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Law's Influence on Medicine and Medical Ethics

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date yourself. If you love, you want to give—you are tireless, selfless, and generous. If you love, you really want to serve and not just work. One does not spare oneself if one loves."

It has been said that a distinctive feature of Christianity is a proclamation of the resurrection, of hope, and that this means the establishment of a genuine religion of salvation in the sense of release from this world. But Dietrich Bonhoeffer has called this attitude a dangerous mistake. Bonhoeffer says that "Salvation from cares and needs, from fears and longings, from sin and death into a better world beyond the grave is not the distinctive picture of Christianity as proclaimed in the gospels and St. Paul."

Christianity offers nothing to be seen but ordinary life in its ordinariness. Christian hope sends us back to our life on earth. We can create hope for our patients regardless of the statistics in a particular disease. We have to learn how to dispense hope and encourage our patients to pray and to pray for them and with them. We must help them to find meaning and the possibilities in the situation. The American Psychiatric Association, in its 1984 meeting, had an important seminar on "The Role of Hope in Remission from Illness." It showed that the patient's hope—and that of the health professionals—has a relevance to the immune system of the patient.

Finally, in this healing ministry we share ourselves. We are the presence of Christ for others. We choose life for ourselves and others and thus witness to the healing ministry of the Church.

REFERENCES

4. Ibid., article 19.
5. Ibid., articles 23, 24.
7. Ibid.

Ginzberg recently described in the Journal the monetarization of medical care. Law follows money, and along with monetarization have come new laws and legal regulations—constraints that cast a lengthening shadow over the clinical practice of medicine. PSRO (professional standards review organization), PRO (professional review organization), DRG (diagnosis-related group), and CON (certificate of need) are acronyms that have entered the physician's consciousness along with malpractice liability, antitrust actions, and federal and state regulation. The health-insurance industry, increasingly the target of legal regulation by administrative agencies, legislatures, and courts, is itself a powerful regulatory influence and has acted in a quasi-governmental capacity, extending the lengthening shadow of legal constraints. Physicians have expressed growing concern about the impact of these legal constraints on their traditional professional standards and ethical responsibilities to patients. Critics of the medical profession tend to dismiss these concerns as the grumblings of a vested interest group opposing needed reforms of the health care "market" to protect its own substantial financial advantages. The American Medical Association's (AMA's) codified ethics have been repeatedly criticized over the years as "protectionist," serving the interests of doctors rather than patients or the larger society. The history of "ethical" opposition to Blue Cross, to Medicare, to Medicaid, and to health maintenance organizations (HMOs) is often cited as "protectionist" ethics deployed against necessary reforms of the health care market. Nonetheless, the purpose of this essay is to highlight the harmful and confusing effect of uncoordinated and contradictory legal regulations of health care. Despite the history, the current concern that professional standards and medical ethics are being swamped by the recent waves of administrative, legis-
ative, and judicial reform is not just the Medical Establishment trying "wolf" again but an intelligible and realistic concern deserving pub-

cit attention because there are important public consequences.

One should acknowledge at the outset that there is real confusion

and perplexity among physicians because the import of legal con-

straints seems to be so contradictory. Much of the recent federal

regulation has been aimed at creating incentives to lower aggre-

gate health care costs.3 On the other hand, the "judges at the side"

Sakiewicz decision,4 Baby Doe regulations, judicial decisions that

expand the reach of hospital liability,5 and the ever-present threat

of malpractice litigation, which is time-consuming and thought to

be professionally damaging, impel the physician to ignore cost and
effectiveness considerations. The legal constraints aimed at contain-

ing expenditures suggest that the aggregate cost of health care is to

be considered as an explicit factor in deciding what is ethically and
clinically appropriate treatment in particular cases. The other types

of constraints suggest, explicitly in the case of the proposed baby

Doe regulations and implicitly in the threat of malpractice litigation,

that cost cannot be either an ethically or clinically relevant considera-

tion. How does the responsible physician respond to these mixed legal

messages?

Even when legal policy has been aimed solely at reducing or con-
taining aggregate health care costs, contradictory methods have been

applied, with conflicting clinical and ethical implications. Basically,

legal experts in health policy disagree about whether costs are better

contained by command and control regulation or by deregulation and

competition. The former legal approach to health policy treats the

health care system as an industry to be regulated, imposing five-year

plans, hospital rate setting, price fixing, CON, and other controls on

capital expansion. The latter approach favors an end to centralized

control, believing that competition, entrepreneurial ingenuity, and a

free market will lower costs and enhance efficiency.6 These contra-
dictory political-economic philosophies translated into conflicting legal

policies have attracted different political constituencies. As a result,

legislation affecting health care is sometimes a strange compromise

between contradictory legal approaches. Federal health-planning legis-

lation exemplifies such provisions. Federal guidelines ask state plan-

ning agencies to consolidate and regionalize health care services, but

the agencies are also asked to promote competition and innovation

among health care providers. How these contradictory goals of con-
solidation and competition are to be reconciled is unclear.7 Critical com-
tment on planning for obstetrical services offers a good example of

the irreconcilable conflicts.8

Perhaps even more important in their clinical and ethical implica-
tions are legal constraints acceptable to politicians on both sides of

the struggle between regulation and competition. DRGs are the most

recent example. They appeal to the supporters of regulation because

they allow regulators to set the categories and fix the price tag of

hospital treatment. The supporters of competition are appeased by the

fact that at least DRGs provide an incentive for economic efficiency,

and more efficiently managed physicians will benefit financially from

the fixed price. But it is probably safe to say that one other good reason politi-

cians endorse DRGs as they did HMOs and PSROs is that all the

painful decisions inherent in balancing cost control and the quality of

health care are passed on from government officials to health care

providers. Even where such measures seem to be effective in contain-
ing costs, these developments are changing the practice of medicine,

diffusing ethical responsibility, challenging the physician's professional

identity and autonomy, and affecting the doctor-patient relation-

ship.9 And if the time comes when patients are deprived of needed

services or suffer some negative consequence, it will be the providers

who will be held accountable for their decisions.

The standards of practice that may result from the response of

physicians to these legally imposed economic constraints and to incen-
tives intended to lower the aggregate cost of health care have yet to be

reconciled with the body of law that pushes physicians to ignore cost.

The most important practical consideration is malpractice litigation.

How will a jury respond when economic rather than medical considera-
tions are offered as the reason for a diagnostic or treatment decision

that has led to a malpractice claim? The physician's alleged negligence

is measured in court against the professional standard of care — an

ambiguous concept based on expert medical testimony. But lawyers

agree that the current professional standard is different and higher

than a standard of care responsive to economic constraints.

It is clear that the physician is now at risk of being found liable for

malpractice if any negative consequences occur as a result of devia-
tions from the professional standard of care, undertaken to meet econo-

mic constraints and incentives created by new cost-controlling legal

policies. It is difficult to measure the actual importance of this new mal-

practice liability, but there can be no question that the doctor's legal
dilemma is real. And the legal dilemma mirrors in many ways the
doctor's ethical dilemma.

Ethical Implications

Although many physicians have welcomed the "committee approach" to ethical problems, some have become increasingly con-
cerned about their personal ethical responsibilities to their patients.
The ethical questions attendant on rationing health care to control
cost, touch directly on physicians' personal responsibilities, and such
questions have frequently been discussed in this journal and else-

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where. Many prominent physicians seem to feel that there is a need to draw firm ethical lines against these threatening legal intrusions. Even highly interventionist courts have expressed a willingness to consider medical ethics in their decision making. But are there principles in medical ethics that are sufficiently clear to permit us or the lawmakers to draw sharp lines? Much has been written in the past three decades about medical ethics, but has this spate of scholarship produced any real or compelling consensus among practicing physicians? It seems that although ethical, stable, and principled foundation.

The author of a recent article in the Journal denounced discrimination against the elderly as an emerging and dubious result of cost-benefit analysis for the control of health care costs. The views expressed were in sharp contrast to those in a paper published only weeks before, in which the author argued that it is ethical, under appropriate circumstances, to provide resuscitation and intensive care “sparingly” to “pleasantly senile” patients. Although the thrust of the latter article was patient autonomy and death with dignity, cost-saving and cost-benefit analysis hovered in the background as legitimate ethical considerations: “as society tries to contain the soaring cost of health care, the physician is subject to insistent demands for restraint, which cannot be ignored.” These contrasting papers are indicative of the medical profession’s current confusion and uncertainty about where we stand on our own ethical principles when confronted with demands to reduce the aggregate cost of health. The AMA’s Principles of Medical Ethics, as currently formulated, certainly give few, if any, firm practical guidelines on this issue. They seem intended more to pacify the Federal Trade Commission and others who have attacked our “protectionistic ethics” than to instruct the practitioner. Even “primum non nocere” is absent from the AMA’s principles.

Is medical ethics a myth, is it a reflection of law and contemporary values pronounced in solemn tones, or does it have bite drawn from professional values and centuries of tradition? Consider this question in the light of the recent Baby Doe controversy. The Justice Department’s legal theory of discrimination against the handicapped, whether right or wrong, was a principled position — that the quality of future life is not an appropriate consideration in withholding treatment from a newborn. The American Academy of Pediatrics, speaking for a divided profession, did not offer a different principled ethical response in contesting the promulgated regulations. The alternative presented was decision making by local committee. It suggested no countervailing ethical guidelines with respect to the relevancy of the future quality of life. The only principle involved was local committee control rather than national legal control. And the proposed composition of the local committee seemed geared to the political accommodation of interest groups rather than to the facilitation of decisions made on the basis of ethical medical principles.

Nothing I have said is meant to suggest that particular medical ethicists or particular practitioners do not have principled responses to important ethical questions. The claim is rather that whether or not they do, there is no longer even the appearance of an effective consensus in the medical profession and, further, that our professional code of ethics lacks a coherent, stable, and principled foundation.

Veatch has suggested that we “abandon the idea that an ethic for medicine can be based on a professionally articulated code.” Some medical ethicists have gone even further and have argued that the attempt to supplant a professional code and to apply other a priori ethical principles to particular cases has failed. The correct ethical conduct of the practitioner is too bound up, they suggest, with the particular context of the particular case. This argument appeals to many physicians, but it is an argument that cuts two ways. It does not suggest that the physician need not worry about governing ethical theories and that rigid legal or ethical rules must bend to particularistic clinical judgments. But it also makes the problem of relying on ethical principles in order to resist legal regulation all the more difficult. What is the ethical principle that will send physicians to the barricades to resist legal reform aimed at lowering the aggregate cost of health care?

Cost Saving and Practical Ethics

Even without a guiding set of professional ethical principles, most physicians are highly ethical in their practice. Their practical ethics are based on two familiar maxims: “do what you think will benefit the patient,” and “primum non nocere,” or first of all, do no harm. Veatch notes that the “conveyors of these traditions often do not realize that these traditional slogans are potentially in conflict.” Yet, every physician who has cared for a dying patient has faced both the question of how much more to do and the problem of determining when the benefit becomes the iatrogenic harm of prolonging futile suffering. These maxims may not constitute a theory of ethics, but they provide the dialectical framework within which the physician actually practices and judges the practice of other physicians.

Physicians learned how to proceed within this framework primarily by identifying at the start of their careers with role models. These role models were typically physicians who practiced in teaching hospitals. The best were conscientious and compassionate physicians who demonstrated a dedication to high-quality care, who in their quest for excellence practiced at the frontiers of medical knowledge, and who
pressed for certainty of diagnosis and every possible benefit of treat-
ment even at what is now described as the flattening end of the curve.
Their ethical practice and their quest for professional excellence were
combined, not separate, virtues. If the art of practical medical ethics is
finding the proper balance between doing everything that may benefit
the patient and doing no harm, then it may well be true that we as
identified with role models who erred on the side of doing too much.
But the quest for excellence is a value that cannot easily be dis-
misse in the education of future physicians—nor should it be. The
wish to practice at the frontiers of medical knowledge and to expand
those frontiers is an equally important value in medical education.
Those values may have skewed the balance of the art of practical
medical ethics, but they are values that have made American medicine
preeminent and have made American physicians deserving of their
patients' trust. It is those values that are threatened by both regulator
ary constraints and the emphasis on entrepreneurial ingenuity and
competitive efficiency.

Havighurst, one of the leading legal proponents of market reform in
health care, has specifically attacked the "tyranny of professional
norms and standards" as the basic obstacle to such reform. Even
Fuchs, an economist sympathetic to the "caring physician," worries
that physicians are counterproductively "imprinted" with the "best
medical practice" in medical school.22 But what these well-inten-
tioned critics who are concerned about the aggregate cost of health
care fail to appreciate is the ethical void created when medical practice
is viewed through the prism of cost-benefit analysis. For where the
law attempts to control aggregate costs, either through regulation or by
promoting competition, it creates a potential conflict of interest
between patient and physician.

Critic s of medical paternalism and the traditional maxims I have
described argue that physicians have ignored the importance of the
patient's autonomy and rights. Informed consent is the focus of
attempts by ethical and legal reformers to remedy medical paternal-
ism. Certainly, the patient has a right to know not only the risks and
benefits of alternative treatments but also when cost-benefit analysis
plays a part in the doctor's recommendations. But why should a sick
and anxious patient accept the doctor's economic calculation? What is
the patient's interest in reducing the economic risk to the doctor or
the aggregate cost of health care by foregoing a bed in the coronary
care unit or a CAT scan? It is one thing to entrust your life and health
times of crisis to a physician who is committed to the practical
ethics that involves a quest for excellence and who may err on the side
of doing too much. It is quite another to entrust your life and health
times of crisis to a physician whose diagnostic and therapeutic
interventions are limited by new regulatory constraints or incentives
of competitive efficiency that "place the provider at economic risk."