Physicians as Advocates

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ARTICLE

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William M. Sage*

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I. INTRODUCTION

In William Goldman's fantasy The Princess Bride, the unlikely criminal trio of a diminutive Sicilian, a swashbuckling Spaniard, and a giant have kidnapped Princess Buttercup from the kingdom of Florin and are making their carefully planned escape when they unexpectedly find themselves pursued by a mysterious man in black. They attempt evasive maneuvers, but each time Inigo Montoya, the Spaniard, is forced to point out to Vizzini, the Sicilian mastermind of the operation, that they have again failed to elude their pursuer. Each time Vizzini replies, "Inconceivable!" Finally, exasperated, Inigo exclaims: "You keep using that word! ... I do not think it means what you think it does."

Similarly events are unfolding closer to home. As the American health care system shifts from a purely professional model to a structure dominated by corporate and government interests, physicians frequently style themselves "advocates" for patients.\(^1\) It is a professionally attractive image, and one that the

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2. Physicians are not the only health professionals to be dubbed "patient advocates." For example, nursing arguably has a stronger tradition than medicine of aligning its professional goals with those of the patient, and is facing equally intense pressure to reconcile those ideals with the pace and direction of change in the health care industry. See Karen Markus, Comment, The Nurse as Patient Advocate: Is There a Conflict of Interest?, 29 SANTA CLARA L. REV. 391, 401-10, 413-14 (1989) (examining some situations in which nurses have garnered little support as advocates and suggesting that scientific advances and the willingness of the profession justify nurses acting as advocates); see also CAL. BUS. & PROF. CODE § 4051 (West 1996) (declaring that a pharmacist plays a critical role as advocate). However, the advocacy duties of professions other than medicine are beyond the
public wholeheartedly endorses. Moreover, courts and regulators are attempting to capture these sentiments in law. The thesis of this Article, however, is that the term means different things to different people. Specifically, those seeking "advocacy" in a health care system increasingly beset by conflict over the allocation of financial resources have a more adversarial construct in mind than physicians typically envision. In short, they are looking for a lawyer.

Certainly, some degree of confusion between professional norms can be forgiven. The rhetorical resemblance between doctors' advocacy and lawyers' advocacy is striking, if superficial. For example, the classic description of the lawyer's role as neutral partisan for his client was offered more than a century ago by Lord Brougham:

[A]n advocate, in the discharge of his duty, knows but one person in all the world, and that person is his client. To save that client by all means and expedients, and at all hazards and costs to other persons, and, among them, to himself, is his first and only duty; and in performing this duty he must not regard the alarm, the torments, the destruction which he may bring upon others.

Equally strong statements have been made in support of physicians' exclusive allegiance to patients. According to the philosopher Hans Jonas:

In the course of treatment, the physician is obligated to the patient and to no one else. He is not the agent of society, nor of the interests of medical science, nor of the patient's family, nor of his co-sufferers, nor of future sufferers from the same disease.... [T]he physician is bound not to let any other interest interfere with that of the patient in being cured.... We may speak of a sacred trust; strictly by its terms, the doctor is, as it were, alone with his patient and God.

The similarity of these aspirational visions, however, conceals important differences in the professional meaning of

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4. Refer to Part II.B infra.

5. 2 The Trial of Queen of England in the House of Lords 1820 3 (1821).

“advocacy,” especially when statements of belief are reduced to practice. This is not merely a Clintonian quibble. Professional language has real consequences with respect to expectations, obligations, and outcomes. In a sense, physicians have always been patients’ advocates. The patient’s welfare is the doctor’s bible. In another sense, they have not. To a lawyer, advocating for clients means playing a focused, instrumental part in a broader social system of dispute resolution. Doctors do not see their role as similarly limited. Rather, physicians have served as counsel, judge, and jury—articulating possibilities, presenting and weighing evidence, balancing competing considerations, and arriving at a decision as to the manner in which the resources of the health care system should be brought to bear on illness or injury.

Let me illustrate by describing an uncontrolled sociological experiment. I teach a seminar on professions and professionals to a mixed class of law and medical students. In order to elicit nascent professional biases, I asked the class to imagine that each of them is a surgeon, and to describe how they would go about deciding which of two patients they had operated on should receive the last available post-operative bed in an intensive care unit. The medical students immediately identified a variety of clinical factors evidencing the need for intensive monitoring, and outlined their likely reasoning in weighing those factors and reaching a decision. The law students were silent. When pressed, several expressed reluctance to divide their loyalty between competing clients, preferring instead that a third party make the final determination. The reasons for this difference of approach went beyond issues of technical competency. To the medical students, being a patient advocate was entirely compatible with disadvantaging particular individuals if a physician’s motives were pure and her decisionmaking process objective and scientific. The law students, on the other hand, were comfortable being either advocates or arbiters, but not both.

Although differences between doctors’ and lawyers’ advocacy long predated managed care, until recently, there was little reason to delve deeply into this aspect of the professional psyche.

7. Other commentators have drawn attention to the changing language of health care. See, e.g., W. Clay Jackson, In a Word, 280 JAMA 493, 493 (1998) (discussing the influx of unfamiliar terms into the health care profession as a result of the onset of managed care in the United States); Theodore R. Marmor, Hope and Hyperbole: The Rhetoric and Reality of Managerial Reform in Health Care, 3 J. HEALTH SERV. RES. & POLY 62, 62 (1998) (explaining the language used in the current health care industry debate, and noting how misuse of the language has warped conceptions of successful management).
The established view of patient advocacy was uncontroversial. Physicians had a duty not to harm patients, to practice in patients' best medical interests, to respect patients' wishes, to put patients' welfare above personal considerations, and to preserve patients' confidences. Physicians also had well accepted privileges. These included the privilege to follow their own values and beliefs, to serve whom they chose, and to shield patients from bad news. In addition, for a brief historical period, they also had both the ability to provide beneficial services to patients and the freedom to do so regardless of cost.

Whether this freedom has become a duty is the core challenge for advocacy in today's health care system, in which physician paternalism has given way to consumer autonomy as the basis of professional practice, and rapidly rising expenditures have stripped physicians of their unilateral, cost-unconscious control over health care resources. Cost once again matters in this environment, forcing physicians to interact not only with needy individuals, but with prospective patients as consumers, with their purchasing agents, with third-party managers, and with fiscally prudent governments. This tension, between physicians' ethical commitment to do everything possible for patients and the existence of both public and private constraints

8. From roughly 1940 to 1980, virtually unlimited funding was available to support medical science, which was itself rapidly burgeoning. Money came initially from private health insurance, which was enhanced by tax subsidies beginning during World War II, and was supplemented generously by government expenditures for hospital construction and, in 1965, public insurance for selected groups of beneficiaries. Although the United States never made an explicit commitment to universal coverage, health care spending increased so persistently that cost-containment became the driving concern of both the public and private sectors by 1980. See Paul Starr, The Social Transformation of American Medicine 290-378 (1982). Many of today's challenges to physician "advocacy" arguably derive from this history. Conducting the reverse "thought experiment" to that contained in this Article—asking what legal advocacy would look like if law had a similar history of generous subsidy leading to uncontrolled growth—would be an enlightening exercise.

9. See, e.g., Allen Buchanan, Rationing Without Justice, 23 J. Health Pol'y, Pol'y & L. 617, 629-30 (1998) (arguing that it is not unethical for physicians to practice medicine of less than the highest quality, but it is unethical for physicians to encourage patients to regard them as advocates under those circumstances).


on health care resources, is a defining characteristic of managed care, and triggers the need to revisit the medical profession's notion of advocacy.\textsuperscript{12}

In managed care, advocacy takes on a very different look. When times are good and illness remote, everyone wants reasonably priced insurance and low out-of-pocket costs.\textsuperscript{13} Once they become ill, however, patients enrolled in managed care plans want physicians to put their interests ahead of organizational or budgetary goals, to resist countervailing financial incentives, to give them information about all possibly beneficial treatments, to provide the treatment they select, and to contest contrary utilization review decisions or denials of coverage.\textsuperscript{14} This is a more lawyer-like construct of the advocate's role. As Maxwell Mehlman observes, in contrast to traditional fee-for-service medicine, “managed care creates a new adversarial relationship: between the health care system and the patient.”\textsuperscript{15} Patients want to know not only that the doctor is in, but which side the doctor is on.\textsuperscript{16}

The principal theme of this Article is that many dimensions of physicians' advocacy in managed care remain to be established, and those dimensions may turn out to be inconsistent with one another or with normative goals for the health care system. Specifically, attempting to map physician

\begin{itemize}
\item \textsuperscript{12} See David Mechanic, From Advocacy to Allocation: The Evolving American Health Care System 139-41 (1986) (discussing the constraints imposed upon physicians by managed care). Not surprisingly, the medical profession regards the rise of managed care as signaling a period of moral crises. See Robert Baker et al., Crises, Ethics, and the American Medical Association: 1847 and 1997, 278 JAMA 163, 164 (1998) (asserting the importance of professional ethics in “ensur[ing] that free-market medicine remains moral medicine”).
\item \textsuperscript{13} Marc Rodwin argues that consumers buying health insurance also hope that physicians will behave prudently with respect to the costs of treatment, even if an acutely ill, insured patient prefers that everything possible be done for him. See Marc A. Rodwin, Patient Accountability and Quality of Care: Lessons From Medical Consumerism and the Patient's Rights, Women's Health and Disability Rights Movement, 20 AM. J.L. & MED. 147 (1994). On the other hand, often unwarranted beliefs about the scientific necessity of medical recommendations, and the concealment of true health insurance costs through invisible payroll deductions and generous tax subsidies suggest that relatively few consumers think about the relationship between insurance costs and medical practice.
\item \textsuperscript{14} See E. Haavi Morreim, Economic Disclosure and Economic Advocacy: New Duties in the Medical Standard of Care, 12 J. LEG. MED. 275, 293-301 (1991) (examining physician's obligations to patients in managed care).
\item \textsuperscript{15} Maxwell J. Mehlman, Medical Advocates: A Call for a New Profession, 1 WIDENER L. SYMP. J. 299, 305 (1996).
\item \textsuperscript{16} See David Mechanic, The Functions and Limitations of Trust in the Provision of Medical Care, 23 J. HEALTH POL. POL'Y & L. 661, 668 (1998) (stating that patients place a great deal of emphasis on having physicians act as their agent rather than as an unbiased decisionmaker or cost-cutter).
\end{itemize}
behavior onto an advocacy template created for lawyers raises three difficult questions. First, given the undisputed importance of clinical expertise to an efficient health care system, should physicians' primary role be to advocate for causes or to direct the provision of care? Second, would the medical professions' reputation for independent competence withstand the adversarial partisanship that accompanies lawyerly advocacy? Third, would patients be willing to accept procedural justice in lieu of substantive entitlements to limited resources? The Article's goal is to demonstrate that physicians should not aspire to be lawyers when they claim the mantle of "advocate," and the public should not regard them as such. However, the Article's comparative analysis of the medical and legal professions is intended to be provocative, not definitive, and leaves the development of a normative framework for physician advocacy to future work.

The argument proceeds as follows. Part II of the Article sets forth the ways in which the American health care system is adopting a more adversarial posture and simultaneously imposing lawyer-like advocacy duties on physicians. Part III then steps back to consider the milieu necessary to support legal advocacy, as well as the objections to advocacy that have been aired within the community of lawyers and legal scholars. Part IV discusses the professional and structural compatibility of medicine with an advocacy model, and Part V explores the implications of physician advocacy for system performance. The Article concludes that physicians cannot be patients' advocates in the legal sense of the word, and that efforts by both the profession and the public to construct that role for them are fundamentally misguided.

II. AN ADVERSARIAL HEALTH CARE SYSTEM?

In traditional medical practice, decisions about treatment were made in private by doctors and patients. Patients selected physicians without restriction, and followed their recommendations without impediment. For several decades, health insurers paid the rising cost of these choices with minimal objection. Disputes between patients and insurers, if they arose at all, typically concerned fringe treatments or arguably non-medical services. Moreover, disputes tended to involve money, not medicine, and were temporally and emotionally removed from the process of providing and receiving care. In the vast majority of cases, the parties to a medical transaction were allies, not adversaries.
Not so in managed care. Managed care takes the conflict, inherent in all insurance relationships, between resources devoted to one individual and those preserved for the pool of potential beneficiaries away from the abstract, leisurely domain of determining contractual rights and financial obligations, and puts it on the front lines of ensuring timely receipt of health care services. As a general matter, managed care reduces costs by limiting access to health care professionals and pre-screening proposed treatments for appropriateness. This makes it more important for health care consumers to understand their options and to assert rights, sometimes in adversarial fashion. It also introduces a formal notion of advocacy into the discourse of health policy. For example, George Annas proposes "the right to an advocate" as one of five core rights for patients in managed care, although he does not assign that role to the physician.\(^1\)

A. The Rhetoric of Physician Advocacy

The advent of managed care has brought forth a chorus of voices calling on physicians to defend the interests of their patients against both population-based resource allocation and profit-oriented corporate incursion—in other words, to become advocates. These protests often reflect strongly held ethical beliefs about medical professionalism. For example, the editor-in-chief of the *New England Journal of Medicine* has clearly stated the case for physician advocacy:

Should [physicians] accept a new ethic that is population-based? Given the current structure of the health care system, I think not. I believe that intentionally providing minimally acceptable care to some for the benefit of others in an arbitrary group—let alone for the benefit of the bottom line—is wrong. Customizing care on the basis of a patient's insurance coverage is also wrong. When patients are sick and vulnerable, they expect their physicians to be their advocates for optimal care, not for some minimalist standard. . . . If we capitulate to an ethic of the group rather than the individual, and if we allow market forces to distort our ethical standards, we risk becoming economic agents instead of health care professionals.\(^8\)


\(^{18}\) Jerome P. Kassirer, *Managing Care—Should We Adopt a New Ethic?*, 339 NEW ENG. J. MED. 397, 397-98 (1998). Other scholars disagree, taking the position that physicians may ethically withhold marginally beneficial treatment because of
As this passage confirms, managed care clearly has awakened physicians to the primacy of agency relationships in today’s health care system. Health plans and other managed care organizations claim to represent the interests of their shareholders, their customers (usually employers and ERISA plans), and their insurance subscribers as a group. Whether health plans have agency obligations to individual patients, however, remains an open question. Because most physicians are contractually affiliated with or even employed by large organizations, they sometimes must struggle to maintain their traditional commitment to serve patients rather than corporate interests.

The renewed importance of advocacy to physicians’ self-conception also reflects a loss of physician independence under managed care. According to David Mechanic and Mark Schlesinger, the public expects that “those who serve them will perform their responsibilities in a technically proficient way (competence), that they will assume responsibility and not inappropriately defer to others (control), and that they will make patients’ welfare their highest priority (agency).” Traditionally, these responsibilities were all borne by the medical profession, albeit imperfectly. By contrast, managed care removes aspects of competence and control from individual professionals to institutions using techniques such as selective contracting, practice guidelines, and utilization review. As Professor Berenson observes, however, agency is the hardest precept to accommodate within a framework of institutional accountability, yet is also arguably the most important one to preserve, given managed care’s financial constraints, unfamiliarity to patients, and overall commercial orientation.

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19. See Mehlan, supra note 15, at 303 (commenting that many times the interests of individual patients are superseded by the interests of managers, insureds, or shareholders).

20. See Tracy E. Miller, Center Stage on the Patient Protection Agenda: Grievance and Appeal Rights, 26 J.L. MED. & ETHICS 89, 94 (1998) (claiming that physicians who receive the majority of their work from one or two managed care plans may be discouraged from advocating for costly treatments).


22. See Mehlan, supra note 15, at 300 (observing that these methods influence resource allocation decisions made by health care professionals).

23. See Robert A. Berenson, Issues of Professionalism Under Managed Care, Presentation to the Committee on Medicine and Society of the New York Academy of
therefore, physicians should actively advocate patient interests when seeking approval for coverage or contesting utilization review decisions, serve as honest brokers of clinical and administrative information, ensure that clinical care is focused on patient well-being, and sever ties from managed care organizations if care is seriously compromised by cost constraints.²⁴

In addition, it should not be surprising that calls for physician advocacy frequently use metaphors drawn from law. Certainly, managed care has intensified physicians’ awareness of conflict in health care by pitting benefit-minded patients against cost-minded insurers,²⁵ and by framing many of those disputes contractually, making the application of legal process intuitively attractive. However, medicine was drawn to legal discourse even before managed care, largely as a result of expanding moral diversity and the rapidly increasing technical and structural complexity of contemporary clinical practice.²⁶ For example, Robert Schwartz and Joan Gibson describe the influence of bioethics in extending the notion of “rights” to matters that previously had been addressed through professional morality, and suggest that the law’s redefinition of the physician’s role as adviser and advocate was seductive to physicians because deferring to personal autonomy or public adjudicative processes was simpler, given changing values, than having to reorient one’s moral compass.²⁷

Another strand supporting the recent trend to cast medical advocacy in adversarial terms comes out of political movements that employ legal tools to achieve their objectives. For example, Marc Rodwin’s belief in the need for organized consumer

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²⁴. See id.
²⁵. See Mehlman, supra note 15, at 305-06 (delineating that the law may aid patients in dealing with the adversarial relationship between patients and health care systems).
²⁷. See id. at 793-94. Similarly, Howard Brody notes that the core ethical obligation of fidelity:

“[P]hysicians are required to do everything that they believe may benefit each individual patient without regard to costs or other societal considerations[,] ... has proven extremely attractive to physicians ... [because] [i]t promises clear ethical guidance, grounded in a clear sense of professional duty, and without any messy conflicts of interest to navigate.

Howard Brody, Managed Care, the Marketplace, and the Future of the Physician-Patient Relationship, in 23 SOCIAL RESPONSIBILITY: BUSINESS, JOURNALISM, LAW, MEDICINE 53, 58 (Louis W. Hodges ed., 1997).
advocates to protect patients in managed care is informed by his perception of the women's health and disability rights movements as examples of successful advocacy. These models have a legal heritage, working through funded institutions such as the Legal Services Corporation and the National Health Law Program, and represent efforts by traditionally marginalized constituencies to achieve under law what has been denied them in the political process or in the marketplace. Similarly, the increasing appeal to physicians of an adversarial model may reflect the medical profession's perception of diminishing economic influence and political power in the transition to a managed health care system. Managed care has even prompted physicians to urge their colleagues to be "advocates" in the sense of becoming social activists. An important issue raised by use of the term "advocate"—one applicable to other social movements as well—is whether medical advocacy should be directed primarily to obtaining benefits for identifiable individuals, or to securing future rights for groups or for society as a whole.

Laws creating rights to formal advocacy in health care have arguably shifted physicians' conception of their role toward a similar model. For example, federal statutes provide that residents of nursing homes must be guaranteed access to funded ombudsmen who assist with complaints and assess the impact of legal requirements. In addition, as of 1996, ombudsman programs designed specifically to protect Medicaid beneficiaries enrolled in managed care had been enacted in California, Michigan, Minnesota, Oregon, Tennessee, and Wisconsin.

28. See Rodwin, supra note 13, at 166 (discussing the use of law by the women's health and disability rights movements).
29. See id.
31. See Brody, supra note 27, at 58-60 (detailing the conflict of interest for a physician between advocating for individual patients and for society as a whole).
32. See 42 U.S.C. § 3058(a) (1994); see also REAL PEOPLE REAL PROBLEMS: AN EVALUATION OF THE LONG-TERM CARE OMBUDSMAN PROGRAMS OF THE OLDER AMERICANS ACT (Jo Harris-Wheeling et al. eds., 1995) (Institute of Medicine report). The term "ombudsman" derives from the Swedish practice of investing an individual of high reputation with the role of investigating citizen complaints and mediating disputes between citizens and the government. See id. at 42. For an overview of advocacy in long-term care, see generally Anthony Szczygiel, Long Term Care Coverage: The Role of Advocacy, 44 U. KAN. L. REV. 721 (1996) (examining admission to, and payment for, long-term health care services in the United States with a focus on home care, nursing home care, and care provided by various types of government and private insurance).
33. See CAL. WELF. & INST. CODE § 9711 (West 1998); MICH. COMP. LAWS ANN. § 2.638(56) (West 1997); MINN. STAT. ANN. § 256B.031 (West 1998); OR. REV. STAT. §
States are now expanding these services; Florida, for example, has established state and local ombudsman offices to assist all consumers with managed care.\footnote{See FLA. STAT. ANN. § 641.60 (West 1998).}

Voluntary efforts to apply established advocacy techniques to managed care similarly affect evolving professional roles.\footnote{Some programs are even profit-driven. For example, one entrepreneur is marketing a nurse and technician staffed telephone service to large employers that supposedly would direct employees to the appropriate care setting, provide educational materials, help patients assess treatment recommendations, and negotiate with physicians and health plans. See Linda O. Prager, Phone Service Aims to Help Patients; Others Fear Intrusion, AM. MED. NEWS, May 11, 1998, at 3. This service assumes that physicians will not be pure advocates for patients in managed care due to time constraints and financial incentives, making external assistance necessary.} Although consumer views are minimally represented in most debates over managed care, particularly compared with wealthy, powerful constituencies such as insurers and providers, organized advocacy is on the rise.\footnote{See Marc A. Rodwin, Consumer Voice, Participation, and Representation in Managed Health Care (May 1998) (White Paper prepared for Consumer Federation of America).} For example, the Medicare Rights Center is offering its services to unions and employers as an ombudsman to evaluate plan performance, respond to telephone queries, and report on problems experienced by members.\footnote{Similarly, a private group has been formed in Wisconsin to advocate for Medicaid beneficiaries and state employees, and national managed care advocacy programs are being sponsored by the Public Citizens Health Research Group and the Children's Defense Fund. See id. According to Professor Rodwin, private organizations are necessary because employers and labor unions are imperfect proxies for consumer interests, and government officials such as attorneys general, and dedicated ombuds agencies, can handle only a small number of complaints. See id. at 6-8. Professor Rodwin believes that alliances between consumer groups and physician organizations will be essential to the success of these efforts. See id. at 13.}

B. Formal Manifestations of Advocacy Obligations

Concrete manifestations exist in law and ethics of these sociological pressures to turn medical professionals into lawyer-like advocates for patients, and are increasing in response to managed care. Measures to facilitate or require physician advocacy take several forms, which the remainder of this section reviews. Included among them are official statements of professional responsibility, judicial findings regarding probative value of testimony in coverage litigation and consequent liability.
for patient injury, regulations mandating external review of coverage denials and statutory restrictions on managed care contracting practices that create financial conflicts of interest, limit physician-patient communications, or threaten physician participation in provider networks.\(^{38}\)

It bears mentioning, of course, that calls for patient advocacy in managed care sometimes represent advocacy of another kind entirely. Historically, defense of patients has been the lingua franca of economic self-interest on the part of lobbyists for the medical profession. Concern over physicians’ waning economic power in today’s market environment has focused this argument on managed care. For example, one can view external review requirements as a means to assure payment to physicians as much as to assure necessary treatment to patients. Because physicians who participate in managed care systems are generally subject to financial constraints, requests for coverage often arise when outside providers recommend services for which they would receive separate payment. If physicians are to serve as expert reviewers on the independent review panels that oversee these disputes, a review requirement in essence restores control over coverage to the medical profession. Reflecting similar concerns, David Blake cautions against blind adherence to the rhetoric of patient advocacy in managed care on the grounds that the apparent conflict between the medical profession and managed care may be more economical than ethical.\(^{39}\) Analogous reservations apply to other health care workers who have fought against managed care on advocacy grounds. Because painful layoffs have accompanied the transition of the health care system to managed care, for example, hospital employees fearing job loss often align themselves with patient interests by asserting roles as advocates.\(^{40}\)

1. **Medical Ethics.** As the practice of medicine grown to include a vast array of services beyond an individual physician’s knowledge and technical proficiency—the high cost of which

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38. Refer to Parts II.B.1-3 infra.

39. See David C. Blake, *Ethical Boundaries of Patient Advocacy in the Managed Care Revolution*, 16 CAL. HEALTH L. NEWS 44, 50 (1996) (noting the choice “between one system of financing health care that is economically advantageous to physicians, since it inextricably diverts resources to physicians services and away from other goods . . . and another . . . that limits the physician’s income while holding down the cost of health care”).

created the need for insurance and gave rise to powerful institutions that would offer it—the Hippocratic commitment to serve the patient's interests above all others has evolved from a statement of philosophy to a navigational tool. "Other interests" are no longer ethereal moral abstractions or occasional earthly temptations, but everyday participants in the working environment of physicians. As a result, the categorical statements of resistance to outside interference that characterized medical ethics in the earliest years of third-party payment—flatly declaiming that hospitals and other institutional providers are "but expansions of the equipment of the physician" and that "[t]here should be no restrictions of treatment not formulated and enforced by the organized medical profession"—have given way to a more refined approach. In this newer version, the medical profession continues to assert a general right to oversee clinical care, but also frames itself as an advocate for patients vis-à-vis other constituencies that are now accepted as necessary to the operation of the health care system.

Accordingly, the AMA's current Code of Medical Ethics includes several provisions delineating this role. The Code states, for example, that "[w]hile physicians should be conscious of costs and not provide or prescribe unnecessary services, concern for the quality of care the patient receives should be the physician's first consideration." The Code also lists as a fundamental principle that, as part of ensuring patients their "basic right to have available adequate health care[,] . . . [p]hysicians should advocate for patients in dealing with third parties when appropriate." More specific guidance regarding the balance between cost consciousness and patient advocacy was added in 1996 in connection with an intensive study of managed care conducted by the Council on Ethical and Judicial Affairs. This new opinion notes that "[t]he duty of patient advocacy is a

41. See Starr, supra note 8, at 299-300 (describing the AMA's 1934 Principles for Medical Service).
42. Council on Ethical and Judicial Affairs, American Medical Association, Code of Medical Ethics Op. 2.09 (1996) [hereinafter AMA Code]; see also id. Op. 2.19 ("Physicians should not provide, prescribe, or seek compensation for services that they know are unnecessary.").
43. Id. Fundamental Element 6.
44. See id. Op. 8.13 (setting forth general principles to assist physicians in carrying out their ethical responsibilities under managed care); see also Council on Ethical and Judicial Affairs, American Medical Association, Ethical Issues in Managed Care, 273 JAMA 330, 330 (1995) (providing recommendations "to preserve the fundamental duty of physicians as patient advocates by reducing the risk of rationing and inappropriate financial incentives").
fundamental element of the physician-patient relationship that should not be altered by the system of health care delivery in which physicians practice."

The revised Code also begins to segregate the physician's role in directing resources to patients from that of the health plan, itself a major concession to the realities of managed care. To that end, the Code specifies that "broad allocation guidelines that restrict care and choices—which go beyond the cost/benefit judgments made by physicians as a part of their normal professional responsibilities—should be established at a policy-making level so that individual physicians are not asked to engage in bedside rationing." This statement is also noteworthy because it seems to permit physicians ethically to deny beneficial treatment based on cost, a check on advocacy to which we will return later.

With respect to specific advocacy functions, the Code calls for "adequate appellate mechanisms . . . to address disputes regarding medically necessary care" in managed care systems. The Code requires physicians to play a role in these proceedings, noting that "in some circumstances, physicians have an obligation to initiate appeals on behalf of their patients." Furthermore, in situations in which care that would materially benefit the patient is unfairly denied, "the physician's duty as patient advocate requires that the physician challenge the denial and argue for the provision of treatment . . . ." Similarly, physicians are assigned ethical duties to attempt to secure formulary exceptions for drugs that would be significantly advantageous to a patient, and failing that, to disclose to the patient the option of paying for the drug out-of-pocket.

45. AMA CODE, supra note 42, Op. 8.13(1); see also id. Op. 8.13(2)(B) (directing physicians to advocate on behalf of their patients regarding all beneficial care, "regardless of any allocation guidelines or gatekeeper directives").


47. Id. Op. 8.13(2)(D).

48. Id. (discussing cases of unfair denials of coverage or instances in which an unfair guideline is in place by the health care provider).

49. Id. The Code also includes, within physicians' advocacy, duties seeking elimination or modifications of allocation guidelines that are unfair in operation. See id.

50. See id. Op. 8.135(5). The AMA has even opined that a physician's duty to advocate extends to attempting to convince a pharmaceutical company to produce or reinvestigate a drug, despite the fact that an investigational trial of the drug had been discontinued as ineffective, if the drug benefited one of the physician's patients who had been enrolled in the trial. See Patient Advocacy Includes Obtaining Orphan Drugs, Am. Med. News, Mar. 23-30, 1998, at 26.
2. **Coverage Disputes, Malpractice Litigation and Fiduciary Duties.** Advocacy duties are also evident in litigation involving individual patients. Based on reported opinions, lawsuits against health insurers have become much more frequent in recent years.\(^5\) While these cases are not necessarily representative of the routine body of health care decisions and disputes, they are nonetheless revealing in terms of the roles assigned to the various actors in them.\(^6\) For example, with occasional exceptions for rulings based conservatively on policy language or constrained by ERISA,\(^5\) most judicial opinions regarding health insurance coverage resemble morality plays, pitting needy patients against greedy, or at least heartless, insurance bureaucracies.

Importantly for our purposes, courts ruling on insurance coverage disputes generally assume that physicians who testify as witnesses should be patient advocates in the sense of focusing exclusively on clinical benefit to the individual. This in part reflects the posture of litigation, in that cases often arise when patients find providers willing to deliver care, which insurers then refuse to pay for as "not medical necessary" or "experimental."\(^5\) Nonetheless, physicians who are directly involved in the plaintiff's care, and whose testimony is limited to purely clinical matters, tend to fare much better with judges than physicians with managerial responsibility, expertise in economic analysis, or any other aggregate, policy-oriented perspective.\(^5\)

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51. See Mark A. Hall & Gerard F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. Pa. L. Rev. 1637, 1639-40 (1992) (noting the tremendous amount of coverage litigation regarding whether bone marrow transplants are experimental and, thus, fall outside the scope of insurance); Mark A. Hall et al., *Judicial Protection of Managed Care Consumers: An Empirical Study of Insurance Coverage Disputes*, 26 Seton Hall L. Rev. 1055, 1060 (1996) (detailing the increase in insurance litigation over the past few decades).


55. See, e.g., Florence Nightengale Nursing Serv., Inc. v. Blue Cross & Blue Shield, 832 F. Supp. 1456, 1466 (N.D. Ala. 1993) (concluding, based on the doctrine of contra proferentem, that an insurer's expert definition of "reasonable" was contrary to the policy language and, therefore, a breach of contract). The court further commented on Blue Cross's internal claims review expert: "Dr. Holloway's training is not only in medicine but in 'cost containment.' In which of these
Occasionally courts have held physicians legally liable for failing to plead patients' cases against insurers with sufficient zeal. The classic statement attaching legal force to physicians' ethical obligations as advocates is *Wickline v. California*. In *Wickline*, Ms. Wickline developed complications after vascular surgery, however her surgeon's request for eight additional days of hospitalization beyond the period initially authorized by the Medi-Cal program was cut in half by the state's utilization review personnel. Ms. Wickline, therefore, was discharged four days later, and suffered additional complications at home that ultimately led to the amputation of her leg. The resulting malpractice complaint against Medi-Cal was dismissed, but the court observed in dicta that "the physician who complies without protest with the limitations imposed by a third party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care." The *Wickline* decision, therefore, obligates physicians, as part of the professional standard of care, to contest payment decisions by managed care organizations.

Initially, physicians challenging utilization review decisions did so informally. More recently, the expansion of managed care has drawn attention to the process by which health plans reach decisions on coverage, which often seems arbitrary.

disciplines she is better trained would be an interesting question with which to spend some time." *Id.* at 1461. Even testimony on cost-effectiveness from the eminent Dr. David Eddy is frequently ignored as irrelevant. See Adams v. Blue Cross & Blue Shield, 757 F. Supp. 661, 670-71 (D. Md. 1991) (rejecting testimony that certain bone marrow transplants were experimental).


68. *See id.* at 663-65.

69. *See id.* at 666-68.

70. *Id.* at 671.

61. One study found that insurers vary greatly in their approval rates for breast cancer patients seeking coverage of high dose chemotherapy with autologous bone marrow transplantation, and concluded that plan practices were unscientific and overly restrictive. See William P. Peters & Mark C. Rogers, *Variation in Approval by Insurance Companies of Coverage for Autologous Bone Marrow Transplantation for Breast Cancer*, 330 NEW ENG. J. MED. 473, 476-77 (1994). On the other hand, a later study explored prospective approval of tympanostomy tube placement for childhood ear infection, and found that physicians employed by a utilization review firm were consistently more lenient in individual cases than would be predicted by the objective criteria they were supposed to apply. See Lawrence C. Kleinman et al., *Adherence to Prescribed Explicit Criteria During Utilization Review: An Analysis of Communications Between Attending and Reviewing Physicians*, 278 JAMA 497, 501 (1997).
Consequently, a major focus of recent legislation and regulations is to establish formal procedures for coverage denials and appeals that accord patients due process, even in private managed care organizations.\textsuperscript{62} One by-product of these mechanisms is a much more structured role for physician advocacy.

The culmination of this trend has been to require health plans to allow coverage denials to be appealed to independent adjudicatory bodies external to the organization.\textsuperscript{63} According to Professor Miller, external review serves several policy functions: (1) assuring an impartial final decisionmaker; (2) opening the review process to public scrutiny; (3) improving the quality of review; (4) enhancing the scientific basis for decisions; and (5) increasing enrollee satisfaction and public confidence.\textsuperscript{64} Beginning with Rhode Island, fourteen states had enacted external review laws by 1997,\textsuperscript{65} and another six followed suit in 1998.\textsuperscript{66} Many other states have bills under consideration. Access to external review apparently resonates with the public; according to a 1997 study of consumer complaints by the Lewin Group, sixty-six percent of respondents “would have used” an independent source to resolve disputes.\textsuperscript{67} Health plans themselves frequently support external review requirements because of the public relations nightmare, and potential legal liability, created by perceptions that they are wrongfully withholding life-saving treatment.\textsuperscript{68}

In essence, independent review requirements displace health care coverage decisions from private to publicly accountable actors. As occurs when courts get involved, this will inevitably

\begin{itemize}
\item \textsuperscript{62} For an overview of procedural standards for managed care prior to the most recent legislative cycle, see Eleanor D. Kinney, \textit{Procedural Protections for Patients in Capitated Health Plans}, 22 AM. J.L. \& MED. 301, 326-27 (1996).
\item \textsuperscript{63} See Karen Pollitz et al., \textit{External Review of Health Plan Decisions: An Overview of Key Program Features in the States and Medicare} (Nov. 1998) (Report prepared for the Kaiser Family Foundation); Miller, supra note 20, at 92.
\item \textsuperscript{64} See Miller, supra note 20, at 92.
\item \textsuperscript{65} See id. at 92 \& n.38.; Pollitz, supra note 63 (reviewing statutes in 13 states).
\item \textsuperscript{66} See Vida Foubister, \textit{Court Ruling Throws HMO Review Process into Jeopardy}, AM. MED. NEWS, Oct. 26, 1998, at 15 (noting that 20 states have now established independent review processes, although Texas’s process was invalidated as preempted by ERISA).
\item \textsuperscript{67} See Laurie McGinley, \textit{Managed-Care Industry Body May Back Right to Appeal Denials of Treatment}, WALL ST. J., Jan. 20, 1999, at B6 (reporting support for external review among insurers).
\item \textsuperscript{68} See, e.g., Robert Cunningham, \textit{External Appeals Touted As Consumer Confidence Builder and Liability Shield}, MED. \& HEALTH PERSPECTIVES, June 1, 1998, at 1; Julie A. Jacob, \textit{Insurer to Ask Outside Review of Experimental Treatment}, AM. MED. NEWS, Feb. 17, 1997, at 10 (describing the voluntary effort of Empire Blue Cross Blue Shield).
\end{itemize}
result in greater procedural intricacy and more precisely defined partisan roles. Although one could imagine external review procedures in which both the treating physician and the insurer cede their authority to a public body, the American health care system remains firmly embedded in a model based on private, decentralized activity. Therefore, it is likely that mandated rights to independent review will lead in the direction of heightened adversarial conflict. This may place greater pressure on physicians to assume a lawyerly posture and cast their patient’s case for treatment in the best possible light. New York’s law, for example, assumes that the treating physician will present specific evidence to the reviewing tribunal on behalf of the patient.69

In addition, juries hearing malpractice cases seem more likely to infer negligent care when judges allow the introduction of evidence suggesting that a physician’s decision to administer or withhold treatment did not demonstrate complete allegiance to the patient. Compared with malpractice suits alleging breach of a physicians obligation to provide professionally competent services, legal enforcement of physicians’ fiduciary duty of loyalty to patients has been uncommon. This is changing because of the financial conflicts of interest that seemingly pervade managed care. Although malpractice judgments are typically isolated incidents not specifically traceable to particular causes of action, other legal theories may support the formal imposition of advocacy responsibilities on doctors. For example, a federal appeals court recently concluded that a physician-controlled health plan violated its express fiduciary duty under ERISA by offering financial incentives to participating physicians on the theory that the self-dealing transaction benefited physicians at a quality-related cost to beneficiaries as a group.70 Although the opinion does not go into detail on this point, the court seems to have been concerned that physicians were playing too many roles within a single organization, and apparently would have preferred that the decision to adopt financial incentives come from non-physician managers instead of from the physicians themselves.71

69. See N.Y. PUB. HEALTH LAW § 4910 (effective July 1, 1999), available in WESTLAW, NY-ST Database.

70. See Herdrich v. Pegram, 154 F.3d 362, 373 (7th Cir. 1998). Because of its strain with respect to the connection between loyalty to individual patients and loyalty to the plan as a whole, this case may not be followed by other courts. See id. at 372-73.

71. See id. (commenting on the financial interests of the physician-decisionmakers).
Similarly, federal prosecutors seeking to deter fraud in publicly funded health programs such as Medicare have announced their intention to bring mail fraud actions against physicians who have been corrupted by managed care based on breaches of common law fiduciary duties. Although actual prosecutions have yet to materialize, enforcement officials have identified failure to advocate on behalf of patients as a principle factor in determining whether potential fraud liability exists.

3. Managed Care Contracting Practices. A formal commitment to advocacy by physicians is also evident in the law's approach to the contractual relationship between physicians and managed care organizations. Because managed care organizations selectively contract with physicians and, thereby, confer economic benefits on them, one area of intense legislative interest is protecting physicians from being terminated or otherwise disadvantaged as a result of arguing in favor of treatment or coverage. These laws reinforce the idea that physicians are obligated to advocate on behalf of patients.

California enacted protection for physicians who "advocate for medically appropriate health care" in 1994, in response to the medical profession's concern over incurring liability for failure to advocate following the Wickline decision. The law proclaims: "It is the public policy of the State of California that a [health care practitioner] be encouraged to advocate for appropriate health care for his or her patients," and defines advocacy as "to appeal a payer's decision to deny payment for a service pursuant to the reasonable grievance or appeal procedure established by a [managed care organization] or to protest a decision, policy, or practice that the health care practitioner... reasonably believes impairs the... ability to provide appropriate health care...." Although this section appears permissive rather than mandatory, it is predicated on Wickline's obligation to advocate; moreover, other statutory provisions imply a duty to advocate from the quoted language, even if they do not specify

73. See id.
74. See CAL. BUS. & PROF. CODE § 2056(a) (West Supp. 1998) (prohibiting the termination of or retaliation against physicians as a result of patient advocacy).
75. Id. § 2056(b); see also id. § 510(b).
corresponding rights and remedies. The Medical Board of California has also stated:

Open communication and patient advocacy are vital elements of the [physician-patient] relationship. This relationship is not to be constrained by any considerations other than what is best for the patient. Any act or failure to act by a physician that violates this trust and jeopardizes this relationship places the physician at risk of being found in violation of the Medical Practice Act.

Other states have followed suit, outlawing retaliation against physicians who advocate for patients. For example, Georgia law tracks the California language by declaring a public policy of encouraging health care professionals to advocate for medically appropriate health care for their patients. New York's version, which took effect in 1997, makes it unlawful for health plans and insurers to prohibit or restrict a health care professional from complaining to a government agency about organizational policies that may negatively impact access to or quality of care, "or for the provision of health care services."

At the federal level, the Consumer Bill of Rights issued by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, which has been applied to federal health programs by executive memorandum, urges in

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76. See CAL. HEALTH & SAFETY CODE § 1368(e) (West Supp. 1997) (noting "a provider's duty to advocate for medically appropriate health care for his or her patients pursuant to Sections 510 and 2056 of the Business and Professions Code... ").

77. Alan E. Shumacher, Board Member Speaks at Department of Corporations Hearing on Effect of HMOs, MED. BD. OF CAL. ACTION REP., Apr. 1997, at 3.

78. See, e.g., ME. REV. STAT. ANN. tit. 24-A, § 4303(3) (West Supp. 1998) ("A carrier offering a managed care plan may not terminate... a participating provider because the provider advocates for medically appropriate health care."); MD. CODE ANN., INS. § 15-812(f)(1) (1997) (stating that an insurer may not deny, limit, or impair participation of an attending provider for advocating certain types of treatment); MO. REV. STAT. § 354.609(5)(1) (1997) (providing that no health carrier may terminate a contract solely because a provider advocates on behalf of an enrollee in good faith); NEV. REV. STAT. ANN. § 695G.250 (1998) (refusing to allow contract termination for good faith advocacy regardless of whether done in public or private); OR. REV. STAT. § 743.803(2)(f) (Supp. 1998) (allowing a physician to advocate "a decision, policy or practice"); TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(f) (West Supp. 1998) (stating that advocacy shall not be the basis of removal from a plan or refusal to renew a provider contract); VA. CODE ANN. § 32.1-137.15(G) (Michie Supp. 1998) (stating that termination of employment or contractual relationships shall not occur for "advocating the interest of [the] patient or patients in the appeals process" accompanying utilization review).


80. See N.Y. INS. LAW § 4325(b) (McKinney 1996).

81. See Memorandum on Federal Agency Compliance with the Patient Bill of
chapter four that health plans should "[be] prohibited from penalizing or seeking retribution against health care professionals or other health workers for advocating on behalf of their patients." Moreover, the Health Care Financing Administration ("HCFA") has included a prohibition on retaliation for advocacy in comprehensive regulations governing the new Medicare+Choice ("M+C") program, which were released in June 1998:

An M+C organization may not prohibit or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising, or advocating on behalf of, an individual who is a patient and enrolled under an M+C plan about . . . [t]he patient's health status, medical care, or treatment options . . . including the provision of sufficient information to the individual to provide an opportunity to decide. 3

Courts are beginning to hear cases based on these provisions. The first lawsuit filed under California's prohibition against retaliation for advocacy resulted in a $1.75 million compensatory damage verdict for the plaintiff, and was settled for $2.5 million before the jury could finalize an award of punitive damages. 4 The case involved a pediatrician who claimed that he was criticized and ultimately fired by members of his own medical group for spending too much time with patients and arguing the need for more costly tests and treatments. 5 Courts are also addressing similar issues in personal injury litigation. In

Rights, 34 WEEKLY COMP. PRES. DOC. 298 (Feb. 20, 1998).


83. 42 C.F.R. § 422.206(a) (1999).

84. For details regarding Self v. Children's Associated Medical Group, Cal. Super. Ct., No. 695870, see Julie Marquis, Doctor Gets $2.5-Million Settlement, L.A. TIMES, April 28, 1998, at A3, and Daniel B. Wood, California Doctor Fires Shot Against the Bow of HMO Industry, CHRISTIAN SCI. MONITOR, May 1, 1998, at 3. Other claims of retaliation for patient advocacy are also being pursued. See Tracy Wilson, Doctor's Suit Over Firing to be Test of Law, L.A. TIMES, June 17, 1997, at A3 (reporting on another test case in which a doctor was terminated after complaining that having to field 158 phone calls and treat 20 different patients in a 72-hour period was an "unacceptable" way to treat patients).

85. See Sarah A. Klein, Court Agrees: Calif. Plan Shouldn't Have Fired Doctor, AM. MED. NEWS, Apr. 27, 1998, at 3 (describing the case as the first successful wrongful termination suit by a physician who "put[] patient care ahead of profits"). An important but seldom recognized aspect of the litigation is that the defendant was a physician group practice, not an insurance company. Because responsibility for claims review and coverage denial is increasingly being delegated to professional organizations, one can no longer assume that physicians' interests will be aligned with those of individual patients.
one case that yielded a $1 million arbitration award for the plaintiff, the plaintiff presented evidence that the defendant HMO had threatened the treating physicians with termination if they protested the plan's denial of coverage. 86

Another area of legal support for physician advocacy involves the financial relationship between managed care organizations and health professionals. Considerable regulatory activity has focused on methods of compensation that reward physicians for conservative treatment approaches rather than paying them an additional amount for every service rendered. 87 These arrangements have generated political resistance less because of their effect on clinical outcomes than because they threaten the professional ideal of fidelity to individual patients. 88 In fact, a causal connection between incentives and poor care has not yet been demonstrated empirically, and physicians in managed care remain liable for medical malpractice under the same standard applicable to fee-for-service medicine. Nonetheless, public fears of physician disloyalty are mirroring, in the regulatory arena, some of the trends in malpractice litigation.

Financial incentives in managed care are constrained by both ethics and law. The Code of Medical Ethics requires disclosure to patients of financial inducements to limit treatment and places substantive limits on the magnitude and targeting of incentive payments. 89 Similarly, several states and the federal government prohibit or regulate financial incentives paid to


87. The potential incompatibility between advocacy and financial conflicts of interest has been noted more generally. Supporting a congressional ban on patent rights in medical procedures, for example, Representative Charlie Norwood (Georgia), himself a dentist, exclaimed in the debate that “[i]t is the moral and ethical duty of every health care provider to be a patient advocate[ ]” and observed that profiting from every other providers’ use of a patented procedure “is a twisted way to practice medicine.” 142 CONG. REC. E1389 (daily ed. July 26, 1996) (statement of Rep. Norwood). For an overview of conflict of interest see MARC A. RODWIN, MEDICINE, MONEY, AND MORALS: PHYSICIANS’ CONFLICTS OF INTEREST (1993) (explaining that financial conflicts of interests “can compromise a physicians’ loyalty to patients”).

88. With respect to regulation of financial incentives, managed care arguably is being hoisted on its own petard. After years of arguing that clinical decisions should be based on objective, scientific evidence rather than being driven by unproved professional custom, managed care organizations are hard pressed to justify the use of financial incentives by invoking a large gray area of acceptable practice.

89. See AMA CODE, *supra* note 42, Op. 8.13(3)(A)-(C) (noting that serious potential conflicts between physicians’ financial interests and patients’ needs are created when physicians are given financial incentives to limit care, and providing certain ethical guidelines to prevent abuse).
physicians as an inducement to limit treatment. In the first enforcement action commenced under these laws, the Texas Department of Insurance recently recommended to its Commissioner that an HMO pay an $800,000 fine and repay financial penalties to its network physicians.

The law is similarly evolving to encourage physician advocacy by promoting full and open communication between doctors and patients. For example, physicians' informed consent obligations probably include disclosure of treatment alternatives that are not readily available to the patient because of the patient's insurance status or enrollment in a managed care plan. Although no court appears to have ruled on such a case, the Code of Medical Ethics expressly obligates physicians to inform patients of services not covered by managed care if the physician believes the patient's condition requires such services.

A high-profile issue that reflects public support for physician advocacy involves so-called "gag clauses" in managed care contracts that may prohibit physicians from revealing to patients the existence of potentially beneficial but uncovered treatments. According to a recent General Accounting Office ("GAO") study, however, few such clauses actually exist, and most are "boilerplate" confidentiality, non-solicitation, or non-disparagement provisions that are seldom, if ever, enforced. Nonetheless, the notion that

90. See, e.g., 42 U.S.C. § 1320a-7a(b)(1) (1994) (prohibiting hospital payments that induce physicians to limit services to Medicare and Medicaid patients); id. § 1395mm(i)(8)(A) (requiring contractual provisions between the provider and the doctor that prohibit payments by managed care plans that limit services to specific individuals, and regulating Physician Incentive Plans that place doctors at substantial financial risk for referral services); see also Fred J. Hellinger, Regulating the Financial Incentives Facing Physicians in Managed Care Plans, 4 AM. J. MANAGED CARE 663, 668-69 (1998) (describing a mix of substantive regulation and disclosure requirements).

91. See Regulators Say Harris Methodist HMO Must Repay Doctors' Financial Penalties, 7 Health L. Rep. (BNA) 598 (1998). The incentives consisted of pooled bonuses to, or withholds from, individual physician fees. See id. The HMO based these incentives on utilization of pharmacy, specialty and inpatient services, and adjustments to capitation rates for physician groups. See id. A private class action suit based on the same behavior has been filed. See id.; see also Spetman v. Harris Health Plan Inc., No. 352-173216-98 (352d Dist. Ct., Tarrant County, Tex., Apr. 1, 1998).


93. See AMA CODE, supra note 42, Op. 8.132 ("[P]hysicians have an obligation to assure the disclosure of medically appropriate treatment alternatives, regardless of cost.").

94. See HEALTH, EDUC., AND HUMAN SERVS. DIV., U.S. GENERAL ACCOUNTING OFFICE, MANAGED CARE: EXPLICIT GAG CLAUSES NOT FOUND IN HMO CONTRACTS, BUT PHYSICIAN CONCERNS REMAIN 3 (1997) ("It appears that HMO contract provisions that may be interpreted as limiting the medical information that
physicians were being contractually restrained from urging patients to pursue necessary treatment prompted the immediate passage of legislation banning gag clauses in several states. At the federal level, the HCFA quickly issued an advisory notice to health plans participating in Medicare and Medicaid that gag clauses violated their coverage agreements, and followed it with a specific prohibition in the M+C regulations. Gag clauses have also been condemned by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

The close connection between these measures and unfettered advocacy is clear from the remarks of a physician member of Congress, Representative Greg Ganske, who condemned gag clauses: "Doctors should be patients' advocates. They should not be the company doctor." Protection of advocacy also ties the debate over gag clauses to the issue of financial incentives. The Office of Personnel Management recently issued a final rule banning gag clauses in contracts of health plans participating in the Federal Employees Health Benefits Program ("FEHBP"). Significantly, the rule not only outlaws express prohibitions on physicians giving information to patients, but also financial incentives that would limit or reduce communication about "appropriate medically necessary services.

physicians may provide patients are not likely to have a significant impact on physician practice."); see also David A. Hyman, Consumer Protection and Managed Care: With Friends Like These . . . , in 1998 HEALTH LAW HANDBOOK 283, 301 (Alice G. Gosfield ed., 1998) (pointing out that there is "considerable dispute" about whether pure gag clause provisions exist).

95. See Tracy E. Miller, Managed Care Regulation: In the Laboratory of the States, 278 JAMA 1102, 1105 (1997) (noting that anti-gag rule policies were introduced in 33 states and adopted in 18 states between 1995 and 1996).

96. See HEALTH CARE FIN. ADMIN., DEP'T OF HEALTH & HUMAN SERVS., OPERATIONAL POLICY LETTER No. 44, Nov. 25, 1996 (visited Nov. 10, 1998) <http://www.hcfa.gov/medicare/opl044.htm> (stating that Medicare beneficiaries are entitled to “advice and counsel from their physician on medically necessary treatment options” and declaring that contractual provisions which “limit a physician’s ability to so counsel” a Medicare beneficiary about treatment options are “a violation of the law”).


98. See CONSUMER BILL OF RIGHTS, supra note 82.


100. See, e.g., Office of Personnel Management Press Release, Vice President Gore Reports to President: Federal Employee Health Benefits Program Complies With Patients' Bill of Rights (November 2, 1998) (announcing that the Federal Employees Health Benefits Program has banned the use of gag clauses in provider contracts); see also FEHBP's HMOs, POS Plans Raise Rates 8.8%, Expand Protections, MANAGED CARE Wk., Sept. 21, 1998, available in 1998 WL 9851184 (noting that the entire Patient's Bill of Rights, including the ban on gag clauses, has been adopted for those in the FEHBP).

101. Minimum Standards for Health Benefits Carriers, 63 Fed. Reg. 42,584,
Future changes to federal law take on considerable importance because of ERISA. Although it has been narrowed significantly since the Supreme Court’s decision in New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co., the preemptive reach of ERISA remains the principal obstacle to state regulation promoting advocacy. In 1997, for example, Texas enacted a measure intended primarily to subject managed care organizations to liability for personal injury caused by their negligent conduct, but which also established an external review process for coverage decisions and prohibited health plans from retaliating against physicians who advocated on behalf of their patients. Ruling on a challenge brought by Aetna, a federal district judge upheld imposition of liability under the Texas Act but overturned the external review and non-retaliation provisions as preempted by federal law, on the theory that they “limited the choices” available to ERISA plans and were not saved from preemption as laws regulating insurance. Similar to many recent decisions interpreting ERISA, the ruling was hardly Solomonic, in that it tried to find a compromise position but ended up slicing the child in two. For example, the court allowed Texas to apply liability to managed care organizations, but held the State’s accompanying prohibition on indemnification agreements governing that liability to be preempted. To be fair, Congress has repeatedly declined to amend ERISA to address the realities of managed care, leaving courts to do the best they can with an outdated statute.

These ethical and legal developments do not in themselves establish a clear duty of lawyerly advocacy for physicians in managed care. In the aggregate, however, they strongly suggest that significant constituencies are working to create conditions conducive to physician advocacy by emulating the legal profession’s model of adversarial dispute resolution. In the following section, this Article will take a closer look at this adversarial legal model with respect to both the preconditions to

104. See TEX. CIV. PRAC. & REM. CODE ANN. §§ 88.001-003 (West Supp. 1998).
106. See id. at 627.
legal advocacy and the objections to advocacy as the sine qua non of lawyering.

III. THE LAWYER'S PERSPECTIVE ON ADVOCACY

A. Preconditions to Advocacy

The starting point for any discussion of lawyerly advocacy is that it cannot exist apart from a formal system of dispute resolution. For example, Nathan Crystal writes:

The fundamental purpose of our judicial system is the fair resolution of disputes. This objective serves an essential need of any society: maintenance of social stability. By providing parties involved in a dispute with a mechanism for resolving the controversy that the parties are likely to accept because of its fairness, a system of dispute resolution minimizes the possibility that individuals will take the law into their own hands.108

Echoing this sentiment, the Model Rules of Professional Conduct set forth the responsibilities of lawyers in its preamble. The first sentence states: "A lawyer is a representative of clients, an officer of the legal system and a public citizen having special responsibility for the quality of justice."109 This statement immediately suggests that the lawyer's mission is not advocacy per se, but advocacy in the context of an administrative framework designed to achieve particular social goals.

What are the principal features of that framework? One core characteristic is universal, or near universal, access to the forum in which disputes are resolved. A second is fairness; specifically, the existence of a neutral tribunal before which adversarial positions are argued. A third is the existence of consistent rules to govern the conduct of proceedings. The legitimacy of the system, and by extension of the advocates who practice within it, depends on these elements. Reflecting this framework, Professor Crystal circumscribes the advocate's role not by external issues of morality, but by limitations that derive from the concept of adversarial dispute resolution itself.110 He concludes that advocates must: (1) only present claims that involve bona fide disputes; (2) not interfere with the impartiality of the

110. See Crystal, supra note 108, at 672.
decisionmaker; and (3) follow procedural rules that are designed to be truth-maximizing.\textsuperscript{111}

These aspects of the legal system are so intuitive that legal scholars tend either to take them for granted or to deconstruct and reinterpret them. Either approach is appropriate to an introspective examination of law. When extrapolating from one profession to another using techniques of comparative analysis, however, it is worth pausing to consider them at face value. The conclusion one reaches with respect to physician advocacy is straightforward: there is as yet no established system of adversarial decisionmaking in medicine. In fact, the genesis of this Article is the transitional quality of today's health care system, and the resulting need to define clearly the contours of the medical profession's future role. For example, the external review laws discussed above barely adumbrate a neutral tribunal capable of resolving health care disputes.\textsuperscript{112} Moreover, the American health care system is notorious for its lack of universal access, particularly when compared with other Western nations.\textsuperscript{113} Consequently, empowering physicians as advocates requires constructing a coherent system in which they will function.

The issue of rules is an important one. Disciplinary rules governing lawyers exist in all jurisdictions and are generally enforced through integrated efforts of state bar associations and courts (whose members are, of course, lawyers themselves).\textsuperscript{114} The American Bar Association is responsible for the two major ethical codes currently in use. The \textit{Model Rules of Professional Conduct} were approved in 1983, and have been adopted at least in part by about two-thirds of the states.\textsuperscript{115} The remaining states, except

\textsuperscript{111}. \textit{See id.} at 675 (describing the three principles that provide a framework for analyzing legal ethics). The first principle is violated by frivolous claims; the second by ex parte communications, some pretrial publicity, a failure to disclose grounds for judicial disqualification, or not reporting juror misconduct; and the third by failure to disclose information required in connection with discovery requests, and failure to disclose information needed to prevent death or serious bodily harm, perjury, exculpatory evidence in criminal prosecution, or of adverse law. \textit{See id.} at 675, 690-91, 694, 707, 715-26.

\textsuperscript{112}. Refer to notes 76-83 \textit{supra} and accompanying text (detailing various state external review laws).

\textsuperscript{113}. \textit{See}, e.g., RUDOLF KLEIN, THE NEW POLITICS OF THE NATIONAL HEALTH SERVICE (3d ed. 1995) (describing historical cycles of privatization and public control in Great Britain's National Health Service (NHS)).

\textsuperscript{114}. For an overview of attorney regulation and discipline, see DEBORAH L. RHODE, PROFESSIONAL RESPONSIBILITY: ETHICS BY THE PERSUASIVE METHOD 40-81 (2d ed. 1998).

\textsuperscript{115}. \textit{See id.} at 43.
Physicians as Advocates

California (which has a unique legislative code\textsuperscript{116}), enforce some version of the ABA's \textit{Model Code of Professional Responsibility}, which was adopted in 1970.\textsuperscript{117} Legal professionals situate themselves within rule-based systems with a level of comfort that may not be easy to replicate in medicine. Lawyers are trained to understand and exploit the domains occupied by rules and the interstices between them. This suggests several things about the special subset of rules that governs lawyers' conduct. First, lawyers who are predisposed to adversarial conduct realize that they need rules because they are unlikely to attain consensus on an ad hoc basis. Second, lawyers know enough about rules to recognize the occasional value of incompleteness and ambiguity, making it likely that lawyers' rules address what lawyers prefer to have made certain, while leaving other issues open to interpretation and debate. Third, lawyers are well-equipped to monitor compliance with rules and to take action against violators.

Having established a basic framework for legal advocacy, let us now state a few of its specific criteria.\textsuperscript{118} To begin with, lawyers have an obligation to their clients of zealous advocacy, enforceable through professional disciplinary processes. Under the \textit{Model Code of Professional Responsibility} the title of a central canon of conduct is that "A Lawyer Should Represent a Client Zealously Within the Bounds of the Law."\textsuperscript{119} This imposes a high standard for advocacy: "A lawyer shall not intentionally . . . fail to seek the lawful objectives of his client through reasonably available means permitted by law and the Disciplinary Rules."\textsuperscript{120} Furthermore, the \textit{Model Rules of Professional Conduct} make clear that "[t]he advocate's task is to present the client's case with persuasive force[,]" limited only by a duty of candor to the tribunal, and that the tribunal, not the advocate, is responsible for determining the probative value of the evidence presented.\textsuperscript{121}

\begin{itemize}
\item \textsuperscript{116} See id. at 43-44 (noting that California grants its Board of Bar Governors the statutory authority to directly promulgate rules).
\item \textsuperscript{117} See id. at 43.
\item \textsuperscript{118} Lest the sophisticated legal reader find the following discussion ingenuous, it bears repeating that the purpose of this section is to identify the foundational components of an effective system of adversarial advocacy, not to claim that everyone operates smoothly.
\item \textsuperscript{119} \textit{Model Code of Professional Responsibility} Canon 7 (1981).
\item \textsuperscript{120} \textit{Id.} DR 7-101(A)(1).
\item \textsuperscript{121} \textit{Model Rules of Professional Conduct} Rule 3.3 cmt. (1997).
\end{itemize}
Deferring to the client’s preferences is another essential facet of the legal advocate’s role. Under the traditional view, a litigator’s function is instrumental, not corrective. Although a lawyer may ethically terminate a representation if “a client insists on pursuing an objective that the lawyer considers repugnant or imprudent,” lawyers are frequently required to suppress personal beliefs that conflict with professional responsibilities. For example, the Model Rules state that “[a] lawyer shall abide by a client’s decisions concerning the objectives of representation.” Even when counseling clients, the authors of a leading student text argue that personal opinions may be offered to clients only if “you can base your opinion on the client’s subjective values, not your own.” However, conscious abstention from influencing one’s clients reduces a lawyer’s moral accountability. The challenge for lawyers is to find “a way . . . to accept responsibility . . . without controlling the lives of others.”

122. See id. Rule 1.2(a) (“A lawyer shall abide by a client’s decisions concerning the objectives of representation, . . . and shall consult with the client as to the means by which they are to be pursued.”). An unusually dramatic example is a defense attorney who is personally opposed to the death penalty, but who argues for execution of a convicted murderer who wishes it. See Mark Hansen, Death’s Advocate, A.B.A.- J., Dec. 1998, at 22.

123. MODEL RULES OF PROFESSIONAL CONDUCT Rule 1.16(b)(3).

124. See Bruce A. Green, The Role of Personal Values in Professional Decisionmaking, 11 GEO. J. LEGAL ETHICS 19, 29-55 (1997) (giving examples relating to confidentiality, judicial decisionmaking, defining and undertaking the objectives of representation, establishing the lawyer’s fee, withdrawal from representation, client counseling, and disclosure).

125. MODEL RULES OF PROFESSIONAL CONDUCT Rule 1.2(a).

126. DAVID A. BINDER ET AL., LAWYERS AS COUNSELORS: A CLIENT-CENTERED APPROACH 279 (1991). This passage stakes out an extreme position, though the authors have retreated somewhat from the even more radical view taken in a previous edition. See DAVID A. BINDER & SUSAN C. PRICE, LEGAL INTERVIEWING AND COUNSELING: A CLIENT-CENTERED APPROACH 148-49 (1977) (“[I]t is our belief that, by and large, lawyers cannot know what value clients really place on the various consequences . . . [and] usually cannot determine which alternative will provide maximum client satisfaction and [therefore] that decisions should be left to the client.”). The Model Rules state more temperately that “a lawyer shall exercise independent professional judgment and render candid advice.” MODEL RULES OF PROFESSIONAL CONDUCT Rule 2.1 (adding that the lawyer may refer to considerations outside the law, such as moral or political circumstances). Moreover, lawyers who are committed in theory to client autonomy may in practice find themselves influencing clients’ decisions. See, e.g., William H. Simon, Lawyer Advice and Client Autonomy: Mrs. Jones’s Case, 50 Md. L. REV. 213, 215-16 (1991) (examining the difficulties attorneys face in offering the client a fully autonomous choice).

Legal advocacy implies freedom from most, if not all, conflicts of interest. For one, the advocate's role is supposed to be pure and unconnected from other services a lawyer might render to a client. For example, a lawyer or law firm involved in structuring a transaction typically will think twice before litigating a case arising from that transaction, and may be ethically prohibited from doing so. Under the Model Rules, for example, a lawyer may not be both a witness and an advocate at a trial unless the testimony relates to an uncontested issue, the testimony relates to the nature and value of legal services, or disqualification of the lawyer would work undue hardship on the client.

Prohibited conflicts of interest frequently arise when a single lawyer is asked to represent two clients with opposing goals. The Model Rules state that a lawyer may not represent a client if the representation will be directly adverse to another client's interests, or will be materially limited by the lawyer's responsibilities to another client, a third party, or the lawyer's interests, unless the lawyer believes the representation will not adversely affect any client and each client consents after consultation. These restrictions extend even to former clients.

Institutional conflicts of interest are also for the most part addressed by ethical rules. Conflicts between clients are generally imputed to lawyers practicing in partnership with one another, and can result in disqualification of entire law firms. Lawyers representing corporate clients owe their allegiance to the organization, not its officers, directors, members, employees, or shareholders, and must disclose that fact to individuals with potentially adverse interests.

129. See MODEL RULES OF PROFESSIONAL CONDUCT Rule 3.7(a); see also MODEL CODE OF PROFESSIONAL RESPONSIBILITY DR 5-102 (1981) (obligating a lawyer to withdraw from representation if he, or a lawyer in his firm, ought to be called as a witness).
130. See MODEL RULES OF PROFESSIONAL CONDUCT Rule 1.7(a)-(b).
131. See id. Rule 1.9(a) ("A lawyer who has formerly represented a client in a matter shall not . . . represent another person in the same or a substantially related matter in which that person's interests are materially adverse to the interests of the former client unless the former client consents after consultation.").
132. See Epstein, supra note 128, at 584-87 (discussing institutional conflicts of interest and the rules that regulate them).
133. See MODEL RULES OF PROFESSIONAL CONDUCT Rule 1.10(a) ("While lawyers are associated in a firm, none of them shall knowingly represent a client when any one of them practicing alone would be prohibited from doing so.").
134. See id. Rule 1.13(a), (d).
Lawyers are severely restricted in their ability to ethically engage in self-dealing transactions that arise in the course of representation. For example, the Model Rules ban lawyers from business dealings with clients, and from acquiring pecuniary interests adverse to clients, unless the terms of such transactions are fair and reasonable, disclosed to the client, and the client consents in writing after having the opportunity to seek the advice of independent counsel.  

Legal fees are similarly structured to avoid conflicts of interest. Most clients pay their own fees. Under the Model Rules, a lawyer may only be paid by a party other than the client if the client consents, the paying party does not interfere with the lawyer’s independence or professional judgment, or with the client-lawyer relationship, and information deriving from representation is kept confidential. To allow less wealthy clients to employ counsel, the Model Rules permit written agreements that establish fees contingent on successful representation, except in cases involving domestic relations, criminal defense, or other areas that may be prohibited by law. Like any set of financial incentives, these arrangements are imperfect motivators, particularly with respect to the time the

135. See, e.g., id. Rule 1.8 (prohibiting lawyers from engaging in certain transactions in which the lawyer has an interest); MODEL CODE OF PROFESSIONAL RESPONSIBILITY DR 5-101(A) (1981) (prohibiting self-dealing for monetary or personal gain).

136. See generally Kevin M. Clermont & John D. Currivan, Improving on the Contingent Fee, 63 CORNELL L. REV. 529, 535 (1978) (evaluating various fee structures and concluding that “an important goal in structuring legal fees should be the elimination, or at least the minimization, of economic conflict of interest between lawyer and client”).

137. Lawyers are ethically obligated to charge only “reasonable” fees. See MODEL RULES OF PROFESSIONAL CONDUCT Rule 1.5(a). Factors to be considered in establishing reasonableness include: (1) the time and labor required; (2) the novelty and difficulty of the questions involved; (3) the skill necessary to perform services properly; (4) the likelihood that accepting representation will preclude other employment; (5) the customary fee in the locality; (6) the amount at issue in the representation and the results obtained; (7) the time constraints imposed; (8) the nature and length of the professional relationship; (9) the experience, reputation and ability of the lawyer; and (10) whether the fee is fixed or contingent. See id. Significantly, these factors generally assume that recovery is monetary and that the costs of representation consist of the lawyer’s personal services. Although enforcement of the reasonable fee requirement is predictably difficult, sanctions have been imposed in egregious cases. See, e.g., In re Haskell, 962 P.2d 813, 824 (Wash. 1998) (imposing a two year suspension for false and inflated bills).

138. See MODEL RULES OF PROFESSIONAL CONDUCT Rule 1.8(f).

139. See id. Rule 1.5(c)-(d). Prohibited fee arrangements in domestic relations cases are those in which the payment or amount of the fee depends upon the lawyer securing a divorce, or a settlement or payment in lieu of a divorce. See id. Rule 1.5(d)(1).
lawyer expends and the lawyer's eagerness to settle litigation. For example, contingent fees are open to criticism in easy cases because they tempt lawyers to settle quickly without expending effort to maximize the client's recovery, and in hard cases because they may prompt lawyers to "win at all costs" regardless of ethical restraints. Nonetheless, fee structures in law serve for the most part to align lawyers' interests with those of their clients.

However, the notion frequently articulated by the medical profession that advocacy requires complete disregard of cost finds no support in legal ethics. According to the Model Rules, a lawyer "should act with commitment and dedication to the interests of the client and with zeal in advocacy" but "is not bound to press for every advantage that might be realized for a client." This fits well with a system of direct payment of fees. Similarly, physicians in earlier times had to pay strict attention to their patient's financial resources when making house-calls and dispensing medications; those who pressed the need for treatment at any cost were more likely considered to be charlatans than advocates. The situation in medicine has changed not because of a strengthened commitment to advocacy, but because of two related factors: (1) the expansion of medical practice to include complex and expensive resources beyond the physician's time and skill; and (2) the introduction of third-party payment through health insurance. By contrast, the costs of lawyering remain largely connected with the expenditure of human capital, and legal fees are either paid directly or generated from successful litigation, so that lawyers only rarely experience financial conflicts of interest pitting cost-consciousness against zealous advocacy.

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140. For this reason, a lawyer must promptly inform a client of a settlement offer, and the decision to accept or refuse the offer is exclusively the client's. See id. Rules 1.2(a), 1.4 cmt. (obligating the lawyer to keep the client reasonably informed and to abide by the client's substantive decisions).

141. See Lester Brickman et al., Rethinking Contingency Fees (1994).

142. Underlying this generalization is a host of imperfections regarding legal fees and the incentives they create. For an analysis of fee-based tensions in law, see generally Robert Mnookin, Lawyers as Negotiators (forthcoming 1999). Nonetheless, my overall sense of the issue comes from personal experience. When I shifted from the practice of medicine to that of corporate law, I found it ethically reassuring that my monetary rewards usually would be based on monetary benefit to my client, even though I had my doubts about the overall social value of my new career compared to my previous one.

143. MODEL RULES OF PROFESSIONAL CONDUCT Rule 1.3 cmt.

144. Conflicts still arguably arise in contingent fee litigation in which nonmonetary goals, such as injunctive relief, matter as much to the client as recovery of damages, and in class action litigation when the true client interest must
The factors previously mentioned enable advocacy; other factors constrain it. Lawyers tolerate various limits on their use of the justice system. As already mentioned, a lawyer is an "officer of the court," as well as an instrument of her client. Under the Model Rules, for example, lawyers must argue in good faith and not bring frivolous claims, must "make reasonable efforts to expedite litigation consistent with the interests of the client[,]" must act with candor toward the tribunal, must act fairly to opposing parties and counsel, must respect the impartiality and decorum of the tribunal, and must not use the media to influence the outcome of an adjudicative proceeding. These ethical mandates are frequently honored in the breach; nonetheless, they remain enforceable in egregious cases. In addition, although a lawyer generally must pursue a client's lawful objectives, a lawyer may not counsel a client to engage or assist a client in conduct that the lawyer knows is criminal or fraudulent. Lawyers are also held to a high standard of truthfulness, and may not knowingly make a false statement of material fact or law to any person, or fail to disclose a fact necessary to avoid assisting a criminal or fraudulent act.

On the other hand, limits on advocacy are generally construed most favorably to the client's interests, and may be subordinated to other values. For example, defense counsel in criminal cases may be obligated to allow defendants to testify, even if they know that testimony will be false. Moreover,

be asserted by a supervising court.

145. Refer to note 108-09 supra and accompanying text (discussing the lawyer's duty to the client, the legal system, and society); see also Eugene R. Gaetke, Lawyers as Officers of the Court, 42 Vand. L. Rev. 39, 69 (1989).

146. See MODEL RULES OF PROFESSIONAL CONDUCT Rule 3.1 (requiring lawyers to bring only meritorious claims and contentions).

147. Id. Rule 3.2.

148. See id. Rule 3.3 (prohibiting a lawyer from engaging in certain fraudulent acts in connection with a tribunal). This prohibition means that lawyers may not make material false statements of fact or law to the court, must inform the court of facts necessary to avoid assisting a criminal or fraudulent act, must disclose controlling legal authority, and may not knowingly offer false evidence. See id.

149. See id. Rule 3.4 (prohibiting a lawyer from obstructing another party's access to evidence).

150. See id. Rule 3.5 (listing conduct that threatens the integrity of the tribunal).

151. See id. Rule 3.6 (stating that a lawyer shall not make a public statement concerning pending litigation if it will have a substantial likelihood of prejudicing an adjudicative proceeding in the matter).

152. See id. Rule 1.2(d).

153. See id. Rule 4.1 (adding that such disclosure need not be made if it would violate the attorney's duty of confidentiality).

154. See id. Rule 3.3 cmt. (suggesting that the lawyer permit the defendant to
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Lawyers are bound by strict confidentiality from revealing information relating to clients' past behavior, which limits their affirmative obligations to disclose wrongdoing. Under the Model Rules, a lawyer is forbidden from revealing confidential information without the client's consent, except that a lawyer may (but is not required to) reveal information necessary to prevent the client from committing a criminal act that is likely to result in imminent death or substantial bodily harm.

B. Objections to Legal Advocacy

In the aggregate, these duties and strictures form a theoretically balanced system of adversarial advocacy intended to protect individual rights and maintain social harmony. Whether the system accomplishes these goals is another matter entirely. In recent years, scholars of all political and philosophical bents have ventured forth to criticize legal advocacy in operation and, occasionally, to suggest that its underlying premises are flawed as well. It is ironic that medicine may be moving toward an adversary system for resolving disputes just when law is moving away from it. Notably, law is placing much greater emphasis on mediation and other more cooperative forms of dispute resolution.

Legal advocacy is also being subjected to a strong theoretical critique. For example, William Simon stresses that an ideal system of dispute resolution should uphold the individual values underlying the rule of law: autonomy, responsibility, and dignity. Identifying neutrality, partisanship, procedural justice, and professionalism as the foundational principles of lawyerly advocacy, Professor Simon argues that a positivist view of advocacy, which views the lawyer as instrumentally advising the

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155. See Harry I. Subin, The Lawyer as Superego: Disclosure of Client Confidences to Prevent Harm, 70 IOWA L. REV. 1091, 1096 (1985) (arguing that confidentiality is "fundamentally important to preserving individual autonomy" and that confidentiality stems from the attorney-client privilege).

156. See MODEL RULES OF PROFESSIONAL CONDUCT Rule 1.6(b)(1).

157. See, e.g., WALTER K. OLSON, THE LITIGATION EXPLOSION 2-4 (1991) (arguing that "[t]he unleashing of litigation in its full fury has done cruel, grave harm and little lasting good").


client on how to navigate the legal system, ultimately fails because the inevitable influence of procedural choices on substantive outcomes forces the lawyer to intrude on the client's autonomy. Similarly, he surmises that a purposivist view of advocacy, which emphasizes the lawyer's role in advancing general welfare by counseling the client on the importance of shared social norms, fails because specialization and time-limited involvement render lawyers incapable of effectively serving broader goals. Professor Simon concludes that "non-professional advocacy" should supplant the current formalism of legal ethics, which might give pause to other professions contemplating adoption of a legal model.

Taking a different approach, Carrie Menkel-Meadow focuses on the contingent nature of knowledge in what she calls the "poststructural, postmodern" world to suggest that the binary nature of adversarial dispute resolution no longer adequately serves goals of truth and justice. She emphasizes the difficulty of ascertaining the facts upon which decisions are based, and the existence of situations in which shared, even conflicting, entitlements are preferable to winner-take-all results such as emotional-laden disputes in which the underlying human equities are indivisible. At its heart, Professor Menkel-Meadow's argument is a plea for pluralism, and should serve as a caution against efforts to construct a single form of "impartial" dispute resolution in health care.

A frequently articulated criticism of the lawyerly ideal of advocacy is that it strips the legal profession of moral accountability for its behavior. Calvin Woodard was one of the first to decry the secularization of law and the loss of implicit morality in the lawyer's professional role. Richard Wasserstrom similarly objects to the notion that lawyers should be amoral technicians for clients, and points out that lawyers assuming this role will develop unpleasant character traits: "[T]o be competitive

160. See id. at 40-41.
161. See id. at 42-43 (stating that the procedural problems of enforcement and access specifically work to "subvert" client autonomy).
162. See id. at 63.
163. See id. at 74-75.
164. See id. at 142-44 (adding that the death of the lawyer may be a more appropriate solution to ethical dilemmas than the "death of law").
166. See id. at 6-7, n.7. Professor Menkel-Meadow's example is child custody, but coverage disputes involving potentially life-saving therapy also fit the bill.
rather than cooperative; aggressive rather than accommodating; ruthless rather than compassionate; and pragmatic rather than principled." \(^{168}\)

Strict adherence by lawyers to rules of conduct, rather than acting according to moral principles, has also been criticized as eroding public confidence in the justice system. \(^{169}\) This concern is longstanding. In 1906, Dean Roscoe Pound addressed the American Bar Association as follows:

The idea that procedure must of necessity be wholly contentious . . . leads counsel to forget that they are officers of the court and to deal with the rules of law and procedure exactly as the professional football coach [deals] with the rules of the sport. . . . If the law is a mere game, neither the players who take part in it nor the public who witness it can be expected to yield to its spirit when their interests are served by evading it. \(^{170}\)

Some commentators make affirmative cases for abandoning advocacy on moral grounds. Professor Simon, for example, states that lawyers should exercise discretion in the pursuit of justice, \(^{171}\) and Robert Gordon argues that lawyers should be independent moral agents for society, rather than having their beliefs subjugated to their clients' wills. \(^{172}\) Charles Fried urges the lawyer to regard client representation as an act of friendship, \(^{173}\) a notion that suffers from obvious flaws but that at least proposes a common morality between legal professionals and those they serve. However, others defend the adversarial legal system as

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168. Richard Wasserstrom, *Lawyers as Professionals: Some Moral Issues*, 5 HUM. RTS. 1, 13 (1975); see also *THE NEW YORKER BOOK OF LAWYER CARTOONS* 17 (1994) (showing a gentleman introduce himself at a cocktail party with the disclaimer that "I am a member of the legal profession, but I'm not a lawyer in the pejorative sense").


172. See Robert W. Gordon, *The Independence of Lawyers*, 68 B.U. L. REV. 1, 13 (1988) ("The loyalty purchased by the client is limited, because a part of the lawyer's professional persona must be set aside for dedication to public purposes.").

173. See Charles Fried, *The Lawyer as Friend: The Moral Foundations of the Lawyer-Client Relation*, 85 YALE L.J. 1060, 1072-73 (1976) (defining the friendship relationship as one in which the lawyer adopts the client's interests as his own "insofar as this is necessary to preserve and foster the client's autonomy"). This commonality of values is more representative of the physician-patient relationship than of most legal representations.
having its own moral worth. For example, Robert Bone claims that a rich theory of adjudication not only balances process values such as judicial economy, outcome accuracy, substantive norm enforcement, participation, and legitimacy, but also understands judging as a social institution that engages in moral reasoning as it reaches decisions and establishes precedents.174

The practicing bar itself is immersed in debate over the limits of adversarial tactics. Under the rubric of "civility," several bar associations have promulgated voluntary standards for lawyers' behavior.175 These standards continue to generate controversy on three levels. First, their aspirational nature, and their uncertain relationship to procedural rules and mandatory codes of conduct, are confusing to lawyers accustomed to judicial directives.176 Second, the potential tension between civility and effective advocacy discomfits lawyers who consider the latter obligation paramount.177 Third, some attorneys fear that client demands for aggressive lawyering will prohibit more restrained behavior in the market for services and perpetuate a "Prisoner's Dilemma."178

A specific criticism of the adversarial system in law is the low priority it accords truth as an independent objective. As Judge Marvin Frankel observes: "The advocate in the trial courtroom is not engaged much more than half the time—and then only coincidentally—in the search for truth. The advocate's prime loyalty is to his client, not to truth as such."179 In his best-known article, Judge Frankel suggested that the profession adopt a new rule of conduct obligating lawyers to reveal relevant evidence to the court and opposing counsel, to prevent or report false or misleading testimony, and to question witnesses so as to elicit the whole

176. See generally Lawyers' Roundtable: Civility in the Legal Profession, WASH. LAW., Sept.-Oct. 1998, at 34, 34 (discussing the difficulties that have arisen in understanding and applying the civility rules).
177. See id. at 35 (statement of Phil Fox, Partner, Asbil & Brennan, Washington, D.C.) (stating that judges may interpret the voluntary rules in such a way that will "inhibit lawyers from being as aggressive as they should be in representing their clients").
178. See id. at 36 (statement of Phil Fox, Partner, Asbil & Brennan, Washington, D.C.).
This recommendation provoked a sharp response from Monroe Freedman, who argued that the adversarial system is a better way to promote truth than an inquisitorial system, and that our adversarial system reflects values more important than truth, such as constitutional protections against self-incrimination.\textsuperscript{161}

As Debra Rhode points out, inequality of resources between opposing sides and the possibility of biased decisionmaking by the arbiter are additional reasons that the adversary process does not necessarily achieve accurate outcomes, beyond the strategic obfuscation implicit in litigation.\textsuperscript{162} Moreover, the procedural safeguards presumed by the judicial system are absent from the vast majority of disputes that are settled prior to trial, or even before the filing of a lawsuit.\textsuperscript{163} This may not be problematic in commercial litigation, in which routine cases can be processed ministerially by various tribunals, and corporations engaged in large disputes may reasonably choose to sidestep the unpredictability of judges and juries. In cases involving human liberties, however, one might question the legitimacy of a system that purports to be democratic but provides full adversarial protections only in the occasional, well-publicized “show trial.”\textsuperscript{164}

Another set of objections to the traditional model of legal advocacy and adversarial dispute resolution is pragmatic, and concerns the evolving organization of professional practice and the changing nature of client needs. For example, the contractual and employment relationships between physicians and managed care companies have an analogy in the law: insurance defense. Typically, liability insurance policies obligate the insurer to pay for the defense of covered claims against the insured, a task

\begin{itemize}
\item 180. See id. at 1057-58.
\item 182. See Deborah L. Rhode, Institutionalizing Ethics, 44 CASE W. RES. L. REV. 665, 718 (1994). Professor Rhode observes as well that the ability to secure a benefit through legal process does not automatically make it a moral act, especially when one considers the rights of inadequately represented parties. See id. at 671.
\item 183. Despite the myth of open, public determination of rights through litigation, most civil lawsuits not dismissed by courts are resolved by voluntary settlement between the parties. See id. at 669 (asserting that about 90% of litigated cases are resolved without a trial and, thus, not afforded the “oversight” of a disinterested third party); see also Samuel L. Gross & Kent D. Syverud, Don’t Try: Civil Jury Verdicts in a System Geared to Settlement, 44 UCLA L. Rev. 1 (1996); George L. Priest & Benjamin Klein, The Selection of Disputes for Litigation, 13 J. LEG. STUD. 1 (1984).
\item 184. Taking a historical view, Lawrence Friedman observes that these “propaganda plays” taught the public “a curious, double message... that justice was real... but... also... that it was absurd.” LAWRENCE M. FRIEDMAN, A HISTORY OF AMERICAN LAW 576 (2d ed. 1985).
\end{itemize}
usually performed by lawyers employed by or on retainer to the insurer. Predictably, this dual representation raises difficult ethical questions for defense counsel regarding conflicts of interest between insurer and insured, the scope of representation, and the sharing of confidential information. Charles Silver and Kent Syverud take the position that, in these circumstances, sweeping principles of client loyalty and strict adherence to traditional ethical precepts should give way to informed private contracting, under which defense counsel could efficiently serve the interests of both clients. Interestingly, they draw a medical analogy in support of cost-effective insurance lawyering:

[C]onsumers of health insurance increasingly choose cost savings over unlimited expensive medical care. We believe that just as doctors should not have exclusive authority to define how much medical care consumers must buy, lawyers should not be able to employ professional responsibility law to control the amount of legal services insureds must buy.

We will return to the question of the physician's role in cost containment later in this Article.

Traditional advocacy also seems incompatible with the increasing corporatization of legal practice. Whereas client conflicts of interest are seldom fatal to the business operations of solo practitioners, large corporate law firms may have

185. A commonly cited problem is that a defense lawyer may learn from the insured party that the individual's conduct had been willful, or similar information that would exclude the claim from coverage. See A.B.A. National Conference of Lawyers and Liability Insurers, Guiding Principles, 20 FED'N OF INS. COUNS. Q. 93, 97-98 (1970) (obligating defense counsel not to reveal information received from the insured that could jeopardize coverage). An insured might also request information from the lawyer about the company's behavior. In cases involving disputes over the scope of fiduciary duties under ERISA, several courts have held that the attorney-client privilege does not shield confidential communications between plan fiduciaries and legal counsel from discovery by plan participants. See, e.g., In re Long Island Lighting Co., 129 F.3d 268, 271-72 (2d Cir. 1997) (holding that the attorney-client privilege only extends to communications that are non-fiduciary in nature); Washington-Baltimore Newspaper Guild, Local 35 v. Washington Star Co., 543 F. Supp. 906, 910-11 (D.D.C. 1982) (holding that the communications between plan trustees and the attorney for the plan are not confidential).


considerable difficulty identifying conflicts, and potential disqualification can threaten major, longstanding relationships. As a result, ethical rules are often ignored, or jerry-built compromises such as "Chinese Walls" are erected, increasing risk and uncertainty for law firms and their clients. Furthermore, the formal rigidity of adversarial ethics arguably is placing law firms at a competitive disadvantage to diversified accounting and consulting conglomerates that employ individuals with legal training and offer similar counseling and advisory services.  

This phenomenon is also relevant to health care because it raises in another context the tension between assisting clients and furthering the public interest. For example, recent changes to the tax code that confer a limited evidentiary privilege on accountant-client communications were opposed in part on the ground that an accountant serving as auditor should not be exclusively the client's advocate, but should be obligated to the broader public as well.  

Finally, formal advocacy is being questioned because law can no longer even pretend to be a monolithic profession. Modern lawyers play many roles with respect to clients, of which advocate is but one. The preamble to the Model Rules states:

As advisor, a lawyer provides a client with an informed understanding of the client's legal rights and obligations and explains their practical implications. As advocate, a lawyer zealously asserts the client's position under the rules of the adversary system. As negotiator, a lawyer seeks a result advantageous to the client but consistent with honest dealing with others. As intermediary between clients, a lawyer seeks to reconcile their divergent interests as an advisor and, to a limited extent, as a spokesperson for each client.  

Furthermore, ethical rules that further advocacy tend to be backward-looking, best suited to instances in which the facts are the facts, and must be accepted, rather than situations in which lawyers are advising clients regarding future conduct.

190. For an excellent discussion of the relationship between the ideal of advocacy and lawyers' personae, see RHODE, supra note 114, at 125-62.
191. MODEL RULES OF PROFESSIONAL CONDUCT pmbl. (1997). The Model Rules of Professional Conduct were drafted in part because the previous Code of Professional Responsibility largely ignored this diversity of function.
All in all, this backlash against the ideal of zealous advocacy offers a useful lesson for medicine. As law becomes more complex, it seems that both the public and senior members of the profession want lawyers to display greater personal sensitivity and social responsibility. It is less clear, however, that lawyers who do so will be forgiven for harm that may result to clients' interest. In addition, the increasing specialization and variety of practice in an era of rapid economic and technologic change is challenging professional solidarity from both within and without the legal community. Similar to medicine, then, law is being challenged by high and potentially inconsistent public expectations, as well as by evolving self-conceptions of the profession itself, to which traditional standards of conduct will adapt only with difficulty.

IV. BARRIERS TO MEDICAL ADVOCACY

David Samuelson makes the point that rules of conduct, courts and judges, jurisprudence, and tradition all combine to make our legal system work.192 The same is true in medicine. Physician advocacy means little without a coherent system of decisionmaking. Now that we are familiar with the justifications for and principal characteristics of legal advocacy, as well as with various practical and theoretical objections to it, we are ready to conduct the thought experiment that forms the core of this Article. As Mark Hall notes, proposing an advocacy role for physicians depends on showing that an adversarial system of medical decisionmaking, with physicians arguing the case for medical benefit regardless of cost, is both available and desirable.193 Therefore, we must ask and answer two questions. First, what would need to change in the health care system in order for physicians to function as advocates? Second, would those changes be for the better? The first question is addressed by considering two types of barriers that exist to medical advocacy: those derived from the selection, training, and professional socialization of physicians; and those involving the structure of health care financing and delivery. The second question can be approached by looking at the normative implications of those professional and structural changes.

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193. See MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS, AND ECONOMICS OF RATIONING MECHANISMS 134 (1997) (explaining that an equivalent role morality for doctors would require showing that “an adversarial system of medicine is equally (1) present and (2) desirable and (3) that physician oblivion to costs is equally essential to this system of medicine”).
A. Professional Barriers

Doctors and lawyers are different. Over the last three decades, increases in litigation and regulation have become defining features of the health care system and have forced the medical profession to learn to deal with law, lawyers, and legal obligations. These encounters have revealed that qualities lawyers prize often run contrary to the ideals of medicine. Although their legendary antipathy may derive from the fact that the average physician’s only business contact with lawyers until recently was as a defendant in a medical malpractice suit, the differences in world view between the two professions go deeper that can be explained by unpleasant associations. Consequently, doctors might well have to unlearn basic facets of their professional selves, and adopt wholly new personality traits, in order to take a lawyerly approach to patient advocacy.

1. Consensus and Conflict. The hardest adjustment for physicians might simply be to accept the adversarial process as legitimate. Daniel Fox observes that lawyers perceive authority as derived from man-made law and, thus, appropriate to vest in social institutions, while doctors regard authority as based on science and, therefore, subject to individual control apart from precedent or government. Consequently, physicians generally consider adversarial proceedings before neutral decisionmakers as an ineffective and irrational mechanism for resolving uncertainty.

194. See Schwartz & Gibson, supra note 26, at 779 (positing that “legal intrusion” cuts to the very core of medicine).

195. The infrequency with which doctors traditionally required assistance from lawyers illustrates how sheltered from competition and accountability the medical profession has been. How many business owners earning several hundred thousand dollars annually by providing services that involved considerable risk of personal injury to the customer could make a similar boast?

196. See, e.g., Daniel M. Fox, Physicians Versus Lawyers: A Conflict of Cultures, in AIDS AND THE LAW: A GUIDE FOR THE PUBLIC 210, 212 (Harlon L. Dalton et al. eds., 1987) (speculating that the division between lawyers and doctors is the result of fundamental disagreements regarding: (1) the nature of authority; (2) how conflict should be solved; (3) the relative importance of substance and procedure; (4) the nature and significance of risk; and (5) the legitimacy of the political forum for solving problems).

197. See id. at 212-13 (arguing that lawyers make law while physicians, as scientists, discover it). Physicians occasionally ignore law entirely when it contravenes professional conventions. For example, New York’s statutory limitations on hours worked by physicians-in-training have been openly disregarded by teaching hospitals, including some of the premier medical institutions in the country. See Esther B. Fein, Flouting Law, Hospitals Overwork Novice Doctors, N.Y. TIMES, Dec. 14, 1997, at A1 (interviewing resident physicians).

198. See Fox, supra note 196, at 213 (claiming that “most physicians do not
Particularly, when technical matters are at issue, they are often shocked by the deference given to juries of laypeople, baffled by judges' preoccupation with procedural fairness, and offended by the extreme versions of the facts and law presented by opposing counsel.\textsuperscript{199}

Physicians are trained to reach decisions by peer consultation, consensus-building, and deference to superior information. For example, one of the most persuasive arguments in favor of legalizing physician-assisted suicide is that it would allow physicians to consult freely with their colleagues about the very difficult decision. Adversarial argument seems counterintuitive to physicians because, unlike litigation,\textsuperscript{200} medicine is not a zero-sum game.\textsuperscript{201} This difference is a principal source of confusion between the professions in their casual use of "advocacy" to connote aggressive representation. Although images of struggle are well known to medicine, the battle is with disease and death—natural rather than human adversaries.\textsuperscript{202}

Physicians are much less comfortable "advocating" against identified opponents. As Leonard Marcus observes: "Schooled in the dictum of 'doctor's orders,' many physicians find themselves ill equipped to effectively negotiate on behalf of their patients . . . using a competitive and positional stance."\textsuperscript{203} Furthermore, the advocate's posturing conflicts sharply with most physicians' self-perception as objective, scientific and dispassionate. As Felix Frankfurter famously wrote: "The function of an advocate is not to enlarge the intellectual horizon. His task is to seduce, to seize the mind for a predetermined end, not to explore paths to

\textsuperscript{199} See id. at 213-15. Professor Fox uses the example of a trial relating to the risks to uninfected children of a child with AIDS attending a public school. Physicians testifying and observing the proceedings were dismayed that only extreme theories were being urged by counsel when the best clinical judgment lay in between. See id. at 215-16.

\textsuperscript{200} One reason it is often more difficult for transactional lawyers than for litigators to adhere strictly to the rules of advocacy is that particular zero-sum contests must often be evaluated in light of an overall endeavor that benefits both parties.

\textsuperscript{201} Of course, physicians' decisions to make resources available to some patients implies sacrifices by others. The implications of this for advocacy are discussed below.

\textsuperscript{202} See WILLIAM F. MAY, THE PHYSICIAN'S COVENANT: IMAGES OF THE HEALER IN MEDICAL ETHICS 64-65 (1983) (analogizing medicine and medical professionals as "fighters" who "attack" illness and "battle" disease).

\textsuperscript{203} Leonard J. Marcus, On the Bridge Between Health Care and Dispute Resolution: Two Common Misconceptions About Change and Managed Care, NIDR FORUM, Dec. 1997, at 11, 13.
Physicians may be uncomfortable taking an aggressive, confident position before a tribunal if the underlying science is less clear.

Nor does traditional medical ethics favor adversarial advocacy. Rather, physicians' advocacy obligations have been limited to the provision of medical services, even when physicians possess other skills that might benefit their patients. Specifically, medical witnesses are cautioned "not [to] become an advocate or a partisan in the legal proceeding."\(^2\) This caveat might surprise lawyers, who assume that a battle of credible, honest, yet partisan experts is a routine occurrence in litigation. Similarly, contingent fees paid physicians in malpractice or workers' compensation cases are considered improper because they create an "ever-present danger that the physician may become less of a healer and more of an advocate."\(^3\) In cases in which the patient's health is not in tension with the success of the legal claim, courts that have upheld this prohibition seem to believe that the appropriate social role for physicians is something other than advocacy.\(^4\)

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205. AMA CODE, supra note 42, Op. 9.07; see also PETER W. HUBER, GALILEO'S REVENGE: JUNK SCIENCE IN THE COURTROOM 198 (1991) ("[A] scientist who becomes the alter ego of a lawyer is no longer a scientist."). Despite this admonition, of course, expert witnesses in malpractice cases are often aggressively partisan. In response, the American Medical Association is supporting efforts to censure physicians who testify falsely in legal proceedings. See Diane M. Gianelli, NONEXPERT WITNESSES RAISE DELEGATES' Ire, AM. MED. NEWS, Jan. 4, 1999, at 7, 7. Whether this position reflects discomfort with advocacy or merely professional self-interest is an open question.


207. A simplistic objection to physician advocacy in legal claims is that it benefits the patient financially, not medically. On the other hand, approximately half the value of damage awards in malpractice litigation and an equal or greater portion of workers' compensation payments, represents medical expenses. See HARVARD MEDICAL PRACTICE STUDY, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION AND PATIENT COMPENSATION IN NEW YORK 8 (1990).
Occasionally, the two professions have addressed the distinction between medical and legal partisanship in practical terms. For example, the state bar and the medical society of New Mexico have adopted a joint statement of principles governing the interprofessional relations of attorneys and physicians. The principles state that "[a]n attorney's responsibility is always first to his client" and "[a] physician's primary responsibility is always the health of his patient," but note that, when a physician has a patient involved in a legal process, the "physician is not an advocate and should leave the representation of his patient and advancement of the patient's interests to the patient's attorney." Although this admonition can be dismissed as a temporary truce engineered to address recurring representations involving medical malpractice, workers' compensation, and the like, it is still noteworthy for its clear demarcation of the line between expertise and advocacy.

Of course, one can easily dismiss the importance of this distinction in the clinical context by assuming it away. If "advocacy" means "doing what is best for the patient," one might argue, then, a committed physician is a committed advocate. There are three problems with this reasoning. First, adversarial discourse has a tendency to escalate, so that physicians confronted by insurance representatives who seem more motivated by cost than by patient benefit may find themselves making arguments they would otherwise consider intemperate. Second, as discussed in greater detail below, signing on as advocate in an adversarial setting often implies greater deference to the patient's hopes and beliefs than traditionally has prevailed in medicine. Third, the skill set for effective advocacy is different from that possessed by an expert clinician. As a result, patients contemplating an eventual need for adversarial representation may gravitate toward doctors who are better advocates but worse physicians.

2. Reliance on Process. Professor Fox regards "[l]awyers' attachment to procedure, sometimes to the seeming detriment of substance, [as an] issue that fundamentally divides the medical and legal professions." Physicians are selected and trained to be autonomous decisionmakers and sometimes have difficulty

208. See generally STATEMENT OF PRINCIPLES RELATING TO THE RESPONSIBILITIES OF ATTORNEYS AND PHYSICIANS IN THEIR INTERPROFESSIONAL RELATIONS, reprinted in N.M. STAT. ANN. § 36-2-10 (Michie 1991) (compiler's notes).
209. Id. art. IV.
210. Id. art. V.4.
211. Fox, supra note 196, at 215.
participating in activities that require cooperation with non-physicians. This behavior can manifest itself as distaste for paperwork and bureaucracy, which formal procedures seem to epitomize. Yet rules of procedure comprise the necessary structure for any organized system of advocacy.

If physicians do not consider procedures to be legitimate, they are more likely to manipulate the system to achieve what they believe is the right result. For example, physicians are frequently confronted with ethical dilemmas with respect to insurance documentation if examinations or clinical interventions are reimbursable only if certain diagnoses are present. Many doctors express their resentment of these procedural formalities by evading the letter or spirit of such requirements. When I was a medical student, some resident physicians at the Veterans Administration hospital where I worked made a practice of forcing patients to exercise immediately prior to discharge in order to lower the oxygen content of blood samples and qualify the patients for home oxygen therapy. Medical ethics allows doctors to rationalize these kinds of behavior, at least in minor situations in which they can pretend ignorance of true legal constraints.

In this respect, the special case of organ transplantation may offer lessons for advocacy in general. Unlike most medical care, an effective transplant system depends on a fair process in order

\[212.\] This likelihood is ironic because, as Professor Fox writes, "[p]hysicians disdain the use of the word client by lawyers, or social workers, or by some nurse practitioners because it connotes advocacy rather than an obligation to act honorably." Id. at 214.

\[213.\] See, e.g., Mandated use of PA in Surgery Raises Two Concerns, AM. MED. NEWS, Feb. 23, 1998, at 25 (discussing a situation in which a doctor upcoded a patient's chart in order to ensure insurance coverage). In a column answering readers' letters to the AMA's Institute for Ethics, Haavi Morreim opines that "such dilemmas cannot be avoided, so long as patients' needs are boundless and endlessly diverse, and payers must limit what they cover" and concludes that physicians should not "bypass the problem, but [should] live with it in morally credible ways." Id.

\[214.\] Professor Morreim notes that deliberate miscoding is unlawful, can impair trust between patient and physician, and can harm patients by suggesting that they have illnesses which do not in fact exist (or by adversely affecting future insurability). See id.

\[215.\] I was shocked by this practice, not because it arguably defrauded the government but because strenuous exertion seemed unnecessarily hazardous to the patients. Brief investigation revealed that the same result could be achieved without physical risk by misreporting the patient's temperature when the blood sample was taken.

\[216.\] The Code of Medical Ethics states as a fundamental principle that "[a] physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient." AMA CODE, supra note 42, princ. III. This arguably opens the door to civil disobedience.
to stimulate donations and match them efficiently to potential recipients. Transplant surgeons must work within this system in order to obtain organs for their patients and, therefore, fulfill a role closer to that of advocate than do most other physicians. As a result, the Code of Medical Ethics imposes rules of conduct to protect the integrity of the allocation system; for example, the Code notes that "[p]atients should not be placed on the waiting lists of multiple local transplant centers, but rather on a single waiting list for each type of organ." 217

New federal standards for the Organ Procurement and Transportation Network will be a useful test of physicians' commitment to advocacy. A final rule issued in April 1998 establishes a national system allocating organs to the patients with the greatest medical need and eliminates former preferences for local transactions. 218 Anecdotal reports suggest that physicians are already "working" the system by keeping patients in intensive care units to establish a high acuity of medical need, even if intensive monitoring is not in fact required. 219 In addition, physicians at local centers that had previously given priority to certain healthier patients who might enjoy greater benefit from transplantation may abandon that approach because, under the new system, failing to list one's sickest patients means that all organs will go elsewhere. The establishment of a formal process for allocation, therefore, tends to channel all behavior into an advocacy model.

In the future, physician acceptance of process probably will be an important determinant of health system performance in other areas as well. An international, multidisciplinary gathering of physicians and health policy experts known as the "Tavistock

217. Id. Op. 2.16(7). Some states, such as New York, have banned multiple listings with mixed effects on availability and equity. See Alan J. White et al., The Effects of New York State's Ban on Multiple Listing for Cadaveric Kidney Transplantation, 33 HEALTH SERVS. RES. 205, 215-17 (1998) (discussing the results of a study designed to determine the effectiveness of New York's multiple listing ban and its impact on equity in access to transplantation).

218. See 63 Fed. Reg. 16,296 (1998). However, Congress has delayed the effective date of the new system for one year. See Playing the Organ Game, WASH. POST, Oct. 21, 1998, at A8 (discussing the politics and policy behind the moratorium).

219. See Robert Steinbrook, Allocating Livers—Devising a Fair System, 336 NEW ENG. J. MED. 436, 437 (1997) (describing gaming practices, such as placing patients on waiting lists early in order to help them get higher priority). Importantly, gaming the system furthers the physician's interest as well as the patient's. A national allocation system based on medical need favors the largest transplant centers, which attract many patients, including very sick ones. Unless smaller centers can compete, they will fall below the number of procedures required to maintain accreditation for their programs.
Group” recently published a proposed statement of shared ethical principles. The principles argue that “[d]octors and other clinicians should be advocates for the patients or the populations they serve but should refrain from manipulating the system to obtain benefits for them to the substantial disadvantage of others.” However, the line between advocacy and manipulation remains to be drawn.

3. Roles or Rules. This dilemma connects to a more general point: physicians are not accustomed to having appropriate behavior defined by rules. By contrast, rule-based governance is natural to lawyers whose business is writing, interpreting, and enforcing rules. One reason for the difference is that medicine is preoccupied with immediacy. Because scientific knowledge is improving rapidly, settled rules quickly seem outdated and, hence, illegitimate. A striking difference between law and medicine is that a ten year-old research article that seems modern in law would often be of merely historic interest in medicine. A second reason is that physicians view their daily decisions as demanding constant adaptation and compromise, which until very recently went unchallenged by patients or other parties.

The pretense of professional homogeneity in medicine is a third explanation for the relative absence of rules governing conduct. Although physicians practice in many specialties, and also serve in diverse research, educational, managerial, and governmental capacities, professional socialization during the mandatory coursework and intensive clinical experiences of medical school and residency is astonishingly unitary. To the profession as well as the public, every doctor is a white-coated healer. Physicians are “role-governed” rather than “rule-governed.” By contrast, lawyers’ formal education is classroom-based and largely elective, breeding less commonality of approach and leaving professional socialization to the differentiated settings of legal practice. Arguably, written rules of conduct are more necessary in this heterogeneous community.

221. Id. at 250.
222. This may seem counterintuitive because legal rules can change as quickly as society wants them to. Nonetheless, the recent pace of scientific change exceeds even that of our democratic process.
4. Control and the Judging Function. Significantly, physicians considered themselves patient advocates long before anyone seriously questioned their judgment, much less argued a contrary position. The Hippocratic Oath pledges: "I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone." The principal characteristic of this role, however, is not so much advocacy as control. Physicians are very comfortable making decisions to serve what the physician believes is the patient’s interest. Moreover, as exemplified by the medical students’ attempts to apportion a single ICU bed between two patients that opened this Article, physicians are both willing and able to accommodate a variety of competing considerations. Roger Evans believes that physicians live with a conflict between being a perfect agent for the patient and being the protector of society. I suspect that physicians do not generally view this as a conflict, but accept it as the responsibility that naturally accompanies their near-absolute authority. Put another way, doctors think of themselves not as lawyers but as judges.

Advocacy conflicts with control. To assume the duties of an advocate means to cede ultimate authority, something the medical profession does not yet seem ready to do. Professor Hall accurately observes that "adversarial medicine is loudly denounced by the same medical establishment that advances the absolutist physician ethic [because doctors consider themselves] the ultimate arbiters of medical appropriateness, and they vigorously oppose the establishment of any counterbalancing role representing the purchaser’s or insurer’s interest." For example, a recent resolution of the AMA House of Delegates lists nearly every aspect of patient care as being "so integral to high-quality care that practicing physicians should always maintain control." A few states are taking these claims seriously. In Massachusetts, the Board of Registration in Medicine attempted

224. Refer to Part I supra (discussing the responses by medical and law students to a hypothetical dilemma).
225. See Roger W. Evans, Health Care Technology and the Inevitability of Resource Allocation and Rationing Decisions: Part II, 249 JAMA 2208, 2217 (1983) (stating that future “decisions must be made concerning which patients will maximally and optimally benefit from expensive health care technology”).
226. As with judges, the public often sees physicians as all-around experts, capable of rendering opinions on matters well beyond their specific training and expertise.
227. HALL, supra note 193, at 134.
in 1996 to require that, as a condition of allowing physicians to practice in for-profit settings, managed care organizations to prove to the Board that all health care decisions remained under physician control.\textsuperscript{229}

Physicians are admittedly imperfect judges. For example, Donald Redelmeier and Amos Tversky have found that recognized professional norms lead physicians to practice differently with respect to individual patients than they would recommend in the aggregate.\textsuperscript{230} A physician's practice is ruled by identified lives, which society values more highly than statistical ones.\textsuperscript{231} One manifestation of this phenomenon is the physician's "technologic imperative" to apply all learned techniques and available resources to the treatment of each individual patient.\textsuperscript{232}

Professor Hall concludes—as do I—that the medical profession must choose between adversarial advocacy and beneficent balancing of interests. Although physicians espousing the rhetoric of advocacy may dismiss the distinction between persuasive and decisionmaking authority as a matter of semantics, a legal advocate plays a more limited part than physicians are accustomed to. As discussed below, Professor Hall and I also agree that confining physicians to the restricted role of advocate is unlikely to improve the quality of social decisions about health care.\textsuperscript{233}

5. Patient Autonomy. Not only are physicians generally unwilling to relinquish authority to third parties, they are

\textsuperscript{230} See Donald A. Redelmeier & Amos Tversky, Discrepancy Between Medical Decisions for Individual Patients and for Groups, 322 NEW ENG. J. MED. 1162, 1163 (1990) (arguing that this conclusion is consistent with the notion that physicians consider personal concerns when thinking of patients as individuals and general criteria of effectiveness when considering them as a group). Using a written questionnaire with hypothetical scenarios constructed in different versions—one describing an individual patient and one describing patients as a group—the researchers found that physicians were more likely to do the following for the individual: recommend an additional test with a low cost and a possible benefit, examine a patient directly rather than follow progress by telephone, avoid discussing organ donation, and recommend a therapy with a high probability of success but a chance of an adverse outcome. See id.
\textsuperscript{231} See generally T.C. Schelling, The Life You Save May Be Your Own, in PROBLEMS IN PUBLIC EXPENDITURE ANALYSIS 127, 133 (Samuel B. Chase, Jr. ed., 1968) (describing the difference between "identified" and "statistical" lives).
\textsuperscript{232} See VICTOR R. FUCHS, WHO SHALL LIVE?: HEALTH, ECONOMICS, AND SOCIAL CHOICE 94-95 (1974) (noting that third-party payment encouraged each physician to demand greater resources and deliver more intensive care for his patients, even when the collective effect was a possibly unwarranted increase in cost).
\textsuperscript{233} Refer to Part IV.B.
unaccustomed to allowing their own patients the level of
direction typical of an advocacy relationship. After all, the
AMA's first set of ethical principles commanded physicians to
"unite tenderness with firmness, and condescension with
authority"—a far cry from patient control. Bioethics has
largely been credited with reorienting medical practice from
paternalism to respect for patient autonomy. Even in bioethics,
however, Professor Annas observes that the lawyer’s focus on
promoting liberty and self-determination sometimes comes into
conflict with the physicians’ major goals of preserving life and
enhancing health. "Both professionals often look at each other
incredulously in such situations," he writes, "simply unable to
comprehend how the other could be so narrow-minded and pig-
headed."

Differences in client control between the medical and legal
professions, which may be subtle, have several implications for
advocacy. As Professor Rodwin puts it, "[u]ntil very recently,
medical professionals interpreted the ethical injunction to work
in the interest of patients to mean that they should make
decisions for patients." Similarly, Paul Starr points out that,
although physicians lack the coercive powers of the state to
enforce their recommendations, "the authority of the doctor is . . .
‘more than advice and less than a command, an advice which one
may not safely ignore.”

Even today, medical ethics frames patient autonomy as “the right to make decisions regarding the

234. On the other hand, Professor Simon challenges the notion that lawyers work to advance clients’ actual goals, arguing instead that certain standard objectives are imputed to clients, such as freedom of movement and accumulation of wealth. See Simon, supra note 159, at 54. Could one similarly allow physicians to advocate for patients’ imputed goals? Prolongation of life, reduction of suffering, and normalization of activity would be examples. However, the literature on end-of-life decisions shows that physicians have an imperfect track record predicting patients’ preferences and tradeoffs. See SUPPORT, Principle Investigators, A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments, 274 JAMA 1591, 1596 (1995) (demonstrating that patient preferences regarding end-of-life care are seldom followed by medical personnel, even when specific efforts were made to promote communication). Effective physician advocacy would, therefore, appear to require a greater degree of direct patient control than currently exists.

235. Schwartz & Gibson, supra note 26, at 791.


238. Id. at 441.

239. Rodwin, supra note 13, at 150.

240. STARR, supra note 8, at 14.
health care that is recommended by his or her physician[,]” not an absolute right to request specific care. Nor are day-to-day interactions generally characterized by client control and professional responsiveness. Even family physicians frequently interrupt patients and interfere with the effective communication of patient needs. One recent article somewhat radically urges physicians to go beyond narrow scientific appraisals of clinical problems by asking the patient what he or she would like the physician to do, and either carry out the request or openly negotiate a suitable alternative.

For example, medicine and law differ regarding consumer access to professional records, which is an indicator of control. The Code of Medical Ethics holds that, subject to law, notes relating to treatment are the property of the physician, although they should be made available to other physicians treating the patient. By contrast, papers and other records relating to legal representation are the property of the client, and must be returned upon termination of the lawyer-client relationship.

Moreover, physicians traditionally have been allowed to define their obligations according to personal morality, while lawyers have not. An obvious example is the provision of abortion services and contraceptive care, which is never forced upon physicians who hold incompatible religious beliefs. Similarly, physicians’ moral opinions are given considerable latitude in the debate over end-of-life care and physician-assisted suicide. These concessions are understandable because medical care involves

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244. See AMA CODE, supra note 42, OP. 7.02. The patient is entitled to a “copy or summary.” See id. Ops. 7.01, 7.02. Some states have changed this by statute. See, e.g., N.H. REV. STAT. ANN. § 332-1:1 (1998).
245. See MODEL RULES OF PROFESSIONAL CONDUCT Rule 1.16(d) (1997) (outlining the duties of a lawyer in the event of withdrawal, including giving reasonable notice, allowing time for employment of other counsel, surrendering papers or property, and refunding any advance payment); see also CAL. RULES OF PROF. CONDUCT Rule 3-700(d)(1) (1996) (providing that a lawyer must “promptly release . . . at the request of the client, all the client papers and property”).
246. See Christopher Meyers & Robert D. Woods, An Obligation to Provide Abortion Services: What Happens When Physicians Refuse?, 22 J. MED. ETHICS 115, 115 (1996) (noting a problem at a California hospital in which, due to staff refusal to perform abortions, the hospital was unable to meet its legal obligation to provide the service); see also Kathleen M. Boozang, Deciding the Fate of Religious Hospitals in the Emerging Health Care Market, 31 HOU S. L. REV. 1429 (1998).
intimate physical contact, which must be agreed to in advance. By contrast, however, lawyers are encouraged to accept clients whom they are qualified to represent, on the theory that the conduct at issue has already taken place and equal access to justice is a fundamental need of a stable society.  

The Hippocratic invocation to “do no harm” constrains physician deference to patients. Patients frequently request care that physicians refuse to provide because the proposed treatment would be useless or even harmful. Unlike law, in which the ACLU lawyer can proudly represent the marching Nazi, medicine has no easy way to separate the principle involved from the substantive result. In response, the medical profession has developed a collective sense of what constitutes appropriate therapy. Differentiating the medical profession’s reliance on internal authority from the market’s insistence on consumer sovereignty, Professor Starr observes that “[a] professional who yields too much to the demands of clients violates an essential article of the professional code: Quacks, as Everett Hughes once defined them, are practitioners who continue to please their customers but not their colleagues.”

Let me illustrate these observations with a personal experience. During my years as an associate in a large firm, I was also a licensed physician. One day, a senior partner asked me to represent a valued client of the firm who had contracted an incurable disease, and to help the client procure experimental medication from abroad that had not been approved for sale in the United States by aggressively pursuing regulatory exemptions. I met with the client, his family, and a neurologist they had located who was willing to supervise treatment if the medication were made available. Shortly thereafter, I asked permission of the partner to withdraw from the matter, leaving the representation to others in the firm. Though I was never

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247. See Model Rules of Professional Conduct Rule 1.2 & cmt. (observing that “representing a client ... does not constitute endorsement of the clients ... views or activities” but that “representation should not be denied to people who are unable to afford legal services, or whose cause is controversial or the subject of popular disapproval”). A lawyer may avoid appointment by a tribunal to represent a client only if representing the client is likely to violate other ethical rules or laws, is likely to impose an unreasonable financial burden on the lawyer, or the client or cause is so repugnant to the lawyer as to be likely to impair the representation. See id. Rule 6.2.

248. Issues of physician control have arisen most frequently with respect to end-of-life treatment that patients or their families desire, but physicians consider unpromising. See Steven Miles, Futility and Medical Professionalism, 25 Seton Hall L. Rev. 873, 881 (1995) (proposing a public due process mechanism to resolve disputes about futility).

249. Starr, supra note 8, at 23.
asked to do anything unlawful, and though I was arguably obligated as an attorney to assist my client, my sense of his medical condition and the likely results of treatment belied the mission I had been assigned. For me, the client had become a patient and advocating on behalf of that patient for a treatment I did not believe to be in his best interests seemed to violate my ethical duty as a physician.

Furthermore, physicians not only withhold services that they perceive as useless or harmful, but comfortably deny patient requests for marginally beneficial care that the physician simply believes would be wasteful. For example, few doctors would succumb to a patient's demand for an MRI of the head, essentially a risk-free test, when the only symptom was a mild headache. Of course the definition of "waste" varies from physician to physician and takes into account factors such as the nature of the service, the intensity of the demand, the persuasiveness of the patient, the potential for litigation, and the financial implications of treating or refraining from treatment. Nonetheless, the basic point remains: physicians sometimes ignore patients' preferences because they consider themselves guardians of clinical resources. This position is in direct conflict with the role of the legal advocate.

As a result of these professional biases, patient's control over their physicians is limited. Reconstituting physicians as lawyerlike advocates implies redistributing authority to the client. However, to the extent physicians view advocacy in managed care as the ability to counter pressures toward corporatization and profit-seeking, the subservience to patients

250. For a discussion of this issue, see Allen S. Brett & Laurence B. McCullough, When Patients Request Specific Interventions, 315 NEW ENG. J. MED. 1347 (1986); see also Gail B. Agrawal, Chicago Hope Meets the Chicago School, 96 MICH. L. REV. 1793, 1803-04 (1998).

251. On the other hand, lawyers are also obligated not to waste scarce resources, such as the already overcrowded dockets of courts. As discussed below, however, law usually draws a clear distinction between procedure and substance which is lacking in medicine, and allocates control accordingly.

252. Of course, one should not overstate the deference with which lawyers treat clients. Even the most "client-centered" approach is arguably manipulative. See Stephen Ellmann, Lawyers and Clients, 34 UCLA L. REV. 717 (1987). As both Professor Ellmann and Professor Morris note, however, a client's degree of sophistication or vulnerability is an important but ambiguous determinant if both her levels of control and her interests in retaining autonomy remain strong. See John K. Morris, Power and Responsibility Among Lawyers and Clients: Comment on Ellmann's Lawyers and Clients, 34 UCLA L. REV. 781 (1987); see also Stephen Ellmann, Manipulation by Client and Context: A Response to Professor Morris, 34 UCLA L. REV. 1003 (1987). Although medical ethics struggles with similar questions, it is significant that legal ethicists take autonomy as a natural starting point for discussion, whereas it is a relative latecomer to medicine.
implicit in the legal model may be counterproductive because it breaks the illusion of absolute authority. Alexander Capron asserts, for example, that bioethicists' emphasis on patient autonomy at the expense of physician authority may ironically "undermine the physician's emerging role as the advocate for and protector of the patient in her relationship with health care institutions that may have strongly conflicting interests." More practically, anecdotal evidence suggests that health plans that submit coverage disputes to supposedly impartial experts using external review mechanisms are discounting the opinion of the treating physician as mere advocacy.

B. Structural Barriers

In addition to these changes in professional culture, a shift to physician advocacy and an adversarial model of medical decisionmaking would require many adjustments to the structural characteristics of the health care system. Most of these relate to the two principal prerequisites for effective advocacy: preventing advocates from laboring under conflicts of interest that could dilute their commitment to their clients, and constituting a neutral tribunal to hear and decide argued cases. However, other important structural issues exist as well, such as accountability for failure to advocate zealously or competently.

1. Conflicts of Interest. Particularly in connection with managed care, the subject of conflicts of interest has generated an extensive literature, although previous commentators have not focused on the implications for advocacy per se. Professor Rodwin divides conflicts of interest in medicine into two main types: conflicts between a physician's personal, often financial, interests and the interests of a patient; and conflicts that divide a physician's loyalty among patients or between patients and third parties. Similarly, Haavi Morreim distinguishes between what she calls "conflicts of interest," in which the physician-agent benefits personally at the expense of the patient-principal, and


255. Refer to Part III.A supra (discussing the necessary preconditions to advocacy).

256. See Rodwin, supra note 87, at 9 (harmonizing the definition of conflicts of interest with the definition of potential conflicts of interest and acts of disloyal behavior).
conflicts of obligation,” which involve duties to multiple constituencies that are in tension with one another.\textsuperscript{257} The latter can include other patients, institutional actors, or even society generally. As the preceding discussion attests, both types of conflicts have parallels in legal advocacy.

The Code of Medical Ethics seemingly stakes out a clear position on financial conflicts of interest: “Under no circumstances may physicians place their own financial interests above the welfare of their patients. [Any] conflict . . . between the physician’s financial interest and the physician’s responsibilities to the patient . . . must be resolved to the patient’s benefit.”\textsuperscript{258} Nonetheless, financial conflicts of interest are widespread in medicine, and are probably inevitable in medicine, as long as physicians have control over clinical decisions because a physician’s treatment recommendations mobilize resources, such as hospital beds and medical technologies, which far exceed the value of his or her time. As previously mentioned, the high cost of these resources in cases of serious illness is what makes health insurance necessary, which in turn introduces moral-hazard into the physician-patient relationship and limits the potential for patients to monitor physician spending. At the time, the complexity of medical practice leads physicians to affiliate with a variety of professional and non-professional organizations such as hospitals, outpatient clinics, and ancillary service providers.

Conflicts of interest arising from the use of collateral services exist in both fee-for-service practice and managed care. In fee-for-service medicine, physicians can supplement the income they receive from hands-on care by referring patients for tests and services provided by entities with which the physician has a business relationship. In doing so, however, the physician risks elevating personal interest over patient benefit, a clear failure of advocacy. To discourage this behavior, the Code of Medical Ethics cautions that “[p]hysicians should derive their income from medical services rendered,” not special fees or financial interests in associated businesses.\textsuperscript{259} Similarly, state law bans on fee-

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\item \textsuperscript{258} AMA CODE, supra note 42, Op. 8.03. In the hospital context, “[t]he organized medical staff has an obligation to avoid wasteful practices . . . [but] where the economic interests of the hospital are in conflict with patient welfare, patient welfare takes priority.” Id. Op. 4.04.
\item \textsuperscript{259} Id. Op. 4.01. Physician investment in referral facilities, particularly in hospitals in small communities, is sometimes justified by the absence of other sources of capital financing. However, the presence of widespread insurance worsens the temptation to abuse such relationships. For example, most physician-owned
\end{itemize}
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splitting between referring and treating physicians,\textsuperscript{260} and federal fraud and abuse prohibitions on kickbacks and physician self-referral,\textsuperscript{261} can be seen as preventing the corruption of physician advocacy as well as avoiding unnecessary treatment and expense.

In managed care, the relationship between physician judgment and the use of external resources seems to generate intractable conflicts of interest. Instead of tempting physicians to overtreat, managed care seeks to moderate the growth of health care spending by inducing physicians to decrease utilization of referral services. This is typically accomplished by rewarding physicians financially, using devices such as withhold arrangements and capitation payments.\textsuperscript{262} Over one-third of U.S. physicians have at least one capitation contract, with capitation accounting for about one-quarter of their revenues.\textsuperscript{263} Even a recent article proposing standards to reduce the likelihood that financial incentives would induce physicians to deny patients needed treatment confessed: “Reducing financial conflict of interest to zero... is neither possible nor even desirable. There is a delicate balance between the positive and creative power of capitation to encourage physicians to be cost conscious and the risk that it will lead to the withholding of necessary services.”\textsuperscript{264}

\textsuperscript{260} See, e.g., Greg Borzo, \textit{Controversial Ruling in Florida: Splitting Fees or Splitting Hairs?}, \textit{AM. MED. NEWS.}, Nov. 17, 1997, at 3, 29 (discussing a Florida Board of Medicine ruling that sharing revenue with a physician-practice management company is unlawful).

\textsuperscript{261} See 42 U.S.C. §§ 1320a-7b, 1395nn (1994); see also \textit{FURROW, supra note 259, at 644-60 (discussing anti-kickback and self-referral laws).}

\textsuperscript{262} In a withholding arrangement, a percentage of the fees payable to a physician by an insurer are retained in a separate fund, from which amounts reflecting excess utilization are deducted according to a formula before the balance is remitted. A physician participating in capitation receives a fixed monthly fee for each member the insurer assigns to her instead of being paid on a per-visit basis. Because capitation eliminates the reward for seeing patients personally and, therefore, increases the tendency to refer, while withholds have the opposite effect, the two devices are frequently combined.


\textsuperscript{264} Steven D. Pearson et al., \textit{Ethical Guidelines for Physician Compensation Based on Capitation}, 339 NEW ENG. J. MED. 689, 693 (1998).
At the same time, conflicts of interest are a central challenge for any adversarial model of dispute resolution based on advocacy. First, as already noted, advocates operating under a conflict may place other interests ahead of those of their clients as disputes proceed. Moreover, if conflicts of interest are systematic, meaning that most advocates suffer from them, a second problem comes into play. To the extent that the conflicts produce a conspiracy of silence, clients who consult advocates may never learn that relief would be available to them through a system of dispute resolution. This silence has always been a problem in cases involving medical malpractice, because the treating physician is often the only source of confirmation that a mistake has been made.\footnote{265}

Conflicts of interest can jeopardize advocacy in managed care to an even greater degree. If physicians are given financial incentives that encourage cost-consciousness, they may never alert patients to expensive treatment options, mooting any right to appeal denials of coverage, and rendering impotent legal requirements for independent review. For example, a recent study of coverage decisions in Oregon and Washington concluded that denials of coverage by health plans based on contractual language—that could be challenged in court—had less influence on treatment availability than hidden financial incentives and other discretionary provider-based review mechanisms.\footnote{266} In its most recent revisions to the Medicare grievance and appeals regulations, which include a right to independent review, the HCFA noted the potential for physicians operating under incentives to make clinical decisions not in the best interests of the beneficiary.\footnote{267} However, the regulations do not expressly...

\footnote{265. Although a causal relationship between information availability and filed claims has never been demonstrated, the fact that only about one in eight instances of medical negligence leads to a claim alleging malpractice is suggestive. See A. Russell Localio et al., \textit{Relation Between Malpractice Claims and Adverse Events Due to Negligence}, 325 NEW ENGLAND J. MED. 245, 248 (1991). Moreover, many patients and families who file malpractice suits do so primarily to force suddenly taciturn health care providers to explain why a bad outcome occurred. See Gerald B. Hickson et al., \textit{Factors That Prompted Families to File Medical Malpractice Claims Following Prenatal Injuries}, 267 JAMA 1359, 1361 (1992) (finding that 24\% filed suit because the doctor lied or was not completely honest, and 20\% did so because they could not get anyone to tell them what happened); cf. David Hilfiker, \textit{Facing Our Mistakes}, 310 NEW ENGLAND J. MED. 118 (1984) (exploring personal issues for physicians confessing error).


allow beneficiaries to challenge decisions of physicians subject to managed care incentives as “organizational determinations”—in which case, of course, the patient would require an advocate other than the physician being complained against. These situations demonstrate that systems depending on physician advocacy and impartial review of coverage decisions to protect patients may prove illusory given the current popularity of physician financial incentives in managed care.

At the extreme, risk-bearing by physicians potentially turns advocacy on its head. Managed care organizations increasingly subcontract to physician groups on a “full-risk” or “global” basis, making the physicians responsible for paying all the costs associated with care to beneficiaries, including hospitalization. In these instances, the physician group, not the insurer, bears the risk of high utilization and, therefore, has the incentive to deny services, while the insurer’s interest becomes to ensure that patients receive all the care to which they are contractually entitled. One might argue under these circumstances that the managed care organization, not the physician, is the logical patient advocate!

As discussed above, lawyers would consider these conflicts incompatible with effective advocacy. In health care, by contrast, physician financial incentives are regulated but not prohibited. It remains to be seen whether a workable compromise can be engineered. To date, most commentators try to steer a middle ground between fostering physician advocacy and incentivizing cost-conscious practice, primarily to allow physicians to retain control over care decisions. For example, Professors Hall and Berenson conclude that it is not essential

untoward result of... failure to furnish medically necessary covered services,” and that the right to appeal denials of care is, thus, “an important protection for beneficiaries”).

268. Typically, a large physician group receives either a negotiated dollar amount per member per month, or a fixed percentage of the premium charged by the managed care organization. Under these global risk contracts, the managed care organization’s responsibilities are largely limited to marketing and enrollment. Alternatively, managed care organizations may give physician groups authority to negotiate rates with hospitals, using withhold arrangements to reward physicians for obtaining low prices. The difference between this and global risk is that the physicians never actually receive the hospital component of the premium, which is still paid directly to the hospital by the managed care organization.

269. Refer to Part IV.A.5 supra.

270. See Ezekial J. Emanuel & Lee Goldman, Protecting Patient Welfare in Managed Care: Six Safeguards, 23 J. HEALTH POL. POLICY & L. 635, 646 (1998) (noting that prohibition of financial incentives is impossible and that the regulation should be implemented by considering the likelihood of the incentive’s influence on physician decisionmaking and the seriousness of the harm that may occur).
that "role separation [between physicians and insurers] be absolute and pure," and suggest conflict-ameliorating devices such as providing advisory practice guidelines to physicians, creating internal divisions of authority within risk-bearing medical groups, removing "life and death" decisions to outside actors, and using second opinions and independent review to verify clinical judgment.271 The closest analogy to the position on financial conflicts of interest taken by legal ethicists is to require disclosure, which is typically achieved by obligating health plans to reveal in written enrollment materials how participating physicians are paid.272 However, disclosure requirements in managed care have their own problems, primarily the limited range of insurance options available to most individuals and the logical difficulties of permitting patients to consent to modifications of fiduciary duties that were originally imposed on physicians precisely because patients seemed unable to protect themselves.273

One managed care organization attempting a balanced approach is Allina Health System, a non-profit integrated delivery system centered in Minneapolis, which has issued a set of "guiding principles" for ethical managed care.274 These principles include a commitment by the system to the "protection and promotion of advocacy on the part of providers as well as on the part of members and patients." They define health providers' advocacy obligation as "to act in the best interest of the individual patient without regard to conflicting financial constraints or to the potentially competing interests of other persons."275 To that end, Allina supports "fair process" that is public, open to member input, inclusive of varied interests, and

271. See Mark A. Hall & Robert A. Berenson, Ethical Practice in Managed Care: A Dose of Realism, 128 ANNALS INTERNAL MED. 395, 399-400 (1998). They urge physicians to treat patients consistently without regard to source or amount of payment, but concede that physicians ethically may make differential judgments on the basis of insurance status, such as not providing a service that insurance does not cover, as long as they inform patients of the basis for their recommendation. See id. at 400.

272. See Tracy Miller & William M. Sage, Disclosing Financial Incentives in Managed Care (unpublished manuscript on file with author).

273. See id.; see also Maxwell J. Mehlman, Fiduciary Contracting: Limitations on Bargaining Between Patients and Health Care Providers, 51 U. PITT. L. REV. 365, 384-85 (1990) (noting that bargaining literature does not discuss disclosure in depth because of the difficulty in establishing effective disclosure).


275. ALLINA HEALTH SYSTEM, GUIDING PRINCIPLES FOR THE CREATION OF AN ALLINA HEALTH SYSTEM ETHIC 23 (1997).

276. Id.
equitably applied, and calls on providers both to assist patients in appeals of service denials and to participate in system-level decisionmaking. However, Allina’s statement also lists “stewardship” as a core ethical principle, which the company defines as the equitable distribution of limited resources, and invokes a stewardship obligation to justify physician financial incentives. Though it acknowledges the tension between advocacy and stewardship, Allina’s statement defers its resolution, leaving physicians in the unsatisfactory position of receiving incentives to consider the systemic consequences of their treatment recommendations for individual patients while assuming an ethical obligation to ignore them.

Other impediments to advocacy arise from linkages between physicians and health care organizations. Prior to 1980, the Code of Medical Ethics took a hard line against these arrangements: “A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of medical judgment and skill.” The current, milder statement in the Code, that a physician shall “be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services,” was adopted because of pending antitrust litigation against the AMA for banning contract practice as unethical. Nonetheless, the profession’s ethical prohibition dovetailed for many years with a near-universal legal ban on the “corporate practice of medicine.” Under the corporate practice doctrine, only duly licensed individuals were entitled to provide medical services, and were required to do so free of organizational constraints such as employment relationships. Although the nominal justification

277. See id.
278. See id. at 5.
279. See id. Interestingly, the Allina statements never charge physicians with a direct duty of stewardship, although presumably the managed care organization would fail to fulfill its own stewardship duty if physicians did not respond to the incentives they were offered. The statements are even more ambivalent when patients (“members”) are concerned, burdening them simultaneously with a “new responsibility to advocate on in his or her own behalf” and a stewardship duty “to behave and utilize resources in a manner consistent with fairness to others.” Id. at 4, 23.
280. COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AMERICAN MEDICAL ASSOCIATION, CODE OF MEDICAL ETHICS princ. VI (1971).
282. See Patricia F. Jacobson, Prohibition Against Corporate Practice of
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for the corporate practice doctrine was to insulate physicians from concerns other than the welfare of their patients, it also served to shelter the profession from economic competition. However, the doctrine has eroded significantly over time in most states, and physician employment by HMOs, hospitals, and other provider organizations that serve the general public is now widespread.  

Various organizational conflicts of interest can arise in fee-for-service medicine apart from outright employment by corporations. For example, academic physicians who conduct medical research on subjects who are also their patients sometimes experience conflicts between career advancement in one's institution and individual patient benefit. The Code of Medical Ethics states that clinical investigators "should demonstrate the same concern and caution... as is required of a physician who is furnishing medical care to a patient." Nonetheless, research physicians may find themselves unable to advocate zealously for patients in individual cases. For example, a researcher and a non-research physician may differ over the desirability of having a patient participate in a controlled clinical trial of a new treatment, in which the patient is assigned at random to new or conventional therapy. The tensions inherent in combining research with clinical practice are not merely based on self-interest, of course, but reflect the fact that society values scientific progress as well as compassionate care.

Similarly, physicians paid by corporations to serve workers inevitably have conflicting allegiances. The Code of Medical


Few States still prohibit physician employment, although even these states make exceptions for professional corporations, academic medical centers, and the like. See Freiman, supra note 281, 712-23. In the most recent challenge to physician employment practices, the Illinois Supreme Court held that hospitals may employ physicians because they hold institutional licenses to provide health care services, but general corporations may not. See Berlin v. Sarah Bush Lincoln Health Ctr., 688 N.E.2d 106, 110, 114 (Ill. 1997).

AMA CODE, supra note 42, Op. 2.07(2).

See MAY, supra note 202, at 173-74 (describing the conflict as a problem of "double agency"). Professor May also notes that lawyers may similarly be tempted to develop an argument not because it serves a client's best interest, but because it might yield a valuable precedent for an important cause, and observes that legal ethics prohibit lawyers from being "more concerned with the establishment or extension of legal principles than in the immediate protection of the rights of the lawyer's individual client." Id. at 174.

See generally Matthew W. Finkin, Employee Privacy, American Values, and
Ethics has been interpreted to provide that no physician-patient relationship exists when a company physician’s services are limited to pre-employment or fitness-for-work examinations, but nonetheless imposes a duty of confidentiality with respect to information gained during such encounters.\textsuperscript{287} The Massachusetts Supreme Judicial Court has gone further, holding that a physician retained by an employer may disclose confidential patient information if “reasonably necessary to serve a substantial and valid business interest of the employer.”\textsuperscript{288}

Consider, as an example, physicians who provide services to professional sports franchises, and who, therefore, may find themselves caught between the priorities of management and the long-term health of their player-patients.\textsuperscript{289} According to the Code of Medical Ethics: “The professional responsibility of the physician . . . at an athletic contest . . . is to protect the health and safety of the contestants. The desire of spectators, promoters of the event, or even the injured athlete that he or she not be removed from the contest should not be controlling.”\textsuperscript{289} This position is noteworthy not only because it places the athlete’s well-being above the financial interest of the team that pays the physician, but because it commands the physician to disregard the athlete’s own judgment regarding potential health risks, demonstrating again the ambivalence that medical ethics has toward client control and, hence, lawyerly advocacy.
Potentially the most significant organizational conflict in the pre-managed care era was between physicians and hospitals following the introduction in 1983 of Medicare’s Prospective Payment System ("PPS"). By converting hospital reimbursement from "cost-plus" to a fixed fee per admission based on diagnosis, while physicians were still paid fee-for-service, PPS changed physicians and hospitals virtually overnight from fast allies to potential economic adversaries. Physicians concerned about preserving their medical staff affiliates might, therefore, be tempted to make decisions in the hospital’s interest rather than the patient’s. However, the threat posed by PPS to physician advocacy was mitigated by three factors: hospitals generally have open medical staffs from which qualified physicians cannot be excluded; hospitals still depend on physicians for admissions more than physicians depend on hospitals for privileges; and federal law strictly prohibits hospitals from paying physicians to limit treatment.

Again, however, managed care is bringing organizational conflicts of interest to the fore. Professors Hall and Berenson note physicians’ concern that aggressive advocacy on behalf of patients could jeopardize their relationships with health plans. In addition to financial incentives, the other principal method by which managed care organizations reduce expense is selective contracting. Predictably, most health plans choose to extend network membership to physicians who not only provide high-quality care, but whose style of practice conserves health care resources. Because managed care organizations often control large blocks of patients through their relationships with employers and other group purchasers, physicians increasingly rely on these contracts for their livelihoods. Moreover, many physicians belong to large medical groups, or are affiliated with hospitals or other institutions, all of which have their own economic relationships with health plans to consider.

These allegiances exert substantial pressure on physicians to conform to health plan expectations. Two academic physicians

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291. See FURROW, supra note 259, at 574-80.
292. See 42 U.S.C. § 1320a-7a(b)(1) (1994) (prohibiting hospitals from making “payment, directly or indirectly, to a physician as an inducement to reduce or limit services provided with respect to individuals enrolled in Medicare or Medicaid”).
293. See Hall & Berenson, supra note 271, at 399 (observing possible problems with role separation related to patient advocacy). Legal prohibitions on retaliation for advocacy are likely to address only a small proportion of these cases. Refer to Part II.B.3 supra.
tell the story of a young child with cancer initially referred to
them for evaluation, but subsequently required by the patient's
HMO to obtain bone marrow transplantation from a distant
facility with which it had a contract despite extreme hardship to
the family. In this situation, the authors urge physicians to
"stand up for the doctor-patient relationship and for continuity of
care... [and] speak out: write letters to the insurance carrier,
the insurance commissioner, and elected officials when
necessary." However, they themselves encountered many
obstacles attempting to do so: being told by their own institution
not to offend the insurance carrier because the institution was
bidding for a similar contract, hearing from colleagues that it
was futile to argue with the new economic reality, and suffering
accusations by the HMO of interfering with the "client-carrier
relationship."

The more tightly integrated the managed care organization,
the more physicians will be dependent upon their employment or
affiliation relationship. For example, any-willing-provider laws
enacted because of supposedly unequal bargaining power
between physicians and health plans can also be justified on
advocacy grounds. In a similar vein, a California consumer
group recently filed suit against one of the state's largest
managed care organizations claiming, among other things, that
the defendant's use of "economic profiling" to select and deselect
participating physicians violated California's ban on retaliation
for advocacy. At its logical (or illogical) extreme, preserving
physician advocacy without turning insurance organizations
themselves into patient advocates would suggest that all
managed care networks be non-selective.

295. See Brent Weston & Marie Lauria, Patient Advocacy in the 1990s, 334 New
296. Id. at 544.
297. See id. at 543.
298. Any-willing-provider laws, which have been enacted in several states to
protect physicians, hospitals, pharmacists, and others from being excluded from
managed care networks, require health plans to contract with whoever is willing to
meet their standards terms and conditions. See Physician Payment Review
any-willing-provider, freedom of choice, and direct access laws).
299. See Consumer Group Suit Seeks End to Practice of Physician Profiling, 7
300. Excess provider capacity that allows insurers to negotiate low per-unit
prices, and current consumer preferences for unlimited choice of physician, have
already moved the market away from closed-panel HMOs toward broad networks
and point-of-service plans. See generally Jon Gabel, Ten Ways HMOs Have Changed
During the 1990s, HEALTH AFF., May-June 1997, at 134 (discussing recent changes
in the managed care industry).
The last type of conflict of interest deemed unacceptable by legal advocates but increasingly common in medicine is the situation in which a professional is faced with two or more clients with inconsistent objectives. Although this problem can also arise in connection with front-line clinical decisions, it is most frequently confronted by physicians in supervisory capacities. Once again, moreover, the Code of Medical Ethics is clear but unhelpful: "Physicians in administrative and other nonclinical roles must put the needs of patients first." This statement confirms an overriding ethical obligation to patients as a class, as opposed perhaps to shareholders or management, but it does not indicate how an administrative physician should behave when individual patients' interests are in tension with one another.

Organ transplantation demonstrates the medical profession's ambivalence toward lawyerly advocacy and client conflicts. It is possible for the same physician to take care of both the potential organ donor and the potential recipient. In this circumstance, the Code of Medical Ethics states that "[t]he physician owes the patient primary allegiance... in all medical procedures, including those which involve the transplantation of an organ from one person to another where both donor and recipient are patients," and forbids a physician from assuming organ transplantation responsibilities "unless the rights of donor and recipient are equally protected." Nonetheless, medical ethics allows concurrent representation of patients with directly opposing interests, a conflict anathema to lawyers. Similar conflicts arise in the treatment of domestic violence. Rejecting a pure advocacy model, an expert panel recently concluded that physicians may ethically treat both the victim and the perpetrator, even though their medical needs and rights to information and confidentiality may be at odds.

The medical profession has not been as sanguine about distributing limited resources among identified patients, except in emergency triage situations. Returning to the prior example,

302. On the other hand, most transplantation centers are sufficiently large and well-staffed to divide these responsibilities.
303. Id. Op. 2.16(1).
304. Refer to Part III.A supra (discussing the legal conflict of interest rules that govern the lawyer-client relationship).
305. See Lorraine E. Ferris et al., Guidelines for Managing Domestic Abuse When Male and Female Partners Are Patients of the Same Physician, 278 JAMA 851, 853 (1997) (explaining that providing information on domestic violence is not championing one patient over the other, but merely ensuring quality of care); cf. Martha Minow, Who's the Patient?, 53 MD. L. REV. 1173, 1173 (1994) (describing the ethical challenge of bringing families into the physician-patient relationship).
Code of Medical Ethics draws the line at physicians selecting patients to receive scarce organ transplants, advising that “[t]he treating physician must remain a patient advocate and therefore should not make allocation decisions.” Nonetheless, physicians make lesser allocation decisions all the time, involving both services themselves and the financial resources that might support them. Moreover, the obligation to share limited resources equitably among beneficiaries is implicit in managed care. The Consumer Bill of Rights, for example, acknowledges physicians’ multiple allegiances, and tempers physicians’ advocacy duties by including among consumer responsibilities to “[b]e aware of a health care provider’s obligation to be reasonably efficient and equitable in providing care to other patients and the community.” Whether these duties represent potentially disqualifying conflicts of interest for physicians serving as advocates, or merely parallel the lawyer’s unavoidable dilemma of spending time on one client’s case that could be spent on another’s, is likely to depend on individual circumstances.

If we are to adopt an advocacy model, the ubiquity of these conflicts of interest argues for choosing an advocate other than the patient’s treating physician. As Professor Mehlman observes, “[m]anaged care is simply too strong and the conflicts too great” for physicians to adequately represent patient interests. In Professor Mehlman’s view, traditional fiduciary obligations and the threat of malpractice liability are insufficient counterweights to altered financial incentives and shifting social priorities regarding medical expense. He therefore concludes, that a well trained, highly motivated, properly monitored, independent

306. AMA CODE, supra note 42, Op. 2.03 (“A physician has a duty to do all that he or she can for the benefit of the individual patient. Policies for allocating limited resources have the potential to limit the ability of physicians to fulfill this obligation to patients.”) However, the Code also notes that “[p]hysicians have a responsibility to participate and to contribute their professional expertise in order to safeguard the interests of patients in decisions made at the societal level regarding the allocation or rationing of health resources.” Id. This obligation is similar to that of lawyers in furthering justice and social progress.

307. An early, influential statement asserting physicians’ responsibility to consider the collective consequences of decisions to expend resources on marginally beneficial treatments for their patients was David Eddy’s exposition of the costs to other patients of using expensive, low-osmolarity radiologic contrast agents universally, rather than limiting them to high-risk situations. See generally David M. Eddy, Brooding the Responsibilities of Practitioners: The Team Approach, 269 JAMA 1849 (1993) (interviewing practicing radiologists and reporting their sentiments).

308. CONSUMER BILL OF RIGHTS, supra note 82, app. A, ch. 8.


310. See id. at 315 (discussing the inability of physicians to properly advocate for patients).
professional is necessary to serve as the patient’s advocate.\textsuperscript{311} The role of such an individual would be time-consuming and complex: providing information, reviewing coverage, advising on choices, attending consultations, reviewing documentation, and, if necessary, challenging adverse decisions.\textsuperscript{312} This is a full-time job, not an add-on to a physician’s already overburdened schedule. It is also a costly job, which would require public subsidy for all but the wealthy, and which would be affordable only by having the majority of functions performed by personnel who are paid much less than physicians.\textsuperscript{313} Responding to Professor Mehlman, Susan Goldberg objects to the notion of constituting an advocacy role independent of the physician on several grounds: (1) it legitimizes conflicts of interest and allows physicians to abdicate responsibility for patients; (2) it institutionalizes an adversarial posture between doctor and patient; (3) it treats doctors as mere technicians; (4) it increases cost and bureaucracy; (5) it dismisses patients’ direct voice; (6) it creates its own conflicts of interest; and (7) it leads to unrealistic patient demands on resources.\textsuperscript{314}

On the whole, then, physicians start as potential advocates with a broader and more significant range of conflicts of interest than beset lawyers. Some of these conflicts seem easily curable, others less so. To reach an informed conclusion about its desirability, the value of pure advocacy must be weighed against the costs of cure, a point to which we will return below.

2. Constituting the Tribunal. Even if physicians were unsullied by conflicts of interest and could, therefore, single-mindedly represent patient interests, other structural considerations would need to be addressed in order for them to serve effectively as advocates. The most important of these is constituting the tribunal that would rule on medical disputes.\textsuperscript{315}

\begin{thebibliography}{99}
\bibitem{311} See id. at 320-23 (viewing effective advocacy primarily in preventive terms, consistent with the prospective nature of coverage decisions in managed care, rather than as assistants in obtaining compensation for injuries suffered).
\bibitem{312} See id. at 321.
\bibitem{313} See id. at 322 (suggesting nurses, social workers, and paralegals).
\bibitem{314} See Susan L. Goldberg, A Cure for What Ails? Why the Medical Advocate is Not the Answer to Problems in the Doctor-Patient Relationship, 1 WIDENER L. SYMP. J. 325, 331-45 (1996).
\bibitem{315} As a threshold matter, all procedural solutions are vulnerable to problems of access and resources. For example, Professor Rodwin observes that the benefits of independent review of managed care decisions depend on several factors: the consumer knowing about a service denial or incident of poor quality care; believing the plan is at fault and that filing a complaint would be productive; and having the time and resources to pursue the matter. See Marc A. Rodwin, Consumer Protection and Managed Care: The Need for Organized Consumers, HEALTH AFF., Fall 1996, at 110, 115. Because enforcement resources are limited, moreover, external review
Two related issues immediately present themselves. First, who should make those decisions? Second, on what should those decisions be based? Despite the current popularity of laws imposing external review requirements on managed care organizations, these basic questions have yet to be answered definitively.

Any arbiter of health care disputes, particularly those involving serious illness and potentially life-saving treatment, must be both competent and legitimate. Satisfaction of these requirements is not easy to accomplish. Even the established judicial process falls short in more ways than time and expense. Professors Hall and Anderson assert that courts are not well-equipped to decide coverage issues because of their difficulty with clinical questions and bias toward individual over group preferences, and suggest instead that parties be allowed contractual freedom to establish coverage standards and a fair decisionmaking process. On the other hand, the American Arbitration Association announced in July 1998 that it would no longer administer mandatory arbitration of health care coverage disputes because “here it’s someone’s life [at stake],” and urged plans to adopt voluntary processes, especially mediation, while emphasizing the need for patients to be represented by attorneys and have other protections.

How would one design a tribunal before which physicians could advocate? A frequent complaint of organized medicine is that “medical judgments” made by managed care organizations are being assigned to laypersons, or to nurses who lack specialized knowledge and experience. The medical profession

programs may be designed to discourage their use. In New York, for example, high review fees are assessed against health plans in part to give them incentives to avoid disputes or resolve them in other ways. See N.Y. State Health Commissioner Barbara DeBuono, Remarks at the American Society of Law, Medicine & Ethics Annual Meeting (Oct. 9, 1998).

316. See Hall & Anderson, supra note 51, at 1675-76, 1711-12. Another reason one should consider carefully the rationale for, and characteristics of, a dispute resolution system based on physician advocacy and neutral arbitration is to determine whether and to what extent health plans, providers, and patient-beneficiaries should be permitted to contract out of that system.


318. See Mark J. Schlesinger et al., Medical Professionalism Under Managed
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has, therefore, lobbied for laws requiring utilization review to be performed by exclusively qualified physicians. In addition, the principal accrediting body for health plans, the National Committee for Quality Assurance, recently adopted a standard requiring claims review to be performed by a doctor in the same or similar specialty as the treating physician. New York and New Jersey now limit certain claims denial authority within health plans to physicians and the Massachusetts Board of Registration in Medicine is considering going even further by redefining the practice of medicine to include all utilization review activities, so that only a physician could decide to deny coverage denials. Similarly, the many state laws mandating external review generally vest ultimate authority in independent entities that contract with physicians to render expert medical decisions.

Although measures requiring health plans to cede claims review responsibilities to physicians are open to criticism as thinly veiled efforts to impose higher costs on managed care organizations and discourage their activities, they nonetheless respond to the general sense of both the public and the profession that medical decisions should be made by doctors. Empowering an expert tribunal composed of clinicians seemingly confers the essential attribute of legitimacy on the dispute resolution process. Much the way practicing lawyers regard lawyer-judges as qualified to supervise them, physicians might be reassured that one of their number remains in control, who will decide cases according to shared professional norms. At the same time, patients might feel that economic exigencies have not wholly eviscerated the scientific authority of the medical profession.

One issue certain to arise in creating medical tribunals is bias. For example, the rationale for external review of coverage denials is that decision processes internal to the health plan may

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319. See NATIONAL COMMITTEE FOR QUALITY ASSURANCE, STANDARD RR 3.2 (1998). Interestingly, the NCQA also requires that plans allow members a hearing on further appeal at which a “practitioner or member representative” may act on behalf of the member. Both doctors and lawyers qualify for this role.

320. See N.J. ADMIN. CODE tit. 8, § 8:38-8.3(b) (1997); N.Y. PUB. HEALTH LAW §§ 4900(2)(a), 4903(1)(c) (effective July 1, 1999), available in WESTLAW, NY-ST Database.


322. See, e.g., N.Y. PUB. HEALTH LAW §§ 4913, 4915 (effective July 1, 1999), available in WESTLAW, NY-ST Database (prohibiting external review agents from engaging in certain practices and mandating the absence of any conflicts of interest on the part of external review agents).
not be impartial. Laws that have been adopted, therefore, require 
external reviewers to have no financial connection to the plan. 323 
Conflicts of interest also can be more subtle. On one hand, 
repeat-play relationships develop between health plans and 
reviewers, especially when plans pay the cost of review. On the 
other, clinical review may be performed by physicians affiliated 
with academic medical centers, or by other leading practitioners 
who have their own interests in the availability of sophisticated 
treatments. The important point is not being able to predict the 
direction of bias, but understanding that any system based on 
lawyery advocacy will expend considerable energy trying to 
avoid it. 324 Moreover, achieving sufficient insulation may require 
sacrifices in expertise or commitment.

Medical dispute resolution and advocacy, moreover, are 
complicated by the absence of an analogy to two core distinctions 
made in the legal system: between fact and law, and between 
substance and process. For example, creating an adversarial 
system in health care requires deciding whether the tribunal will 
operate solely as "experts," attempting to find an objective, 
scientific answer to the question of medical benefit (or possibly 
cost-effectiveness), or if it will try to capture in some sense 
broader public values and preferences regarding the fair 
allocation of resources. 325 Courtroom procedure allows a division 
of labor between expert arbiters (judges) who resolve issues of 
law, and lay arbiters (juries) who apply community values to 
determine facts and reach final decisions. By contrast, an appeal 
of a health plan's denial of coverage as not medically necessary 
seldom segregates as easily into similar categories. Most 
contested elements of a finding of medical necessity—whether 
the patient suffers from a particular condition, the efficacy of the 
proposed treatment, and the prognosis under available 
alternatives—mix aspects of the factual situation and the clinical 
rules that govern its resolution.

323. Of the 13 state laws examined in a recent survey, 12 specifically prohibit 
conflicts of interest. See Pollitz, supra note 63.

324. For example, bias is a frequent concern in private arbitration of medical 
malpractice claims. See, e.g., Kaiser Found. Hosps. v. Coburn, 23 Cal. Rptr. 2d 431, 
433-34 (Cal. Ct. App. 1993) (vacating an arbitration award for failure to disclose 
possible bias of the arbitrator).

325. An important caveat is that systems justified under the former rationale 
often operate in fact under the latter, or under some alternative framework 
controlled by politically powerful but socially undesirable forces. See generally Gary 
S. Belkin, The Technocratic Wish: Making Sense and Finding Power in the 
"Managed" Medical Marketplace, 22 J. HEALTH POL. POL'y & L. 509, 511 (1997) 
(arguing that the power of managed care is based in part on its claim to be a better 
science).
Consequently, the consensus apparently favoring expert medical tribunals may be sensitive to underlying assumptions. If one starts with the belief that patients should receive all beneficial treatment, then the question whether a treatment is beneficial is indeed appropriate for expert medical resolution. If, however, one starts from the premise that patients should only receive treatments that do not unduly waste social resources, opinions may differ over whether the ideal decisionmakers are clinical experts, economists, community leaders, or average citizens—or whether a framework even exists within which the case may be judged. If one goes still farther and assumes that the outcome of cases should depend in part on non-medical attributes of the patient’s situation, there is little reason to have physicians decide. In these cases, the perceptions of the medical profession and the public as to the legitimacy of any physician-dominated tribunal are likely to diverge significantly.

A microcosm of this problem is already manifesting itself in the administration of external review laws. Most coverage denials are based on contractual language in a health insurance policy. However, only the subset of these derived from professional standards of medical practice is susceptible to expert verification on clinical grounds. Some external review laws, such as California’s, therefore, focus on coverage requests that were denied because the proposed treatments were “experimental,” a clear-cut clinical category. Similarly, the Consumer Bill of Rights recommends access to external review of denials based on experimental or investigational status, for expensive or clinically significant treatments, or for lack of medical necessity. New York’s external review law is also limited to medical questions. On the other hand, states that apply external review to all health plan decisions have had to find ways to separate clinical from contractual disputes; Connecticut’s insurance regulators, for example, screen the complaints they receive and review the latter group internally, only referring the former to expert clinicians.

327. See CAL. HEALTH & SAFETY CODE § 1370.4 (West Supp. 1997) (providing an external, independent review process to examine the plan’s coverage decisions).  
328. See CONSUMER BILL OF RIGHTS, supra note 82, app. A, ch.7.  
329. In New York, external review requirements apply, first, to services ruled not medically necessary by the health plan; and, second, to services denied as experimental or investigational if the enrollee’s condition is life-threatening or disabling, and (i) standard procedures are ineffective or inappropriate, (ii) there is no more beneficial standard treatment that would be covered, or (iii) a clinical trial exists for the proposed treatment. See N.Y. PUB. HEALTH LAW § 4910(a)(1), (b) (effective July 1, 1999), available in WESTLAW, NY-ST Database.  
However, even this bifurcated approach will eventually fail if contracts of coverage begin to specify in detail the clinical standard of care to which the patient is entitled, making it necessary for an expert tribunal to display a mixture of medical and legal competencies. Moreover, physicians serving as advocates before any such tribunal would possess only a part of the skill set necessary to represent their patient-clients.

Without a fact/law dichotomy, however, problems with an advocacy model arise even in purely clinical disputes. One advantage of the physician-advocate is her ability to present evidence in support of a proposed treatment. However, the underlying premise of managed care is that cost savings can be realized through improvements in clinical processes. To a significant degree, moral authority to challenge the judgment of physicians was conferred on managed care by research demonstrating wide geographic variations in practice patterns not explainable by patient characteristics or clinical outcomes.

Therefore, a tribunal reviewing a dispute over medical necessity will usually demand evidence beyond the customary standard of care that supports a verdict of medical malpractice.

Under New York's external review law, for example, the enrollee's attending physician must offer in support of the proposed treatment at least two "documents from the available medical and scientific literature" unless a clinical trial is ongoing, and in any event must include a statement of the evidence relied upon in reaching his or her recommendation.

This aspect of the law puts the physician-advocate in a difficult position. In legal proceedings, the facts of a dispute are not typically within the control of the lawyer. Facts are presented in their best light, but cannot be altered. By contrast, the treating physician creates the factual record that forms the basis of the argument. It would be as if the lawyer were also the key fact witness, a conflict generally prohibited by legal ethics.


Dr. John Wennberg has been the motive force behind these "clinical variation" studies. See DARTMOUTH ATLAS OF HEALTH CARE (1998).

See N.Y. PUB. HEALTH LAW § 4910(2)(b)(iii) (effective July 1, 1999), available in WESTLAW, NY-ST Database.

See MODEL RULES OF PROFESSIONAL CONDUCT Rule 3.7(a) (1997) (prohibiting a lawyer from being an advocate in a proceeding in which the lawyer is likely to be a witness except in certain limited situations, including: (1) when the lawyer's testimony relates to an issue not in contention; (2) when the testimony relates to legal services rendered; or (3) when disqualification of the lawyer will not
We have also taken for granted that patients could easily identify an appropriate physician to serve as advocate. Just because one physician desires to provide treatment to a patient does not automatically confer legitimacy on that physician as advocate to the exclusion of others. The image of the physician as an advocate in an adversarial dispute resolution system belies the fact that medicine is highly specialized, and many physicians are typically involved in the care of any patient sick enough to be asserting the need for expensive services. Moreover, a considerable amount of care is often provided to patients through institutional processes not under the direct control of any single physician. This is often the case in tightly integrated managed care settings, such as closed-panel HMOs. Selection of a physician-advocate should not require the patient to abandon the rest of her system of care.

Furthermore, clinical disputes will be hard to resolve in a fashion that generates consistent precedents. Despite the efforts of Langdellian legal education to equate the two, the resemblance between law and science is superficial. While science is nature-made and absolute, law is man-made and relative. The modern response to Professor Langdell's assertion that law is a scientific truth empirically discoverable from case reports and judicial writing has been to point out, correctly, that law is socially constructed and, therefore, inseparable from its origins and context. For purposes of creating a dispute resolution system, however, this apparent failing of law turns out to be a great strength. Gaps in law can be filled by the mortar of legal interpretation that quickly becomes incorporated into the legal edifice through stare decisis. In addition, the edifice itself

unduly harm the client).


336. See ROBERT STEVENS, LAW SCHOOL: LEGAL EDUCATION IN AMERICA FROM THE 1850S TO THE 1980S 51-64 (1983) (discussing Professor Langdell’s assumption that law is a science).

337. Arguments can be made that science is socially constructed as well. See, e.g., HARRY M. COLLINS & T.J. PINCH, FRAMES OF MEANING: THE SOCIAL CONSTRUCTION OF EXTRAORDINARY SCIENCE (1982). Nonetheless, the comparative point remains accurate.

338. See id. at 52; see also FRIEDMAN, supra note 184, at 617 (“If law is at all the product of society, then Langdell’s science of law was a geology without rocks and astronomy without stars.”).
can be torn down and deliberately rebuilt. Not so with science. Scientific truth may be absolute, but scientific knowledge is incomplete, an approximation teeming with uncertainty.\textsuperscript{339} Moreover, scientific uncertainty cannot be reduced by interim compromises but must await new discoveries. Any systematic process of medical dispute resolution that proposes to apply expert knowledge to specific cases must recognize this limitation, or else risk devolving health care decisionmaking into a restatement of customary but unproved clinical practices.\textsuperscript{340}

This fact brings us to the lack of clear division in medical advocacy between substance and process. On the assumption that procedure was merely a technical means to an end, legal scholars traditionally drew a sharp distinction between procedural and substantive law, so much so that Congress felt comfortable delegating authority to establish rules of procedure to a committee structure overseen by the Supreme Court.\textsuperscript{341} More recently, however, the inevitable connection between procedure and substance has been recognized with respect to both the value choices that underlie decisions about process and the influence over substantive outcome that controlling the procedural agenda can bestow.\textsuperscript{342}

Fiction or not, the distinction between substance and process, like the fact/law dichotomy, is highly relevant to physician advocacy. In the legal system, an instrumental purpose

\textsuperscript{339} As Richard Feynman observes: “All scientific knowledge is uncertain . . . . Scientists are used to this. We know that it is consistent to be able to live and not know . . . . That is easy. How you get to know is what I want to know.” RICHARD P. FEYNMAN, THE MEANING OF IT ALL: THOUGHTS OF A CITIZEN SCIENTIST 26-28 (1998).

\textsuperscript{340} A major debate is underway among scholars of coverage policy between customary and evidence-based standards for determining medical necessity, the resolution of which is beyond the scope of this Article. Compare David M. Eddy, Benefit Language: Criteria That Will Improve Quality While Reducing Costs, 275 JAMA 650 (1996) (suggesting contractual language basing coverage on scientific evidence), with Sara Rosenbaum et al., Who Should Determine When Health Care is Medically Necessary?, 340 N.EW. ENG. J. MED. 229 (1999) (arguing for deference to professional custom). Suffice it to say that a professional standard sets a low bar for physician advocacy in individual, but sacrifices potential efficiencies in the system as a whole. An evidence-based standard, by contrast, encourages research on best practices, but requires careful oversight by payors or regulators to ensure that contractual coverage standards are fair and reasonable.


\textsuperscript{342} See, e.g., JOHN HART ELY, DEMOCRACY AND DISTRUST: A THEORY OF JUDICIAL REVIEW 181 (1980); see also Kenneth A. Shepsle, Congress Is a "They," Not an "It": Legislative Intent as Oxymoron, 12 INT'L REV. L. & ECON. 239, 248 (1992) (describing the implications of Arrow's Impossibility Theorem for agenda-setting and legislative procedure).
of the distinction is to separate domains of attorney and client decisionmaking. Clients are entitled to choose among substantive goals and arguments; lawyers are generally free to decide on procedural tactics. This division of authority is hard to recreate with physician advocacy. Because both rely on the same clinical evidence, the process of arguing one’s case to an expert tribunal tends to converge with the substantive plan of treatment. Because an advocacy model assigns great importance to client autonomy, physician advocates and their patients may, therefore, struggle with issues of day-to-day control.

The other major issue arising from the overlap between process and substance in health care is whether patients who are denied treatment after review will accept the legitimacy of that determination. Professor Simon excoriates traditional legal advocacy as leading to “procedural fetishism,” in which conflict is sublimated into process at the cost of divorcing the individual client from his personal goals and actions and, thus, sacrifices his autonomy to the scripted behavior of characters in a stage-play. Arguably, one goal of external review and other procedural safeguards in health care is to mimic the sublimation that occurs in the courtroom. Whether it will be successful is another matter. Patients who select and place their trust in a personal physician may not feel equivalently comfortable with the judgment of a reviewing tribunal, however exalted, when the physician's recommendation is countermanded. In addition, patients seeking what they perceive to be life-saving treatments cannot compromise the same way that clients litigating a monetary dispute might settle for an intermediate sum. Disappointed claimants, therefore, may go outside the dispute resolution

343. See Model Rules of Professional Conduct Rule 1.2(a), cmt. (1997) (noting that the lawyer shall follow the directives of the client concerning the objectives of representation while assuming responsibility for tactical and technical issues).

344. Refer to Part V.E infra and accompanying text (discussing procedural justice).

345. See Simon, supra note 159, at 119-30 (discussing the failings of the "Ideology of Advocacy").

346. Russell Korobkin and Chris Guthrie suggest that the reason settlement occurs more frequently in the legal system—as behavioral scientists would estimate based on studies of client motives and preferences—is that lawyers drive settlement decisions. See Russell Korobkin & Chris Guthrie, Psychology, Economics, and Settlement: A New Look at the Role of the Lawyer, 76 Tex. L. Rev. 77, 124 (1997). If physicians serving as advocates played a similar role by persuading patients to compromise their personal feelings for incommensurate monetary concessions or for larger social goals, one might wonder if the ideal of physician advocacy is merely an empty vessel, no different from the current professional practice of balancing competing interests.
system more often than befits a successful adjudicatory mechanism. For example, strategic use of the press or focused lobbying may, through fears of marketplace retaliation or legislative intrusion, secure benefits for unhappy patients to which they are not fairly entitled, thereby undercutting the legitimacy of the system.

These difficulties are compounded when the basis for the arbiter's judgment extends beyond purely clinical considerations. Litigation allows compromise and settlement when people can prioritize goals and negotiate acceptable outcomes within a common framework. However, some conflicts are often incapable of resolution along a single axis, a problem that philosophers term "incommensurability." If the conflicting values are incommensurable, however, such as the dollar cost to society of covering a particular treatment and the human cost to an identified patient of forgoing potentially life-saving care, there is little reason to think that an external process will be able to reach an acceptable outcome. Certainly, experience with health insurance coverage cases suggests that courts are not well equipped to render decisions that trade off dollars against human suffering.

347. See generally Cass R. Sunstein, Incommensurability and Valuation in Law, 92 Mich. L. Rev. 779, 780 (1994) (discussing the idea that if something cannot be assessed along a single metric, it is not commensurable).

348. See W. Bradley Wendel, Reconstructing Professional Responsibility: Plural Values and Ethical Choices 3 (Sept. 8, 1998) (unpublished manuscript, on file with the author) (discussing the different values that are in play in professional ethics including loyalty to one's client, social justice, and interpersonal considerations such as care, mercy, and connectedness).

349. This observation is true generally in health care regulation. Two aspects of the health care system distinguish it from regulated activities. First, most government policies involving health insurance and access to health care services are necessarily redistributive: from young to old, from healthy to sick, and from rich to poor (although, occasionally, redistribution is from poor to rich, as with the tax subsidy that favors highly compensated employees receiving generous health benefits). See Sherry Glie, Chronic Condition: Why Health Reform Fails 122-56 (1997) (discussing redistribution in the health care system and the various forms it takes). Second, health care decisions at the margins typically involve identified rather than statistical lives, which cannot be "valued" ethically. Calculations of the value of a statistical life proceed by measuring public willingness to pay for an incremental reduction in mortality risk, and multiplying that incremental value to reflect a risk reduction from one to zero. The initial increment is always measured at a low level of risk, not risk approaching certainty, because there is no ethical monetary equivalent of an identified life.
3. Confidentiality. As a general matter, lawyers’ obligations to society are more closely circumscribed than physicians’, which is a direct result of the former profession’s overarching role as advocate. Rules governing confidential communications are illustrative. Similar rationales for strict confidentiality exist in both professional spheres, namely that patients and clients will freely share information important to serving them only with assurances of non-disclosure. Nonetheless, the two professions operate under notably different constraints.

The Code of Medical Ethics lists as a “fundamental element of the patient-physician relationship” that “[t]he physician should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.” The Code goes on to explain:

The obligation to safeguard patient confidences is subject to certain exceptions, which are ethically and legally justified because of overriding social considerations. Where a patient threatens to inflict serious bodily harm to another person or to himself or herself and there is a reasonable probability that the patient may carry out the threat, the physician should take reasonable precautions for the protection of the intended victim, including notification of law enforcement authorities. Also, communicable diseases, gunshot wounds, and knife wounds should be reported as required by applicable statutes or ordinances.

Furthermore, statutes mandating disclosure of public health hazards have been upheld by courts against claims of

350. See Model Rules of Professional Conduct Rule 1.6 cmt. (1997) (noting that confidentiality encourages the client to communicate fully and frankly with the lawyer).

351. Confidential information is also defined expansively in law, including “all information relating to representation,” of whatever nature and however acquired. See id. Rule 1.6(a). For example, attorneys who submit copies of bills for legal services to outside auditors without the informed consent of the client arguably breach the duty of confidentiality. See Debra Baker, You Charged How Much?, A.B.A. J., Feb. 1996, at 20, 20-21 (describing auditor oversight of billing by insurance defense lawyers). By contrast, consent to physician disclosure of medical bills to insurers is generally implied because it is necessary for claim payment. Imposing constraints on physicians similar to those experienced by attorneys would be difficult, in large part because there is no clear line between services delivered as advocate and as care provider.

352. AMA Code, supra note 42, Fundamental Element 4; see also id. Principle IV (“A physician . . . shall safeguard patient confidences within the constraints of the law.”).

353. Id. Op. 5.05.
confidentiality, and courts have also been receptive to more general disclosure if it serves the public interest. By contrast, lawyers are held to strict standards of confidentiality with respect to matters learned from clients or in the course of representing them. For example, physicians are legally required to disclose suspected prior instances of child abuse to state authorities, while lawyers may not do so without their client’s consent.

The bearing that disclosure has on client or patient service does not fully explain these differences. Although disclosure by criminal defense lawyers would be obviously incompatible with successful representation, attorneys are equally bound by client requests for non-disclosure when the client is the victim or a third party, instead of the perpetrator. Similarly, it is sometimes the victim who requests in vain that a physician keep an incident confidential. Neither is the temporal relationship between the triggering event and the receipt of professional service particularly illuminating. If physicians learn of past events subject to reporting, they must generally disclose them. On the other hand, attorneys acting as advocates are strictly forbidden to reveal past matters of which they learn. There are also differences with respect to future harm. Infectious disease

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355. Refer to note 156 supra and accompanying text (discussing the prohibition against revealing client information under the Model Rules of Professional Conduct).


358. See Victor I. Vieth, Passover in Minnesota: Mandated Reporting and the Unequal Protection of Abused Children, 24 WM. MITCHELL L. REV. 131, 151, 161 (1998) (noting that Minnesota is the only state that does not require physicians to report incidents of child abuse more than three years old).

359. See MODEL RULES OF PROFESSIONAL CONDUCT Rule 1.6 cmt. (1997) (observing that “[t]he confidentiality rule applies... to all information relating to representation”).
presents a risk of spread, and physicians are often involved in treating reportable conditions close to the time they are contracted. Similarly, most states create an exception to confidentiality in situations in which an attorney learns that a client intends to commit an act inflicting serious bodily harm on another. Unlike medical reporting statutes, however, these exceptions are permissive rather than mandatory. Moreover, California still strictly prohibits disclosure by attorneys of the risk of serious future harm, a position strikingly different from the duty to third persons the state imposes on physicians treating potentially violent patients. On the whole, then, one is left with the impression that single-minded attention to the needs of those they serve is valued less by society for medical professionals than for legal professionals.

4. Professional Discipline and Liability. If physicians are to act as advocates, what standards will govern them, and how will those standards be enforced? Lawyers' standards of professional conduct have been adopted as legally binding rules by the judiciary (or, in California, by the legislature) in all fifty states, so that failures of advocacy are punishable by formal professional discipline, potentially including disbarment. By contrast, the body of medical ethics does not have the force of law except insofar as specific provisions of the Code of Medical Ethics are incorporated into state professional codes. Violations of the Code of Medical Ethics that do not also contravene law are enforceable only by the AMA's Council on Ethical and Judicial Affairs, and are punishable only by expulsion from membership in the association. Moreover, the AMA is prohibited from

360. See id. Rule 1.6(b)(1) (permitting disclosure when the lawyer reasonably believes it is necessary to prevent the client from engaging in a criminal act likely to result in death or serious bodily injury). Attorneys serving as advisors also may not assist clients in future illegal or fraudulent activity. See id. Rule 1.2(d).

361. See id. (noting that "A lawyer may reveal such information..." (emphasis added)).

362. Compare CAL. BUS. & PROF. CODE § 6068(e) (West 1996) (requiring lawyers to "maintain inviolate" client confidences), with Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 340 (Cal. 1976) (requiring disclosure when necessary to protect an individual or the community as a whole). Other states have followed Tarasoff and have imposed disclosure duties on physicians and, primarily, upon psychiatrists. See, e.g., Perreira v. State, 768 P.2d 1198, 1201 (Colo. 1989) (en banc); McIntosh v. Milano, 403 A.2d 500, 511-12 (N.J. Super. Ct. Law Div. 1979).


364. See RULES OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS Rule XIII (1997). AMA membership is not a prerequisite to medical practice, so this threat carries little weight.
enforcing ethical directives that involve the economic organization of physician practice as a result of litigation brought by the federal antitrust agencies. 365

Few of the ethical precepts necessary for physicians to be patient advocates have been enacted by states. 366 True physician advocacy would, therefore, require an expanded system of professional discipline to enforce physicians’ obligations. However, the physician’s dual role as participant in treatment and as advocate makes oversight problematic. Because advocacy would occur before a specialized tribunal, existing medical disciplinary bodies may not be appropriately skilled or motivated to monitor conduct. Moreover, it might be hard to isolate the actions that constitute faulty advocacy, as opposed to flawed treatment. Disciplinary standards would also have to address statements made in formal proceedings, and these statements could be considered both advocacy and testimony. 367

A professional disciplinary mechanism is necessary because enforcement of advocacy duties cannot easily be performed by medical malpractice law. For one, unprofessional conduct and professional negligence are distinct issues. 368 For lawyers, merely violating an ethical directive does not imply that they have practiced negligently, which must be established by expert testimony as to the standard of care in the community. In Hizy v. Carpenter, 369 for example, the Washington Supreme Court held that a private right of action for legal malpractice cannot be

366. Exceptions usually include breaches of confidentiality and certain financial conflicts of interest. See, e.g., Cal. Bus. & Prof. Code § 2263 (West 1996) (providing that the willful violation of professional confidence constitutes unprofessional conduct); see also id. § 650 (prohibiting rebates for patient referral).
367. However, some courts have already made exceptions to witness immunity statutes so as to allow professional discipline by state licensing boards of physicians who testify fraudulently or incompetently as experts in personal injury litigation. See, e.g., Deatherage v. State Examining Bd. of Psychology, 948 P.2d 828, 829 (Wash. 1997) (en banc) (upholding the suspension of a psychologist’s license); see also Gianelli, supra note 205, at 7 (describing an AMA resolution supporting expert witness discipline).
368. It is also worth noting in this connection that the concept of the advocate as devoted solely to the client’s interest is not universally shared. In England, an advocate is immune from malpractice liability on the theory that immunity is necessary to ensure that the advocate will honor his or her overriding duty to the court even when that duty conflicts with the client’s wishes. See Rondel v. Worsley, 1 A.C. 191, 227-28 (1969); see also Melissa Newman, Note, The Case Against Advocates’ Immunity: A Comparative Study, 9 Geo. J. Legal Ethics 267, 268 (1995) (arguing for the American system of malpractice liability as enhancing public confidence in professional competency).
based on a violation of the Code of Professional Responsibility or the Rules of Professional Conduct because those ethical standards are intended to ensure the integrity of the legal system as a whole, and involve the relationship between lawyers and the court, not between lawyers and their clients.\textsuperscript{370}

In addition, professional negligence is defined by indicia of habitual rather than ideal practice. Once again, the fact that a physician performs both treatment and advocacy functions for a patient complicates the analysis. Whereas the lawyer's malpractice exposure depends solely on her competency as an advocate, the physician's is inevitably tied to the underlying provision of care. As Eugene Grochowski observes, the standard of care applicable to medical malpractice cases limits effective oversight of physician advocacy.\textsuperscript{371} Under malpractice law, physicians are not legally obligated to provide any potentially beneficial care to their patients, but only to meet the standard of a reasonably competent practitioner. It would be strained, if not outright illogical, to hold a physician to a higher standard when making the case for patient treatment than when actually treating the patient.

Furthermore, unlike the case with rapidly disseminated technologic innovations or scientific discoveries, the malpractice standard of care will only slowly adjust to changes in physicians' ethical obligations. Although the reasoning of the Wickline decision may suffice to allow a plaintiff to survive a motion for summary judgment, a jury finding of professional negligence based on faulty advocacy would require expert testimony as to the standard of care. In the interim, courts may predicate liability on other causes of action, such as the violation of common law fiduciary duties. However, it seems likely that liability for negligent advocacy will have to be imposed by statute if it is to become widely accepted within the near future. Interestingly, the only statute governing liability for advocacy currently in existence tends in the opposite direction, allowing physicians to consider the societal implications of treatment decisions even if the patient's interest would dictate otherwise. Oregon's controversial Medicaid program, which ranks health care services according to their degree of clinical benefit and offers coverage only for those that can be provided within the State's available budget, expressly immunizes physicians from liability that might

\textsuperscript{370} See id. at 653.

\textsuperscript{371} Eugene Grochowski, Presentation at the University of Michigan Journal of Law Reform Symposium on Managing Care (Oct. 17, 1998).
attach as the result of their refraining from providing services that were not approved for funding by the legislature.\textsuperscript{372}

An interesting approach is to force health plans to support physician advocacy. For example, Clark Havighurst proposes imposing liability on health plans when physicians do not act in patients' interests.\textsuperscript{373} Extending general theories of "enterprise liability" to the advisory context, he suggests holding health plans vicariously responsible for harm that results when an affiliated physician fails to inform patients of treatment alternatives or fails to provide an internal utilization review mechanism with facts that might support a coverage decision in favor of the patient.\textsuperscript{374} However, it makes little sense in an adversarial model to make a litigant responsible for the competence of his opponent's counsel. Professor Havighurst's proposal can equally be viewed as promoting a vision of physician advocacy that falls well short of the lawyerly model. In fact, its goal arguably is to render adversarial proceedings unnecessary by aligning the incentives or patients and plans regarding both information and quality of care, so that patients do not need physicians to represent them.\textsuperscript{375}

5. \textit{Universal Access}. Finally, let me make some hesitant observations about universality. The relationship between universal access and advocacy in the two professions is not intuitive, but bears mentioning because it sheds additional light on the professional distinctions discussed above. As is well known, there is no universal right to health insurance in the United States. By contrast, the courts are open to all. On the other hand, health care is highly subsidized, both publicly and privately and is even available regardless of ability to pay in many situations involving emergencies or serious illnesses.\textsuperscript{376}

\textsuperscript{372} See OR. REV. STAT. § 414.745 (Supp. 1998).
\textsuperscript{374} See id. at 640-43; see also William M. Sage et al., \textit{Enterprise Liability for Medical Malpractice and Health Care Quality Improvement}, 20 AM. J.L. & MED. 1, 15 (1994) ("Under enterprise liability, health plans would also be responsible for practitioners' failure to obtain the informed consent of their patients.").
\textsuperscript{376} See, e.g., Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395d (1994) (discussing the emergency screening and treatment obligations of hospitals that receive federal funds).
While health care is an end in itself, however, the legal process is merely a means to an end, and society provides only limited payment for legal services and even fewer substantive entitlements to its indigent citizens.\textsuperscript{377}

These characteristics of the medical and legal systems have paradoxical consequences for professional advocacy. Many obstacles to physician advocacy, such as the prevalence of financial conflicts of interest, stem from the widespread economic redistribution that occurs in the health care system.\textsuperscript{378} Without sophisticated health facilities and expensive technology, without generous tax subsidies for private insurance, without public expenditures exceeded only by social security and national defense—in short, without the social risk-pooling that characterizes modern health care—an advocate’s role would be far less complicated. An old-fashioned, cash-on-the-barrel country doctor might advocate for patients free from many of the conflicts that beset real-life physicians today. Under those circumstances, of course, he might not have much reason to do so.

At the same time, however, the moral legitimacy of doctoring does not depend on universal access to physician services (notwithstanding a clear professional commitment to acts of private charity), whereas the legitimacy of the legal profession rests on its availability to everyone. David Luban points out that “the community plays a constitutive, not merely regulative role in the creation of the services that lawyers purvey,” and that the lawyers consequently have an obligation to repay that debt by offering pro bono services.\textsuperscript{379} Moreover, the adversarial structure of the legal system makes balanced representation more important.\textsuperscript{380}

\textsuperscript{377} Without making a moral judgment either way, one might argue that the paucity of general substantive entitlements in American society allows the legal process to be universally available but miserly in social investment. To the extent legal disputes arise over property, need for legal services tends to correlate directly with wealth, while the relationship between wealth and need for medical care is more often inverse. As substantive entitlements expand beyond basic civil and criminal rights, or if economic cycles shift property disputes more toward the indigent, the case for subsidized access to legal process to vindicate those interests becomes compelling. Although explication of these concepts is beyond the scope of this Article, they nonetheless provided food for thought when translating legal models to health care.

\textsuperscript{378} See GLIED, \textit{supra} note 349, at 122-56.

\textsuperscript{379} See David Luban, Presentation to the Association of American Law Schools (Jan. 1999).

\textsuperscript{380} In the words of a recent call for improved access to legal services:

Our justice system cannot proclaim in the bold letters of the law that it is just, but then block access to justice. We cannot say that we stand for equality before the law, but honor this right only for those who can afford to
Our willingness to empower lawyers fully as advocates may reflect this aspiration to equality before the law. Compared to doctors, for example, lawyers are discouraged from selecting clients capriciously. Similarly, the Model Rules of Professional Conduct prohibit the use of non-compete clauses in lawyers' partnership or employment agreements. While medical ethics discourages such provisions, they are commonplace in health care and are generally upheld by courts if reasonable in scope and duration. Joelyn Levy asserts that courts assessing medical non-compete clauses focus on the adequacy of the supply of medical services to meet the general needs of the community, while decisions voiding lawyers' non-competition agreements turn on the fact that a particular person might be denied her desired representative. In other words, our universal system of justice demands that lawyers be available to advocate for individuals, while the health care system requires merely that physicians serve as resources for the group. How these social inclinations and regulatory structures might adapt to an adversarial, though not explicitly universal health care system, is an open question.

pay their own way. To give with one hand and take away with the other is mean deception.

Committee to Improve the Availability of Legal Services, Final Report to the Chief Judge of the State of New York 26 (1990).

381. The Code of Medical Ethics states that "[a] physician may decline to accept [any] individual as a patient." AMA Code, supra note 42, Op. 9.06; see also id. princ. VI ("A physician shall in the provision of appropriate medical care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services."). The only exception is for HIV-infected patients. See id. Op. 9.131 ("A physician may not ethically refuse to treat a patient . . . soley because the patient is seropositive for HIV."). Lawyers are more constrained. See Model Rules of Professional Conduct Rule 1.3 cmt. (1997) (observing that "representing a client . . . does not constitute endorsement of the client's . . . views or activities, " but that "representation should not be denied to people who are unable to afford legal services, or whose cause is controversial or the subject of popular disapproval"). For example, a lawyer may avoid appointment by a tribunal to represent a client only if representing the client is likely to violate other ethical rules or laws, is likely to impose an unreasonable financial burden on the lawyer or the client, or the cause is so repugnant to the lawyer as to be likely to impair the representation. See id. But see Model Code of Professional Responsibility EC 2-26 (1981) ("A lawyer is under no obligation to act as advisor or advocate for every person who may wish to become his client.").

382. See Model Rules of Professional Conduct Rule 5.6.


V. THE PRICE OF SUCCESS

The intention of the preceding section was to demonstrate how many aspects of the medical psyche would have to be modified, and how many elements of medical practice altered, in order to empower a "physician advocate" in the strictest sense of the term. From this discussion, it should be clear to the reader that medical professionalism is a square peg and lawyerly advocacy a round hole. Nonetheless, it remains worthwhile to perform the last step of our mental experiment, and examine the normative implications for health care of a duty of physician advocacy, were one to persist in creating it. This examination encompasses both specific, foreseeable changes to the overall system, and the less tangible sacrifice of the doctor's traditionally balanced beneficence to a more focused role.386

A. Trust and Morality

Trust between physician and patient is generally regarded as an essential component of effective medical care.387 Ironically, reconstituting the physician as advocate—that is, as the patient's champion in the struggle against cost-conscious society and its corporate representatives—might have the effect of reducing rather than increasing the intimacy of the physician-patient relationship. Although nominally enhancing physician loyalty, lawyerly advocacy might well present the patient with a novel and potentially disturbing image of the physician. The risk arises because caring is vital to the healing role, particularly in furthering communication between physician and patient.388 However, aggressive partisanship is not an intuitive trait of a caring healer and may be incompatible with healing. For

386. Victor Fuchs, an ideal health care system is led by "physicians who strive to balance their obligations to patients, the organization, and themselves." See John K. Iglehart, Interview, Physicians as Agents of Social Control: The Thoughts of Victor Fuchs, HEALTH AFF., Jan.-Feb. 1998, at 90, 91. Professor Fuchs also believes that professional norms in medicine play an essential function for which neither competition nor government regulation can substitute. See id. at 91-92 (citing Kenneth Boulding's theory of integrative control, "in which people do things because of who they are and what their relationship is to others," as representative of medical care).

387. See Mechanic & Schlesinger, supra note 21, at 1693 (noting that "[t]rust always has been central to relationships between physicians and patients").

388. See Robert A. Scott et al., Organizational Aspects of Caring, 73 MILBANK Q. 77, 78 (1995) (pointing out that 85% of a physician's diagnostic knowledge comes from communications with the patient). Professor Scott defines caring as "expressions of humaneness by physicians and other health care providers toward patients as evidenced by such qualities as interest, concern, compassion, sympathy, empathy, attentiveness, sensitivity, and consideration." Id. at 78-79.
example, emphasizing conflict could provoke or worsen patient anxiety, while overstated arguments by a zealous physician-advocate might reduce a patient's confidence in the honesty and, therefore, reliability, of her physician. Furthermore, the existence of adversarial debate over the appropriate course of treatment, coupled with the fact that judgment is rendered by a neutral arbiter rather than an intimate partner, would likely confuse and worry patients accustomed to relying on a single, authoritative professional presence.

The instrumentalism associated with lawyerly advocacy also threatens the therapeutic basis of medical relationships. Loss of respect for the legal profession is sometimes attributed to increased public perception of lawyers as "tools." Analogously, the physician's role in caring—providing sympathy, reassurance, encouragement, explanations, and justifications—is often as important as her role in curing. Modern medicine has already lost some of its reputation for caring. For example, physician subspecialization made necessary by advancing science and technology, and rendered professionally attractive by academic role models and lucrative practice opportunities, has emphasized technical aspects of medical practice to the detriment of personalized attention. In addition, recent criticisms of physicians' professional behavior describe widespread failures of communication and other problems that arise from the transitory nature of many interactions between physicians and patients. Formal advocacy obligations might further reduce the stature of the profession from guardian to "fixer."

An advocacy model of physician behavior might also have adverse effects on patient expectations, which are already high. The rapacious client is already a problem for the moral lawyer; the moral doctor might reasonably prefer never to encounter an equally greedy patient. Patient forbearance, specifically to benefit others in society, is an ethical feature of medicine quite distinct from the presumption (and, in criminal cases, the constitutional protection) of self-interest common in law. The Code of Medical Ethics charges patients with the obligation to "be cognizant of the costs associated with using a limited resource

389. See Wasserstrom, supra note 168, at 14.
390. See FUCHS, supra note 232, at 65.
391. See Dimitri A. Christakis & Chris Feudtner, Temporary Matters, 278 JAMA 739, 739 (1997) (discussing the problems that transient relationships create in the lives of medical students and residents); Dennis H. Novack et al., Calibrating the Physician, 278 JAMA 502, 502 (1997) (suggesting a curriculum for physicians' personal awareness that can enhance their professional relationships, including their ability to communicate).
like health care and try to use medical resources judiciously." Patients are even urged not to violate the spirit of rules regarding allocation of truly scarce, clearly lifesaving resources. For example, the Code states: "Patients who are part of an organ allocation system and await needed treatment or transplant should not try to go outside of or manipulate the system."

If lawyers' experience is any guide, a long-term risk of physician advocacy is declining public regard for the medical profession. Lawyers' advocacy obligations often lead them to say things that they do not really believe or at least to overstate their case. While the public at some level understands the need for such behavior in an adversarial system, it nevertheless discounts much of what it hears from the legal profession. Despite flagging support over economic matters, the medical profession still enjoys a good reputation for objectivity and candor. An advocacy model for physician conduct might change that for the worse. One advantage that physician-advocates have over lawyers is that their advocacy would generally be confined to cases pitting their patients against institutions, not other individuals. As a result, they would seldom be in the position of knowing what "micro-justice" was not done if their patient prevailed, and the public would be spared that stark an image of hypocrisy.

Finally, making the physician into an advocate risks relegating a considerable amount of professional activity to an amoral, technical realm governed by the impersonal discourse of justice. Carl Schneider cautions against using the language, and presumably the processes, of law as one's exclusive approach to resolving the difficult moral issues that predominate in modern health care. Despite its veneer of heartfelt commitment, legal advocacy often becomes rote or sterile. Robert Levine writes: "A focus on rights and rules . . . has a tendency to yield a 'minimalist ethics.' In a minimalist ethics, much of the behavior we value in the caring physician is regarded as supererogatory or optimal—nice but not morally required." This rights and rules model is not the best for the medical

392. AMA CODE, supra note 42, Patient Responsibility 5.
393. Id. Patient Responsibility 9.
395. See Carl E. Schneider, Bioethics in the Language of the Law, L. QUADRANGLE NOTES, Summer 1997, at 53-59 (warning against reliance on often inadequate legal concepts while acknowledging that law has nonetheless "enriched bioethical disclosure").
profession as it confronts increasingly complex ethical and financial pressures, and as it navigates a health care system in wrenching structural transition.

B. Rule-Based Medicine

Physician advocacy implies a health care system governed by rules, rather than incentives. Although financial incentives create conflicts of interest that taint physician advocacy, managed care organizations that place physicians at financial risk for the overall cost of patient care have less cause to make appealable decisions denying coverage. If the use of financial incentives is foreclosed or significantly restricted, as appears to be happening, health plans will be forced to employ more visible mechanisms to review proposed treatments and grant or deny approval. When these decisions are subjected to independent review requirements, they must be defended—and in any event an ultimate decision must be rendered—based on explicit rules and standards.

Unfortunately, a rule-based health care system is grossly inefficient, if not wholly impractical. Certainly, a significant contribution of managed care has been to demand objective evidence of clinical benefit and cost-effectiveness, rather than meekly deferring to customary practice. For example, evidence-based

397. See Alan L. Hillman, Managing the Physician: Rules Versus Incentives, HEALTH AFF., Winter 1991, at 138, 142 (arguing that the establishment of “rules” delineates a structure from within which physicians may make clinical decisions and advocate those decisions more effectively).

398. Professors Hall and Berenson believe that medical treatment recommendations should remain separate from insurance coverage decisions, allowing physicians to “aggressively advocate for medically optimal care” if insurers deny coverage. They define advocacy as “presenting the patient’s claim for benefits in the most favorable light and pressing appeals with merit.” Hall & Berenson, supra note 271, at 399. They acknowledge, however, that strict role separation removes authority from physicians and places it in centralized, rule-based decision processes. See id. (promoting role separation theory as a means of dealing with these potential conflicts of interest); see also Robert A. Berenson, Beyond Competition, HEALTH AFF., Mar.-Apr. 1997, at 171 (describing the pressures confronting physicians in modern health care markets).

399. Other laws and regulations may act synergistically with measures intended to preserve physicians’ loyalty to patients so as to favor rule-based over incentive-based managed care. In particular, recent interpretations of ERISA’s preemptive effect on personal injury suits against managed care organizations suggest a trend toward allowing state law claims to proceed when the defendant-ERISA plan is vicariously responsible for wrongful conduct by a physician working under incentives to limit care, but voiding claims based on the plan’s direct malfeasance when engaging in utilization review. See William M. Sage, Enterprise Liability and the Emerging Managed Health Care System, LAW CONTEMP. PROBS., Spring 1997, at 159, 180-88 (predicting that as illogical as these claims appear, they will increase as managed care grows).

400. As Tia Powell notes in response to the medical profession’s complaints
clinical practice guidelines developed by experts are helpful in terms of disseminating useful information about common medical conditions. However, no compilation of guidelines can feasibly substitute for the clinical judgment of individual physicians. Medical decisions must be customized to the needs of particular cases. Physician participation is needed on both ends, describing “best practices” and applying them to specific situations. This is hard to reconcile with advocacy. Having two sets of physicians, one group to treat patients and serve as their advocates and another to rule on disputed claims, seems obviously wasteful in most situations. Nor would most members of the medical profession, notwithstanding their theoretical desire to be patient advocates, prefer an externally micromanaged health care system to one that allows physicians to reach decisions using clinical discretion and established patterns of collegial consultation, even if those decisions were subjected to incentive-based financial constraints.

In addition to their impracticality, rules also arguably detract from the moral foundation of medical professionalism. Beyond its technical complexity, medicine is not supposed to be an easy career choice. A fixation on rules, guidelines, and standardized procedures was criticized as a misguided approach to the more difficult problems in medicine even before the rise of managed care. Consider the intensity of Leon Kass's concern, as expressed in the following passage:

There is a notion abroad that there is, or that there can and should be, a science of medical right and wrong or, at least, of proper decision making to which doctors can turn for expert help to solve medicine's ethical dilemmas. This is worse than an illusion. It represents a declaration of moral bankruptcy on the part of the profession, which once understood the ethical as integral to the medical, and which never supposed that the ‘dilemmas of caring for the ill' could be neatly solved.
Yet it is precisely the hard cases, those most likely to require formal advocacy, that would be subjected to rule-based definition in order to permit adversarial resolution.

On balance, then, the rule-based system envisioned by an advocacy model is likely to be both cumbersome and morally bereft. On the other hand, the use of financial incentives in managed care preserves professional autonomy and improves efficiency even if it compromises advocacy at the margin. As David Orentlicher points out, "[m]oderate financial incentives have the virtue of constantly encouraging cost consciousness by physicians while also permitting physicians broad discretion to individualize the care they provide their patients." Similarly, Professors Hall and Berenson support financial incentives to limit care despite their effect on advocacy, and treat conflicts of interest pragmatically as an issue of degree. This is not an unqualified endorsement of incentives, only a caution against severely curtailing them in the name of advocacy. Extreme financial incentives can compromise treatment or induce physicians to accept only healthy patients, as well as potentially burden them with imprudent levels of insurance risk that exposes them to insolvency. Still, an incentive-based system seems both theoretically and practically preferable to one based on rules, despite the greater compatibility of the latter with physician advocacy.

C. Institutional Quality Improvement

The institutional focus of modern health care delivery presents a conceptual challenge with respect to protecting the interests of individual patients. One can either design institutions that themselves have both individual and collective obligations, or one can try to separate health care institutions from their constituent professionals, assigning direct patient care obligations only to the latter. An adversarial model generally assumes that individual professionals represent individual patients and, therefore, presupposes an institutional environment that is peripheral to individual care decisions.

406. See Hall & Berenson, supra note 271, at 397-98 (arguing that financial incentives should be tempered by ethical values rather than eliminated).
407. For example, the debate over malpractice liability in managed care is, in part, a struggle between professional and institutional visions of accountability for and, therefore, control over, treatment decisions for individual patients. See Sage, supra note 399, at 195-97.
408. For an excellent discussion of institutional ethics in managed care, see
However, this premise is open to question. Institutional control over many aspects of health care is a fait accompli, reflecting the dependence of modern medicine on sophisticated technology and coordination of specialized services. The resources and processes of institutions also offer tremendous potential advantages over cottage-industry professional practice with respect to improved patient safety and clinical performance. In addition, health care institutions provide services more efficiently, and can even supply social and emotional support that is not readily available from physicians. Robert Scott, for example, observes that time constraints and cost considerations in modern health care argue for an institutional commitment to caring that extends beyond the physician, but of which the physician will generally be the "chief architect." If physicians are to oversee the institutional provision of care, serving as advocate is an isolating and potentially counterproductive role, specifically because the opposing party will often be the institution whose skills and compassion the physician is charged with furthering. There is no role for nonaligned institutions in an advocacy model. Institutional resources are either controlled by the physician-advocate or opposed to her. Given the overall need for cost-consciousness and the mix of insurance and provider organizations in today's health care system, this seems a strained use of valuable assets.

D. Obligations to Society

The last point connects directly to perhaps the greatest difficulty with an advocacy model in operation: society needs doctors to do more than represent individuals. As discussed above, physicians must protect public as well as individual health and, therefore, are obliged to report communicable diseases and intervene to prevent harm to third parties. As Professor Simon observes, a duty of zealous advocacy can impede this function because although "doctor[s] are expected to serve

Alycia C. Regan, Regulating the Business of Medicine: Models for Integrating Ethics and Managed Care, 30 COLUM. J.L. & SOC. PROBS. 635, 645-47 (1997) (distinguishing a "facilitator model," in which the ethical role of institutions is to foster patient-physician relationships and form a "collective responsibility model" in which the institution itself has ethical obligations to patients).

409. See DONALD M. BERWICK ET AL., CURING HEALTH CARE: NEW STRATEGIES FOR QUALITY IMPROVEMENT 16 (1990) (discussing modern health care institutions, including the technology and resources available); Sage et al., supra note 374, at 11.

410. See Scott et al., supra note 388, at 89.

411. Refer to notes 358-62 supra and accompanying text (discussing physicians' reporting obligations).
the general public without regard to the ends of those who seek their help[,] ... they are not expected to engage in the partisan pursuit of individual ends ... Only the lawyer seems to insist on making a virtue of both neutrality and partisanship."

To state a controversial conclusion baldly, society also requires doctors to allocate health care resources. Medical ethicists are sensitive to social needs. For example, Howard Brody concludes that rationing of health care services is necessary, and physicians can perform such rationing morally. However, he also urges physicians, especially those acting as managed care gatekeepers, to approach patients assuming they require an informed, compassionate advocate. Professor Brody rationalizes this position by asserting that the tension between advocacy and stewardship should arise only occasionally, because most medical interventions offer reasonable benefit at reasonable cost. This model is compatible with a weak version of advocacy, but not a lawyerly construct, particularly because the contested cases—involving high-cost but potentially life-prolonging treatment—will be those most requiring a committed advocate.

Some ethicists even take issue with “patient empowerment” when it conflicts with the equitable division of resources. Professor Blake questions zealous health care advocacy that seeks to further individual interests at the expense of overall social welfare. Similar to Professor Levine, Professor Blake believes that ethics means building community by doing good for others, not merely respecting their rights, so that “limiting access to treatment is not in and of itself an ethically problematic affair

412. Simon, supra note 159, at 37.
413. There is vast literature on health care rationing, analysis of which exceeds the scope of this Article. For an excellent overview, as well as several original contributions, see Hall, supra note 18 (critiquing the ethical and policy rationales that underpin the various arguments that refuse to allow doctors to withhold beneficial treatment due to cost).
414. See Brody, supra note 27, at 55, 64 (noting that rationing is not merely an economic or political choice, but also a moral one).
415. See id. at 61.
416. See id. This conclusion assumes a generous level of funding for the health care system and considerable “low-hanging fruit” in terms of obviously wasteful care that can be eliminated painlessly.
417. See David C. Blake, Ethical Boundaries of Patient Advocacy in the Managed Care Revolution, CAL. HEALTH L. NEWS, Summer 1996, at 44. Professor Blake goes beyond many others by expressing his conviction not only that health care should be equitably distributed, but that resources must be fairly apportioned between health care and other uses. See id. For example, he criticizes the World Health Organization’s highly expansive definition of “health” as a human right on the basis that, first, the definition medicalizes all human evils and, second, elevates health above other moral goods. See id. at 48.
that need provoke moral outrage." Professor Blake concludes that even lawyers should be "virtuous advocates" when dealing with the health care system, and urges them to exercise self-restraint when representing patients in managed care, rather than react to all treatment denials as power struggles between needy individuals and greedy corporations.

A different way to understand the inevitability of physician involvement in allocation decisions is to revisit the debate over financial incentives to limit care. The simplest way to ensure the single-minded pursuit of client interests by a professional is to pay only for success. In law, this model of fee calculation is called a contingent fee. Why wouldn't a contingent fee work in medicine? The reason cannot be that posited by the medical profession: contingent fees "are unethical because they imply that successful outcomes from treatment are guaranteed, thus creating unrealistic expectations of medicine and false promises to consumers." Contingent fees exist in law specifically because the outcome of litigation is uncertain, making it desirable to give lawyers incentives to devise creative strategies and work hard to implement them. In fact, the leading critics of contingent fees argue that most cases brought on contingency generate quick, predictable settlements and, therefore, that lawyers are being rewarded for bearing zero risk.

There are two related reasons why contingent fees do not fit well within the health care system. First, apart from occasional

418. Id. at 47, 49 (citing John Glaser's Three Realms of Ethics, and observing that "an ethics of respecting rights gets us an ethics of strangers, which is hardly ethics at all").
419. See id.
420. Contingent fees in law are themselves controversial, though for different reasons. See generally Symposium, Contingent Fee Financing of Litigation in America, 47 DEPAUL L. REV. 227 (1998) (publishing several excellent articles on the subject).
421. AMA CODE, supra note 42, Op. 6.01.
422. Contingent fees also provide poor patients with access to legal assistance, which highlights the fact that law (specifically, in the context of criminal defense) has a much more limited range of public entitlement than medicine. However, there are ways to reallocate costs without offering attorneys a percentage of the recovery. In England, for example, the loser in litigation pays the attorney fees of both parties. The major difference between a loser-pays and a contingency fee system is that the former acts as a conservative force on changes to the law, while the latter encourages lawyers to pursue innovative theories that might yield high rewards.
423. See BRICKMAN, supra note 141, at 20-23 (noting that in so called "indefensible" cases, some amount of recovery is certain, and some attorneys are compensated for work at the rate of thousands of dollars per hour).
424. It bears mentioning that a vigorous debate over contingent fees reminiscent of the legal context is underway in one area of medical practice: assisted reproductive technologies. Compare John A. Robertson & Theodore J. Schneyer,
expenses for expert witnesses and other consultants, a lawyer working on contingency is risking only his or her human capital. By contrast, physicians must recruit outside resources such as hospital beds, diagnostic equipment, and therapeutic technology from a vast and costly array of institutions, manufacturers, and other professionals. Second, the fruits of success in litigation subject to contingent fees are measured in monetary terms, while the patient who is cured becomes healthy, not wealthy, and someone else must still pay the costs of achieving success. Consequently, a physician whose fee depended entirely on success would tend to waste resources rather than conserve them, employing low-yield diagnostic tests and heroic therapies while ignoring palliative and compassionate measures.

Bringing the cost of these outside resources within the physician's realm of responsibility in order to expand access or improve efficiency means creating exactly the sort of financial incentives that jeopardize physicians' commitment to advocacy.

One possible objection to this interpretation of contingent fees in medicine is that performance-based payment is used in health care to promote population-based preventive goals. For example, physicians in managed care may be paid in part based on documented rates of childhood immunization or retinal examination of diabetics within their assigned patient groups. However, this method is merely selective fee-for-service payment emphasizing preventive care and represents only a small part of

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425. Similar concerns apply in law. Causes of action in which the principal relief desired is non-monetary, such as injunctions under the civil rights laws, typically have explicit provisions authorizing the award of attorney fees. See, e.g., 42 U.S.C. § 1988(b) (1994) (providing for the recovery of attorney's fees in a civil rights enforcement action). Contingent fees are prohibited in criminal matters for a combination of reasons, including the absence of a clear source of payment. See Model Rules of Professional Conduct Rule 1.5(d)(1) (1997).

426. Moreover, a contingent fee in medicine assumes that the need for health care can be objectively defined. If not, physicians would tend to accept as patients persons who were not really sick, in order to cure them with greater ease. In law, the monetary nature of the client's recovery and the adversary party's strong interest in preventing success act as checks on such behavior, although lawyers still may bring highly speculative claims in the hope of finding a sympathetic jury or, more frequently, pressuring a settlement through a nuisance suits.

physician compensation. True indicators of preventive success, such as a lower incidence of heart disease or advanced cancer, or reduced need for hospitalization in chronic diseases such as diabetes or asthma, ultimately converge with using cost as a proxy for success and present the same advocacy and risk-selection incentives described above.\textsuperscript{428}

The only other ways to allow unfettered advocacy while containing the cost of health care is to strip physicians of decisionmaking authority. These range from the rule-based systems considered and rejected above,\textsuperscript{429} to centralized mechanisms of government control. However, political micromanagement arguably suffers from greater potential irrationality than rules applied by managed care organizations. Countries with national insurance typically use politically determined “global budgets” to constrain medical spending, but even these systems connect to the structure and compensation of physician practice and, therefore, depend on influencing professional behavior.\textsuperscript{430} To the contrary, physicians in these systems are made acutely aware of prevailing cost constraints through a variety of formal and informal mechanisms and are, therefore, compromised as advocates.\textsuperscript{431}

Even in the United States, over half of the trillion dollar annual cost of health care represents public expenditures.\textsuperscript{432} Consequently, one can expect the federal government to resist aggressive physician advocacy if it is likely to increase health care costs.\textsuperscript{433} For this reason as well, then, subordinating

\textsuperscript{428} Over time, it may be possible to link a substantial portion of compensation to population-based “intermediate outcomes” that correlate well with eventual disease and expense, such as using glycosylated hemoglobin tests to indicate the degree to which diabetes is being controlled. This is especially true given that a few chronic conditions account for a large percentage of health care expenditures. See Gray Ellrodt et al., \textit{Evidence-Based Disease Management}, 278 JAMA 1687, 1687 (1997) (stating that 10\% of employees with chronic disease represent 70\% of a company’s medical expenses). Of course, these payments would still need to be risk-adjusted to prevent cherry-picking by physicians or medical groups.

\textsuperscript{429} Refer to Part V.B supra.

\textsuperscript{430} See, e.g., KLEIN, supra note 113, at 75-82 (discussing the relationship between national policy and medical decisionmaking in the NHS). To state an extreme case, the French government recently abandoned its attempt to make physician non-compliance with evidence-based guidelines a criminal offense.

\textsuperscript{431} See generally id.

\textsuperscript{432} See Shiela Smith et al., \textit{The Next Ten Years of Health Spending: What Does the Future Hold?}, HEALTH AFF., Sept.-Oct. 1998, at 128, 129. Although direct public spending makes up less than half of total expenditures, non-taxability of employer-sponsored health insurance represents a substantial additional subsidy.

\textsuperscript{433} Even attorneys who represent health care clients are beginning to find their actions questioned by aggressive federal fraud prosecutors. In a case ongoing in Kansas, for example, two health care lawyers have been indicted for conspiring to
physicians' social responsibilities to their duties as advocates is likely to prove naive and counterproductive.

E. Procedural Justice

It should be clear from the preceding discussion that physician advocacy and adversarial dispute resolution are most compatible with a rule-based system of health care in which physicians sacrifice two core features of their traditional professional role—control over health care resources and responsibility for balancing individual and social needs. Although well-founded unhappiness with physician paternalism and discriminatory behavior supported the emphasis placed on patient autonomy by the bioethics, consumer, civil rights, and feminist movements, a strict interpretation of physician advocacy arguably swings the pendulum too far. At its root, medicine is a healing profession, to which rights discourse and the language of due process are alien. Law itself has been criticized for its disregard of relational values. For example, Professor Menkel-Meadow uses psychologist Carol Gilligan's distinction between an “ethics of justice” and an “ethics of care” to challenge conventional principles of advocacy such as independence, autonomy, and rules and to suggest a new ethical framework for lawyers based on “others, relationship, care, context, and reduction of harm.” The latter framework is already representative of medicine. If advocacy means substituting justice for care, most doctors would resist efforts to turn them into lawyers.

In this respect, physician advocacy is an idea whose time has not yet come. Although it is widely accepted in the legal system, procedural justice is simply not an intuitive basis for health care decisions. Much of the public’s current concern over managed care can be viewed as uncertainty over the outcome of a struggle.

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434. Cf. John Ladd, Legalism and Medical Ethics, 4 J. MED. & PHIL. 70 (1979) (arguing for an “ethics of relationships and responsibilities” in the medical context rather than a “rights model”).


436. Some legal scholars have suggested that attorneys adopt an ethic of care. See Stephen Ellmann, The Ethic of Care as an Ethic for Lawyers, 81 GEO. L.J. 2665, 2668 (1993) (observing that caring is compatible with many current practices).
between two private mechanisms—one professional, the other market-driven—for allocating health care resources. It is a leap of faith, however, to infer that the American public is ready to debate these difficult redistributive issues openly, and to accept “fair” access to services, achieved through procedural due process and adversarial advocacy, in place of either professional beneficence or market discipline.

One might nonetheless argue for physician advocacy on the pragmatic grounds that it is a role that patients expect of their doctors. Professor Simon, for example, identifies a “ritualist” school of advocacy that views adversarial legal process as affirming through ceremony, but not necessarily achieving, social goals of trust, equality, and individual dignity. A physician serving as advocate in managed care might similarly be saying to the patient involved, and indirectly to all other patients, that “I did everything I could,” and might thereby hope to achieve a psychological benefit regardless of the outcome of the fight. However, this placebo effect would likely prove short-lived and might eventually reduce trust and confidence in the medical profession rather than preserve it.

Significantly, public acceptance of a shift from informal, professional, and market allocation mechanisms to a formal system based on procedural justice is about to be tested with respect to decisionmaking by private managed care organizations serving beneficiaries of government entitlement programs. In Grijalva v. Shalala, the Ninth Circuit recently ruled that coverage decisions made by Medicare HMOs constitute state action and, therefore, require constitutional due process.

437. The differences between these approaches are increasingly being documented. For example, a recent study revealed a wide disparity between professional recommendations and insurance coverage decisions over access to growth hormone therapy for childhood short stature. See Beth S. Finkelstein et al., Insurance Coverage, Physician Recommendations, and Access to Emerging Treatments, 279 JAMA 663, 666 (1998).

438. See, e.g., Buchanan, supra note 9, at 621-24 (pointing out that managed care organizations are not intended to serve as just raters of care). Even Oregon’s famous Medicaid experiment, commendable though it was for creating broad political support for expanded access to coverage, ultimately avoided the tough questions it purported to address. See generally Lawrence Jacobs et al., The Oregon Health Plan and the Political Paradox of Rationing: What Advocates and Critics Have Claimed and What Oregon Did, 24 J. HEALTH POL’Y & L. (forthcoming Feb. 1999) (manuscript at 2-3, on file with the Houston Law Review) (noting that Oregon’s attempt to prioritize funding for health care has in many ways failed to materialize).

439. See Simon, supra note 159, at 96.

440. 152 F.3d 1115 (9th Cir. 1998).

441. See id. at 1119-21 (arguing that the congressionally created framework for coverage decisions constitutes “federal action” sufficient enough to mandate a due
Managed care has been attractive to government as a major health care purchaser in large part because it shifts responsibility for controlling costs to private organizations. However, cost control becomes a much harder task if those organizations are held to the high standards of fairness imposed on government, rather than the lower standards applied to private actors. Proponents of market competition as efficiency-enhancing, therefore, argue against Grijalva on the grounds that strict due process handcuffs the marketplace. On the other hand, allocation decisions involving taxpayer funds and legally entitled groups are indisputably public matters. Ultimately, our willingness to engage these difficult questions openly may determine whether the nation finally accepts health care (and limits on health care) as a government responsibility, or whether it retreats from its currently incomplete commitment to providing health care as a right of citizenship to making merely a financial contribution to be spent by selected beneficiaries as they see fit.

VI. CONCLUSION

This Article has attempted to unpack and examine the rhetoric of “physician advocacy” in today’s cost-constrained health care system by asking two simple questions. First, what would it take for doctors to be “advocates” the way that lawyers are? Second, if we made those changes, would we like what we end up with? In brief, the answers are “a lot” and “probably not.”

I have deliberately presented an extreme case of lawyer-like physician advocacy. Examining the situation currently facing doctors from a comparative perspective—specifically, by contrasting

442. The United States, virtually alone among developed countries, has refrained from allocating health care resources through centralized mechanisms and has deferred instead to the judgment of dispersed and largely unaccountable professionals. This is true despite the fact that our government spends as much per capita on health care as any other nation, except Canada, to which Americans add an even greater amount of private financing. See GLIED, supra note 349, at 86-121 (discussing health care costs, including international comparisons).


444. In the language of both employee benefits and health policy, the former is a “defined benefit,” the latter a “defined contribution.” The most recent reform proposal aired by the bipartisan Medicare Commission suggests a defined contribution approach. See Robert Pear, Commission Nears a Consensus on Redesigning Medicare, N.Y. TIMES, Jan. 27, 1999, at A22.
it with the experience of America’s other “sovereign profession”—can suggest useful changes and warn against dead-ends in more pragmatic and immediate fashion than traditional expositions based on abstract theory or historical analysis. Despite my overall pessimism about physician advocacy, I believe that proposals for limited advocacy duties and the use of open, adversarial proceedings in selected circumstances may be valuable. Certainly, “advocating” from within managed care by asserting ethical commitments to patients, rather than arguing adversarial positions, is a good thing. It is also worth exploring the possibility of appointing an independent party to serve as patient advocate for certain types of disputes, particularly someone whose livelihood and job security does not depend on the favor of the health plan.\footnote{445}

I am also open-minded about physicians’ motives for asserting advocacy duties, which strike me as mainly altruistic. Nonetheless, I wonder if the intensity of the medical profession’s current focus on advocacy and adversarial process in coverage and treatment matters represents, in part, a displacement phenomenon in which physicians who feel disempowered by managed care and long for fair process impute those feelings to patients as well.\footnote{446} In addition, one cannot dismiss the political usefulness of advocacy rhetoric. Legislators can be persuaded to protect providers as well as consumers from the perceived excess of managed care, and most statutes that have been enacted include due process safeguards for both groups.

While reserving to future work the specific question of how physicians might best advocate for patients in our evolving health care system, let me offer a concluding observation. Even in the midst of conflict, one can be an advocate without being a lawyer. Milner Ball observes: “All of us need an advocate, and advocacy as intercession for those in need can take lawyering as one of its several forms. But it does not have to.”\footnote{447} For example,

\footnote{445. John Day has proposed a creative mechanism to accomplish this under existing law, at least for patients enrolled in ERISA plans, by having the ERISA plan appoint an independent fiduciary, subject to approval by the Department of Labor, who would not be burdened by the conflict between individual and plan interests that besets the plan itself. \textit{See} John Day, Presentation to the \textit{Univ. of Michigan Journal of Law Reform} Symposium on Managing Care (Oct. 17, 1998).

446. The importance of procedure in resolving conflicts among professionals in institutional health care settings is well established. \textit{See generally} André L. Delbecq & Sandra L. Gill, \textit{Justice as a Prelude to Teamwork in Medical Centers}, HCM REV., Winter 1985, at 45, 45 (discussing structured decisions processes).

447. Milner S. Ball, \textit{A Little Mistrust Now and Then}, 66 U. CINN. L. REV. 877, 893 (1998) (suggesting that law merits public trust when it does something good, not merely because it exists); \textit{see also} Richard A. Posner, \textit{Professionalisms}, 40 ARIZ. L. REV. 1, 13 (1998) (proposing that law “is merely a stage in human history . . . [that] will be succeeded at some time in the future by forms of social control that perform
lawyers are experimenting widely with less adversarial forms of dispute resolution such as mediation, and many of these techniques are finding productive places in the health care arena.\textsuperscript{448} Nonadversarial advocacy may be more compatible with physicians' skills, and more useful to patients, for at least two reasons. First, adversarial processes suggest that outcomes must be "zero-sum," whereas health care disputes often have happier endings if they are approached creatively and constructively.\textsuperscript{449} Second, the procedural rules on which adversarial systems depend for fairness tend to focus attention on determinative facts, while distraught patients may need an emotional as well as a substantive hearing.\textsuperscript{450} Physicians have always been expected to combine technical expertise with compassion; they should try to bring both qualities to the fore when faced with problems requiring advocacy.\textsuperscript{451}

Ultimately, I hope that this Article serves as a reminder of the dramatic change that is occurring in both law and medicine from what Steven Brint calls "social trustee" to "expert knowledge" professionalism, and of the perils this poses to one's sense of place and role in society, even as it expands the substantive benefit one can offer one's patient or client.\textsuperscript{452} In medicine, blind adherence to a cult of advocacy is, if anything, likely to accelerate this transition. That may not be what the doctor ordered.


\textsuperscript{449} See Roger Fisher & William Eury, Getting to Yes: Negotiating Agreement Without Giving In (2d ed. 1991); see also Moore, supra note 158, at 35-39. Edward Dauer and Leonard Marcus give, as an example of interest-based bargaining, a dispute arising from an accidental injury with a contaminated hypodermic needle in which an apology combined with a plan to prevent recurrences substituted for a sizable monetary settlement. See Edward A. Dauer & Leonard J. Marcus, Adapting Mediation to Link Resolution of Medical Malpractice Disputes with Health Care Quality Improvement, 60 Law & Contemp. Pros. 185, 210 (1997).

\textsuperscript{450} I owe this observation to Carol Liebman, who is an experienced health care mediator and mediation instructor.

\textsuperscript{451} For an interesting analysis of similar self-definition challenges for clinical bioethicists, see David J. Casarett et al., The Authority of the Clinical Ethicist, 28 Hastings Center Rep. 6 (1998) (applying Habermas' "discourse ethics" to ethics consultants and suggesting that they combine moral expertise with consensus-building).