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WHY LAW PERVADES MEDICINE: AN ESSAY ON ETHICS IN HEALTH CARE

Charity Scott*

Law pervades medicine because ethics pervades medicine, and in America, we use the law to resolve ethical dilemmas in health care.

Law deals with ethics? Many people react with surprise, amusement, or cynicism when they see those two words—law and ethics—together in the same sentence. To many people, the two concepts seem wholly distinct, like the proverbial apples and oranges, or even radically opposed, as different as night and day. In medical circles, one senses an antagonism to law, not just to lawyers. On hospital ethics committees, talk of law as well as lawyers may be banned from the ethical discussions. On medical rounds, I may be asked to help the residents and medical students keep a bright line between law and ethics so that, I am told, they’ll know when they’re dealing with one and not the other.

A central thesis of this essay is that there is no such bright line between law and ethics in America, at least not in medicine. During the second half of the twentieth century, most difficult issues in health care which have raised profound ethical dilemmas have been addressed by law. For better or for worse, law and ethics have been evolving in health care together; hand in glove is perhaps the more apt simile. The central purpose of this essay is to foster understanding by both legal and health care professionals about how law has influenced the ethical evolution of medicine and health care in America during the past several decades.

Part I analyzes the relationship between law and ethics generally in health care. It posits that law reflects a consensus statement by our society on what we believe to be ethically appropriate behavior, or on how we believe ethical dilemmas ought to be resolved. Like ethics, law fundamentally asks what,

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under all the circumstances, would be the right thing to do? Using several examples of federal legislation, Part I illustrates how our laws have reflected our society's evolving views on ethics in professional and business practices in health care. Unlike ethics, however, law also serves to enforce the socially agreed-upon views of right and wrong. Paradoxically and unfortunately, when law becomes the primary enforcer of ethical views, its power can create problems, or pitfalls, for continued ethical reflection on the very issues that it was called upon to address in the first place.

Part II recounts the evolution of medical ethics at the patient's bedside. Through the lenses of law and ethics, this Part focuses on patients and their relationships to the professionals who provide them health care. It explores how law has supported the ethical concepts of patient autonomy and respect for persons through the legal doctrines of patients' right to consent to and to refuse medical treatment. Through the example of informed consent doctrine and our growing obsession with informed consent forms, this Part illustrates how law's power to enforce an ethical ideal of genuine dialogue between doctors and patients has created a pitfall for ethical reflection about the actual conversations between patients and the professionals who care for them.

Part III examines the recent attention to business ethics in the administrative offices and boardrooms of health care organizations. Increasing marketplace competition has prompted health care organizations increasingly to focus on profits, or at least on financial viability, which in turn has created ethical dilemmas which in turn have been addressed by law. Focusing on managed care and the Joint Commission on the Accreditation

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1. On ethics' inquiry into right and wrong, see Deborah Caswell & H. Gill Cryer, Nursing Grand Rounds: Case Study: When the Nurse and Physician Don't Agree, 9 J. CARDIOVASCULAR NURS. 30, 37 (1995) ("Traditionally, ethics has been defined as the inquiry into rules and principles of morality, of right and wrong conduct, of virtue and vice, and of good and evil as they relate to conduct."); Bethany Spielman, Invoking the Law in Ethics Consultation, 2 CAMBRIDGE Q. HEALTHCARE ETHICS 457, 464 (1993) (stating that ethics is "an attempt to answer the question: what, all things considered, ought to be done in a given situation?"). On law's inquiry, see ROGER B. DWORSKIN, LIMITS: THE ROLE OF LAW IN BIOETHICAL DECISION MAKING 6-7 (1996):

Paul Freund put it best: "The law is dialectic in a deeper sense than its adversary process. It mediates most significantly between right and right." . . . The only questions that matter for the law are those in which there is something "right," or good, on both or all sides of the controversy. . . . When right exists on both sides of an issue, the job of the law is to mediate between the "rights," to accommodate, to adjust, to attempt to sacrifice as little as possible of what is "right" on both sides.
of Health Care Organizations (JCAHO), Part III examines the evolution of organization ethics and corporate health law in the business of health care delivery. All of the business practices which raise ethical issues that JCAHO now requires a hospital’s business ethics code to address—billing, marketing, patient admissions, transfer and discharge, conflicts of interest, and compensation arrangements—are also addressed by health care laws at both state and federal levels, providing civil as well as criminal sanctions. Part III uses the recent flurry of corporate compliance programs throughout the health care industry to illustrate the paradox that law’s power and pervasiveness can create pitfalls for ethical reflection on the very issues that law was called upon to address.

Part IV proposes an alternative to reliance on law as the primary articulation and enforcer of ethics in health care. Lawyers have not usurped the power of health care providers to assume leadership on ethics. The law never took it out of the hands of health care professionals to strive for the ethical high ground. Until those in the health care field—individual practitioners to high-level managers—assert their authority and responsibility for charting the ethical direction of medicine and health care, law will continue to pervade their professions and their institutions.

I. The Relationship Between Law and Ethics in Health Care

A. Law as a Consensus Statement on Ethics

While lawyers may suffer some unpopularity, the law still reflects society’s idealism. Immanuel Kant believed that: “The greatest problem for the human species, the solution of which nature compels him to seek, is that of attaining a civil society which can administer justice universally.”

Justice is an ethical concept of universal fairness for and among individuals; law is the vehicle by which a society attempts to achieve this lofty ideal. Oliver Wendell Holmes observed that: “The law is the witness and external deposit of our moral life. Its history is the history of the moral development of the race.” Thus the law reflects what,

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3. Oliver Wendell Holmes, The Path of the Law, 10 HARV. L. REV. 457 (1897). See also Daniel Callahan, Escaping from Legalism: Is It Possible?, HASTINGS CENTER REP., Nov.-Dec. 1996, at 34 ("No myth is so hardy as the notion that 'you can't legislate morality,' which of course we do all the time.").
at any given point in time, society views as acceptable, ethically appropriate behavior.

We often enact our moral views in our laws; in effect, we legislate morality. Looking at our laws is like looking at a snapshot in time of our society's moral views about how people ought to behave towards each other. Over time we may change our views as to which behaviors are right or wrong, and we reflect that change by changing our laws. For example, for some considerable time in our nation's history we regarded it as morally appropriate for individuals of different color or gender to be treated differently. We reflected those views in our laws governing who could vote, who could own property, who could be educated in which schools, who could marry whom, who could eat or work or live where, and so forth. Today, our anti-discrimination laws reflect the moral view that it is wrong to perpetuate those distinctions among individuals in our society.

In health care, our society has used the law to ask (and answer) questions about what are ethically appropriate behaviors among those who provide, or receive, or pay for health care services. Frequently, the law is a reaction to perceived ethical wrongdoing in health care. As discussed below, federal laws over the past three decades illustrate how American society has reacted to perceived or potential ethical abuses in health care by calling for laws to resolve the ethical conflicts. The legal resolution in effect becomes a societal consensus statement on ethics, at least for the time being and until the laws are changed.\footnote{As used in this essay, the word "consensus" does not imply unanimity or complete agreement on a proposition, but rather a sense of \textit{general agreement}. In a democratic society, consensus among people may be represented by a bare majority, as shown by those who represent the people and are elected to reflect the people's views (as is true for majority passage of a piece of legislation), or by a supermajority, as is required for the passage of constitutional amendments. Consensus may be reflected in court decisions as well, whether there may be one or two controversial court decisions, or a trend among many court decisions, at the federal or state level which are not overturned by a legislature, and may in fact be supported by subsequent legislation. \textit{See infra} note 36 and accompanying text. Law frequently serves as society's forum for airing and resolving ethical debate. \textit{See infra} notes 41-43 and accompanying text. Legislatures and courts may sometimes be responding reactively to changing societal views on what is ethically appropriate behavior. They may sometimes be creating proactively these changes in social opinion. Whether proactive or reactive, the laws that endure reflect our society's views about ethical behavior in health care.}
1. The 1970s and 1980s: Patient Care and Medical Ethics

Federal law was used to address an ethical dilemma caused by the shortage in the 1960s of hemodialysis machines to treat patients with kidney disease. To allocate these scarce resources in Washington, a group (later dubbed the "Seattle God Committee") was given authority to decide, according to various "social worth" criteria, which patients would or would not be given this treatment. Patients were evaluated according to, among other things: age, gender, income and net worth, marital status, number of dependents, educational and employment background, and their "past performance and future potential." Societal unease about the ethics of this form of health care rationing found expression in the enactment of the Social Security Amendments of 1972, allowing Medicare reimbursement for most patients with end-stage renal disease.

Federal law was enacted in the 1970s to address the ethical issues raised by the decades-long decision by the U.S. Department of Public Health to deprive hundreds of African-American men in rural Alabama of available antibiotics to treat syphilis. Government officials who authorized the Tuskegee Syphilis Study viewed it as an opportunity to benefit both scientific research and the Southern black community. After the public revelations and congressional hearings, however, society reacted to what it judged to have been unethical behavior by enacting national laws to develop ethical standards for the protection of human research subjects.

5. Maxwell J. Mehlman, Rationing Expensive Lifesaving Medical Treatments, 1985 Wis. L. Rev. 239, 256 (criticized for preferring Sunday school teachers and scout leaders, the "Seattle God Committee" had policies that "ruled out creative nonconformists who rub the bourgeoisie the wrong way. . . . The Pacific Northwest is no place for a Henry David Thoreau with bad kidneys."); id. at 256 (quoting Sanders & Dukeminier, Medical Advance and Legal Lag: Hemodialysis and Kidney Transplantation, 15 UCLA L. Rev. 357, 377 (1968)).


8. See JONES, BAD BLOOD, supra note 7, at 94 ("Such a study would be an expression of concern for Negro health problems, keeping the PHS involved as a vital force in promoting medical attention to blacks[,] and that Macon County presented a 'ready-made situation . . . for carrying on the proposed study' of untreated syphilis in Negroes."). See also infra note 18 and accompanying text.

9. See generally 2 BARRY R. FURROW ET AL., HEALTH LAW § 23-1 (1995). In 1974, the National Research Act established the National Commission for the
In the 1980s, conflicting ethical views about what was appropriate medical care for critically ill newborns were socially expressed by the legal controversy over the so-called Baby Doe regulations. Promulgated by the Reagan administration, these regulations prohibited hospitals from withholding life-sustaining treatment from very ill infants solely by reason of their handicaps, and allowed the federal government to monitor medical treatment decisions as potential violations of federal anti-discrimination laws through twenty-four-hour hot lines and warning notices posted in hospitals. These regulations have since been invalidated by the Supreme Court. Alternative legislation was subsequently enacted which represented a compromise between the ethical positions held by those (primarily doctors' groups) who believed such treatment decisions should largely be left to the discretion of parents and physicians, and those (primarily advocates for the disabled) who believed that the treatment decisions should not be based on predictions about an infant's future "quality of life."
That a health care law can represent society's views on ethics was also illustrated by the 1980s controversy over so-called "patient dumping," or the practice by many private hospitals of transferring poor or uninsured emergency patients to public hospitals. Prior to the 1980s, hospitals generally had no obligation under state and federal law to give life-saving treatment to emergency patients, or to provide obstetrical care to women in labor, if these patients could not pay for these services.\(^{15}\) Congressional hearings on the nationwide problem of patient-dumping resulted in the Emergency Medical Treatment and Active Labor Act.\(^ {16}\) Prompted by societal concern over individual patient horror stories, the Act reflected emerging societal agreement that it was wrong for hospitals to refuse to treat women in labor or patients in a potentially life-threatening emergency based on their inability to pay.

In each of these four examples, the activities that gave rise to the public controversies and subsequent legislation posed important and debatable ethical questions in health care. Many of the actors at the time did not regard their actions as ethically problematic, even if others later did. The members of the Seattle God Committee\(^ {17}\) and those who authorized the Tuskegee Syphilis Study\(^ {18}\) believed their activities to be ethical promotions prevent or remedy medical neglect. Medical choices not falling below this floor are left to unfettered parental discretion.

15. For a good account of the state of the law prior to EMTALA, see generally Karen H. Rothenberg, Who Cares? The Evolution of the Legal Duty to Provide Emergency Care, 26 Hous. L. Rev. 21 (1989).

16. 42 U.S.C. § 1395dd (1992). See generally Lynn Healy Scaduto, Comment, The Emergency Medical Treatment and Active Labor Act Gone Astray: A Proposal to Reclaim EMTALA for Its Intended Beneficiaries, 46 UCLA L. Rev. 943, 948 (1999) (stating that the legislative intent "behind EMTALA was to deter what Congress perceived to be the burgeoning practice among hospital emergency rooms of dumping indigent and uninsured patients"). See infra notes 19, 84-90 and accompanying text (discussing divergent legal and ethical views over providing a right to receive medical treatment in America).

17. See GUIDO CALABRESI & PHILIP BOBBITT, TRAGIC CHOICES 186-89 (1978) (describing the Seattle God Committee's attempt to allocate kidneys in a socially responsible way).

18. See supra note 8. See also Tom Junod, Deadly Medicine, GQ, June 1993, at 164, 170 (relating that one of the study's defenders, Dr. Sidney Orlinksy, later reflected on subsequent objections to the study: "After seeing these people, knowing them and studying them and the record, I honestly feel that we have done them no real harm and probably have helped them in many ways." At a 1969 meeting at the Centers for Disease Control and Prevention in Atlanta to discuss whether the study should continue, Dr. Orlinksy continued to insist that Tuskegee was "a good study[,]" and "that there were no medical grounds for treating the men, that for the most part their syphilis was inactive and that giving them penicillin could incur 'catastrophic consequences.'").
of the public good. The hospitals who transferred poor patients to public hospitals rather than treat them did not view it as ethically wrong to decline to give service to someone who could not pay for it.\textsuperscript{19} Certainly there remain sharply divergent views about what constitutes the ethical treatment of critically ill newborns.\textsuperscript{20}

\textsuperscript{19} The ethical position of the hospitals is similar to that of doctors today, who are under no legal obligation to provide free medical care to patients who cannot pay for these services and who, according to a recent study, are providing less and less free care in health markets where managed care is prevalent. See Peter J. Cunningham et al., \textit{Managed Care and Physicians' Provision of Charity Care}, 281 JAMA 1087, 1087-92 (1999). The hospitals’ “dumping” practice found legal support (just as today, doctors’ decisions not to provide charity care continues to find support) in the “no duty to rescue” doctrine of the law, which in turn is premised on the ethical view that one is not morally obligated to go out of one’s way to help a stranger. See W. Page Keeton et al., \textit{Frosser and Keeton on the Law of Torts} § 56 (5th ed. 1984) [hereinafter Keeton, \textit{Law of Torts}]. This ethical debate goes back to scripture, with the moral quandary of whether we are our brother’s keeper. See Gen. 4:9 (“Then the Lord said to Cain, ‘Where is your brother Abel?’ ‘I don’t know,’ he replied. ‘Am I my brother’s keeper?’”). See also infra notes 39-40 and accompanying text. While Prosser thought that the law has struck an inappropriate ethical balance in this doctrine, society has not generally agreed with him, by virtue of the doctrine’s continuing without overruling by courts or legislation except in certain cases involving special relationships, see Keeton, \textit{Law of Torts}, 375-77, or in specific legislation like EMTALA addressing specific situations like emergency room patients. For example, the view that there is no general moral obligation to provide goods or services to people who cannot pay for them is currently reflected in America’s unwillingness to enact universal health care coverage, although federal coverage has been enacted for targeted populations, such as certain poor families through Medicaid, or the elderly or disabled through Medicare. Reflecting perhaps basic ethical ambivalence in our society over granting patients a right to receive health care, see infra notes 84-90 and accompanying text, government enforcement of EMTALA has allegedly been inadequate. See Lauren A. Dame, \textit{The Emergency Treatment and Active Labor Act: The Anomalous Right to Health Care}, 8 Health Matrix 3, 11-21 (1998). There continues to be lively academic debate over whether a right to emergency hospital treatment regardless of ability to pay for it is “a good or a bad thing.” Id. at 4, 28 (“the purpose of EMTALA, to protect patients at a time of scary and perhaps desperate medical need, is noble and reflects the finer aspects of our medical system”); cf. David A. Hyman, \textit{Patient Dumping and EMTALA: Past Imperfect/Future Shock}, 8 Health Matrix 29 (1998) (arguing that “[t]he premise of the statute is silly at best”); id. at 54-55 (suggesting that EMTALA is a “symbolic law” resulting from “anecdotal advocacy” rather than hard data, and comparing it to “other ineptly drafted, tunnel- visioned, short-sighted, and counterproductive laws”).

\textsuperscript{20} See Judith Graham, \textit{Weighing Care for “Preemies”}, \textit{Chicago Trib.}, Jan. 10, 1999, at 5 (noting that treatment decisions for extremely premature infants continue to be highly controversial).
The point is that in each case, the law was called upon to weigh the merits of the differing ethical positions, to adopt some and reject others (implicitly if not expressly), and to provide guidelines for what society agreed (by proxy, through the democratic vote on the legislation) would be considered unethical behavior in the future. As a consensus statement on ethics, the law reflected society's views, at least for the time being, of where the ethical balance should be struck.

2. The 1990s: Managed Care and Business Ethics

Many of the legal controversies involving medical ethics in the 1970s and 1980s tended to focus on perceived ethical problems arising out of the provider-patient relationship. In other words, these ethical questions frequently focused on how those who provide health care services (the hospitals, doctors, or researchers) should treat those who receive the services (the patients). By contrast, many of the ethical conflicts in health care in the 1990s involve the business practices of payers (those who pay for health care services, such as managed care and insurance companies), which raise ethical questions about how the payers should treat both patients and providers (particularly doctors and hospitals).

21. See infra note 36 and accompanying text.
22. See infra notes 46-90 and accompanying text (discussing medical ethics at the patient's bedside).
23. See infra notes 91-154 and accompanying text (discussing business ethics in the boardrooms of health-care organizations). Many of these issues are addressed in recent proposals for new federal legislation addressing managed care reform, often referred to as "patient protection" legislation or a "patients' bill of rights." These proposals have been the subject of contentious Congressional debate during 1998 and 1999. See generally Mary Agnes Carey, Patients' Rights May Die Aborning, CQ Weekly, Aug. 1, 1998, at 2074-82. Efforts to pass a federal patients' bill of rights during 1998 became deadlocked by October. See Senate Defeats Final Democratic Effort to Force Debate on Managed Care Bills, 7 Health L. Rep. (BNA) 1642 (Oct. 5, 1998). In early 1999, competing Democratic and Republican bills were re-introduced, and they illustrate how politically divisive the debate over patients' rights is, with the sides in the debate largely following party lines. See Geri Aston, Patient Protections Follow Party Lines, Am. Med. News, Apr. 5, 1999, at 5. In October 1999, the House managed to pass a bipartisan bill which provided broader patient protections than did a Senate bill which was passed in July 1999. See Geri Aston, 'A Big Win for Patients', Am. Med. News, Oct. 25, 1999, at 1 [hereinafter Aston, A Big Win]. As of this writing, it is predicted that negotiations for compromise legislation between the House and Senate will be difficult. See Jonathan Gardner, House Vote Sets the Stage: Conference Panel Must Iron Out Differences On Patient Protection, Modern Healthcare (Oct. 11, 1999); Norwood-Dingell Managed Care Bill Sails Through House in Massive Bipartisan Vote, 8 Health L. Rep. (BNA) 1654 (Oct. 14, 1999). See also Wendy K. Mariner, Going Hollywood with Patient Rights in Managed Care,
patients alike have vociferously expressed their sense of ethical wrong-doing by insurers and managed care companies who, for example, attempt to insert so-called "gag clauses" in their contracts with physicians,24 who may try to cut costs by limiting hospital stays down to the point of paying only for so-called "drive-through" deliveries25 and "drive-through" mastectomies;26 who may create financial incentives for doctors to deny or limit care27

281 JAMA 861 (1999) (distinguishing "consumer rights" from "patient rights" as the focus of recent managed care reform proposals).


26. 19 states have passed legislation requiring minimum lengths of time for hospital stays following a mastectomy. See State-By-State Report, supra note 24. The Senate version of proposed patient protection legislation which passed in July 1999 would ban "drive-through" mastectomies and would require health plans to pay for hospital stays for whatever length of time deemed appropriate by the patient and her physician. See Senate Appoints Managed Care Conferences; GOP Leadership Urged to Respect House Vote, 8 HEALTH L. REP. (BNA) 1688 (Oct. 21, 1999) [hereinafter Senate Appoints].

27. Concern over financially-motivated denials of care is one of the most contentious issues surrounding managed care. See infra notes 135-39 and accompanying text. See generally Henry T. Greely, Direct Financial Incentives in Managed Care: Unanswered Questions, 6 HEALTH MATRIX 53 (1996); David Ornaticher, Paying Physicians More to Do Less: Financial Incentives to Limit Care, 30 U. RICH. L. REV. 155 (1996). For a controversial recent case involving this issue, see Herdrich v. Pegram, 154 F.3d 362, 380 (7th Cir. 1998) (holding that com-
or otherwise interfere with the doctor-patient relationship by denying payment for care that the patient needs and the doctor wants to provide; who impose restrictions on patients' choice of

plaint was sufficient to state a claim for breach of fiduciary duty under ERISA where plaintiff alleged that defendants' incentive system depleted health plan resources so as to benefit physicians who administered the plan, possibly to the detriment of patients), cert. granted, 120 S.Ct. 10 (1999); see also Shea v. Esensen, 107 F.3d 627 (8th Cir. 1997) (allowing breach of fiduciary duty claim under ERISA for failure to disclose financial incentives). The potential for financial incentives to result in medically inappropriate denials or limitations of care is addressed in some states' recent managed care legislation, such as Georgia's Patient Protection Act of 1996 which prohibits a managed care plan from using a financial incentive program that directly compensates a health provider for ordering or providing less than medically necessary and appropriate care to his or her patients. See GA. CODE ANN. § 33-20A-6 (1996). See generally Lead Report, Physician Incentive Plans: States Tell Health Plans that Incentives May Not Limit Medically Necessary Care, 7 HEALTH L. REP. (BNA) 1581 (Oct. 8, 1998) (stating that 21 states currently prohibit managed care plans from using financial incentives to induce physicians to restrict medically necessary services).

28. Getting insurers to approve doctors' medical treatment recommendations for their patients has been one of the "most frustrating and infuriating features" of dealing with managed care, and recently one major HMO announced it would no longer require such prior approvals—a move popularly viewed as returning decision-making power over patient care to the physicians. See Jennifer Steinhauer & Milt Freudenheim, H.M.O.'s Shift May Please Patients, but Raise Costs, N.Y. TIMES, Nov. 10, 1999, at C1. Other health plans are also eliminating unpopular restrictions or emphasizing alternative ways to control costs which are less intrusive in the doctor-patient relationship. See Milt Freudenheim, Medical Insurers Revise Cost Control Efforts, N.Y. TIMES, Dec. 3, 1999, at A1. Widespread dissatisfaction with managed care organizations' cost control efforts which seem to interfere either with the patients' access to the physicians or services they want or with their physicians' ability to obtain approval for recommended treatment have resulted in a societal backlash against HMOs, as reflected by the popular press in such cover stories as the one which ran in Newsweek recently, picturing an angry patient and entitled "HMO Hell: The War Over Patients' Rights." See Newsweek, Nov. 8, 1999. Many people accuse HMOs of "putting profits before patients," and call for laws to stop their unethical practices. Geoffrey Cowley & Bill Turque, Critical Condition, Newsweek, Nov. 8, 1999, at 58-62; Russell Watson, HMO Hell: The Backlash—HMOs Go Under the Knife, Newsweek, Nov. 8, 1999, at 63-68. Anecdotal accounts of HMO denials of treatment which have resulted in injury or death are now routinely related in the popular media and in congressional hearings on proposed legislation. See, e.g., David E. Rosenbaum, House Hears Grim Tales About Managed Care, N.Y. TIMES, Oct. 8, 1999, at A23; Robin Toner, Many Doctors Tell of Denial of Coverage by H.M.O.'s, N.Y. TIMES, July 29, 1999, at A18. HMO denials of coverage have also been the subject of numerous lawsuits. See infra note 138. Whether physicians or health plans should determine whether a given treatment is "medically necessary" is another "flash point in the congressional debate on managed care patient protections." Geri Aston, Patients' Rights Backers Seek Clear Definition of Medical Necessity, AM. MED. NEWS, Mar. 15, 1999, at 9.
provider;\textsuperscript{29} who appear to lack protections for the confidentiality of patients' records;\textsuperscript{30} or who will not pay for emergency services without a lot of pre-authorization red tape.\textsuperscript{31}

\textsuperscript{29} The House and Senate versions of proposed patients' bill of rights legislation differ as to whether to allow patients to have direct access to specialists, or to allow health plans to require a referral from a primary care physician or case manager before a patient may see a specialist. See \textit{Senate Appoints}, supra note 26. 36 states allow women either to choose an obstetric/gynecological specialist as her primary care physician or to have direct access to these specialist services without first having to get a referral. See \textit{State-By-State Report}, supra note 24.

\textsuperscript{30} Dating back to the Hippocratic Oath, keeping the confidences of patients has been a foundational ethical tenet of the health-care professions. Respect for individual privacy has never been an absolute principle, however, and it often has given way to competing ethical concerns for the welfare of the community. See Amitai Etzioni, \textit{Medical Records: Enhancing Privacy, Preserving the Common Good}, 29 HASTINGS CENTER REP. 14 (Mar.-Apr. 1999). Finding social consensus on where the balance is properly struck among the competing ethical concerns in myriad health care situations has proven enormously difficult, however, as reflected in our failure to enact uniform federal legislation in this area despite years of Congressional debate. Most recently, Congress missed its own self-imposed deadline of August 21, 1999 to enact comprehensive medical privacy legislation. Congress established this deadline three years ago when it enacted the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and it further provided that the Department of Health and Human Services (HHS) should enact regulations governing the privacy of individually identifiable health information by February 21, 2000, if Congress did not enact legislation by its deadline. See Pub. L. No. 104-191, § 264(c)(1) (1996). On November 3, 1999, the Secretary of HHS issued proposed medical privacy regulations, 45 C.F.R. pts. 160 to 164, and she has extended the deadline for public comments until February 17, 2000. See Dept. Health & Human Services, \textit{Administrative Simplification} (visited Feb. 15, 2000) <The societal call for minimum federal rules is responsive to the multitude and intricacies of each state's different laws governing medical privacy, of which a comprehensive survey was recently published by the Health Privacy Project of Georgetown University. See Georgetown University Institute for Health Care & Policy, \textit{The State of Health Privacy: An Uneven Terrain} (visited Feb. 15, 2000) <http://www.healthprivacy.org/resources/statereports/contents.html>.

\textsuperscript{31} Emergency care coverage creates tensions between assuring patients access for true emergencies and allowing health plans to control their costs by restricting patients from using the E.R. as a convenient substitute for a doctor's visit. See Daniel B. Moskowitz, \textit{Emergency Care: In Search of Balance}, 17 BUS. & HEALTH 15 (1999). Competing versions of proposed federal patients' bill of rights legislation differ in the extent to which emergency services are required to be covered by a health plan. See Geri Aston, \textit{Patient Protection Bills Differ, Even in the 'Common Ground'}, AM. MED. NEWS, Apr. 12, 1999, at 5 (noting wide variations on emergency coverage provisions in competing proposals); \textit{Senate Appoints}, supra note 26 (H.R. 2990 would allow patients to get more services covered by a health plan in connection with out-of-network emergency care than would S. 1544). 37 states have passed laws requiring health plans to cover emergency services. See \textit{State-By-State Report}, supra note 24. Georgia's Patient
The HMOs and insurance companies who engage in these behaviors do not view them as wrong or unethical: on the contrary, it is just good business to try to contain costs and allocate health care rationally. But others in our society view these behaviors as ethically wrong, unfair, or abusive. And where do they go when their sense of moral outrage gets strong enough? To the law, of course. Each of these asserted unethical behaviors has generated calls for social resolution, principally by legal ban at federal and state levels. In the past few years, new legislation in Georgia and other states has addressed, or has been proposed to address, many of these issues. Competing Democratic and Republican proposals for "patient protection" legislation or a "patients' bill of rights," which have been the focus of so much Congressional debate over the past two years, also address many of these same concerns. As was true for the debates over medical ethics in earlier decades, these calls for legal reform in the 1990s reflect societal judgment about the ethics of many health care business practices.

B. Law as Enforcer of Socially Agreed-Upon Values: Law Packs Ethics With a Punch

While law and ethics both focus on questions of right and wrong in human relationships, they differ starkly in their ability to enforce ethical behavior. Ethics is aspirational only: it posits ethical ideals for human behavior. If we say "ought," we mean ethics. By contrast, law provides penalties for failure to abide by


34. See generally supra notes 23-31. For a comparison of the competing House and Senate bills, see generally Senate Appoints, supra note 26.
socially-agreed upon ethical norms. If we say "must," we mean law. The old adage that "virtue is its own reward" is only partially true: sometimes the threat of jail time or heavy monetary penalties can provide a more compelling incentive for virtuous behavior than simple knowledge that one is "doing the right thing." Law packs ethics with the "punch" of potential sanctions.

C. Clarification about the Consensus

While law often serves these two primary roles—expressing social agreement on what is ethically inappropriate behavior between individuals, and backing that agreement up with penalties for violation—two further points are needed to clarify the nature of this social agreement.

1. Consensus Reflects General Agreement, Not Unanimity

First, by societal "consensus" or social "agreement" this essay does not mean to suggest that everyone in society agrees that the ethically correct resolution has been expressed by the law in every case. Plenty of people obviously will disagree. We live, after all, in a pluralistic society where uniformity of opinion is virtually impossible. What is meant by "consensus" is less than unanimity and more a sense of general agreement. Whether a bare majority or a substantial majority, "consensus" in this essay means a democratic resolution we have agreed to abide by in our social contract, even if individually some (or even many) of us believe a particular resolution is wrong.


[L]aw and ethics are distinct, though related, activities. The law is mandatory, setting standards that can only be breached at the risk of civil or criminal liability. Ethics is aspirational, setting forth universal goals that we should try to meet, but for which we suffer no temporal penalty when falling short.

Dworkin, supra note 1, at 4 ("[L]aw and ethics are not the same thing. Ethics is a branch of philosophy that considers how persons and institutions ought to behave. It claims for itself no temporal sanctions to ensure compliance or punish deviation. Law, conversely, is entirely temporal and very much involved with sanctions.").

36. Even controversial Supreme Court decisions, or other court decisions, can be taken as "consensus" statements in the sense that these judicial opinions may be interpreting legislation or constitutional provisions which have been adopted by majorities through democratic process. On the other hand, if one thinks judges may be "legislating," or creating new law, through such judicial interpretation, then it may be harder to characterize these opinions as "consensus" statements, at least when they are first authored. The same may be true for judicial common law developments. To the extent that such judicial interpretations "stand the test of time," however, and are not overturned by
2. Law Sets Ethical Minimums, Not Maximums

Second, through the law, our society does not attempt to agree upon all conduct which is ethical, and all conduct which is unethical. Law performs a much narrower function. In the universe of ethics, right and wrong behaviors lie along a spectrum, with ethically good or even ideal conduct at one end (perhaps we could agree to put honesty, loyalty, generosity, altruism, and respect for others at this end) and ethically bad behavior at the other end (most of us might place murder, lying, cheating, and stealing, for example, at this end). Much of human behavior lies somewhere in the middle, where there is significant division of social opinion as to whether or to what extent it may be right or wrong, good or bad, acceptable or unacceptable. Society often uses law to identify those behaviors primarily at one end of the spectrum: those behaviors about which there is general agreement that they are unethical, wrong, or unacceptable. In our society, we often express our consensus about behavior being ethically wrong by making it illegal.

Later legislation, case law, or constitutional amendment, their continued vitality suggests that they reflect this kind of "consensus," or general agreement, on the correctness of their ethical resolutions. See supra note 4. The amount of controversy (or lack thereof) generated over a statute or court decision may well be a gauge of the breadth of the consensus over it. See Alexander Morgan Capron, Morality and the State, Law, and Legalism, HASTINGS CENTER REP., Nov.-Dec. 1996, at 35-37:

To some extent, all societies attempt to direct behavior into approved channels by criminalizing certain conduct. In doing so, law is not merely enforcing morality, but reinforcing it, and society's success on the first score is heavily dependent on the second, that is, on whether a broad consensus is achieved on the underlying moral view. When wide agreement exists, the law is at once less visible and more powerful.

37. Corporations often use codes of ethics to do the same thing. One author contrasts two approaches to business ethics codes: the "personal integrity" approach (which tends also to be the focus of the law) and the "social responsibility approach" (concerning ethical conduct which law leaves largely unaddressed). See Leonard J. Weber, The Business of Ethics, HEALTH PROGRESS, Jan.-Feb. 1990, at 76-78. Like the "personal integrity" approach, law focuses more on issues of individual integrity (conflicts of interest, self-dealing or self-interested transactions) than those of social responsibility. See infra note 148 and accompanying text.

38. It should be clarified that not everything that is illegal is unethical. The law is addressed both to acts which are malum in se (a wrong in itself, something inherently wrong based on natural or moral principles) and to acts which are malum prohibitum (something which is wrong because it is prohibited, but is not inherently immoral). See BLACK'S LAW DICTIONARY 494 (5th ed. 1983). Murder and theft are examples of illegal acts which are malum in se, while double parking and jaywalking are legal wrongs, not because these actions violate moral principles, but simply because they are prohibited by law. In other
duct—perhaps most human conduct—simply not addressed by law, and over which there may be significant differences of opinion.

By addressing what we have generally agreed is wrong behavior or bad actions, the law sets the legal minimums for behavior; it does not address the ethical maximums. The law provides sanctions for wrongdoing; it does not tend to provide rewards for doing good or even sanctions for failing to do good. The law will punish you if you hit a person and leave him bleeding in the street; but if you are walking down the street and happen to see someone lying and bleeding in the gutter, the law will not penalize you if you walk on by and fail to help him out. American law does not require you to be the “Good Samaritan,” nor reward you if you are. That is the province of ethics—it goes beyond the law.

D. Too Much Law in the Discourse of Medical Ethics?

1. Translating Moral Problems into Legal Problems

Some people may readily agree that law is the principal forum where our society debates ethics, and yet they may still deplore that this is so. The ethicist Daniel Callahan has recently complained about the “elevation of moral judgments of the courts as the moral standards of the land,” and argues:

[U]nfortunately, because we do let the law legislate considerable morality, or use moral arguments to overcome existing bans, a great deal of the work of ethics ends up being done in courtrooms and enshrined in legal decisions. . . . [Law] may be the best institution we have [to arbitrate moral questions], but it is a poor substitute for moral consensus and public debate on ethics.41

words, we have some laws that reflect our society’s ethical assessment of certain conduct, and we have some other laws that simply make it possible to organize civil society efficiently (like our rules of the road). This essay addresses only the former kind of laws, which reflect societal views on matters of medical and business ethics.

39. The law has long distinguished between acts and omissions, malfeasance and non-feasance, active misconduct and passive failure to take action to prevent harm. As a general proposition, the law seeks to sanction only the former. See Keeton, Law of Torts, supra note 19, at § 56.

40. See id. at 375 (“[T]he law has persistently refused to impose on a stranger the moral obligation of common humanity to go to the aid of another human being who is in danger, even if the other is in danger of losing his life.”).

41. Callahan, supra note 3, at 34-35.
Certainly, there are problems with our society's translation of moral problems into legal ones. Some commentators have said that law is coercive, and tends to end public debate over morality.\(^2\) Some may wish that the law considered more fully what it means for individuals to be members of the community, or that the law did not focus so narrowly on individual rights.\(^3\) And yet for better or for worse, we have not vested any other forum besides the law with sufficient social clout and political authority to decide these ethical questions. We may let our universities, places of worship, the media, public opinion surveyors, or other social institutions raise these questions for us, but not resolve them. Only law is given this authority, reflecting a social agreement to abide by the resolutions it comes up with.

2. Law's Power to Enforce Creates Ethical Pitfalls

One serious problem with "legislating morality" is that when law pervades ethical inquiry and backs its resolutions up with the punch of potential liability, people frequently focus solely on avoiding the punch. In responding to the so-called "chilling effect" of the law, some of us sometimes overreact and assume that we must do something, or must not do something, because we think that's "what the law says," whether it makes any medical sense or even common sense. Often lay people may not know what the law says, or assume they know but in fact are wrong, but they think, "never mind, it's better to be safe than sorry," and so they engage in behaviors, or avoid behaviors, in order to comply with what they blindly, and perhaps erroneously, assume the law


Once the judicial system has reached some sort of conclusion, then the courts are poor friends of moral discourse. In short, I have been arguing that the law’s discourse conflicts with what we ordinarily mean by discourse when it purports to reach an authoritative conclusion and enforces it by claims that further debate is inappropriate and by force. Indeed, it is exactly this aspect of legal discourse that makes it so attractive to partisans of all sorts. Law is more than debate. It is coercion. It is victory, or at least a gratifying step toward it.


The danger, I think, is not exactly or not only that moral problems get translated into legal problems and that discussion is then terminated. Inevitably and necessarily the spheres [law and morality] must intersect in countless ways . . . . What we need . . . is an understanding of law that accepts into public discussion outlooks that picture the human being as more than just an isolated principle of will and choice . . . .
requires of them.\textsuperscript{44} This is the essence of “defensive medicine,” sometimes reflecting misunderstandings about the law and nearly always illustrating concern more about whether one can get sued than about whether one is doing the right thing.\textsuperscript{45} Many lawyers, by the way, are also culpable on this score.

The very power of the law can create pitfalls for real ethical reflection in other ways. Paradoxically, more law can result in less ethical debate. When we focus on the law, we tend to lose sight of the ethical underpinnings for it. In trying to focus on the “letter of the law,” we often lose sight of its “spirit.” When law becomes pervasive, we often forget about the original ethical questions that prompted the legal resolutions. We also tend to forget that generally, the law sets only the floor for ethical behavior, and that we have come to societal consensus only on those behaviors which fall below that ethical level. We get so focused on making sure that our behavior does not fall below that floor—that we cannot be held legally liable for something—that we do not examine whether our behavior is reaching far enough toward the ethical high ground. We worry only about avoiding legal accountability, not about promoting ethical responsibility. Our obsession with the law—or more particularly, with avoiding law’s punch—means that we tend to substitute our conformity with the legal minimums for our need to reflect on the ethical

\textsuperscript{44} A good example of this problem arises in the treatment of critically ill newborns. See supra notes 10-14 and accompanying text. A 1988 survey of neonatologists indicated that implementation of the Child Abuse and Neglect Amendments of 1984 (and the second “Baby Doe” regulations still in effect) resulted in “overtreatment, poor use of resources, and insufficient attention to suffering.” Loretta M. Kopelman et al., Do the “Baby Doe” Rules Ignore Suffering?, 18 SECOND OPINION 101, 101-13 (1993). According to one UCLA physician:

“I know of several instances where neonatologists have used Baby Doe regulations to convince a family that they had no choice but to continue to treat where the family wanted no treatment.” . . . [In reference to the study above,] [o]ne third of the doctors who said that life-sustaining surgery was not in an infant’s best interests in a hypothetical case said they believed such treatment nevertheless was required by law. “The conclusion we drew is that the Baby Doe regulations [for the Amendments] are causing many babies to be overtreated when their conditions are hopeless . . . .”

Glazer, supra note 12, at Z8.

\textsuperscript{45} See generally Marshall B. Kapp, Treating Medical Charts Near the End of Life: How Legal Anxieties Inhibit Good Patient Deaths, 28 U. TOL. L. REV. 521 (1997) (discussing the negative influence of defensive medicine on the clinical and ethical quality of medical care at the end of patients’ lives). See also ANNAS, supra note 35, at 4-5 (“It should be emphasized at the outset that any medical treatment done primarily to protect the physician from potential lawsuits (rather than to benefit the patient), although sometimes legal, is by definition unethical.”).
maximums. We are too quickly satisfied that our compliance with these legal minimums was all that ethics required us to do.

II. MEDICAL ETHICS AT THE BEDSIDE: LAW AND THE RECOGNITION OF PATIENTS' RIGHTS

This Part examines law's influence on medical ethics at the bedside, in particular on the doctor-patient relationship, and will illustrate how law's power has created pitfalls for ethical reflection through the example of informed consent forms. The law's recognition of patients' rights to consent to and to refuse to receive medical treatment is solidly founded on ethical considerations and, it is argued, reflects an emerging societal consensus over how the ethical balance ought to be weighed between doctor and patient at the bedside. Over the past several decades, the courts, legislatures, and society at large have coalesced in the view that a competent adult patient has the right to consent, or to refuse to consent, to medical treatment, even if her health caregivers vehemently disagree with her decision. By contrast, society has not come to a consensus on whether patients should be entitled to receive medical treatment, if, for example, the patient cannot pay for it, or if the doctor thinks it is not medically appropriate, or if the insurance company does not want to pay for it. The lack of societal consensus over when, if ever, a patient should be entitled to receive health care is reflected by the absence of clear legislation or judicial precedent recognizing such rights.

A. The Right of Informed Consent

Throughout most of the history of medicine, the doctor-patient relationship has been founded on the ethics of beneficence, or paternalism. The doctor decided what was best for the patient, and the patient accepted the decision, usually without questioning, understanding, or perhaps even a real choice. The doctor was guided in his decision by another related ethical principle, namely non-maleficence, which required him to "above all, do no harm" to the patient.

46. See infra notes 75-83 and accompanying text. This legal power/ethical pitfall problem is later explored in the context of business ethics. See infra notes 150-54 (discussing corporate compliance programs).

47. See RUTH R. FADEN ET AL., A HISTORY AND THEORY OF INFORMED CONSENT 9-10, 61-76 (1986). "[B]efore the mid-twentieth century, the beneficence model... was the only operative model of the physician's responsibility to the patient." Id. at 100-01. For an exhaustive account of the four-principles (autonomy, beneficence, non-maleficence, and justice) approach to medical ethics, see RAANAN GILLON, PRINCIPLES OF HEALTH CARE ETHICS pt. 1 (1994).
These two principles of beneficence and non-maleficence formed the ethical bedrock of the doctor-patient relationship until relatively recently. Paternalism in medicine was grounded in ethics, and it reflected a social consensus, for most of history and still in many other countries, about what was ethically appropriate behavior between doctors and patients. Doing the right thing for the patient entailed doing what doctors thought was the best thing for the patient: what would benefit her, and above all not harm her. The ethical principle of autonomy, or respect for individual self-determination, played a minor role in the doctor-patient relationship, and was reflected in the doctor's obtaining the patient's consent before treatment. It did not matter that the patient's expression of consent may have been pretty general, such as simply "Yes," or "OK," or "Sure, doctor, whatever you say," or even the failure to say "No." Ethics required at least a minimalist expression of autonomy, and law backed ethics up. Since the early part of this century, the law has expressed society's view that it was wrong—a violation of autonomy—to treat the patient without some kind of consent. The law expressed this ethical view by allowing the patient to sue her doctor for common-law battery if the doctor treated her without prior consent.

48. See Faden et al., supra note 47, at 86-91 (suggesting that the late 1950s and early 1960s marked the beginning of change from a beneficence model to an autonomy model in informed consent theory).

49. See id. at 100 ("Informed consent did not become an issue in medicine until the twentieth century, although we have seen evidence of consent-seeking and the respecting of patient refusals in the nineteenth century."). See also Jay Katz, The Silent World of Doctor and Patient 4, 49-50 (1986):
The history of the physician-patient relationship from ancient times to the present . . . bears testimony to physicians' inattention to their patients' right and need to make their own decisions. . . . [Although] consent to surgical interventions is an ancient legal requirement . . . . [such consent was not meaningful consent] because there was no right for patients to decide, after having been properly informed, whether an intervention was agreeable to them in light of its risks and benefits as well as available alternatives.

50. See, e.g., Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914) (Cardozo, J.) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."). See also Harris v. Leader, 499 S.E.2d 374 (Ga. Ct. App. 1998):

[T]he relationship of doctor and patient is a consensual one, and any unauthorized and unprivileged contact by a doctor with his patient in examination, treatment or surgery would amount to a battery. In the interest of one's general right of inviolability of his person, any unlaw-
With the advent of the civil rights movement in the second half of this century, Americans' views began to undergo substantial change concerning the rights of individuals in relation to government and in relation to other individuals or institutions who were more politically, socially, or economically powerful. Not surprisingly, about this time, societal views concerning the patient's role in the doctor-patient relationship also began to change. Patients began to voice the ethical proposition, founded on the autonomy principle, that they, rather than the doctors, should have the ultimate authority to decide the course of their medical treatment. Patients asserted this ethical view, not by writing philosophy dissertations in universities or passionate editorials in newspapers, but by taking their doctors to court. Throughout the 1970s and 1980s in state courts and legislatures across the country, patients began claiming that doctors had an ethical obligation, not just to get them to agree to treatment, but to talk to them in more depth about the nature and the risks of proposed medical treatment before providing it. In other words, they argued that doctors had an ethical duty to get more than just bare consent; they ought to get the patient's informed consent prior to treatment.

Courts began to side with patients in this ethical debate by allowing patients to sue a doctor, not just for battery, but also for medical malpractice if the doctor failed to disclose, prior to treatment, certain significant information about the proposed treatment which could affect the patient's decision to accept or reject it. Starting from the ethical premise that patients ought to be able to decide which treatments were in their best interest, courts reasoned that patients needed to know a lot about a proposed ful touching of that type is a physical injury to the person and is actionable.

In Georgia, for example, a patient may still have a cause of action for battery when the surgeon exceeds the scope of the patient's consent, see, e.g., Johnson v. Srivastava, 405 S.E.2d 725 (Ga. Ct. App. 1991) (holding battery claim was appropriate where patient alleged that she had consented only to an "excision biopsy" whereas physician had performed a complete excision of a mass on her face without first obtaining a biopsy), or obtained the patient's consent by fraudulent misrepresentations, see, e.g., Lloyd v. Kramer, 503 S.E.2d 632 (Ga. Ct. App. 1998) (where the patient was allowed to sue a podiatrist for, among other things, battery based on allegations that he obtained patient's consent to unnecessary and inappropriate hammer toe surgery through fraudulent misrepresentations).

51. See FADEN ET AL., supra note 47, at 93-95, 101 ("[The American Hospital Association's 1972] Patient's Bill of Rights was connected to various consumer and civil-rights movements that were everywhere demanding increased rights to make free and informed decisions.").

52. See generally id. at 114-50.
treatment before they could reasonably decide whether it was in their best interests to have it. The courts therefore ruled that doctors were required to disclose information which they knew about the treatment, and which patients would find significant in deciding whether to accept it, such as the material risks associated with it, its likelihood of success, its alternatives, and the patient's prognosis without it. In some states, like Georgia, where the courts did not reflect this ethical view in their common law, the state legislatures enacted informed consent statutes which did so, and many states have replaced their common-law developments with legislative enactments on informed consent.

Informed consent doctrine thus reflects an ethical shift away from professional paternalism (doing what in the doctor's view was in the patient's best interest) and toward individual autonomy (letting the patient decide, once fully informed, what was best). In effect, the widespread adoption of informed consent laws reflects a societal consensus that in medical ethics at the bedside, the principle of autonomy ought to prevail, in a case of conflict, over the principle of beneficence. Patients were arguing that it was ethically appropriate for doctors to talk in depth about the medical care they proposed, even though such conversations were largely foreign to the ethical perspective of the medical profession. Law was the vehicle by which the ethics of patient self-determination and shared decision-making in the doctor-patient

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54. Georgia was one of the last states to adopt a legal duty of informed consent, which it enacted in a limited form by statute in 1989. Before 1989, numerous cases in Georgia established that once a doctor had informed a patient in general terms of the treatment or course of treatment proposed for the patient, the doctor had no further duty to disclose the risks of treatment. See Padgett v. Ferrier, 323 S.E.2d 166 (Ga. Ct. App. 1985) (and citations therein). Under the 1989 amendment to Georgia's Medical Consent Law, specific disclosures were required to be made to the patient, including (a) diagnosis of patient's condition; (b) nature and purpose of proposed procedure; (c) material risks of the procedure; (d) likelihood of success; (e) practical and generally recognized alternatives; and (f) patient's prognosis without the procedure. See Ga. Code Ann. § 31-9-6.1 (1996).

55. See Faden et al., supra note 47, at 139 (by 1982, thirty states had replaced common-law developments in informed consent with statutes on informed consent).

56. To put it bluntly, these legal developments in informed consent caused medicine to be "jolted from an exclusive preoccupation with a beneficence model to awareness of an autonomy model of responsibility for the patient." Id. at 142. See also Katz, supra note 49, at 1 ("Disclosure and consent, except in the most rudimentary fashion, are obligations alien to medical thinking and practice").
relationship were introduced to the medical profession. As a profession, doctors may not have readily agreed that they had an ethical duty to engage in these conversations with patients. Understandably, they have resented both the lawsuits and the resulting laws. Those laws do reflect, however, a societal consensus that it was ethically wrong not to engage in these conversations with patients. Actions for battery and malpractice were simply the ways that the law packed ethics with a punch.

B. The Right to Refuse Medical Treatment

Issues in medical ethics at the bedside also arise when a patient wants to refuse treatment that her doctors believe is in her best interests. A right to refuse treatment would seem to be a natural corollary of the right to consent to it. What now are the ethical responsibilities in the doctor-patient relationship? In the name of autonomy, should, for example, a patient be allowed to refuse CPR in the event of cardiac arrest, or to refuse a blood transfusion in an emergency, or to forego other life-extending treatments, whether they be ordinary or heroic measures? Or in the ethical interests of beneficence or non-maleficence, should doctors be able to provide the treatment to save the patient's life, even over her or her surrogate's objections?

1. Incompetent Patients

The first court case to address this question involved Karen Ann Quinlan, a victim of a tragic accident that left her in a persistent vegetative state with no possibility of recovery. After many

57. See Annas, supra note 35, at 3 ("Law sides with patients to oppose the arbitrary use of power whether by physicians or the government; the rubric is patient rights. This is why American law, not philosophy or medicine, is primarily responsible for the agenda, development and current state of American bioethics."); Faden et al., supra note 47, at 101:

Amid the convergence of complicated social causes and reasons that may never be properly sifted by historians, it was case law that introduced the concept of informed consent to medicine in the mid-twentieth century using the language of "self-determination." Shortly thereafter, informed consent was transformed in a social context beyond law from a malpractice issue to a moral duty incumbent on physicians, one straightforwardly linked to the principle of respect for autonomy.

58. See Carl E. Schneider, Making Sausage: The Ninth Circuit's Opinion, Hastings Center Rep., Jan.-Feb. 1997, at 28 ("[T]he history of bioethics is in no small part a reaction to the sobering number of doctors who have not been driven to understand patients' wishes, who have not understood them, and who have ignored them even when they have understood them.").

years, Quinlan's father finally asked to have his unconscious daughter disconnected from the ventilator, in the belief that she would not have wished to have been kept alive by such measures in a state of permanent unconsciousness. With the support of his church, the father believed that it was morally right to stop providing this form of treatment. The doctors, to the contrary, thought it was ethically wrong to disconnect any living patient from a ventilator. What, ethically, should be done? In a thoughtful opinion reflecting both ethical and legal precedent, the court ruled in favor of the father's authority—rather than the doctors—to make the decisions about his daughter's medical treatment on her behalf in light of what she would have wanted done under the circumstances.

The case was controversial. Over the next three decades, state courts across the country considered dozens of cases just like it. The courts have fairly consistently upheld the ethical balance struck in Quinlan's case, and have ruled that it is the patient's right (or a surrogate's right on the patient's behalf if the patient is incompetent) to accept or to refuse medical treatment. Whether these court cases have changed social opinion, or whether changes in social opinion are being reflected in these cases, gradually a social consensus has emerged that patients (or their surrogates)—rather than doctors—ought to decide ultimately how much and what kind of care they should have at the end of life.

When the United States Supreme Court in 1990 recognized under federal Constitutional law that an individual has a liberty interest in refusing unwanted medical treatment, the Court was

60. See id. at 655 ("it seemed to be the consensus not only of the treating physicians but also of the several qualified experts who testified in the case, that removal from the respirator would not conform to medical practices, standards, and traditions"). Twenty years later, many doctors are now taking the contrary ethical position, and are urging that medical ethics allows (and maybe obliges) doctors to remove a permanently unconscious patient like Quinlan from life support they deem to be futile, even if the patient's surrogate objects to its removal. See infra note 85.

61. See generally Furrow et al., supra note 9, at 403-16 (collecting cases and discussing potential civil liability for providers' failure to recognize patient's or surrogate's decision to forego life-sustaining treatment). In a recent case in Texas, parents who had decided against having doctors resuscitate their infant born prematurely at 22 weeks gestation won a $42.9 million verdict for doctors having resuscitated the infant against parents' wishes. See Jury Returns $42.9 Million Verdict in Case of Brain-Damaged Baby, 7 Health Law Rep. (BNA) 183 (Jan. 29, 1998).

62. See supra notes 4, 36.

63. See Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261 (1990). The Court characterized this case as "the first case in which we have been
reflecting this emerging current societal consensus that individuals should have the "right to die with dignity," and that it is wrong to extend life or prolong dying against the patient's wishes. Over the past few decades, all state legislatures have also backed up this ethical viewpoint with legislation recognizing the right of patients to express their wishes, and to have them honored, through advance directives like living wills or durable powers of attorney. Even the federal government in 1991 addressed patients' rights with legislation pointedly called the Patient Self-Determination Act, requiring hospitals to inform patients about their rights under state law to consent to or refuse medical treatment and to express their wishes in advance directives.

2. Competent Patients

The law has also been asked to resolve ethical conflicts at the bedside of patients who are not terminally ill or comatose or in the process of dying. What ought to happen when patients have, potentially, many years of healthy life ahead of them if they are given certain medical treatment? Ethically, in the interest of autonomy, should they be allowed to refuse it, when that decision will likely result in declining health or even death? Or, in the interests of beneficence and non-maleficence, should doctors be allowed to provide the care to improve a patient's health or even save her life, over her objections? Patients and doctors again took these ethical questions to the courts for resolution. In deciding these cases, courts have expressly considered a variety of ethical principles and concerns that compete with the ethical principle of autonomy. In the courts' view, a person's interest in autonomy and control over his body is not absolute, but must be carefully balanced against the ethical interests of the community at large (the state) and of the medical profession in particular.

squaredly presented with the issue of whether the United States Constitution grants what is in common parlance referred to as a 'right to die.'" 64 Id. at 277. The Court assumed, for the purposes of the case, "the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition." Id. at 279.


66. While the courts have not framed their analysis in the terms of the conventional four principles of medical ethics (autonomy, beneficence, non-maleficence, and justice, see supra note 47, they have adopted an analytical, four-factor framework that parallels closely those principles. The four counter-
The state courts across the country have almost uniformly sided with patients in this ethical debate. Courts have generally ruled that mentally competent adults have the legal right to refuse any and all medical treatment, even to the point of death. So, for example, a Jehovah’s Witness may refuse a life-saving blood transfusion, even if she is a parent whose refusal could leave her children orphaned and without parental support. A person with disabilities or serious illnesses, such as quadriplegia, may decline life-saving medical treatment, nutrition, and hydration. Even state prison inmates may refuse food and medical care to the point of death in some cases. Generally speaking, however, courts have weighed this ethical balance against the patient’s interest in refusing medical treatment only when the patient was a minor, or when the patient’s refusal of medical treatment might adversely affect the wellbeing of a minor or a fetus. Even in these prevailing “state interests” which courts have identified as important to balance against the patient’s (autonomy) interest in refusing medical treatment are: (1) preserving life, (2) preventing suicide, (3) protecting the ethical integrity of the medical profession, and (4) protecting the interests of innocent third parties. See, e.g., Bartling v. Super. Ct., 209 Cal. Rptr. 220 (Ct. App. 2d 1984); State v. McAfee, 385 S.E.2d 651 (Ga. 1989); Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417 (Mass. 1977). See, e.g., Norwood Hosp. v. Munoz, 564 N.E.2d 1017 (Mass. 1991); Fosmire v. Nicoleau, 551 N.E.2d 77 (N.Y. 1990).

67. See, e.g., Stamford Hosp. v. Vega, 674 A.2d 821 (Conn. 1996); In re Dubreuil, 629 So. 2d 819 (Fla. 1993).


70. See, e.g., Thor v. Super. Ct., 855 P.2d 375 (Cal. 1993); Zant v. Prevatte, 286 S.E.2d 715 (Ga. 1982). But see Schuetzle v. Vogel, 537 N.W.2d 358 (N.D. 1995) (holding that the state’s interest in orderly prison administration outweighs a prisoner’s right to refuse treatment, and specifically stating that “[w]e, like every court that has considered Zant, refuse to follow it”). In the case of federal prisoners, courts have upheld the prison’s force-feeding of inmates, citing either constitutional bases, see, e.g., In re John Doe, 150 F.3d 170 (2d Cir. 1998) (stating that the state’s interests in preserving life and orderly prison administration outweigh the prisoner’s right to refuse treatment), or Bureau of Prisons Regulation, see, e.g., Martinez v. Turner, 977 F.2d 421, 423 (8th Cir. 1992). See also 28 C.F.R. § 549.65 (1994) (authorizing force-feeding after medical evaluation).

71. See, e.g., Novak v. Cobb County-Kennestone Hosp. Auth., 849 F. Supp. 1559 (N.D. Ga. 1994), aff’d, 74 F.3d 1173 (11th Cir. 1996) (holding that a “mature minor” does not have the right to refuse medical treatment under the U.S. Constitution or Georgia law).

cases, some courts have ruled that the patient may refuse the treatment.\textsuperscript{74}

C. Patients' Rights and the Legal Power/Ethical Pitfall Problem

Do these legal developments in informed consent and refusal of medical treatment reflect societal consensus? This essay argues that, at least in theory, in giving primacy to the ethical principle of autonomy in the doctor-patient relationship, the courts and legislatures have reflected, or perhaps forged in some cases, a societal consensus that patients ought to have more decision-making power in that relationship. By societal "consensus," again it is not suggested that, as a practical matter, everyone in society agrees that the ethically correct resolution has been reached in these cases.\textsuperscript{75} In reality, plenty of people disagree. On ethical issues involving life and death, there are bound to be sharp differences of opinions. While many patients, and many who see themselves as future patients, may have come to believe that they ought to be allowed to steer the course of the health care they receive, and while the courts and legislatures may have agreed with them, the medical profession has been slower to embrace the ethics of patient autonomy at the bedside. So, for example, in the case of patients' rights to refuse medical treatment, numerous studies and litigation have shown that despite court rulings, living wills, durable powers of attorney, and so forth, many doctors continue to provide treatment at the bedside without the consent or even over the objections of patients or their families.\textsuperscript{76}

\textsuperscript{73} See, e.g., Jefferson v. Griffin Spalding County Hosp. Auth., 274 S.E.2d 457 (Ga. 1981) (holding the state may intervene on behalf of fetus and require pregnant woman to have cesarean section surgery).

\textsuperscript{74} Some courts have held that a competent pregnant woman has the right to refuse cesarean section surgery, even when such refusal may threaten the welfare of her fetus. See, e.g., In re A.C., 573 A.2d 1235 (D.C. 1990); In re Baby Boy Doe, 632 N.E.2d 326 (Ill. App. Ct. 1994) (recognizing right of refusal). One recent decision permitted a pregnant woman to refuse less invasive medical care—a blood transfusion—which doctors had recommended for the welfare of her fetus. See In re Brown, 689 N.E.2d 397 (Ill. App. Ct. 1997). See generally Charity Scott, Resisting the Temptation to Turn Medical Recommendations into Judicial Orders: A Reconsideration of Court-Ordered Surgery for Pregnant Women, 10 GA. ST. U. L. REV. 615 (1994).

\textsuperscript{75} See supra notes 4, 36 and accompanying text.

\textsuperscript{76} See, e.g., David A. Asch et al., Decisions to Limit Life-Sustaining Treatment By Critical Care Physicians in the United States: Conflicts Between Physicians' Practices and Patients' Wishes, 151 AM. J. RESPIR. CARE MED. 288, 288-92 (1995) (one-third of surveyed physicians continued life-sustaining measures despite patient or surrogate wishes that it be discontinued); Kapp, supra note 45, at 524-37 (providing examples of medically inappropriate treatment near the end of life as a result
Understandably, doctors resent the intrusion of law at the bedside. Law came to the patients' bedside, however, because there was an emerging societal sense that wrong was being done to the patients there. This invitation to get the law involved in ethical conflicts is nothing new. Whenever there is a social sense of wrong, or injustice, or an abuse of power by some people or some institutions (including government), those who feel abused often turn to the law for protection. In this case, a felt need for patient protection from a power imbalance in the doctor-patient relationship has resulted in consent forms, living wills, and other legal documents and rules. That these legal mechanisms frequently provide only minimal protection in practice—that they often fail to achieve the ethical balance that was their goal—does not alter the point that their purpose was to promote an ethical vision of the doctor-patient relationship.

Although informed consent doctrine is founded on ethical ideals of respect for persons, patient autonomy, and self-determination, as well as ideals of shared decision-making and genuine collaboration between physician and patient, actual practice in the relations between patients and providers is often different. On the floor of so many hospitals and doctors' offices, informed consent doctrine moves from the sublime to the ridiculous: from an active and constructive conversation to a multi-page, incomprehensible consent document, from facilitating a dialogue to of physicians' fears of legal liability); Philip G. Peters, Jr., The Illusion of Autonomy at the End of Life: Unconsented Life Support and the Wrongful Life Analogy, 45 UCLA L. REV. 673 (1998) (citing numerous studies which suggest that physicians routinely ignore patient preferences about life-sustaining care); SUPPORT Principal 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, 1591-98 (1995) (reporting findings of a large study that many physicians were unaware of or ignored their patients' preferences concerning CPR, and that terminally ill patients were hooked up to mechanical ventilation despite their preferences, and were dying in pain). There are a number of cases where allegedly unwanted care was provided despite the presence of a patient's advance directive. See, e.g., Roberts v. Jones, 475 S.E.2d 193 (Ga. Ct. App. 1996); Allore v. Flower Hosp., 699 N.E.2d 560 (Ohio Ct. App. 1997). See also Furrow et al., supra note 9 (discussing potential civil liability for failure to respect patient's decision); Peters, supra (arguing that liability should be imposed on a physician who wrongfully administers life-sustaining care over the objection of the patient or surrogate); Tamar Lewin, Ignoring "Right to Die," Medical Community Is Being Sued, N. Y. TIMES, June 2, 1996, at 1 ("there is a new wave of lawsuits seeking to hold hospitals, nursing homes and doctors liable for ignoring living wills and other advance directives").

77. See ANNAS, supra note 35, at 3 ("American law, especially civil rights law, is dedicated to fostering individual rights, equality and justice. Law sides with patients to oppose the arbitrary use of power whether by physicians or the government; the rubric is patients' rights.").
getting a signature for the files. And who is to blame? One may be tempted to say "the law," or at least "the lawyers."

And to some extent that is true. After all, the law said it was important to have these conversations, and backed that ethical proposition up with the punch of liability for malpractice if the doctor or hospital did not have them. Moreover, most legislation on informed consent provides explicit directions for avoiding law's punch: get it in writing. Georgia's informed consent law, for example, like many state statutes, provides that if one follows the instructions and gets the patient's signature on a consent form that is filled out according to statutory specifications, then the patient's consent will be legally presumed to be valid. The bottom line: if you get the signature on a form like this one, then you won't get sued ("punched").

And herein lies the pitfall which the very power of the law creates for ethical reflection. That bottom line is near the bottom of ethical practice. As argued earlier, law only sets a floor for ethical behavior. At the very minimum, the law needs to be satisfied that the patient at least had the opportunity to be informed about her diagnosis, the risks of treatment, her alternatives, and so forth. The law does not require proof, beyond these minimums, that the patient actually understood any of the information she was given, or engaged in any genuine conversation with her health care providers before accepting treatment, or made truly autonomous choices about her health care. Faced with the power of law, however, we tend to get stuck in our ethical reflections at the ground floor.

As is so often true when law packs ethics with a punch, people tend to over-focus on avoiding the punch, and not on the

78. See 1 Furrow et al., supra note 9, at 439 ("A consent form, or other written documentation of the patient's verbal consent, is treated in many states as presumptively valid consent to the treatment at issue, with the burden on the patient to rebut the presumption."). See also infra note 79.

79. Actually, you can still get sued, but you have increased your chances of defending a malpractice suit successfully. In Georgia, for example, for surgical or diagnostic treatment involving anesthesia, amniocentesis, or injection of contrast material, if the consent form discloses in writing certain specific matters—diagnosis, material risks, likelihood of success, and alternatives—and is signed by the patient, then it is rebuttably presumed to be valid consent. See Ga. Code Ann. § 31-9-6.1(a), (b)(2) (1996). For all other treatment, if the consent form discloses in general terms the course of treatment and is signed and in writing, then it is conclusively presumed to be valid consent in the absence of fraud. See id. at § 31-9-6(d).

80. See supra notes 37-40 and accompanying text.

81. See generally Kapp, supra note 45, at 524-37, 544-46 (discussing how physicians' misunderstandings of the law can lead to medically inappropriate and ethically dubious treatment of critically ill and dying patients).
ethical underpinnings of the law. We get so obsessed about these forms that we forget that they were designed to facilitate conversation, not to be a substitute for it. We forget that they were intended to begin the conversations with patients, not to end them. Forgetting the ethical ideals, we do not ask: did we have a real talk with the patient, did the patient understand, does the patient really know and accept what she is getting into? We worry only about legal compliance, and ask instead: did you get the consent, by which we mean, did you get the signature? So often before surgery one hears practitioners ask: "Did anybody go consent the patient?" Now a transitive verb, "consent" is something that is done to the patient, not something that the patient does.

In reality, the law has done little to move actual medical practice closer to the ideal of shared decision-making between physician and patient. 82 Too often, law has been used only to cover the doctor-patient relationship with bureaucratic red tape. 83 But it is not really the law's fault that ethical ideals have not been achieved in medical practice. Health care providers are the ones who can choose whether or not they want to go beyond

82. See Faden et al., supra note 47, at 100:
Katz seems right in his thesis that informed consent has not changed the fundamental character of the physician-patient relationship. . . . The beneficence model is [still] overwhelmingly predominant. Patients routinely acquiesce to medical interventions rather than autonomously authorizing them. From this perspective all the changes [over the past century] are surface displays, while below the surface there are no more real 'informed consents' than in the past. See also Bruce V. Corsino, Bioethics Committees and JCAHO Patients' Rights Standards: A Question of Balance, 7 J. CLIN. ETHICS 177, 179 (1996) (describing providers' experiences with informed consent and advance directives as "unhelpful, non-medical procedures"); Alan Meisel & Mark Kuczewski, Legal and Ethical Myths About Informed Consent, 156 ARCH. INT. MED. 2521 (1996) (attributing physicians' negative reactions to informed consent to fundamental misunderstandings about what informed consent requires); Informed Consent—Not, Sci. News, July 4, 1998, at 15 (reporting on two studies which raise questions about the utility of informed consent forms as an aid to patient decision-making).

83. See 1 Furrow et al., supra note 9, at 439-41:
These forms operate as a legal surrogate for consent, sometimes memorializing an actual physician-patient discussion, sometimes acting simply as a fiction. . . . Written consent forms predominate in institutional settings, given bureaucratic pressures for a complete patient record, a desire to protect against litigation, and a sense that something is better than nothing. They are often reduced to little more than a bureaucratic formality that the institution hopes will erect a defense shield against malpractice liability. See also John Lantos, Informed Consent: The Whole Truth for Patients?, 72 CANCER 2811, 2813 (Supp. 1993) ("Informed consent forms become waivers of liability.")
law's minimums and strive for the ethical maximums. They can choose to start and end conversations with their patients with the informed consent form. Or they can choose to go beyond the form and begin to engage the patient in thinking about her health and the ways she thinks would best promote it, to allay her fears and to give her confidence in her choices. Law never took it out of the hands of the health care professionals to strive for the ethical high ground.

D. The Right to Receive Medical Treatment

While social consensus has been evolving, at least in ethical and legal theory, over patients' rights to consent to and refuse medical treatment, there is much less social accord on more recently emerging ethical questions involving patients' rights to receive medical treatment. We have never agreed in our society that, ethically, every person who needs medical treatment ought to be able to get it. Not surprisingly, we have no law that requires universal health care coverage. Occasionally, we do agree that some people ought to be able to get some kinds of medical treatment some of the time. For example, the federal law mentioned earlier, which requires hospitals to treat emergency patients and women in labor, reflects the social agreement that these patients ought to be able to get emergency care regardless of their ability to pay for it. The federal Medicaid and Medicare programs also reflect social accord that some people should be able to get some treatment at least some of the time, regardless of their ability to pay.

Generally speaking, however, we have not yet found consensus on a range of ethical questions involving when, if ever, patients ought to be entitled to receive medical treatment that someone else either does not want to provide, or does not want to pay for, or thinks that patients should not get. For example, we have not yet agreed on whether a patient who is severely physically and mentally disabled, such as permanently unconscious, ought to be able to get medical treatment which her doctors do not want to provide because they say it is futile, or her condition is too hopeless. We have not yet agreed on whether patients


85. Unilateral efforts by physicians to terminate life-sustaining treatment they consider futile for a patient over the objections of the patient or the patient's family have generated public controversy and litigation. In the case of Helga Wanglie, a medical center unsuccessfully sought to replace the patient's husband as her guardian when he refused to consent to the removal of her respirator, which treatment the doctors regarded as inappropriate and "non-
with advanced breast cancer ought to be able to get expensive high-tech treatment which their insurance companies do not want to pay for because the insurance companies say it is experimental and unproven treatment. And we are still deciding whether a patient ought to be able to get a physician to help her commit suicide if she is terminally ill and wishes to die.\textsuperscript{86} 

beneficial" in light of the patient's persistent vegetative state. See Marcia Angell, \textit{The Case of Helga Wanglie: A New Kind of "Right to Die"}, 325 \textsc{New Eng. J. Med.} 511 (1991); Steven H. Miles, \textit{Informed Demand for "Non-Beneficial" Medical Treatment}, 325 \textsc{New Eng. J. Med.} 512 (1991). In the case of Catherine Gilgunn, a jury found doctors and a hospital not liable for withdrawing ventilator support from a comatose and severely brain-damaged patient whose daughter had objected to the withdrawal and insisted that her mother would have wanted the aggressive treatment. See Alexander Morgan Capron, \textit{Abandoning a Life}, \textsc{Hastings Center Rep.}, July-Aug. 1995, at 24; Gina Kolata, \textit{Court Ruling Limits Rights of Patients}, \textsc{N. Y. Times}, Apr. 22, 1995, at A6. See also Velez v. Bethune, 466 S.E.2d 627 (Ga. Ct. App. 1995) (denying a motion to dismiss, court observed that doctor "had no right to decide, unilaterally, to discontinue medical treatment even if, as the record in this case reflects, the child was terminally ill and in the process of dying. That decision must be made with the consent of the parents."); \textit{infra} note 88.

86. Public debate over who decides what health plans and insurance companies should pay for continues amid controversial damage awards and "horror stories" after some payers have denied coverage for treatments they consider unproven, experimental, or not medically necessary. See, e.g., Christine Gorman et al., \textit{Playing the HMO Game: Denied Viagra and Inflamed by Horror Stories, Consumers Put Health Reform Back on the Front Burner}, \textsc{Time}, July 13, 1998, at 22 (describing numerous cases of denied coverage); Tom Hamburger, \textit{Clinton Presses for Patients' Bill of Rights: An Apple Valley Woman Relates Her HMO Trouble}, \textsc{Minneapolis-St. Paul Star Trib.}, May 29, 1998, at 10A (stating that President Clinton urged Congress to pass a patients' bill of rights, citing example of woman with breast cancer denied chemotherapy by her HMO); Ron Winslow & Rhonda L. Rundle, \textit{Aetna Reels in Wake of $116 Million Damages Verdict}, \textsc{Wall St. J.}, Jan. 22, 1999, at B4 (describing large jury awards for denials of bone-marrow transplant coverage in the cases of Teresa Goodrich's husband, who died of stomach cancer, and Nelene Fox, who had breast cancer). Even studies designed to determine the efficacy of costly new medical treatments seem unlikely to quell the public debate over whether they should be covered by health payers. See Nancy Ann Jeffrey & Michael Waldholz, \textit{Studies Are Likely to Question Breast Cancer Therapy}, \textsc{Wall St. J.}, Mar. 24, 1999, at B1 (noting that four landmark studies of aggressive chemotherapy-transplant treatment for breast cancer "are likely to spark a firestorm of controversy"); \textit{infra} note 89.

87. The moral and social debate over the ethics of physicians collaborating with patients to hasten their deaths continues both inside and outside courtroom and legislatures. Jack Kevorkian of Michigan has given high visibility to the public debate over physician-assisted suicide, which will probably not be diminished by his March 1999 conviction of second-degree murder for administering a lethal injection to a man with Lou Gehrig's disease. See Sue Ellen Christian, \textit{Opponents Fear Making Martyr of Kevorkian; Conviction Leaves Debate Unfinished}, \textsc{Chicago Trib.}, Mar. 28, 1999, at 3. Having assisted in the deaths of approximately 130 persons since 1990, Kevorkian had been unsuccessfully prosecuted four times before for his role in providing suicide assistance. See Julie
These ethical dilemmas may initially arise at the bedside, but their ethical implications extend well beyond the doctor-patient relationship and affect the broader community. That we are still in the process of finding a social consensus on these questions is reflected, variously, by our lack of laws directly addressing an issue, such as futile treatment;88 or by extensive litigation result-

Grace, Curtains for Dr. Death, TIME, Apr. 5, 1999, at 48. There is also evidence that medical and nursing professionals have assisted in the suicides of their patients. See, e.g., Ezekiel J. Emanuel et al., The Practice of Euthanasia and Physician-Assisted Suicide in the United States, 280 JAMA 507 (1998) (stating that approximately fifteen percent of surveyed oncologists reported participating in euthanasia or physician-assisted suicide); Lee R. Slome et al., Physician-Assisted Suicide and Patients with Human Immunodeficiency Virus Disease, 336 NEW ENG. J. MED. 417 (1997) (relating that a majority of San Francisco-area physicians caring for HIV/AIDS patients who responded to the survey said they had granted at least one patient's request for assisted suicide). Acknowledging that the medical profession has historically failed to address serious deficiencies in the care of dying patients, the AMA has undertaken a number of reform initiatives to improve physicians' skills in the field of end-of-life care, as well as to educate patients on the quality of care they should expect. See, e.g., Kathleen M. Foley, Competent Care for the Dying Instead of Physician-Assisted Suicide, 336 NEW ENG. J. MED. 54 (1997); Diane M. Gianelli, Assisted Suicide Case Consensus: We Need Better End-of-Life Care, AM. MED. NEWS, Apr. 1997, at 1; Diane M. Gianelli, Report Says Myths Dominate End-of-Life Care Debate, AM. MED. NEWS, May 19, 1997, at 8; Daniel P. Sulmasy & Joanne Lynn, Contempo: End-of-Life Care, 277 JAMA 1854 (1997); AMA Hosts Innovative Seminar Addressing End-of-Life Care, AM. MED. NEWS, Feb. 15, 1999, at 24; Warren E. Leary, Many in U.S. Denied Dignified Death: Health Panel Asserts That Too Little Is Done to Ease End of Life Care, N.Y. TIMES, June 5, 1997, at A13; infra note 90.

88. For example, litigation under EMTALA has established the right of an infant with anencephaly (i.e., without a brain) to receive life-saving medical treatment in a hospital's emergency room, even though doctors believed that such extraordinary measures were outside the medical standard of care and that such treatment was both medically futile and ethically inappropriate to render. See In re Baby K, 16 F.3d 590 (4th Cir. 1994); but cf. Bryan v. Rectors & Visitors of the Univ. of Va., 95 F.3d 349 (4th Cir. 1996) (holding that EMTALA did not require doctors to continue treating a woman who had been treated at the hospital for 12 days for an emergency condition). While there are few laws directly addressing the problem of futile treatment (Virginia is the only state with a statute permitting doctors to withhold such care, but it was held to have been preempted by EMTALA in the Baby K case), the literature on the topic of medical futility is voluminous. For views that doctors should not be required (ethically or legally) to render care they believe to be futile, see, for example, Howard Brody, The Physician's Role in Determining Futility, 42 J. AM. GERIATRICS Soc'y 875 (1994); John J. Paris & Frank E. Reardon, Physician Refusal of Requests for Futile or Ineffective Interventions, 1 CAMBRIDGE Q. HEALTHCARE ETHICS 127 (1992); Lawrence J. Schneiderman & Nancy S. Jecker, Is the Treatment Beneficial, Experimental, or Futile?, 5 CAMBRIDGE Q. HEALTHCARE ETHICS 248 (1996). For contrary views that doctors do have such an obligation, see, for example, Felicia Ackerman, The Significance of a Wish, HASTINGS CENTER REP., July-Aug. 1991, at 27; Robert M. Veatch, Why Physicians Cannot Determine If Care Is Futile, 42 J. AM. GERIATRICS Soc'y 871 (1994); Susan Wolf, Near Death—In the Moment of Decision,
ing in conflicting court interpretations of existing laws, such as with breast cancer treatment litigation; or by the passionate calls that there “ought be a law,” such as there is over the issue of physician-assisted suicide, causing litigation going all the way to the Supreme Court and heated debates in a multitude of state legislatures. To move in the direction of patients’ rights to


89. Insurers and employers have attempted to exclude, by the terms of the health insurance policy, costly treatments which have not yet been scientifically proven to be beneficial or which they consider still experimental. A common area of litigation has been over high-dose chemotherapy with autologous bone marrow transplant (HDC/ABMT) or with peripheral stem cell recovery (HDC/PSCR) for advanced breast cancer. Courts have split in their interpretations of these contractual limitations. Some courts have construed such contractual exclusions against the insurers by finding the policy language ambiguous, thus finding that the patients were entitled to coverage. See, e.g., Bailey v. Blue Cross & Blue Shield of Va., 67 F.3d 53 (4th Cir. 1995); Frendreis v. Blue Cross & Blue Shield of Mich., 873 F. Supp. 1153 (N.D. Ill. 1995). Other courts have held that the contractual exclusions unambiguously precluded coverage. See, e.g., Bechtold v. Physicians Health Plan of N. Ind., 19 F.3d 322 (7th Cir. 1994); Fuji v. Benefit Trust Life Ins. Co., 18 F.3d 1405 (7th Cir. 1994). See generally John A. Bourdeau, Annotation, Propriety of Denial of Medical or Hospital Benefits for Investigative, Educational, or Experimental Medical Procedures Pursuant to Exclusion Contained in ERISA-Governed Health Plan, 122 A.L.R. Fed. 1 (1998) (in § 3, collecting cases involving denials of high-dose chemotherapy and autologous bone marrow transplant as treatment for breast cancer); Norman Daniels & James E. Sabin, Last Chance Therapies and Managed Care: Pluralism, Fair Procedures, and Legitimacy, Hastings Center Rep., Mar.-Apr. 1998, at 27 (1998) (analyzing how health plans can make fair determinations about when to cover as-yet unproven and costly treatments). Some litigation has been brought under the anti-discrimination laws, raising the question whether a health plan’s denial of coverage for treatment of breast cancer by high-dose chemotherapy and autologous bone marrow transplant (HDC/ABMT) on the grounds that treatment was experimental constitutes discrimination under Americans with Disabilities Act. See Henderson v. Bodine Aluminum, 70 F.3d 958 (8th Cir. 1995) (arguably YES, remanding case to district court). See generally Laurie Dechery, Note, Preferential Treatment or Discriminatory Standards: Do Employer-Provided Insurance Plans Violate Title VII When They Exclude Treatment for Breast Cancer?, 80 Minn. L. Rev. 945 (1996) (arguing such policy exclusions constitute discrimination under Title VII).

90. The U.S. Supreme Court has ruled that mentally competent, terminally ill patients do not have a right protected by the federal constitution to receive a physician’s assistance in committing suicide by obtaining a prescription of lethal drugs. See Vacco v. Quill, 521 U.S. 793 (1997) (finding no denial of Equal Protection under 14th Amendment); Washington v. Glucksberg, 521 U.S. 702 (1997) (finding no liberty interest under Due Process Clause of 14th Amendment). The issue of physician-assisted suicide has prompted legislative activity at both the federal level, see, e.g., Federal Assisted Suicide Funding
WHY LAW PERVERDES MEDICINE

receive treatment inevitably entails a move beyond the bedside and into the offices and boardrooms of health care providers and payers. Any claim that patients have a right to receive a certain kind of medical care, or a certain quality of medical care, inevitably raises the question, "Who's going to pay for it?" It is at this point that the concerns of medical ethics begin to merge with those of business ethics, to which this essay now turns.

III. ETHICS IN THE BOARDROOM: THE EVOLUTION OF ORGANIZATION ETHICS AND CORPORATE HEALTH LAW

A. Everybody Is a Patient Advocate These Days

Although the medical profession may not have been among the vanguard of patients' rights activists in the past, in the last few years it has increasingly warmed to the role of patient advocate.91

Restriction Act, 42 U.S.C. § 14401 (Supp. 1997) (prohibiting use of federal funds to subsidize physician-assisted suicide), and the state level. At least 37 states and territories have statutes which specifically ban assisted suicide. See Stephanie Graboyes-Russo, Too Costly Too Live: The Moral Hazards of a Decision in Washington v. Glucksberg and Vacco v. Quill, 51 U. MIAMI L. Rev. 907, 912 n.29 (1997) (collecting statutes). In several other states, assisted suicide is illegal under case law or negligent homicide statutes. See id. at 912-13 n.30 (citing laws or cases in Alabama, Wyoming, North Carolina, South Carolina, Ohio, and Massachusetts). Under state statutes authorizing advance directives, such as living wills or durable powers of attorney for health care, 45 States and the District of Columbia expressly disapprove of assisted suicide or mercy killing. See Edward R. Grant & Paul Benjamin Linton, Relief or Reproach: Euthanasia Rights in the Wake of Measure 16, 74 OR. L. Rev. 449, 462-63 nn.44-46 (1995). With the exception of Oregon, discussed infra, no state expressly authorizes the practice of assisted suicide. In addition, since 1994, proposals to legalize assisted suicide have been introduced in at least seventeen different state legislatures, yet none has been enacted. See Glucksberg, 521 U.S. at 717 n.15. After two voter referendums, Oregon has passed a law permitting physician assistance in hastening death under certain circumstances. See OR. Rev. STAT. § 127.800 (1996). For a report on Oregon's experience with its new law, see Arthur E. Chin et al., Legalized Physician-Assisted Suicide In Oregon—The First Year's Experience, 340 NEW. ENG. J. MED. 577 (1999).

91. See Thrust into the Spotlight, AM. MED. NEWS, Aug. 17, 1998, at 21. Dr. E. Ratcliffe Anderson Jr., Executive Vice President of the AMA, characterized the heart of the AMA's work as "doing what is right for patients," and he said pushing for a federal patients' bill of rights was one of the highest AMA priorities "that places everything else on the back burner." Id.; see also infra note 92. This new campaign for adoption of a patients' bill of rights at the federal level broadens the AMA's earlier efforts "for these patient protections in piecemeal fashion—one issue at a time, often one state at a time." Thomas R. Reardon, From the AMA Board Chair:AMA to Continue to Push for "Patient Bill of Rights", AM. MED. NEWS, Dec. 22, 1997, at 17, 19. A primary focus of AMA advocacy will continue to be patient protection. See The Big Picture, AM. MED. NEWS, Mar. 8, 1999. See also supra notes 23-31 (discussing federal proposals and state legislation for patients' bill of rights). It was not until 1996 that the editors at the
And the medical profession is not alone. While it may have taken many individual patient lawsuits and state-by-state legislative initiatives to establish patients' rights to consent to and to refuse medical treatment over the past several decades, in the past few years, many groups have come forward and made it their priority to champion the rights of patients. "Patient protection acts" and "patients' bills of rights" seem to have sprung up everywhere as people seem keen to heed the rallying call of patients' rights. All of a sudden, everybody is a patient advocate. In Congress, the AMA has been waging a "battle for strong patient protection legislation that will support our right as physicians to deliver medically appropriate care to our patients—and to support the rights of our patients themselves."92 The American Hospital Association has revised its own Patient Bill of Rights.93 The American Association of Health Plans has added new patient protections to its initiative called, "Putting Patients First."94 One of the biggest

Journal of the American Medical Association announced the inauguration of a new column in the journal devoted to "the patient-physician relationship," calling it the "center of medicine" and urging physicians to "resist any compromises of the trust this relationship requires." Richard M. Glass, The Patient-Physician Relationship: JAMA Focuses on the Center of Medicine, 275 JAMA 147 (1996). The first featured article addressed to this now-central subject chronicled the history of "patient-centered medicine." Christine Laine & Frank Davidoff, Patient-Centered Medicine: A Professional Evolution, 275 JAMA 152 (1996).


debates on Capitol Hill during the past two years has been over competing Democratic and Republican proposals for a patients' bill of rights.95 Why now is everyone clamoring to portray themselves as friends of patients?

Perhaps the patient has so many friends these days because, as the old saying goes, "The enemy of my enemy is my friend." An editorial in a leading medical journal began with dramatic war-like language: "The patient-physician relationship is under siege."96 The AMA's patient protection campaigns and the competing proposals for a patients' bill of rights are largely targeted at perceived ethical abuses by managed care companies and payers of health care services.97 Doctors and hospitals now see themselves, or at least portray themselves, as aligned with patients as they struggle in the larger battle against their common enemy—insurance companies, HMOs, and others who pay for health care services.98

As was earlier observed in the context of the doctor-patient relationship,99 the invitation to get the law involved in ethical conflicts is nothing new. Whenever there is a social sense of wrong, injustice, or abuse of power, those who feel harmed turn to the law for protection. Today, the clarion call for patient protection legislation reflects a widespread societal concern about potentially ethically abusive practices among those who pay for health care services. Those who feel themselves hurt by such practices—the people who provide those services as well as the patients who receive them—rally for new laws, backed up by sanctions, to demonstrate societal intolerance of such behaviors. The call for law is a call for society to lay down the ethical ground rules, not just as before within the doctor-patient relationship, but now in the whole health care industry.100

95. See supra notes 23-31.
96. Glass, supra note 91, at 147. Note also the AMA's "battle" language to describe its campaign for patient protection legislation. See id.
97. See AMA Advocates, supra note 92, at 310 ("The American Medical Association has launched an intensive, nationwide campaign that it hopes will result in the enactment of a 'bill of rights' to protect patients from abusive health plan practices.").
98. See Aggressive AMA, supra note 92, at 21 (The AMA campaign "emphasizes the rights of both patients and physicians, which . . . are intertwined. . . . If the physician stands up to the health plan, it is the physician who suffers. If the physician is forced to buckle under, it is the patient who suffers.").
99. See supra note 77 and accompanying text.
100. No less a figure than Dr. Arnold Relman, editor emeritus of the New England Journal of Medicine, has in the past urged: "State and federal legislatures must be prepared to develop, together with organized medicine, laws that will define the limits of ethical practice." Janice Perrone, Physician, Police Thyself:
B. JCAHO's Accreditation Requirement for a Code of Organization

Ethics: Law Packs Ethics with a Punch

In 1995, JCAHO saw clearly how the changing marketplace for health care was placing new economic and ethical pressures on health care providers. At that time, the Joint Commission created a new accreditation standard on organization ethics. The new standard required a hospital to implement a "code of ethical behavior" on the following activities: marketing; patient admission, transfer, and discharge; billing practices; and the relationship of the organization and its staff to other health care providers, educational institutions, and payers.101 In 1998, JCAHO added to this accreditation standard for an organization ethics code the requirement that a hospital "protects the integrity of clinical decision-making," regardless of its compensation or risk-sharing arrangements with its leaders, managers, clinical staff, and licensed independent practitioners.102

What prompted JCAHO in the mid-1990s to get serious about business ethics in health care organizations? After all, its accreditation standards already addressed medical ethics and patients' rights.103 JCAHO was probably not just jumping on the bandwagon of corporate mission statements and business ethics codes.104 Rather, JCAHO was concerned that, in the ever increasingly competitive health care environment, health care organizations might be tempted to compromise on patient care. A spokesman for the Commission flatly stated that the newly adopted 1995 accreditation requirements were "guided by the

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104. See Francis J. Aguilars, Managing Corporate Ethics 61 (1994) ("By one account, over 80 percent of major corporations have adopted codes of ethics.").
times, and the current environment in health care suggests a need for standards that address conflict of interest statements and a code of ethical behavior. We must assure that contractual . . . agreements never compromise patient care." According to the Commission, the role of ethics in health care, whether medical ethics or business ethics, is fundamentally to assure quality of patient care: "The question to be considered is always, from an ethical standpoint, will this business practice improve the quality of health care for patients. The answer to that question ultimately will guide each decision." 

What is interesting about the Commission’s targeting these particular activities in the new organization ethics code requirement—marketing, billing, patient admissions and discharge, conflicts of interest, and compensation arrangements—is that these same activities are also the current targets of the most intense legal scrutiny in the history of health care law enforcement. Because of rapid changes in health care markets, increased competition, and an increased focus on constraining costs, redoubled efforts are being made to ensure legal—as well as ethical—behavior by health care organizations. The temptation for health care organizations to put profits ahead of patients is causing a societal backlash that concerns not just the professional accreditors, but law enforcers as well.

As illustrated below, for each business practice which JCAHO briefly identifies for inclusion in a hospital’s organization ethics code, there is a corresponding host of laws, regulations, and litigation addressing the same conduct. JCAHO says simply: “The code ensures that the hospital conducts its business practices and patient care practices in an honest, decent, and proper manner.” Increasingly called upon to define the thresholds of ethical practice, the law packs this straightforward ethical ideal with a punch of regulatory complexity and criminal and civil liability. The threat of that punch—far more than the accreditation requirement for an ethics code—has fostered a virtual industry of corporate compliance programs in health care organizations today. After exploring how the law reinforces each of the organization ethics standards of JCAHO through regulation and potential liability, this essay will turn to the obvious question: Why didn’t JCAHO simply say, “Obey the law”?

105. Managed Care Brings a Demand for Institutional Ethics Policies, 10 Med. Ethics Advisor 125 [hereinafter Managed Care].
106. Id. at 128.
107. JCAHO 1998 Standards, supra note 102, at 55 (setting out, for mandatory compliance, the “Intent of RI.4 Through RI.4.2”).
1. Billing Practices

JCAHO briefly noted in its 1995 accreditation manual: "To support ethical operations, an organization must have in place a mechanism to ensure that patients are billed for only those services and care provided." A simple, clear, straightforward ethical proposition: bill only for the services you actually perform or the care you actually provide. Alleged violations of this ethical proposition have created a virtual firestorm of investigations and litigation throughout the health care industry. Industry concern over the government's crackdown on fraud and abuse topped the Top 10 List of health law developments for 1998 and ranked second for 1999. Health care fraud enforcement has become a top priority at the Department of Justice, which recovered $1.2 billion from its enforcement activities in 1997.

JCAHO's ethical standard to ensure proper billing has been dwarfed by a legion of law enforcement activities addressing hospital billing practices. In the past few years, the federal government has pursued alleged hospital fraud, much of it in the billing area, through at least six major enforcement initiatives: Lab-Scam, the 72-Hour Window Project, the Lab Unbundling

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108. Compare 2 1995 JCAHO Manual, supra note 101, at 23 (requiring that an organization have in place the mechanism described), with JCAHO 1998 Standards ("The code ensures that the hospital conducts its business and patient care practices in an honest, decent, and proper manner.").


110. See Roundup: DOJ Recovered $1.2 Billion in Fiscal 1997 in Fight Against Health Fraud, Report Says, 7 Health L. Rep. (BNA) 1793 (1998) [hereinafter DOJ Recovered]. See also Peter Eisler & Barbara Pearson, Feds Triple Health Fraud Cases / Crackdown Hits Medicare Billing Abuses, USA Today, Feb. 23, 1999, at 1A (stating that U.S. attorneys prosecuted 552 criminal cases of health care fraud in 1997; the Medicare program lost an estimated $12.6 billion last year (six percent of its expenditures) to fraud and abuse; and civil and criminal enforcement actions in 1998 resulted in approximately $500 million in judgments, settlements, and fines).

111. See Ursala Himali, Fraud: Government Approach to Investigating False Claims Varies By Initiative, 6 Health L. Rep. (BNA) 45, d39 (1997) ("law enforcement's approach to investigating the submission of false claims to federal and state health insurance programs is multidimensional, and there is no end in sight to the initiatives being launched").

112. See id. (referring to an investigation targeting fraudulent billing by the nation's largest independent clinical laboratories).

113. See Himali, supra note 111, at 48 ("Since December 1994, the Pennsylvania U.S. Attorney's Office has been investigating abuses of the '72-hour rule' which stipulates that hospitals cannot submit separate bills to cover certain outpatient tests if the Medicare patient is admitted to the hospital within 72 hours of the test."); Health Fraud Comprises Two-Thirds of Pending DOJ Civil Fraud
Project, the Physicians at Teaching Hospitals (PATH) initiative, the diagnosis-related grouping upcoding project, and the transfer/discharge project. As if these government-initiated investigations into alleged health care billing fraud were not enough, hospitals also face the prospect of multi-million dollar litigation in *qui tam* lawsuits initiated by private persons, or whistleblowers (frequently disgruntled former employees), under the False Claims Act. To prevent false billing, or at least to forestall prosecution and litigation for alleged false billing, health care providers are hiring attorneys, accountants, and consultants to create corporate compliance programs in record numbers.

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14. See Himali, *supra* note 111 (this project is also known as "Operation Bad Bundle"); *Health Fraud Comprises, supra* note 113, at 2 ("The Lab Unbundling Project focuses on inappropriately high payments for tests that are performed concurrently on automated equipment.").

15. See Himali, *supra* note 111, at 50 (targeting over 130 teaching hospitals under PATH as of the end of 1997, "the government is investigating Medicare Part B billings by teaching physicians for services performed by interns and residents").

16. See *id.* at 51 (project investigates "hospitals that bill consistently for complex pneumonia, which has a significantly higher DRG than simple pneumonia"); *Feds Eye Circumstances, Clinical Pathways in DRG Upcoding False Claims Cases, Physician Manager,* Oct. 2, 1998, at 12 ("DRG upcoding is shaping up into a major national false claims investigation. The feds say some hospitals exaggerate patients' symptoms and secondary diagnoses to bill Medicare for a more-lucrative version of the correct DRG. Examples: pneumonia and septicemia.").

17. See Himali, *supra* note 111, at 52: At issue in the transfer/discharge initiative is when a patient is transferred from one hospital to another but it is reported as having been a discharge so that the first hospital the patient was admitted to receives the full DRG payment as opposed to what the hospital should have received—a per diem amount based on the number of days the patient was at the hospital, not to exceed the full DRG. The second hospital the patient is transferred to should receive the full DRG. "If the [Medicare] program is billed for two full DRGs, there has been a false claim."


19. See Thomas E. Bartrum & L. Edward Bryant, *The Brave New World of Health Care Compliance Programs,* 6 Annals Health L. 51 (1997); Karen Boxer & Helaine Gregory, *Compliance is Good for Your Corporate Health,* 1057 PLI/Corp...
2. Marketing and Advertising

JCAHO's new accreditation standard also addressed marketing practices: "To support ethical operations, an organization must have in place a mechanism to ensure that . . . marketing . . . practices are conducted in an ethical manner." JCAHO "recommends that the hospital adopt a statement of marketing and public relations practices that addresses issues of truth, accuracy, fairness, and responsibility to patients, community and the larger public." These are good, solid, ethical principles: truth, honesty, fairness. Prior to 1995, the law had already reflected these principles with legislation and regulations governing truth in advertising. The Federal Trade Commission (FTC) has long had authority to investigate and enjoin false or misleading advertising under federal law which prohibits unfair acts and practices and unfair methods of competition. So, for example, the FTC has challenged as false, deceptive, or misleading the advertising claims of health care providers involving diet and weight loss programs, success rates for infertility services and cancer treatments, surgery for bowel-related diseases, and even the efficacy of Prozac as a cure for obes-


120. 1 1995 JCAHO MANUAL, supra note 101, at 23.
126. See 56 Fed. Reg. 56228 (1991) (proposed consent agreement with analysis to aid public comment, requiring Minneapolis cosmetic surgeon to disclose risks and have scientific evidence supporting his claims for benefits of liposuction procedure).
127. See 57 Fed. Reg. 26848 (June 16, 1992) (proposed consent agreement with analysis to aid public comment concerning NME Hospitals, d/b/a/ Continent Ostomy Centers).
One hospital chain has been challenged twice by the FTC for misleading advertising of ileostomy and in vitro fertilization services through its specialized clinics. JCAHO's new standard to ensure ethical marketing practices seems to address the same concerns as are already addressed by federal and state consumer protection laws.

3. Patient Admission, Transfer, and Discharge

JCAHO's new accreditation standard also meant that: "To support ethical operations, an organization must have in place a mechanism to ensure that . . . admission, transfer, and discharge practices are conducted in an ethical manner." In 1995, JCAHO said it wanted to ensure that: "Admissions and transfer policies are not based on patient or organization economics. Only patients whose specific condition or disease cannot be safely treated at the organization are diverted, refused admission, or transferred to another organization." Not coincidentally, this ethical concern is soundly backed up by numerous laws to ensure that, due to financial pressures or incentives, hospitals do not prematurely discharge a patient before he or she is medically stable; that private hospitals do not engage in "patient dumping" of uninsured patients onto public hospitals; or that health care organizations do not engage in other discriminatory practices.

130. 2 1995 JCAHO MANUAL, supra note 101, at 23.
131. Id.
132. State law theories of abandonment, negligence, or intentional or negligent infliction of emotional distress can create hospital liability for denial of treatment or premature discharge. See, e.g., Muse v. Charter Hosp. of Winston-Salem, 452 S.E.2d 589, 594 (N.C. Ct. App. 1995) (holding that hospital owed duty not to institute policy or practice which requires that patients be discharged when their insurance benefits ran out). In 1994, the Health Care Financing Administration (HCFA) published a final rule that makes it a condition of participation in Medicare hospitals to have a discharge planning process for patients. See 42 C.F.R. § 482.43 (1998). HCFA was concerned that lack of adequate discharge planning might result in "systematic underservice of beneficiary needs", which its requirements were designed to guard against. Medicare: HCFA Publishes Final Rule on Hospital Discharge Planning Process, DAILY REP. FOR EXECUTIVES, Dec. 13, 1994, at 237 d12. Interestingly, HCFA expressly found that compliance with JCAHO accreditation standards for discharge planning satisfy the new rule. See 42 C.F.R. § 482.43 (1996).
refusals of treatment based on economics or prejudice, such as fear of AIDS.134

4. Compensation Arrangements and Risk-Sharing

In 1998, JCAHO added to its accreditation standard for an organization ethics code a requirement that the hospital "protects the integrity of clinical decision-making" regardless of its compensation or risk-sharing financial arrangements with its administrators or clinicians. This new requirement is doubtless responsive to emerging ethical concerns about health care providers who may have financial pressures or incentives to deny or limit patient care. One of these concerns is that both individual and institutional providers may feel pressured to cut their costs by "under-utilizing" medical resources, specifically by failing to provide necessary medical care.135 Managed-care programs in


135. The Office of the Inspector General was so concerned about the prospect (and reports) of hospitals providing financial incentives to doctors to reduce the amount of care they provide patients that it proposed a specific rule allowing civil monetary penalties against (1) a hospital "who knowingly makes a payment, directly or indirectly, overtly or covertly, in cash or in kind, to a physician as an inducement to reduce or limit services provided to an individual who is eligible for Medicare or Medicaid benefits and who is under the direct care of the physician that knowingly accepts receipt of such payment," and (2) a physician who knowingly receives such a payment. 59 Fed. Reg. 61571, 61574 (1994). Critics of the proposed rule argued that "its vague wording could jeopardize almost any hospital incentive plan under managed care—including capitation's withholds and risk pools." Julie Johnsson, No Incentives to Limit Care: New Federal Rule Bans Hospitals from Encouraging Reduced Services, Am. MED. NEWS, Dec. 26, 1994, at 1, 24. The Final Rule allows civil penalties against physicians who do not meet Medicare/Medicaid requirements for incentive plans. See 42 C.F.R. § 1003.100 (1998). In turn, the Medicare/Medicaid participation requirements state that a specified insurer "may operate a physician incentive plan only if . . .[n]o specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services . . . ." 42 C.F.R. § 417.479 (1998). Recently, the
particular have been the subject of considerable commentary on this score. Whether or not these financial considerations have actually resulted in limitations or denials of medically necessary care by providers or insurers is still hotly debated. Widespread

OIG said in a special advisory bulletin that a common hospital practice known as "gainsharing"—whereby hospitals financially reward physicians who help achieve cost-savings for the hospitals—implicated these concerns and was illegal under 42 U.S.C. § 1128A(b)(1) and (2). See Katherine E. Harris & Barbara Yuill, IG Strikes Down Gainsharing, Says CMP Law Bans Incentives to Curb Care, 8 HEALTH L. REP. (BNA) 1133 (1999). See generally D. McCarty Thornton & Kevin G. McAnaney, Recent Commentary Distorts HHS IG's Gainsharing Special Advisory Bulletin, 8 HEALTH L. REP. (BNA) 1522 (1999).

136. See, e.g., American Medical Association, Council on Ethical and Judicial Affairs, Ethical Issues in Managed Care, 273 JAMA 330, 330-35 (1995) ("[I]n their zeal to control utilization, managed care plans may withhold appropriate diagnostic procedures or treatment modalities for patients."); Kevin Grumbach et al., Primary Care Physicians' Experience of Financial Incentives in Managed-Care Systems, 339 NEW ENG. J. MED. 1516 (1998) (in one study, 57% of surveyed primary care physicians reported that they were being rewarded by managed care organizations for limiting referrals, and 17% of those believed this compromised the quality of patient care); Alan L. Hillman, Financial Incentives for Physicians in HMOs: Is There a Conflict of Interest?, 317 NEW ENG. J. MED. 1743 (1987); Alan L. Hillman et al., How Do Financial Incentives Affect Physicians' Clinical Decisions and the Financial Performance of Health Maintenance Organizations?, 321 NEW ENG. J. MED. 86, 86-92 (1989); Marc A. Rodwin, Conflicts in Managed Care, 332 NEW ENG. J. MED. 604, 605 (1995) ("Many financial incentives for physicians to control costs create conflicts of interest that compromise the interests of patients. Most [HMOs and a few PPOs] increase or decrease a physician's compensation depending on the cost implications of his or her clinical choices or the organization's profitability."); supra note 27.

137. Some studies find a difference in the provision of treatment to patients depending upon the payment systems for the providers. See, e.g., John Rapoport et al., Resource Utilization Among Intensive Care Patients: Managed Care vs. Traditional Insurance, 152 ARCH. INT. MED. 2207 (1992); Sheldon Retchin et al., Outcomes of Stroke Patients in Medicare Fee for Service and Managed Care, 278 JAMA 119 (1997). Other studies have found little or no difference in the care provided to patients under different payment systems. See, e.g., Derek C. Angus et al., The Effect of Managed Care on ICU Length of Stay: Implications for Medicare, 276 JAMA 1075 (1996); Geri Aston, Study: HMO Hospital Stays Same as Fee for Service, AM. MED. NEWS, Nov. 3, 1997, at 6; Sheldon Greenfield et al., Outcomes of Patients with Hypertension and Non-Insulin-Dependent Diabetes Mellitus Treated By Different Systems and Specialties: Result from the Medical Outcomes Study, 274 JAMA 1436 (1995). Some studies have suggested that the provision of less care due to financial incentives may result in improved quality of care. See e.g., Daniel J. Cher & Leslie A. Lenert, Method of Medicare Reimbursement and the Rate of Potentially Ineffective Care of Critically Ill Patients, 278 JAMA 1001 (1997). See generally Barry R. Furrow, Regulating the Managed Care Revolution: Private Accreditation and a New System Ethos, 43 VILL. L. REV. 361, 384 (1998) (collecting many studies and concluding that the evidence "supports claims that managed care has substantial advantages over FFS [traditional fee-for-service payment] plans not only in controlling costs, but also in maintaining or even improving the quality of care for subscribers"). Many observers have called for more research to determine
societal concern that they have, however, is reflected in the tremendous amount of recent litigation by patients alleging that they have been improperly denied such care by their health plans, doctors, and hospitals based on claims under federal law as well as under traditional state law theories such as malpractice, corporate negligence, fraud, breach of fiduciary duty, and other traditional state law claims. Indeed, the most strenuously con-


138. The explosion in litigation in this area has been matched by the amount of academic writing on it in recent years. For just a few of the array of articles collecting court cases and discussing the effect of federal ERISA pre-emption on this litigation, see, for example, Brian P. Battaglia, The Shift Toward Managed Care and Emerging Liability Claims Arising from Utilization Management and Financial Incentive Arrangements Between Health Care Providers and Payers, 19 U. ARK. LITTLE ROCK L.J. 155 (1997); Jose L. Gonzalez, A Managed Care Organization's Medical Malpractice Liability for Denial of Care: The Lost World, 35 HOUS. L. REV. 715 (1998); Peter D. Jacobson & Scott D. Pomfret, Form, Function, and Managed Care Torts: Achieving Fairness and Equity in ERISA Jurisprudence, 35 HOUS. L. REV. 985 (1998); Jeffrey E. Shuren, Legal Accountability for Utilization Review in ERISA Health Plans, 77 N.C. L. REV. 731 (1999).

HMO denials of medically necessary or medically appropriate care have received considerable negative publicity, see supra note 28, and have been the subject of numerous lawsuits. During the fall of 1999, a series of class actions against HMOs was initiated across the country for alleged violations of federal law under the Racketeer Influenced and Corrupt Organizations (RICO) Act and the Employee Retirement Income Security Act (ERISA). See Plan Liability: Class Actions Against HMOs Climb as 'REPAIR Team, Physicians File More Suits, 8 HEALTH L. REP. (BNA) 1887 (Dec. 2, 1999). Individual actions brought under various federal and state law theories are also increasingly common. See, e.g., In re U.S. Healthcare, 193 F.3d 151 (3d Cir. 1999) (allowing negligence claims); Giles v. NYLCare Health Plans, 172 F.3d 332 (5th Cir. 1999) (allowing vicarious liability and negligence claims); Dukes v. U.S. Healthcare, 57 F.3d 350 (3d Cir. 1995) (allowing negligence and malpractice claims); Moscovitch v. Danbury Hosp., 25 F. Supp. 74 (D. Conn. 1998) (allowing negligence claim); Drolet v. Healthsource, 968 F. Supp. 757 (D. N.H. 1997) (allowing misrepresentation claim under ERISA); Petrovich v. Share Health Plan of Ill., 719 N.E.2d 756 (Ill. 1999) (allowing vicarious liability claim); Neade v. Portes, 710 N.E.2d 418 (Ill. App. Ct. 1999) (allowing breach of fiduciary duty claim); Pappas v. Asbel, 724 A.2d 889 (Pa. 1999) (allowing negligence claim) cert. pet. filed, 67 USLW 3717 (1999). Although numerous state laws already exist that could be used to address wrongful denials of benefits, one problem for plaintiffs has been that courts have often interpreted ERISA to pre-empt these state law claims. See, e.g., Andrews-Clarke v. Travelers Ins. Co., 984 F. Supp. 49 (D. Mass.1997):

This case, thus, becomes yet another illustration of the glaring need for Congress to amend ERISA to account for the changing realities of the modern healthcare system. . . . ERISA has evolved into a shield of
WHY LAW PERVERDES MEDICINE

tested issue in the whole controversy these past two years over proposals for a patients' bill of rights has been whether patients ought to be allowed to sue their health care providers and payers for improper—and potentially unethical—denial of benefits under these traditional state law theories of liability. The JCAHO standard thus identifies an ethical principle, whose potential breach has already been the target of considerable legal attention in recent years.

5. Conflicts of Interest

In 1995, the JCAHO organization ethics standard as originally implemented was addressed to the somewhat more "garden variety" of conflicts of interests that may arise in contracts


Whether patients will be allowed to sue their health plans under state law theories, or whether such claims will continue to be preempted by ERISA, remains one of the most debated issues in managed care reform and proposals for patient protection legislation. See Susan Webster, *Managed Care Regulation Tops 1999 Health Issues List; Fraud Crackdown Ranked Second*, 8 Health L. Rep. (BNA) 5 (1999) (managed care reform is the number one health law issue for 1999, with ERISA preemption being a major component of the debate); see also Aston, *A Big Win*, supra note 23 ("biggest area of disagreement is whether people with employer-based health coverage should be able to sue their health plan for malpractice if they think the plan has denied them a medically necessary benefit"); Geri Aston, *Health Plan Liability Erupts at Center of House Battle*, Am. Med. News, Sept. 27, 1999, at 1 ("the battle over managed care patient protections in the House has boiled down to one issue: health plan liability"). While so far only a few states, such as Texas and Georgia, have enacted laws to allow HMOs to be sued for their coverage decisions such as denials of benefits, 31 states have indicated that health plan liability will continue to be a high priority issue in their legislatures during the coming year. See Stephen Piontek, *Life or Money?*, Nat’l Underwriter Life & Health—Fin. Serv. Ed., Aug. 3, 1998, at 49 ("The nub of all the disputing over patient protections going on in Congress now really comes down to whether patients should be allowed to hold their health plans legally liable for adverse decisions."); State-By-State Report, supra note 24; see also supra note 29. Although numerous state laws already exist that could be used to address wrongful denials of benefits, the problem has been that federal ERISA law has been interpreted to preempt these state law claims. See generally Farrell, supra note 138.
between a health care organization and its suppliers. This sort of conflict of interest, potentially involving self-dealing by the members of a corporate governing board, is standard fare for legal sanction in state corporations laws. The federal anti-kickback laws are also designed to prevent ethical abuses caused by self-interested transactions. In particular, the federal Office of the Inspector General has published numerous Special Fraud Alerts dealing with potential violations of the anti-kickback laws.

140. 2 1995 JCAHO MANUAL, supra note 101, at 23 ("The governing body needs to review relationships carefully and ensure that its mission to its patients and community is not harmed by any contractual relationship. . . . The proposed contract is approved or rejected based on best-bid practices and the potential for conflict of interest."). Some areas where conflicts may arise in a health care institutional setting are relationships between a hospital pharmacy and drug companies, and an institution's financial interests in the research conducted on its premises. See, e.g., Ezekiel J. Emanuel & Daniel Steiner, Sounding Board: Institutional Conflict of Interest, 332 NEW ENG. J. MED. 262 (1995) ("Financial conflicts of interest in a research setting can adversely affect patient care, teaching, and research. . . . Less attention has been paid to the conflicts of interest that arise when health care institutions have a financial stake in the research conducted in their laboratories and clinics."); Managed Care, supra note 105, at 126:

The conduct of hospital pharmacists and physicians who sit on hospital formulary committees that review and determine hospital drug supplies can be compromised by drug company marketing enticements. . . . The capacity for drug companies to influence hospital formulary development is just one of many reasons why it is incumbent upon hospitals to develop a code of ethical behavior.

141. See American Hospital Association, Management Advisory: Resolution of Conflicts of Interest (1990):

Duality of interest can raise the potential for a conflict of interest when the personal interests of institutional officials come in conflict with the interests of the institution. . . . The laws of the various states prohibit or severely restrict actions made under a conflict of interest by a fiduciary, that is, an individual occupying a special position of trust and responsibility. Officers, governing board members, and in some states other officials of health care institutions should be guided by the laws governing a fiduciary. Ethics are supported by these laws. See also Boston Children's Heart Found., Inc. v. Nadal-Ginard, 73 F.3d 429 (1st Cir. 1996) (former president of a nonprofit corporation breached his fiduciary duty by failing to disclose to the board that he was the director of another organization performing work in the same general area at the same hospital where he worked on behalf of the corporation); Mary v. Lupin Found., 609 So.2d 184 (La. 1992) (holding that cause of action for breach of fiduciary duties is made out upon allegations that inside directors of a nonprofit corporation sold a hospital (the corporation's principal asset) for $5 million less than its actual value and secretly structured an improper side deal with the prospective purchaser).

142. See 42 U.S.C. § 1320a-7b(b) (soliciting or receiving illegal remuneration); see also 42 U.S.C. § 1395nn (prohibiting "physician self-referrals," or referrals to providers in which referring physician has a financial interest).
in the health care field, and involving potential conflicts of interest which can compromise the quality of patient care.\textsuperscript{143}

\textbf{C. Why Didn't JCAHO Simply Say, "Obey the Law"?}

The question naturally arises, why did JCAHO decide to require hospitals to adopt a code of organization ethics when there were already numerous federal and state laws on the books addressed to the very same subjects? Why not just tell the hospitals, "Obey the law"? Why would JCAHO require a code of organization ethics that seems to duplicate everything the law already requires health care organizations to do? Was it just window-dressing? Perhaps, but there are a couple of less cynical possibilities.

1. Professional Self-Policing

One possibility is that the Commission is only doing what is required of all sectors of society that want to be called "professions": they insist on self-regulation and self-policing. That is one of the key distinguishing features between a business and a profession. A profession engages in self-regulation.\textsuperscript{144} The law enforcers cannot catch everyone; a lot of misconduct falls between the cracks.\textsuperscript{145} Perhaps JCAHO recognized that a pro-

\begin{itemize}
\item \textsuperscript{143} The OIG has issued ten "Special Fraud Alerts" to the health care industry warning of potential enforcement targets and addressing the following topic areas that could violate the anti-kickback statute: joint venture arrangements; routine waiver of Medicare Part B co-payments and deductibles; hospital incentives to referring physicians; prescription drug marketing practices; arrangements for the provision of clinical laboratory services; home health fraud; fraud and abuse in the provision of medical supplies to nursing facilities; fraud and abuse in the provision of services in nursing facilities; fraud and abuse in nursing home arrangements with hospices; and physician liability for certifications in the provision of medical equipment and supplies and home health services. \textit{See} 59 Fed. Reg. 65373 (1994) (publishing first five alerts, addressing prescription drug marketing schemes, physician investors in joint ventures, waivers of co-payments or deductibles, hospital incentive payments to physicians, and clinical lab services); Dept. of Health and Human Serv, Office of the Sec., Office of Ins. Gen., \textit{Special Fraud Alerts}, (visited March 13, 1999) <http://www.hhs.gov/progorg/oig/frdalrt/index.htm>.
\item \textsuperscript{144} "The hallmark of professionalism is self-regulation," said AMA's then Executive Vice-President James Todd, M.D. Perrone, \textit{supra} note 100, at 3.
\item \textsuperscript{145} EMTALA provides a good example, for there is evidence that government enforcement has been insufficient to prevent ongoing violations of the statute and persistent patient-dumping practices. \textit{See} Dame, \textit{supra} note 19, at 11-21; Scaduto, \textit{supra} note 16, at 968-75. Fraud and abuse enforcement is another example. While in 1997 the DOJ did recover $1.2 billion in settlements and judgments, hired an additional 285 attorneys and agents devoted exclusively to health care fraud, and opened more than 4,000 civil fraud cases (nearly double the number from the year before), \textit{see} DOJ Recovered, \textit{supra} note
\end{itemize}
fession worthy of the name will take it upon itself to uncover and correct wrong-doing. JCAHO understandably takes the position that the primary purpose of health care organizations is to provide patients with appropriate, high-quality health care. Beyond legal compliance, ethical conduct by health care providers ultimately promotes the quality of care delivered to patients.

2. Going Beyond the Law

Another, related possibility is that JCAHO is deliberately reflecting a key distinction between law and ethics, in the sense of recognizing that ethics is aspirational, and covers a lot of conduct not necessarily prohibited by law. Law may set the floors below which behavior may not sink without incurring societal sanction, but ethics creates the ceilings that good people aspire to reach. JCAHO's inclusion of marketing practices in the code of ethics is a good example here. The law's attention to ethical marketing practices focuses on setting ground rules: is the advertising truthful—not false, deceptive, or misleading? If yes, then it is legal. Ethics' attention to marketing practices goes further and might ask, is the advertising responsible and socially appropriate?

110, these efforts address only a fraction of the overall loss to the federal government through erroneous payments to providers, see Kristen Hallam, HCFA Raises the Bar for Fraud Detection, MODERN HEALTHCARE, Feb. 15, 1999 (reporting that an audit by the Department of Health and Human Services of Medicare overpayments revealed that $20.9 billion (11%) of all Medicare payments in 1997 were erroneous overpayments; the error rate decreased in 1998, down to 7%, or $12.6 billion, in overpayments). Federal enforcers know that they are targeting only the tip of the iceberg in bringing civil and criminal actions, and they have relied on a variety of forms of self-help and self-policing, including reliance on (1) so-called whistleblowers to bring qui tam actions under the False Claims Act, see supra note 118, (2) the voluntary corporate compliance programs described in this essay, and (3) voluntary disclosures by health care organizations who discover illegal conduct. See Aaron M. Altschuler et al., Health Care Fraud, 35 Am. CRIM. L. REV. 841 (1998). The OIG has initiated a Provider Self-Disclosure Protocol to encourage providers to voluntarily disclose violations of the fraud laws. See 63 Fed. Reg. 58399 (1998); see also OIG's website (visited Dec. 12, 1999) <http://www.hhs.gov/progorg/oig> (voluntary disclosure will not necessarily protect providers from civil or criminal action, but self-reporting "could be a mitigating factor in OIG's recommendations to prosecuting agencies").

146. See supra note 105 and accompanying text.
147. See Mary J. Pitzer, Health-Care Firms Realizing Need to Clear Up Ethical Fuzzy Areas, L.A. TIMES, June 8, 1998, at D22 ("Although these [corporate compliance] programs start with regulatory compliance, they often don't end there. Billing problems, financial conflicts of interest, harassment and staffing levels all can fall under the ethics umbrella. And they all ultimately affect quality of care if resources are diverted from patient care.").
Does it, for example, encourage unhealthy practices, such as was alleged in the marketing of breast milk substitutes in Third World countries? Does health care advertising create, rather than simply channel, demand for health care services? Does it reflect negative social stereotyping? On each of the issues required to be included in a hospital's organization ethics code, JCAHO has implicitly challenged hospitals to go beyond the legal minimums.

Through the new accreditation standard on organization ethics, JCAHO hopes to instill ethical sensitivity throughout the institution, rather than allow ethics to be seen as the purview of the few members of the ethics committee. As a JCAHO spokesperson said, "Ethical behavior ideally will become a daily interest of management and staff." But will people really care about ethical ideals when the federal agents are knocking at the door, or the accountants and lawyers keep interrupting with new and improved corporate compliance programs? Once they all leave, is it "OK everybody, back to work"?

D. Corporate Compliance Programs: Example of the Legal Power/Ethical Pitfall Problem

Unfortunately, corporate compliance programs may be doing to organization ethics what informed consent forms did to personal integrity. See Leonard J. Weber, The Ethics of Health Care Advertising, Mich. Hosp., Dec. 1988, at 29, 31 (discussing the distinction between a "personal integrity" model of ethics (which tends to be law's focus) and a "social impact" model of ethics). Weber observes:

The 'personal integrity' approach to business advertising focuses on the relationship of advertising to truth-telling and to individual freedom, two important values in personal ethics. . . . [Under this approach,] Advertising should not be deceptive or make false claims . . . Advertising should not be so manipulative that individuals cannot resist . . . The 'social impact' approach to business ethics . . . insists . . . that there are other important ethical concerns as well, that it is not sufficient to be concerned about manipulation or deception.

The author goes on to discuss advertising that may promote harmful practices, create needs, or reinforce harmful stereotypes:

It is important to ask what message is being communicated and received about health care when a hospital advertises its childbirth services by stressing the medical complications associated with labor and delivery. It is important to ask what message is being communicated and received when a hospital's advertising stresses the life-saving 'miracles' that take place because of the latest in high-technology medicine. It is important to ask what the impact of these messages is on the public's expectations of the kind of health care they can expect to receive.

Id. at 31-32.

148. See Leonard J. Weber, The Ethics of Health Care Advertising, Mich. Hosp., Dec. 1988, at 29, 31 (discussing the distinction between a "personal integrity" model of ethics (which tends to be law's focus) and a "social impact" model of ethics). Weber observes:

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Id. at 31-32.

149. Changes in Accreditation, supra note 121, at 7.
medical ethics: They distract us from thinking about ethics. We can get so focused on complying with "the letter of the law" that we are too tired or busy or frustrated to wonder about adhering to its ethical "spirit." We understandably become satisfied that compliance with the legal minimums was all that ethics required us to do.

Here again, the very power of the law creates pitfalls for ethical reflection. We open up the daily and weekly health care newspapers and journals, and what do we see? We see evidence of the law's punch everywhere. We see the reports on who is being investigated, who is being indicted, who is going to jail, who paid how many millions of dollars in fines to settle the investigations, who paid how many millions more when the investigators would not settle and demanded fines and prison terms, and so forth. Is it any wonder that ethical ideals get lost in the legal shuffle?

Even if it is understandable that our obsession with law distracting us from ethical reflection, that distraction is not necessary or even necessarily excusable. Neither the law nor the devil makes us do it. The law does not make us forget our ethical moorings; we just allow ourselves to get side-tracked. Strong corporate compliance programs under the law do not have to supplant even stronger ethical direction by management. The law in this area even often reminds us that its purpose is about ethics.


151. For a discussion contrasting two approaches to corporate compliance programs, one that assimilates compliance into corporate culture and one that is "superimposed as a bureaucratic replacement for clear conscience," see William Nolan, Corporate Compliance, Corporate Culture: A Way to Avoid Having the Lawyers' Run Health Care Organizations, Behavioral Health Mgmt., Jan.-Feb. 1998, at 34. See also Pitzer, supra note 147 ("To have just a compliance-driven program will not ultimately be successful. . . . Ethics without compliance is a
The settlement agreements between the government and health care organizations in health care fraud cases, for example, are often called "corporate integrity agreements" which set up "corporate integrity programs" within the settling health care organization. These formal agreements may acknowledge at the very outset that the settling organization "has expressed an interest in demonstrating, notwithstanding [its alleged misconduct, that it] can be trusted to deal fairly and honestly with the Government . . . [and that it possesses] the high degree of business integrity required of a provider participating in federally-funded health care programs."152

But those are just the legal forms, and the forms themselves so often blind us to the ethical substance behind them. The ethical objectives become buried under the pages and pages of forms, the mountains and mountains of documents: the subpoenas, the filings, the records, the interrogatories, the financial statements, the releases, the contracts, the disclaimers, the memorandums, the charts, the codes, the questionnaires, the reports, and the compliance plans themselves.153 The paper trail seems to lead us into ethical darkness. Who can help but laugh and think JCAHO was just spitting in the wind back in the mid-1990s when it said about its new accreditation standard for an organization code of ethics that: "In some real way this code of ethics has to be more than just nice words on a piece of paper"?154

And yet JCAHO was right for the very reason that everyone is now drowning in paper. This avalanche of paper is in no small
part a result of the fact that too often, too many people in health care were not paying attention to the basic ethical question, "What would be the right thing to do under these circumstances?" In the administrative offices and boardrooms of health care organizations, too many people simply did not ask whether their billing practices accurately reflected their health care services. If some even noticed that board members, administrators, or clinicians were engaging in self-interested transactions with contractors or suppliers, they looked the other way. Through aggressive prosecutions and defensive corporate compliance programs designed to forestall prosecutions, the law now forces examination of the basic ethical question in a variety of contexts: billing, advertising, patient care, conflicts of interest, and compensation arrangements. It is nonetheless ironic that the law's very power in focusing attention on ethical issues can so easily create the pitfall of accepting law's minimum requirements as ethical maximums. As earlier observed, the law itself has never taken it out of the hands of the health care professionals to strive for the ethical high ground.

IV. Ethics in Health Care: An Alternative to Law

It is easy to be cynical about law and ethics and to believe that, inverting the old saying, in law "it's not the principle, it's the money." Unfortunately, it is just as easy to be cynical and say the same thing about medicine and ethics, or about business and ethics. It is possible, for example, to transform the medical ethics concerns about the provision of futile medical treatment or physician-assisted suicide into financial concerns about saving money rather than saving lives. Certainly cynics can (and do) argue that many of the recent calls for patients' bills of rights have less to do with protecting patients than with protecting doctors, employers, or even the managed care companies themselves. 155 Newspapers report as front-page news the views of

155. See Peter T. Kilborn, In Managed Care, "Consumer" Laws Benefit Doctors, N.Y. TIMES, Feb. 16, 1998, at A1:
Under the banner of consumer protection, legislators are wrestling with the complaints of specialist physicians who have been losing their patients, fees and autonomy, those of insurance and managed care companies whose profits have sunk in competition for patients, and those employers who pay for much of the coverage. . . . ["The quip going around is that this is physician protection, not consumer protection."] See also Kassirer, supra note 94 (Kassirer, expressing skepticism about the AAHP's "Putting Patients First" initiative because it has less to do with protecting patients than protecting managed care companies from increased federal and state regulation).
those who say that all the recent patient protection initiatives are really not about patients, but about "protecting the incomes, jobs and turf of the health care system's biggest and richest vested interests."  

Unless we are prepared to say that money turns all of the phrases—"legal ethics," or "business ethics," or "medical ethics"—into oxymorons, we should acknowledge that professional conduct and business conduct ought to be consistent with ethical conduct. The question then becomes, "Who is going to ensure ethical conduct in health care?" The lawyers or the accountants? Compliance officers? The patients? The hospital chaplain? An institutional ethics committee?

This last candidate has increasingly been saddled with this responsibility in recent years. Having previously gotten organized to address the ethical issues involving patient care, these


157. See generally Leonard H. Friedman & Grant T. Savage, Can Ethical Management and Managed Care Coexist?, HEALTH CARE MGMT. REV., Apr. 1, 1998, at 56 ("notwithstanding the pervasive cynicism about the state of business ethics," the authors propose a model for health care management which combines business ethics and biomedical ethics, positing that "the values of truth-telling, avoiding harm, respecting authority, and honoring agreements have a higher institutional priority than earning short-term profits. In the for-profit world of managed care, the values of social equity and fairness should be added given the unique status of health care in our society.").

158. The Office of the Inspector General has suggested it may be preferable, where feasible, to separate the roles of general counsel or chief financial officer from the role of chief compliance officer, to ensure independent judgment on behalf of the hospital. See OIG Compliance Guidance for Hospitals, 63 Fed. Reg. 8987-02, at 8993 n.35 (1998).

159. To have any effect within a health care organization, a compliance office must have high-level authority and be able to exercise independent judgment, a tall order for any employee charged with uncovering his or her employer's ethically or legally questionable conduct. See Kirsten Hallam, A Compliance Problem: HHS, Others Rule out CFOs, Counsels as Ethics Czars, MODERN HEALTHCARE, Oct. 5, 1998, at 116 (Columbia/HCA's head of compliance said that a "compliance officer should look at a situation without assuming the company is right and without assuming management's point of view," while Quorum Health Group's head of compliance observed that a compliance officer has to be "fearlessly" independent: "you can't always be everyone's friend").

160. Interestingly, both JCAHO and the federal government have recently initiated programs to recruit patients to report potentially questionable practices by their health care providers. See JCAHO Sets Up Toll-Free Hot Line, 8 HEALTH L. REP. (BNA) 554 (1999) (toll-free hot line to encourage patients, their families, and others to "share concerns regarding quality-of-care issues at accredited health care organizations"); Pear, supra note 150 ("The federal government will begin enlisting millions of Medicare beneficiaries in its war against Medicare fraud next week, urging them to report billing errors, overcharges and other evidence of possible wrong-doing by their own doctors and hospitals.").
hospital committees are now often asked to adopt and implement the organization ethics code as well.\textsuperscript{161} It seems a lot to ask one committee—and usually a volunteer committee at that—to take the brunt of ensuring the ethical integrity of an entire institution. Ethics committees already have far too much on their plate. It is humanly impossible for members of an ethics committee to be able to understand, let alone absorb and process, all of the ethical dilemmas faced both at the bedside and in the boardrooms of health care organizations.\textsuperscript{162}

In any event, should ethics be handled by committee in the first place? Admittedly, the law had a hand in promoting ethics committees a few decades ago.\textsuperscript{163} Before the law's intervention,

\begin{footnotes}
\item[161] For an overview of the history, role, and function of hospital ethics committees, see William S. Andereck, \textit{Development of a Hospital Ethics Committee: Lessons from Five Years of Case Consultation}, 1 \textsc{Cambridge Q. Healthcare Ethics} 41 (1992); George A. Annas, \textit{Ethics Committees: From Ethical Comfort to Ethical Cover}, \textsc{Hastings Center Rep.}, May-June 1991, at 18-21. See also infra note 166.
\item[162] Some hospitals have divided the ethics committees in two, "[one] is for clinical ethics and the other for organization ethics." John C. Fletcher, \textit{Responding to JCAHO Standards: Everybody's Business}, 7 \textsc{J. Clin. Ethics} 182, 183 (1996). Even handling one typical piece of a clinical ethics committee work—the individual patient case consultation—requires a diversity of people and strategies which alone can stretch the capacities of committee members to perform adequately. See Cynthia B. Cohen, \textit{Avoiding "Cloudcuckooland" in Ethics Committee Case Review: Matching Models to Issues and Concerns}, 20 \textsc{J.L. Med. & Health Care} 294 (1992).
\item[163] Referring to a 1975 \textit{Baylor Law Review} article, the court in \textit{In re Quinlan} suggested that a hospital ethics committee could assist the family and physicians in making treatment decisions for incompetent patients. See \textit{In re Quinlan}, 355 A.2d 647, 648 (N.J. 1976) ("I suggest that it would be more appropriate to provide a regular forum for more input and dialogue in individual situations and to allow the responsibility of these judgments to be shared."). A later New Jersey court commented, "The suggestion of such a committee traces its origins to \textit{Quinlan}, where the court contemplated an 'ethics committee' to confirm the medical prognosis of the patient and, thereby, to immunize the doctor and the hospital from civil and criminal liability." \textit{In re Jobes}, 529 A.2d 434, 463 (N.J. 1987). Although not expressly calling for ethics "committees", JCAHO began in 1992 in its accreditation standards to require hospitals to have in place "a mechanism(s) for the consideration of ethical issues arising in the care of patients, and to provide education to caregivers and patients on ethical issues in health care." \textsc{1 Joint Commission on Accreditation of Healthcare Organizations}, 1992 \textsc{Accreditation Manual for Hospitals}, Standard RI. 1.1.6.1 (1992). See also Annas, supra note 35, at 6:
\item[166] The strategy of using ethics committees to provide 'comfort' for physicians and others worried about either legal liability or public reaction has prospered. Ethics committees have grown from an anomalous entity to provide ethical comfort to a few, to an almost standard entity to provide ethical cover for many. Without the threat of legal liability and community disapproval (which could lead to new laws), ethics committees would probably not have developed at all.
\end{footnotes}
there generally were no institutional forums for raising, let alone formally addressing, ethical questions in health care organizations. Should health care providers continue to rely so heavily on ethics by committee today? Like law, the very existence of an ethics committee poses a pitfall for ethical reflection in the institution. Whenever any committee is charged with a task, one problem is the tendency of everybody else in the organization to refer that task to that committee. Everyone can say, "Hey, that's their job, that's not my job." 164

The point is, ethics is everybody's job. 165 Institutional ethics committees can certainly help everybody do their job. The committees can educate; they can set policy; they can even consult on cases from time to time. 166 It is the responsibility of the highest management in the institution, however, to instill in everybody a sense that ethics is their individual priority. Perhaps the best alternative to having the law take the lead in promoting ethical conduct in a health care institution is for the members of its

As suggested in this essay, a similar charge may well be leveled at corporate compliance programs.

164. Corsino, supra note 82, at 177 ("[O]verreliance on bioethics committees in meeting JCAHO standards can result in ... a disincentive for clinicians and administrators to understand and promote patients' rights as a regular part of daily patient care."). Corsino's observations in the context of medical ethics concerns is equally apt in the context of organization ethics issues: "If ethics committees become proxies with sole accountability for [JCAHO] standards, then hospital staff may never acquire the wisdom, commitment and multi-disciplinary participation necessary to fully incorporate patient rights into daily patient care." Id. at 180. When ethics is handled by committee, other problems can arise as well. See Gregory J. Hayes, Ethics Committees: Group Process Concerns and the Need for Research, 4 CAMBRIDGE Q. HEALTHCARE ETHICS 83, 84 (1995) (identifying various problems with group dynamics, such as a lack of diversity within the committee, dominance by a few powerful members, drifting away from the original mission, and failure to consider alternatives adequately in an effort to reach consensus quickly); Diane E. Hoffman, Evaluating Ethics Committees: A View from the Outside, 71 MILLBANK Q. 677, 683 (1993) (noting a concern about potentially conflicting roles of an ethics committee in trying to serve the interests of both caregivers and patients); Giles R. Scofield, Ethics Consultation: The Least Dangerous Profession?, 2 CAMBRIDGE Q. HEALTHCARE ETHICS 417 (1993) (noting common criticisms of ethics committees that they are time consuming and unwieldy and suffer from "group-think" and "non-think").

165. See Fletcher, supra note 162, at 182 (observing that "the ethics of patient care is everybody's business").

166. These three functions are frequently viewed as the primary ones for hospital ethics committees. See, e.g., David C. Blake, The Hospital Ethics Committee: Health Care's Moral Conscience or White Elephant?, HASTINGS CENTER REP., Jan.-Feb. 1992, at 6; John C. Fletcher & Mark Siegler, What Are the Goals of Ethics Consultation? A Consensus Statement, 7 J. CLINICAL ETHICS 122 (1996).
highest management to shoulder that responsibility—visibly, credibly, and passionately.  

Ethics in health care inevitably means asking how conduct will affect the quality of care of patients. Those who serve in the highest levels of a health care organization have the greatest opportunity—and responsibility—for ensuring its ethical integrity. Like the law, management has the power to pack ethics with a punch. It only needs the will to do so. The highest levels of administration have the power—and the duty—to set the ethical tone of an organization, to demonstrate their ethical commitment throughout every department of the institution, and to provide ongoing oversight and sanctions, if necessary. Ethics committees can greatly support management and can even take the lead in charting an institution's responses to ethical dilemmas as they arise. But ethics committees, like ethics in general, serve primarily an aspirational role. They often lack the power within the institution to make ethics happen. The highest administrative levels in the organization do have this power, and they have the duty to exercise it responsibly.

167. A case in point may be Columbia/HCA Healthcare Corp. In the wake of numerous government investigations in recent years:

[Columbia/HCA says it is now] putting teeth into its new ethics and compliance program. ... [T]he new emphasis of Columbia's top management has gone beyond demonstrating legal and regulatory compliance to establishing a "set of aspirations in terms of overall conduct that doesn't have to do with the law," says Alan Yuspeth, Columbia's senior vice president of ethics and compliance. "It has to do with what we're about as an organization, what kind of culture we want to have."

Vida Foubister, Fostering a New Corporate Culture, Am. MED. NEWS, Aug. 10, 1998, at 12. Some observers remain skeptical, however. George J. Annas believes: "It's not a serious attempt to do ethics. ... It's a serious attempt to avoid legal liability." Id. Whether skeptical or not, health care observers are watching the compliance programs at both Columbia/HCA and Tenet Healthcare Corp., whose predecessor National Medical Enterprises paid millions to settle fraud charges in the mid-1990s, as potential models for genuine attempts to "do ethics." Pitzer, supra note 147. The government has also urged that responsibility for ethics as well as legal compliance begin at the top levels of a health care organization. See Justice Department to Increase, supra note 154 (the DOJ urges "good stewardship" as a top priority); OIG Compliance Guidance for Hospitals, 63 Fed. Reg. 8987, 8990 n.8 (1998):

The OIG strongly encourages high-level involvement by the hospital's governing body, Chief Executive Officer, Chief Operating Officer, General Counsel, and Chief Financial Officer, as well as other medical personnel as appropriate, in the development of standards of conduct. Such involvement should help communicate a strong and explicit statement of compliance goals and standards.

168. See supra notes 105-06, 146-47 and accompanying text.
Management must both ask the hard questions, and make sure that they get answered. If it does not, then eventually society will—through law. This essay has traced the history of law's influence on the ethical evolution of health care providers. It has illustrated how, whether health care professionals liked it or not, the law has had to address difficult questions in medical ethics and how it is currently addressing serious questions in business ethics. Many people do not like the ways that the law (through courts, legislatures, or enforcement agencies) handles these hard questions. Many people vehemently disagree with the law's resolution of ethical dilemmas, or detest the power of law to coerce societal views of ethical behavior. Until those within the health care profession and industry assume leadership and take responsibility to define and debate the ethical questions and continually refine the ethical answers—in other words, to go beyond the law and to do the right thing—history is probably bound to repeat itself. And then the law's presence will loom even larger in the ethical life of health care organizations.

169. See Fletcher, supra note 162, at 183 (observing that accountability for meeting JCAHO standards does not rest with the ethics committee: "That obligation clearly falls on the governing body and the most senior administrators and clinicians."). See also Weber, supra note 148, at 32:

Management may need to develop an institutional framework for assessing the ethics of any proposed advertising. The key is to have the right persons ask the right questions. The right questions are questions about both the content and the impact of the advertising. . . . The right persons are those who are willing to ask—and answer—the hard questions, no matter who is proposing or sponsoring the activity.

170. See Annas, supra note 35, at 10. Prof. Annas's suggestion about ethics committees is equally applicable to management:

What we might try . . . is to engage in a real effort to see if multidisciplinary committees can "do ethics" and encourage real change in our hospitals and medical care facilities to go beyond the law and risk management and to "do the right thing." Good ethics (and a good ethics committee) begins where the law ends.

See also Foubister, supra note 167 ("[A] corporate-led compliance program that goes beyond the minimum required by law is critical to any business, whether it's defense or health care."); Pitzer, supra note 147 (according to Alan Yuspeth, senior vice president at Columbia/HCA Healthcare Corp. to oversee its ethics and compliance program: "At a minimum, we want to ensure compliance with complex laws and regulations. . . . But in a larger sense, we want to do the right thing.").