends upon a series of seemingly minor clinical decisions: a decision not to order a particular diagnostic procedure, to engage in watchful waiting before initiating treatment, to withhold a treatment that promises a small benefit in comparison to its cost, or to perform the least costly of alternative treatments. Physicians must be empowered and, on occasion, encouraged to say “no” to the demands of their patient-customers in order to avoid self-prescription of wasteful, inappropriate, or harmful tests, treatments, or medications. The cumulative effect of minor acts of medical irresponsibility will result in major expenditure on health care.

Such cost-conscious clinical decisions will be a necessary but not a sufficient method of addressing health care spending. They respond to the desire to contain costs based on current information, but do not offer insights into allocative or social efficiencies. Sound allocation decisions will depend upon the development of scientific knowledge about how best to use health care resources to minimize financial waste and maximize medical benefit. Many current medical practices lack sound scientific justification, because medical science is imprecise. Diagnostic and treatment decisions are based on probabilities, rather

238. For purposes of this discussion, I refer to clinically responsible methods to limit health care spending, rather than methods that rely on the path of least resistance. See discussion supra notes 81-83 and accompanying text (cost can be controlled by limiting treatment in cases in which patients are not likely to discover that beneficial care was withheld or are not likely to protest).

239. See HALL, supra note 15, at 117-19 (discussing the nature of bedside rationing as Hall envisions it).

240. For purposes of this section, I assume that professional standards can be influenced to acknowledge that cost control is a desirable end in which physicians should participate. See infra text accompanying notes 297-301 (discussing how that might occur).

241. See KOMESAR, supra note 117, at 5-6 (identifying the “correct question” as which of the imperfect alternatives is better or worse at achieving a goal).
than absolutes. Ongoing research and dissemination of scientific information will be required to improve medical decision-making in a continual effort to eliminate financial waste and to identify best medical practices.

The inquiry for comparative institutional analysis, then, is which institution is most likely to lead to the behavior that results in achieving the social goal. Here, achieving cost control requires, in the short term, a myriad of small clinical decisions made in the course of treating individual patients and, in the long term, a commitment to acquiring and sharing new knowledge. Self-regulation offers two advantages over other control mechanisms as a means to facilitate cost-conscious clinical behavior. First, self-regulation is most likely to lead to voluntary compliance. Second, professional standards are more likely than market forces to facilitate the generation and sharing of new medical knowledge. Even in a regulated medical marketplace, therefore, self-regulation and professional norms can influence physician conduct in ways that affect cost-control efforts.

Voluntary compliance is essential when behavioral deviations cannot be detected by market participants or through regulatory oversight. The clinical decision-making process is largely shielded from public view. Managed care organizations have conceded that physician-managers' oversight of each of the many clinical decisions made by treating physicians in the ordinary course of medical practice is not feasible. Patients lack financial incentives to exercise their buying power to control clinical conduct; more to the point in this context, they lack the specialized knowledge necessary to make the multiplicity of decisions associated with medical care.

242. This lack of scientific evidence to support many medical practices has been offered as an argument for the use of physician-managers and third-party payers to oversee treating physicians. This argument proves too much. That medicine is at least as much art as science says nothing about whether the better decisionmaker is the treating physician or a third party. There is no reason to believe that a profit-seeking organization is a better decisionmaker than a profit-seeking caregiver. The use of financial incentives to reward cost-conscious decision-making has addressed the profit-seeking caregiver problem.

243. See KOMESAR, supra note 117, at 5-6 (identifying the "correct question" as which of the imperfect alternatives is better or worse at achieving a goal).

244. Voluntary compliance is also important when the system relies more on preventing than punishing wrongful conduct. See PRIEST, supra note 160, at 265 (arguing that cooperation is preferred when preventing harm is more important than punishing wrongdoing after harm has occurred).

245. While minor acts of noncompliant behavior are likely to escape notice, gross or repeated errors in medical judgment or intentional harmful acts are likely to come to the attention of regulators through patient or peer reports and through the tort system.

246. See supra note 74. Attempts to impose excessive controls are also likely to generate antipathy on the part of treating physicians, and feelings of antipathy will undermine cooperative compliance. Use of controls, therefore, would be efficient only if the controls would detect and countermand more acts of noncompliance than would result from voluntary compliance.
choices that are required to achieve health care spending control. Market mechanisms, therefore, are ill suited to ensuring that cost-conscious clinical decision-making will occur on a regular, ongoing basis, because they cannot effectively direct compliant behavior or detect non-compliant behavior.

Rule-based command-and-control systems are also likely to fail. Formulating rules for medical conduct is undesirable because they could obscure the need for physicians to respond creatively and flexibly to the particularized clinical and personal needs of individual patients. Moreover, the complexity of factors that affect medical judgment cannot be specified categorically, which makes the promulgation of rules infeasible. In addition, rule-based systems, which tend to rely on inspections, would be unlikely to uncover violations even if rules could be formulated. Scholars long have recognized that tasks, which require technical expertise and do not lend themselves to standardization, must be organized in a way that motivates individual responsibility. Cost-conscious clinical decision-making involves just such tasks.

Physicians are also more likely to respect and respond to the judgment of their professional peers than to the dictates of persons or entities that do not possess clinical expertise; self-regulation in medicine, relies on professional peer review and professional standards. Systems that rely on actors who are not highly regarded, in contrast, are more likely to generate apathy or antipathy, each of which undermines cooperative behavior. Because voluntary cooperation offers the most effective means to combat minor acts of irresponsibility that would go undetected in the marketplace and by command-and-control type regulation, a self-regulation system, which promotes voluntary compliance and responsible behavior, is preferable to both.

247. See Freidson, supra note 221, at 435 (arguing that a bureaucratic model, which is based on rules and regularized processes, forfeits professional discretion and objectifies patients).

248. In addition, reliance on rule-based systems would require rule makers who possess technical expertise and medical knowledge.

249. See Priest, supra note 160, at 265 (arguing that cooperative implementation has the greatest potential when inspections will not detect violations).

250. See Freidson, supra note 221, at 435, 461 (discussing progressive-functionalist views); see also William H. Simon, Ethics, Professionalism and Meaningful Work, 26 Hofstra L. Rev. 445, 460 (1997) (discussing the organization of work of professionals and self-regulation by lawyers).

251. See Hall, supra note 31, at 536 (noting that physicians are resistant to lay influence). Methods that result in apathy, like those that result in antipathy, are likely to undermine cooperative compliance.

252. See David Orentlicher, The Role of Self Regulation, in Regulation of Healthcare Professions 129 (Timothy S. Jost ed., 1997) (noting that physicians are more likely to comply with standards formulated by their professional peers).

253. See id.
Self-regulation is also more likely to promote the generation and sharing of new knowledge that is necessary if the health care system is to focus on cost-effectiveness, as well as cost containment. The market has contributed to the possibility of medical outcomes research through well-designed utilization management systems that permit the collection and analysis of large amounts of data to identify medical best practices and to eliminate ineffective treatments. Marketplace competitors, however, are not committed to developing knowledge that does not offer a competitive advantage or sharing knowledge that could provide them an economic edge. In contrast, traditional professional norms encourage the development and sharing of medical information that has the potential to enhance the scientific basis for medical treatment and for resource allocation. The professional norm of cooperation, therefore, serves the public good by requiring prompt dissemination of new scientific information, including information that can be used to eliminate wasteful medical treatments and to identify treatments that yield medical results comparable to the alternatives at less cost. As outcomes research becomes available to inform a wider range of health care allocation decisions, the rapid regulatory responsiveness offered by self-regulatory systems will foster both good medicine and sound social policy.

4. Self-Regulation and a Problem the Law Created

Self-regulation also might offer an opportunity to address partially an instance of questionable social policy. Federal law has provided a perverse argument in favor of self-regulation in the context of health care spending controls initiated by physician-managers. The Employee Retirement Income Security Act of 1974 ("ERISA") broadly preempts state laws that relate to private-employer sponsored benefit plans and substitutes a narrow-range of ERISA causes of action and remedies. State law challenges to the coverage decisions of managed care organizations have been preempted, without regard to whether those decisions concerned simple contract interpretation or reflected a physician-manager's medical judgment about the necessity of treatment for an individual patient.


255. See David Blumenthal, The Vital Role of Professionalism in Health Care Reform, 13 HEALTH AFFAIRS 252, 253-56 (1994) (identifying the values of professionalism as altruism, commitment to self-improvement, and peer review).

256. Cf. Michael, supra note 169, at 184 (noting that the expertise of self-regulators gives them the ability to modify rules in response to change more rapidly than government agencies).


258. ERISA does not preempt state law challenges to the conduct of physicians.
Despite the generally broad preemption of state laws, however, some recent court decisions have suggested that traditional areas of state regulation, like physician licensure and discipline, might not fall within the scope of ERISA preemption. At least two courts have held that a managed care medical director making medical necessity decisions is subject to the jurisdiction of his peers on the state board of medicine.\(^{259}\) The United States Court of Appeals for the Fifth Circuit has noted, in dicta, that while “ERISA preempts malpractice suits against doctors making coverage decisions... it does not insulate physicians from accountability to their state licensing agency or association charged to enforce professional standards regarding medical decisions.”\(^{122}\) Accordingly, if congressional intent to preempt state-mandated self-regulation is not established, physician-managers will be subject to the same licensure and disciplinary standards as their physician peers in more traditional roles. This would enable the states to oversee the clinical decisions of physician-managers who are otherwise immune from challenge under state law, including medical malpractice law.\(^{261}\)

In a related development, the United States Supreme Court has suggested that medical necessity decisions might have more in common with clinical decisions than with ERISA plan administration. In *Pegram v. Herdrich*,\(^{262}\) the Court acknowledged a distinction between clinically based coverage determinations and routine benefit determinations in managed care plans.\(^{263}\) The Court stated “[p]ure ‘eligibility decisions’ are those made to determine whether a managed care organization covers ‘a particular condition or medical procedure providing treatment to patients, even if those patients are enrollees in an ERISA plan. If, for example, an incentivized physician harms a patient by limiting care, she can be held liable for medical malpractice.

259. Murphy v. Bd. of Med. Exam’rs of Ariz., 949 P.2d 530, 538 (Ariz. Ct. App. 1997); State Bd. of Registration for the Healing Arts v. Fallon, No. SC 82841, 2001 WL 348980 (Mo. Apr. 10, 2001) (holding that ERISA does not preempt state law regulating the medical profession and physician’s medical necessity decision is subject to oversight by the Board); see also discussion infra notes 271-80 and accompanying text.

260. Corporate Health Ins., Inc. v. Tex. Dep’t of Ins., 215 F.3d 526, 534-35 (5th Cir. 2000).

261. State law redress would be limited to licensure and discipline under the state medical practice act. It would not provide a remedy to individual patients who suffer harm as a result of a medical necessity decision.

262. 530 U.S. 211 (2000).

263. Not every coverage decision made by a physician-manager involves clinical judgment. For example, a physician-manager might interpret the terms of the managed care contract to determine whether a prescribed treatment is covered. In addition, a physician-manager will make not every clinically based coverage decision. Managed care organizations frequently delegate the responsibility for utilization management to incentivized physicians when they bear the financial risk for treatment they do not provide.
for its treatment." The Court then acknowledged a newly created category consisting of "mixed eligibility and treatment decisions" intended to determine the "when-and-how" of coverage and treatment. The Court analogized these mixed decisions to "the sorts of decisions made by licensed medical practitioners millions of time every day." Pegram, however, held only that mixed eligibility/treatment decisions do not implicate fiduciary duties under ERISA. The opinion leaves for another day the question whether state law challenges to mixed eligibility/treatment determinations will be treated different from pure eligibility determinations for purposes of ERISA preemption. If mixed eligibility/treatment decisions are analogized to treatment decisions, rather than benefit determinations, they may be subject to state malpractice law, an area of "traditional state regulation" in health care.

The result that physician-managers will be subject to state law when they are exercising medical judgment in ways that affect the treatment of individual patients is intuitively appealing. Nonetheless, the prospect of holding physician-managers answerable to their professional peers presents starkly some of the risks of self-regulation. Those risks became reality in the single reported case in which a state board of medicine exercised jurisdiction of a physician-manager.

C. A Case Study in the Perils of Professional Self-Regulation

The principal criticisms of professional self-regulation center on the discrepancy between its promise and its performance. Proponents of self-regulation point to its ability to form and communicate values, to reflect current knowledge, and to foster voluntary compliance. Opponents of professional self-regulation argue that the values it introduces may represent a narrow or parochial view of the community the profession is designed to serve: in this context limiting its view to the individual and failing to embrace obligations to the community. Furthermore, critics maintain that professional standards are too often a guise for self-protection and that enforcement of standards aimed at patient protection is lax. As the case discussed below reveals, subjecting

264. Pegram, 530 U.S. at 228. The Court distinguished "treatment decisions" made by physicians to determine the "appropriate medical response" in the light of a patient's "constellation of symptoms." Id.
265. Id. at 229.
266. Id. at 232.
physicians who are engaged in disfavored activities to the oversight of their peers also creates the possibility of selective enforcement, bias, and double standards.

On December 28, 1992, Dr. John Murphy, the medical director of Blue Cross Blue Shield of Arizona ("BCBSA"), was asked to pre-authorize payment for a laparoscopic cholecystectomy (surgery to remove the gallbladder). The patient, identified only as "S.B.", was a forty-six-year-old woman who received health care coverage through BCBSA. Surgery had been recommended by her treating physician, Dr. Richard Jonas, and the consultant surgeon, Dr. David Johnson, to whom Dr. Jonas had referred S.B. On December 29, Dr. Murphy refused to pre-authorize payment for the recommended surgery on the ground that it was not medically necessary. He based his decision on his interpretation of the findings of an ultrasound study, which did not reveal the presence of gallstones, other clinical test results, and on the patient's past history of similar complaints. He also spoke with the patient's treating physicians. Dr. Murphy attributed S.B.'s condition to "irritable colon syndrome," a condition that does not call for removal of the gallbladder.

This was not a case of a physician-manager who lacked training or experience. Dr. Murphy appeared to be qualified to make a medical necessity decision concerning a patient with S.B.'s symptoms. He was employed and licensed as a physician in Arizona, the patient's home state; he, therefore, possessed the minimum indicia of competency required by the State of Arizona to practice medicine. Moreover, he was a gastroenterologist, the kind of sub-specialist who routinely treated problems like S.B.'s. Before making his decision, he consulted with the physician who had recommended and would be performing the surgery. Accordingly, Dr. Murphy possessed the same qualifications that would have been required for him to treat the patient, although his training would not extend to performing the surgery. Reflecting traditional medical values in making his decision about the surgical procedure, he consulted with a physician with appropriate training and expertise.

270. Id. at 533.
271. Because managed care organizations take the position that utilization-management decisions are not the practice of medicine, physician-employees are generally not required to be licensed in the state where the patient-enrollee resides. A physician located in Connecticut, for example, might make a medical necessity decision about the care of a patient residing in New Mexico.
272. Private accrediting agencies recommend that physician-reviewers be in the same or similar specialty that typically treats the condition at issue. National Committee for Quality Assurance, Standards for Accreditation of Managed Care Organizations, Standard UM 3.3 (1999) ("managed care organization has procedures for using board-certified physicians from appropriate specialty areas to assist in making determinations of medical appropriateness").
273. Contrast the facts of this case with those of Pappas v. Asbel, 724 A.2d 889.
Despite Dr. Murphy's decision not to pre-authorize payment for the surgery, the patient decided to undergo the surgery. The post-operative pathology reports revealed that the surgery was warranted by the patient's medical condition. Based on the surgical reports, BCBSA paid for the surgery, despite its previous decision not to pre-authorize payment. As a result of her decision to proceed with the surgery despite the medical necessity decision and BCBSA's subsequent payment decision, S.B. suffered no medical or financial harm from Dr. Murphy's original, and seemingly erroneous, medical necessity decision.

Dr. Johnson, nonetheless, reported Dr. Murphy to the Arizona Board of Medical Examiners for medical incompetence and unprofessional conduct. Dr. Johnson contended that Dr. Murphy's medical necessity decision caused S.B. to question Dr. Johnson's judgment, and, thereby, interfered with and compromised his relationship with the patient and "required the patient to 'gamble' with her own money." In its discussion of the charge against Dr. Murphy, members of the state medical board characterized the case as "the most important case in our book" and suggested that the board should "do it up big" and "invite the press." The state board eventually issued an "advisory letter of concern," a mild non-disciplinary action that did not affect Dr. Murphy's license or good standing. The board justified the sanction on the ground that Dr. Murphy had made an "inappropriate medical decision which [sic] could have caused harm to a patient."
This case highlights many of the problems with professional self-regulation as practiced, some more apparent than others. Note first how the case came to the attention of the state board of medicine; another physician reported Dr. Murphy. State boards of medicine rarely have sufficient funding to support an ongoing policing function. Therefore, they rely on reporting by third parties, usually patients, payers, or other physicians. Conventional wisdom is that physicians are reluctant to report their peers. Here, the opposite occurred. Dr. Johnson reported Dr. Murphy although Dr. Murphy possessed appropriate qualifications, followed customary procedures, and no harm came to the patient as a result of his decision. If underreporting characterizes self-regulation generally, this case suggests that that reluctance will dissipate when the subject of disciplinary action is engaged in disfavored activities.

Selective reporting in this case was followed by selective and seemingly biased enforcement. The standards used to evaluate Dr. Murphy’s conduct were unclear; he was charged with unprofessional conduct and medical incompetence. The only conduct evinced by Dr. Murphy was his disagreement with the treating examiners had jurisdiction to review Dr. Murphy’s medical necessity decision, characterizing it as a “medical decision.” Murphy v. Bd. of Med. Exam’rs of Ariz., 949 P.2d 530, 536 (Ariz. Ct. App. 1997).

279. See AMERINGER, supra note 39, at 69-71 (noting the traditional problems with funding and improved funding in recent years).

280. Patients might fail to detect physician misconduct, because they lack the technical expertise. Patients who are harmed by a decision not to recommend a course of treatment, for example, may not realize that a cost-based clinical decision was made. Furthermore, patients are unlikely to report problems where physician conduct aided them at the expense of others, including decisions to over-treat or to make misstatements in order to obtain reimbursement. Even if patients were to detect misconduct, they lack incentives to report physicians to state boards of medicine, because state boards cannot provide compensation for harm. To the extent that disciplinary authorities rely on patient reporting, then, the self-regulatory system suffers from the same shortcomings as the market: uninformed consumers who cannot predict what services should have been provided or evaluate the quality of the services actually rendered.

281. Payers might be more inclined to report physician misconduct than patients. They are also more likely to detect misconduct as a result of their ability to collect and analyze data across large numbers of physicians and patients. It is possible, however, that managed care organizations, which contract with physicians to provide services to their enrollees, might prefer to simply terminate or not renew the physician’s contract, rather than undergo the time and expense of a board proceeding. Even if payers elect to report, professional boards are likely to be hostile to managed care organizations and are unlikely to respond to their complaints, especially when those complaints allege overtreatment of patients.

physicians. But disagreement among physicians about the proper course of medical treatment is common, although it typically occurs in the course of the much-encouraged professional consultation.\textsuperscript{283} The only evidence of medical incompetence before the board was a single instance of an error in medical judgment.\textsuperscript{284} Disciplinary action is rarely based on a single medical error of judgment. It is unlikely, therefore, that the board would have taken any action against a treating physician who had erroneously decided that surgery was not required.\textsuperscript{285} The differential treatment suggests that either existing standards for discipline of practicing physicians are too low, or that the inexact nature of existing standards lend themselves to manipulation based on favor or disfavor. The mild sanction imposed by the board suggests that if the case were, as the board contended, the "most important" among those under its consideration, that importance arose from something other than the seriousness of the error. The conclusion that \textit{Murphy} was one of selective and biased enforcement intended to chill unpopular market innovation by enforcement actions against the physicians who participate in that activity is difficult to avoid.

This case indicates that professional self-regulation is another in a series of flawed alternatives to address intractable problems in health care. It, like market mechanisms and command-and-control legislation, has its shortcomings, and also like them, it has its benefits. Those that reject self-regulation altogether on the basis of its imperfections, are engaged in a type of wishful utopian thinking, searching for a perfect regulatory alternative that is always just beyond reach and ignoring a present-day opportunity to address existing problems.

\textsuperscript{283} See Roberts, \textit{supra} note 228, at C12 (describing medical practice at Mayo Clinic noting that "the battle against cancer begins with an argument" among physicians about appropriate treatment).

\textsuperscript{284} See \textit{Murphy v. Bd. of Med. Exam'rs of Ariz.}, 949 P.2d 530, 533 (Ariz. Ct. App. 1997). The board's request for documents from BCBSA concerning twenty cases in which Dr. Murphy denied pre-certification for payment were not produced. \textit{Id.}

\textsuperscript{285} Lax enforcement is a common criticism of self-regulation. Commentators have estimated that five to fifteen percent of practicing physicians lack competence. \textit{See} Ross D. Silverman, Book Review Essay, 21 J. LEGAL MED. 143, 144 & n.2 (2000) (reviewing \textit{AMERINGER}, \textit{supra} note 39). Yet, disciplinary actions are taken against substantially fewer physicians. In 1998, the Federation of State Medical Boards data bank reported a total of 4,520 disciplinary actions against 673,781 physicians practicing in the United States, Guam, the Virgin Islands, and Puerto Rico. Federation of State Medical Boards, \textit{FSMB Facts}, available at http://www.fsmb.org (last visited July 28, 2000). Although the Federation contends that these data present an incomplete picture of the performance of the states' regulatory systems, little else is available.
VI. NEXT STEPS

Society has signaled a legitimate need for physician cooperation with and participation in health care spending control. Although physicians cannot decide for society how much of its resources to spend on health care or which medical uses are more deserving of resources, society cannot begin to allocate health care resources without the profession’s recognition of its professional responsibility as a steward for society’s funds. In current practice, treating physicians and physician-managers facilitate the allocation of health care resources by making cost-conscious clinical decisions about individual patients. Because of the medical and technological advances that the medical profession has achieved, health care spending control will be inevitable regardless of the present-day or future mechanisms devised to deliver and finance health care services. Health care spending controls will require physician cooperation. And, meaningful physician participation will be facilitated by a self-regulatory system and professional norms that require physician cooperation with social goals to control health care spending.

Those who have examined self-regulation in the past have expressed justifiable disappointment with the results. The power to self regulate was conferred by the state on the medical profession in exchange for its commitment to select its members well, ensure their clinical competence, and serve the public interest. The current regulatory framework has failed to provide guidance and direction to physicians to address the complexities of a managed care system of delivery or the societal need to control health care spending. Its standards have not been re-examined in light of changes in physicians’ roles in the medical marketplace. Moreover, it has failed to address those circumstances in which self-interest and ethics are at greatest divergence and the power of self-interest most powerful, where behavior is most likely to fall short of ethical ideals and the authority to direct with specificity and to sanction might be most usefully employed.

286. See David B. Wilkins, Redefining the “Professional” in Professional Ethics: An Interdisciplinary Approach to Teaching Professionalism, 58 LAW & CONTEMP. PROBS. 241, 249 (1995) (noting that professional ethics must be designed to serve specific societal needs).


288. See supra note 11; see also Frank Welsh, Self-Regulation: The True Key to Success of Physician-Directed Networks, 23 J. HEALTH CARE FIN. 1, 3 (1996) (noting disappointing results of studies from the 1980s and more favorable results from recent physician-led efforts to influence clinical behavior).

289. See AMERINGER, supra note 39, at 25-38.

290. See discussion supra notes 84-93.
To serve the public interest, the medical profession must develop an aspirational alternative to patient primacy, reconceptualize a professional duty to a population of patients, acknowledge conflict within the physician's duty to the patient and the public, and create professional standards to balance conflicting aspects of professional duty. Professional esteem must be awarded for advancing knowledge about and providing cost-effective care based on a myriad of minor clinical decisions much as professional status is currently reserved for the treatment of patients who have rare diseases or who have failed to respond to traditional therapies. Until the professional duty is expanded to include the group while serving the individual, the profession cannot begin the difficult work of laying ground rules for integrating population-based needs with individual concerns and of training medical students and physicians to carry out these new obligations. These shifts in professional duties and values will require a shift in the social norms of professional conduct, not merely changes in economic incentives.

Social norms reflect societal conditions existing at the time of their formation. Professor Einer Elhauge observed that the professional paradigm, with its emphasis on patient primacy, worked well as long as medical benefits exceeded the cost of providing care. Advances in medical technology and pharmacology made it possible to provide increasingly smaller marginal medical benefit in exchange for disproportionately higher costs. The patient-primacy directive became unsustainable in light of the changed conditions. Deviations from the patient-primacy directive have occurred in the past, and, therefore, modification is possible in the context of cost control. Despite the rhetoric of the overriding commitment to patient primacy, physicians have recognized trade-offs required by the need to protect the public health. For example, under a public health paradigm, physicians have restricted their prescriptions of antibiotics to address the threat of drug-resistant strains of bacteria. They also have embraced universal immunization against contagious diseases beyond the rate required to create herd immunity, despite that immunizations pose known and inherent risks that will materialize for some patients. To date, however, the medical profession has resisted undertaking a duty to society at large to marshal its health care resources.

Society's need to control health care spending presents a classic collective action problem. Society is concerned about health care spending not because it wishes to restrict an individual's spending of her disposable income on health care services. Rather, health care spending control is motivated principally by the desire to control the cost of health care coverage. No single clinical decision

291. See Elhauge, supra note 287, at 1458.

292. Social norm scholars have used norm theory to explain the resolution of collective action problems, which occur when individuals can benefit from a common good without contributing to its existence. For example, institutional economist Elinor Ostrom has discussed the use of norms to conserve community resources such as water. See Rai, supra note 254, at 83 & n.33 (discussing Ostrom's work).
between a patient and a physician will have a measurable effect on overall health care spending by third-party payers or, therefore, on health care premiums. Accordingly, each individual patient can benefit from lower premiums for health care coverage if health care spending is controlled, without personally participating in resource allocation decisions to consume fewer health care services. If professional norms could be influenced to discourage the over-prescription and resulting over-consumption of health care resources that might otherwise result from self-interested decisions about use of health care services, overall spending could be affected.

Although social norms can be used to resolve collective action problems, in this case professional norms have not achieved that result. To consider how to intervene to influence professional norms to respond to changed social conditions, it would be useful to find an explanation for this lack of response. Social norm theorists posit that the failure of norms to respond to changed conditions can be explained by two factors, inertia or affirmative resistance. Professor Dennis Chong has observed that inertia inhibits norm change by preventing actors from recognizing changed conditions. If inertia is the cause of the lack of norm change in response to changed conditions, providing information about changed conditions should facilitate change. Inertia, however, cannot explain the failure of professional norms to evolve in response to heightened cost consciousness. The market changes are profound and their direct effects on physicians are impossible to ignore. Furthermore, medical norms have evolved modestly to develop standards that permit cost considerations, indicating awareness of changed conditions. But, organized medicine and many physicians have rejected resource allocation as a task of medicine and the methods used by managed care organizations to encourage physician allocation. Thus, resistance to the corporatization of health care and fear of loss of professional power is the more likely explanation for the failure of norm evolution.

Because policymakers and scholars discount the utility of self-regulation as a means to overcome that resistance, efforts to initiate and influence norm change in medicine have been sporadic. Nonetheless, existing conditions indicate that norm change is theoretically possible. When norms are at odds with societal

293. Professional self-regulation dictates that physicians' clinical decisions have a scientific basis for assessing the care that is beneficial to the patient's health and that which is harmful or useless, and a professional commitment to provide only the former. See Elhauge, supra note 287, at 1542-43 (noting this benefit of the professional paradigm for allocating health care resources). If self-regulation is to facilitate cost control, that ethical dictate will have to be expanded to consider care that provides low benefit in comparison to its cost.

294. See Chong, supra note 214, at 2084.

295. Scholars just have begun to focus on the methods by which norms can be changed. See Lessig, The New Chicago School, supra note 197, at 666 (stating that norm change is the focus of the "New Chicago School").
conditions, cognitive dissonance results. The contradiction that exists between market demands and professional standards already has been identified. This disparity between existing professional norms and societal conditions could lead to a change in norms as actors attempt to eliminate factors that cause cognitive dissonance.

The evidence of norm change initiated within the profession is sparse. Professional standards have evolved to acknowledge the legitimacy of cost considerations in clinical decisions. There is also some evidence of changes in practice patterns as a result of increased managed care market presence and progress in the identification of clinical best practices through outcomes research. Institutional peer review has taken on economic as well as clinical aspects. Moreover, despite the lack of significant change in medical norms toward undertaking a primary role in resource allocation, there is evidence that a dialogue has been initiated within the medical profession. Physicians are discussing whether to recommit to the patient-primacy directive or to adopt new ethical standards to manage health care resources for the collective benefit. New professional standards are being proposed for reflection and informal consideration.

Norm change can occur based on purely voluntary efforts. Group-initiated voluntary norm change is most likely to succeed with the involvement of individuals or groups who are trusted by the profession. Thus, managed care organizations are unlikely to influence norm change within the profession; nor is lay influence likely to facilitate change. An individual professional with persuasive insights might initiate voluntary efforts. Effective norm change, however, ultimately will require collective action, because norms evolve through mutual agreement, acceptance, and internalization. Those who would effect a change in professional norms must find a means to support voluntary efforts by

296. See Sunstein, supra note 197, at 2049.


298. See, e.g., John Halvorsen, Professionalism Reconsidered: Priorities for Physicians, 8 ARCH. FAM. MED. 173, 174-75 (1999); Herbert M. Swick, Toward a Normative Definition of Medical Professionalism, 75 ACAD. MED. 612 (2000); Vida Foubister, Physicians Torn Between Two Loyalties, AM. MED. NEWS, May 15, 2000, available at http://www.ama-assn.org/sci-pubs/amnews/pick_00/prsc0515.htm (last visited May 8, 2001) (reporting on discussions within the medical profession about the conflict between individual patients and collective needs and questions about the effect on medical ethics).


300. Professor Sunstein classifies such individuals "norm entrepreneurs." Sunstein, supra note 197, at 2034.
those physicians who advocate a reexamination of professional standards and to
influence the outcome of those discussions. To date, however, reliance on
individual physician actors has proved uncertain.

The legal system and changes in law also can facilitate norm change.
Changes in legal standards for physician conduct might be used to enhance
voluntary efforts to facilitate professional norm change. The standards
established through professional self-regulatory mechanisms form the terms of
an implicit contract between medicine and the state.\textsuperscript{301} If medicine has failed to
perform to the satisfaction of society or if the terms of the contract no longer
meet societal needs, the terms of that contract should be renegotiated. Because
the regulation of physicians traditionally has been an area of state concern, the
states might facilitate a renegotiation by a change in substantive law or by legal
statements that express or educate about social needs.\textsuperscript{302} Reliance on law to
change professional norms also would facilitate broader social input into defining
the contours of professional ethical conduct. Because one of the criticisms of
professional self-regulation is its insularity, democratic process might inform, as
well as lend credence to, professional standards. Law also carries with it an
expectation of compliance that could be a powerful signal of a change in
expectations.\textsuperscript{303} If some members of the profession are poised to acknowledge
that changed circumstances require changed ethics, law can empower them by
legitimizing a norm shift. Professor Lawrence Lessig calls this the process of
"ambiguation": using the law to blur the social meaning of a particular act.\textsuperscript{304}
This blurring creates ambiguity about the motive for conduct that might be
viewed with suspicion and condemnation. Physicians and physician-managers
who began to consider the needs of the collective in the treatment of the
individual could be viewed as simply complying with the demands of law, rather
than consciously breaking ranks with a powerful social norm of their profession.
The existence of the law can serve as a kind of permission to norm entrepreneurs
who would change highly valued but dysfunctional social norms.

To date, however, the law too has failed. The signals it has sent to the
medical community and the population-at-large have been contradictory; market
constraints on physician conduct have been encouraged and authorized but legal
standards to which physicians are held have not evolved.\textsuperscript{305} That government has

\textsuperscript{301} See Robert Dingwall & Paul Fenn, \textit{A Respectable Profession? Sociological
and Economic Perspectives on the Regulation of Professional Services}, 7 INT'L REV. L.
& ECON. 51, 62 (1987) (viewing a professional code of conduct as the "outcome of an
implicit bargain between the state and the group" and suggesting that the terms of this
bargain are important and subject to renegotiation).

\textsuperscript{302} If the profession values the right to engage in self-regulation, the desire to
retain that right should serve as a powerful motivator to participate meaningfully in the
process or renegotiation.

\textsuperscript{303} Sunstein, \textit{supra} note 197, at 2028-30.

\textsuperscript{304} See Lessig, \textit{supra} note 197, at 1010-14.

\textsuperscript{305} See discussion \textit{supra} notes 31-38.
failed to act, however, does not mean that it cannot act to influence norms. An initial question will involve the respective roles of the federal and state governments. Federal action spurred the development of HMOs as a means to control health care spending. Having authorized physician involvement in controlling health care spending, the federal government might take the next step to facilitate more active physician participation. Action by federal government offers the benefit of uniformity; consolidation of the disparate voices in medicine is an advantage of a centralized discussion initiated by the federal government. The Institute of Medicine has started a national dialogue with its recent reports on medical error. At the request of federal officials, it would play a similar role with respect to physicians’ roles in cost-control initiatives. Federal efforts to initiate dialogue that could lead to norm change would be beneficial. Meaningful oversight of bedside medical practices at the federal level, however, is unwieldy.

The states already have agencies in place that could facilitate discussion and change in professional standards. Properly funded and staffed, these agencies would have a greater ability to oversee and influence individual physician conduct. A discussion at the state level has the familiar advantage of allowing difficult issues to be vetted in the laboratory of the states as a means to determine which of the disparate approaches yield the most efficient outcome. The Federation of State Medical Boards could serve as a clearinghouse for sharing information generated by state boards of medicine.

Giving the responsibility to change professional standards to reflect contemporary needs to a body with a public charge and local enforcement offers the prospect of some political and public accountability. Legislative pronouncements that state boards of medicine should adopt cost-conscious clinical decisions could open a mandatory dialogue at the state level about a change in ethical norms and initiate the process of developing nuanced rules to make the trade-off between individual patient and populations of patients. This would offer the benefits of rendering medical rationing explicit and allowing all stakeholders to participate in the discussion and have input into the decision-making process. The dialogue must include members of the medical profession, because norm change is most likely to be affected by those respected within the social group. Legitimacy of the standards will be an important factor in compliance. States individually or collectively should seek to involve representatives from a broad spectrum of the profession, including physicians in traditional roles and physician-managers and other physician executives. Because of the importance of physician ethical conduct to society, broader societal input into defining what ethical conduct entails would be beneficial.

306. Antitrust laws have served this purpose in the past. See, e.g., AMA v. FTC, 638 F.2d 443 (1980), aff’d, 455 U.S. 676, reh’g denied, 456 U.S. 966 (1982) (ban on physician advertising struck down as a violation of the federal antitrust laws). Tort law should continue to provide a floor to ensure that cost-control measures do not initiate a race to the bottom.

307. See Brian C. Kalt, Death, Ethics, and the State, 23 HARV. J.L. & PUB. POL’Y
The trade associations that represent the views of organized medicine have a place at the table, but should not be permitted to dominate the conversation. States will have to guard against the influence of self-interest that does not serve public needs. With vigilance, existing legal regimes can be used to dissuade self-protective conduct. In addition, more legislative attention to the standards and procedures employed by state boards of medicine will be required if the boards are charged with implementing new professional standards. Substantive and procedural safeguards will be necessary to ensure that this public agency acts in the public interest.

This is not the place to propose new substantive professional norms; that norm evolution must begin with members of the profession. My aim is simply to urge a reexamination of discarded solutions. The need for social norms to temper professional behavior in a medical marketplace will not go away, and the confrontation between social reality and idealistic myth is inevitable. In a different time, the medical professions' autonomous self-regulation formed the professional norms that led to improved scientific knowledge and methods of diagnosis and treatment of disease. In the cost-constrained environment that resulted, the profession's failure to reconcile professional standards and economic reality has impeded the improvement of social response. The task for the law and public policy is to intervene to ensure that professional self-regulation serves public needs.

487, 514-15 (2000) (making a similar point in the context of decisions about patients' rights to terminate or refuse medical treatment).

308. The AMA has formed an Institute of Ethics to bring physician and lay experts together to consider contemporary ethical issues. In the interest of disclosure, I currently serve on the Expert Advisory Panel on the ethical implications of benefit determinations.

309. For one prominent scholar's initial efforts to define new standards, see David Mechanic, Managed Care and the Imperative for a New Professional Ethic, 19 HEALTH AFFAIRS 100 (2000) (discussing advocacy, population health, and evidence-based medicine).