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Double Agent Dilemma

The Canadian Physician: Patient Advocate and Social Agent

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Abstract

This thesis considers the rationalization of health care in Canada. It focuses on the conflicting roles modern physicians play in our system, acting as both patient advocate and social agent. It begins by tracing the origin of both of these duties. It then examines the ethical, professional, and legal issues which arise in the limited circumstances where front-line physicians must participate in the rationing of health care. It offers a framework for resolving the double agent dilemma and states five interlocking recommendations which are the building blocks of the resolution.

Cette thèse considère le rationnement des soins de la santé au Canada. Elle se concentre sur deux rôles contradictoires qu'occupent les médecins dans notre système: défenseur des intérêts du patient et représentant des intérêts de la société. En première étape, elle trace l'origine de ces deux rôles. En suite, elle éxamine les questions d'éthiques, les questions professionelles, et les questions légales qui s'élèvent lorsqu'un médecin doit participer dans la rationalisation des soins de la santé. Elle termine en offrant une charpente pour résoudre le dilemme causé par un conflit entre ces deux résponsabilités.

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SECTION I

Introduction

A physician performing a radiological exam may use either of two dyes, A or B, for her patient. They are equal in quality of radiological image. Dye A reduces the risk of minor to moderate side effects by seventy percent. There is no difference in the serious side effects or fatalities caused by either dye. Dye A costs $60 more per exam than dye B. Should a physician use dye A or dye B on her patient? If dye A were used universally it would cost the Canadian health care system an additional 50 million dollars annually. Should this be a factor in the physician's decision?

A physician in such a situation faces a conflict between the best interests of her patient and the interests of society as a whole. Her patient would likely experience less discomfort with the more expensive dye. It is simple to argue that ensuring greater comfort for a patient already under the great stress caused by illness is worth an extra $60. If her patient is her only concern, the physician should ignore the cost to the Canadian health care system of her treatment decisions. However, if every radiology patient received dye A, other services available within the fixed overall health care budget would be reduced by $50 million. As she is the front-line manager allocating resources, the physician will bear some

responsibility for the just and equitable use of health care resources.

The first principle of the Canadian Medical Association's code of ethics holds that physicians must consider first the well-being of their patients. The patient-first ethic is a common element that spans the evolution of the healer throughout most of the history of medicine. However, a relatively new role has been added to a physician's duties. Physicians are the authority figures in our health care system. They have the expert knowledge and control over the allocation of services and resources. By virtue of their position, physicians are the front-line managers of one of society's largest and most valuable resources, health care.

Thus the physician has two distinct duties: first as patient advocate; second as social advocate. It is important to clarify the mandate of each. *The duty owed to the patient is to respect the patient, in particular the patient's right to inviolability, autonomy, and self-determination, and to advance his best interests. The duty owed to society is to represent society's interest in health care, and to use the publicly funded health care system, and its resources, to promote health and high quality care consistent with the public values of justice, accessibility, and efficiency.* These duties may not be equal in importance, but they can, and do conflict.

The physician as 'double agent'[1] results both from the physician's changing role in our society and health care's evolution. At the dawn of the 21st century, we witness the most rapid advance of knowledge and therapeutic power in medicine's history. The relationship of society, health care, and medical professionalism poses many new challenges. The 'double agent' dilemma raises fundamental questions about this relationship. They cannot be answered by the medical profession, law-makers, or policy-makers working alone. A multidisciplinary approach is necessary to reflect the many interests at stake.

A good starting point is to review the remarkably consistent tradition of the healer in our society which has developed amidst a radically changing health care landscape.[2] How did this conflict of interest arise? When and how did each of these two physician duties originate? If we examine the sources that over time have defined the physician's role and her relationship with society, and define the ethics, law, professional values, and social values, governing this relationship, we may today construct a framework to resolve the modern conflict in the physician's double duty.

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[1]This term is offered by Marcia Angell in M. Angell, "The Doctor as Double Agent" (1993) 3 Kennedy Institute of Ethics J. 279.
[2]P. Sohl & H.A. Bassford, "Codes of Medical Ethics: Traditional Foundations and Contemporary Practice" (1986) 22 Social Science and Medicine 1175.

We must pose tough questions about the role of the physician in our society. Does the patient-centred ethic that has guided physician services since Hippocrates still apply today? What are the safeguards protecting it? What are the pressures to re-evaluate and reform this ethic? What is the origin of the physician's duty to society? Is it rooted in professional obligations? How are the competing roles of a physician as patient advocate and social agent manifested, prioritized, and calibrated or weighted? What are the limits of each duty? Finally, how can these roles be reconciled?

To put the fundamental question in a relative and historically sensitive context, how far should physicians move away from the traditional patient-centred focus to incorporate concerns for the general welfare of society? Irvine puts the question succinctly: "Against a backdrop of straitened public financing and increasing political pressure for cost-effectiveness in health care, how far may physicians legally or ethically qualify their clinical judgments with non-clinical considerations, when directing the course of therapy for each patient?"[3]

This paper is divided into two small and two large sections. Section I, Introduction, raises the fundamental questions of the physician's double duty. Section IV, Conclusions, provides a framework for resolving the double duty conflict and states

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[3]J.C. Irvine, "The Physician's Duty in the Age of Cost Containment" (1994) 22 Man. L. J. 345.

five interlocking recommendations which are the essential building blocks of the resolution.

Section II, the first large section, employs three chapters to trace the evolution of the double agent dilemma. Chapter 1 examines the changing role and status of the physician in Canadian society from the tradition of the Hippocratic healer to the modern medical professional. Chapter 2 charts society's interest in health care from quality assurance, then to accessibility, then to just and equitable and finally efficient use of public health care resources. It examines how this progression spawned the physician's double duty. Chapter 3 examines the physician's role in our current system and the strains this conflict of interest is causing within the profession and among the public.

Section III, the second large section, uses six chapters to analyze the pertinent ethical, professional, and tort law considerations of the double duty. Chapter 4 introduces these three sources of medical professional norms, setting the stage for a more in-depth analysis. Chapter 5 examines the ethical debate around the second duty, the physician's role in rationing health care resources. Chapter 6 considers professionalism and the profession's leadership role. Chapter 7 discusses the second duty in tort law in Canadian common law jurisdictions, and the evolving legal recognition of the physician's duty to society in rationing health care resources. Chapter 8 takes this further

with a review of tort law's doctrine of negligence and its standard of care. Chapter 9 explores informed consent and Chapter 10 considers the growing role of fiduciary obligations.

This paper is a consideration of the rationalization of health care in the current Canadian health care system. It focuses on the physician's conflict of a double duty- to patient and society- and to the principles of tort law in Canadian common law jurisdictions.

SECTION II

Chapter 1

The Building of the Medical Profession

Since the time of Hippocrates in Ancient Greece, the practice of medicine has experienced many changes. The healer's obligation to advance the patient's welfare however, is one of the few constant tenets. Modern codes of medical ethics are very clear; the patient' s welfare is the physician's primary concern. Increasingly however, Canadian physicians, are expected to represent, and respond to, the interests of the society whose health resources they manage.

Thus, a physician has a dual role as patient advocate and social agent. Conflicts of interest in medicine, particularly financial ones, have received much attention in the last decade.

In financial conflicts of interest, the physician stands to receive direct monetary benefit. The physician as double agent receives less direct benefit by advancing either the patient's interest or that of society.[4] Thus the competing interests of

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[4]A physician whose patients know she will advance their interests regardless of the costs to society may well incur greater loyalty from her patients. This reputation may also increase her patient 'clientel'. Accordingly, she may increase the volume of her practice. She may also be less exposed to potential malpractice law suits. In contrast a physician who conserves resources may gain hospital privileges. Both of these, however, are considered minimal benefits though they may deserve further investigation.

patient and society are not addressed by traditional restraints on physicians' private interests overriding patients' interests.

The conflict between a patient's interests and those of society is also somewhat unique because both have strong moral claims on the physician.

In a publicly funded system, such as Canada's, health care is considered a public good.[5] Resources devoted to health care are taken away from other societal interests such as education, research, defence and security or special interests such as agricultural subsidies and job training programmes. Thus, total investment and the allocation of that investment, is very much a political issue involving social choices in addition to medical decisions.[6]

This view of health care as a social resource creates an obligation for those managing this resource- physicians- to reflect the values of the general public. Since physicians became a self-regulating profession and were granted a monopoly on the provision of medical services, they have become the dominant figures in health care. As the largely autonomous authority in this field, the medical profession has

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[5]Health care is often referred to as a public good. However, it is not a classic public good like national defence. Its status as a public good will be discussed in section II.

[6]R. G. Evans, "Ethical Ambiguities and Economic Consequences in the Allocation of Health Care" in B. Dickens & M. Ouellete,eds., *Health Care, Ethics and Law*, (Montreal: Les Éditions Thémis, 1993) 51.

also assumed an obligation to represent the public interest in health care.[7] As our society's interests in its publicly funded health care system have changed, so has the content of the obligation to represent these interests.[8] In the last two decades, physicians' obligations to society have come to include "the responsibility of physicians to promote fair access to health care resources,"[9] and the duty to ensure that "their patients should not benefit unduly at the expense of others."[10]

In this modern description of a physician's obligation to society, there is a clear conflict with the commitment to act in the patient's best interests. This conflict is largely a construct of modern health care and social values. We should first understand how this conflict arose, and the principles and pressures shaping it. The physician's role has evolved from the Hippocratic healer to today's physician who must, among many responsibilities, act as a social agent. The following chapter will briefly trace this progression.

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[7]This progression will be described in greater detail later in this chapter. However, it should be noted here, that physicians first argued the necessity of a monopoly and autonomy in the provision of health care to allow them to better protect patients. The obligation to represent society arose later.

[8]This is the subject of the next chapter.

[9]Canadian Medical Association, "Code of Ethics" (1996) 6 CMA News 6, article 31.

[10]J.R. Williams & E.B. Beresford, "Physicians, Ethics and the Allocation of Health Care Resources" in Francoise Baylis *et al.*, eds., *Health Care Ethics in Canada* (Toronto: Harcourt Brace, 1995). This view is also presented by Frédéric Grunberg and John Williams, members of the Biomedical Ethics Committee, The Royal College of Physicians and Surgeons of Canada at the time in F. Grunberg & J. Williams, "Ethical Responsibilities of Physicians in the Allocation of Health Care Resources" (1988) 22 Annals of R.C.P.S.C. 311.

The traditional healer

Until relatively recently, the foundations of western medical ethics could be traced to the Hippocratic healers of Ancient Greece.[11] The Hippocratic Oath was embraced as the embodiment of truth in all ages wherever monotheism was the accepted creed.[12] The Oath established the precepts according to which the Hippocratic physicians practiced their art. It has two parts. The first part lays down the physician's duties to his teachers and his responsibility to transmit medical knowledge. The second part lays out the rules governing the physician's obligations to patients.[13] It includes the following covenant: "[t]he regimen I adopt shall be for the benefit of my patients according to my ability and judgment, and not for their hurt or for any wrong."[14] There is no mention of a physician's obligations to society or the community in which he works, nor reference to the public interest.[15]

The Hippocratic healers were only one of many competing schools of physicians offering their own treatments and healing techniques. Each sect protected its healing secrets from

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[11]E.D. Pellegrino, "The Metamorphosis of Medical Ethics" (1993) 269 JAMA 1158.

[12]L Edelstein, *Ancient Medicine*, (Baltimore: The Johns Hopkins Press, 1967) at 63.

[13]*Ibid.*at 7.

[14]The Hippocratic Oath taken from the from the *Encyclopedia Britannica*, 1947 ed., V. 15, "Hippocratic Collection" at 198, discussed in R. Crawshaw & C. Link, "Evolution of Form and Circumstance in Medical Oaths" (1996) 164 West. J. Med. 452.

[15]In contrast, the Canadian Medical Association's Code of Ethics has a section entitled "Responsibilities to Society", see *supra* note 9.

competitors and fought to attract a clientele. In this environment, the physician owed a duty to his teachers and his patients- those who enabled him to make a living. Society invested little in physicians; it made few claims upon them. The physician, then, had scant reason to cast himself as a social agent. Society had even less reason to consider the physician its agent.

The healer crosses the threshold

For most of its history, medical care has been the domain of independent healers with little state support or involvement. With the fall of the Roman Empire, medicine fell into decay. The Church rose in prominence and heavily influenced the practice and organization of medicine, especially in medieval Europe. By the 18th century, scientific, or orthodox, medicine was regaining part of its former prominence and distinguishing itself from religious practice and alternative, less scientific medicine.[16]

When European orthodox medicine, based on the scientific curriculum taught in university medical schools, was introduced to the new world of North America it was largely dissociated from the Church. But it was not a particularly powerful force in building the new societies. The practice of

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[16]J. Nancarrow Clarke, *Health, Illness, and Medicine in Canada*, (Toronto: McClelland & Stewart, 1990) at 163.

medicine had less effect upon the development and welfare of communities than the building of railways. As late as 1867[17], jurisdiction over health care and hospitals was assigned to the provinces in Canada.[18] Similarly, it was largely a state or local responsibility in the United States.[19] Health care was not a particularly costly field nor one of much national importance. Issues of national concern or entailing substantial public investment fell under federal jurisdiction as the federal government had a broader tax base.[20] Health care was not expected to be an important political issue. In contrast, plans for an east-west railway spanning the country could make, or break, a federal election.[21]

This view was justified by the fractured, impotent state of medical practice at the time. Before the mid-nineteenth century, medicine in North America was far from the organised monopolistic institution it is today. In a more agrarian society, individuals could not and did not depend on medical care from

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[17]Constitution Act, 1867(U.K.), 30 & 31 Vict., c.3.

[18]There is current debate over the scope of this jurisdiction. The federal government, for instance, retained responsibility for provision of health services to some specific groups of the population.

[19]The federal government assumed responsibility for specific groups such as seamen and the very poor. See M.I. Roemer, "Government's Role in American Medicine-A Brief Historical Survey" in Chester R. Burns, ed., *Legacies in Law and Medicine*, (New York: Science History Publications, 1977) 183.

[20]E. Vayda & R.B. Deber, "The Canadian Health Care System: A Developmental Overview" in C.D. Naylor, ed., *Canadian Health Care and the State*, (Montreal: McGill-Queen's University Press, 1992) 125.

[21]For a brief overview of the debate surrounding the creation of a national railway in Canada near the time of confederation, see, D. Morton, *A Short History of Canada*, 2nd ed. (Toronto: McClelland & Stewart, 1994) at 136.

a so-called physician.[22] In the communities where a physician's services were available, many people could not afford to pay for them. Much of medicine was practiced in the home. "Care of the sick was part of the domestic economy for which the wife assumed responsibility."[23] There was a general skepticism surrounding the claims of medicine. Further, many different disciplines claimed to practice medicine with a variety of training ranging from none, or self-taught, to orthodox physicians- products of a formal medical school with a scientifically based curriculum.

Thus, in the pre-industrial societies of the 18th and early 19th centuries, medicine's development as an organised and powerful profession was constrained by the public's low use of medical services and skepticism about their value.[24] One large obstacle was cost. In addition to the direct fee charged for a consultation, physicians charged for the travel time to get to a patient. As little as a mile of travel could double the cost of care.[25] Additionally, the time required to travel to a physician to seek help was too great a cost for many who could not spare the time from their responsibilities.[26]

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[22]P. Starr, *The Social Transformation of American Medicine*, (New York: Basic Books Inc., 1982) at 32.
[23]*Ibid.*
[24]*Ibid.* at 65.
[25]*Ibid.* at 67.
[26]*Ibid.*

The growth of cities, improved rail and road transportation, and finally the advent of the telephone, reduced the cost associated with a physician's services. The distance separating patient and physician decreased in many areas and it was easier to contact a physician or have a physician travel to see a patient. Furthermore, medical interventions became more effective as physicians were able to reach patients more quickly.[27]

Industrialization led to a greater separation of work from the home. Thus, it became more difficult to care for the sick at home. A dramatic rise in hospital numbers came with the 20th century spurred primarily by an increase in mental institutions. These developments helped transform an individualistic and self-reliant agrarian population into one that came to expect the intervention of a physician when illness struck. Public dependency on physicians' services increased.[28]

A wealthier society, larger patient base, reduced cost of care, and more effective medical interventions gave medicine greater authority. As Starr points out: "[a]cknowledged skills and cultural authority are to the professional classes what land and capital are to the propertied."[29] These were the medical

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[27] *Ibid.*
[28] *Ibid.*
[29] *Ibid.* at 79.

profession's source of wealth and status. As the public's belief in, and trust of, physicians rose, so did their social position.

These social changes led to a greater work volume for individual physicians. However, they also encouraged greater competition in health care service provision. More and more physicians trained in medical schools, as well as many other health practitioners such as homeopaths and mid-wives, now offered their services to the population.[30] Physicians, except for a small elite, remained in an insecure social position fighting to make a living from practicing their medical skills.

These pressures encouraged medical practitioners to organize themselves. Orthodox physicians began developing consensus on standards and criteria to exclude practitioners from the profession of medicine to promote their security and status as well as to regulate the quality of care offered. To increase their authority, physicians had to eliminate competition and weed out the less trained or 'quacks' practicing as physicians.[31] While higher standards of practice and education would benefit patient care, this mobilisation was largely motivated by a drive for greater security of status on physician's part.[32]

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[30] *Ibid.* at 67.
[31] *Ibid.* at 82.
[32] *Ibid.* at 90.

The genesis of an organized profession: exclusion

Orthodox physicians began attempts to regulate the provision of medical care seeking to exclude all but themselves in the mid-1700's. Until the late 19th century, however, there was little evidence distinguishing one school of practitioners as more effective than another. The first orthodox medical associations received little support from the state, press, or public in their attempts to restrict the practice of medicine.[33] These early associations were run by an elite group who "sought to control the occupation in [their] own image and to 'raise-up' the country healers within orthodox medicine or to exclude those beyond the pale."[34]

In Lower Canada, the governing powers were more receptive to physicians' lobbying than elsewhere. Established physicians raised fears that foreign trained physicians and quacks would do great harm to patients. In response, as early as 1750, the Intendant of New France enacted a bill restricting foreign physicians from the practice of medicine unless they first passed an exam. The motives were clear and contained in the preface to the bill: "...that these strangers whose ability is unknown treat the sick with little care and without giving them relief; distribute worthless remedies which give unsatisfactory

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[33]See R. Hamowy, *Canadian Medicine: a study in restricted entry*, (Vancouver: The Fraser Institute, 1984). For a review of initiatives in the United States see D.E. Konold, *A History of American Medical Ethics: 1847-1912*, (Madison: University of Wisconsin, 1962).

[34]D. Coburn, "State Authority, Medical Dominance, and the Trends in the Regulation of the Health Professions: The Ontario Case" (1993) 37 Social Science and Medicine 129 at 131.

results, not having all the experience necessary, and leading as a final result to abuses which are prejudicial to the well-being of the subjects of the King,..."[35]

Where medical associations were successful in lobbying for standards of training and licensing requirements, the legislation was largely unenforced doing little to restrict the practice of medicine by alternative practitioners. As the supply of orthodox physicians was short and growing more slowly than the population growth rate, there was little popular support for enforcing licensing requirements. People continued to consult a variety of practitioners by choice and out of necessity.[36] At this stage, the orthodox medical associations relied on self-regulation to set standards of practice and training. Great pressure was put on orthodox trained physicians to dissociate themselves from other sects. The American Medical Association's (AMA) first code of ethics went so far as to discourage "fraternal courtesy to irregular practitioners."[37] Self-regulation, however, was not particularly effective. Within the ranks of orthodox practitioners, there was little cohesion and unity.[38]

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[35] The bill is quoted in full in J.J. Heagerty, *Four Centuries of Medical History in Canada* , vol. 2 (Toronto: The Macmillan Company of Canada Ltd., 1928) at 315, and discussed in Hamowy, *supra* note 33 at 9.
[36]Hamowy, *supra* note 33.
[37]Starr *supra* note 22 at 90.
[38]Coburn *supra* note 34.

The making of the medical profession: legislative foundation

Attempts to organise the practice of medicine and secure a monopoly for traditional physicians gained momentum in the mid 19th century. Competing sects began to cooperate in advancing common interests. Further, medical services became increasingly complex and a more important resource in the lives of ordinary citizens. The state now had a greater incentive to intervene in medicine to protect the public welfare. Further, orthodox physicians continued to warn of the dangers of quacks and poorly trained physicians poisoning patients. The profession was also keenly aware of the need to eliminate these competitors to secure its own income. Thus, the state became concerned with controlling the quality of practice.[39]

It was not until the 19th century that provincial and state legislatures officially recognized the orthodox medical associations and gave them authority to set the standards of knowledge required to practice. Legislators delegated power to the medical profession to control the requirements to practice rather than maintain government involvement in the setting and enforcing of standards through state appointed examiners. Such legislation gave a monopoly to orthodox practitioners, on who and how to practice, by allowing them to control the requirements to practice medicine and to exclude from practice

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[39]Hamowy *supra* note 33.

those who did not meet their standards. The state, at the urging of the profession, created a self-regulating profession controlling medical care.[40]

This was a significant policy choice. It prevented practitioners trained in other traditions from practicing their chosen occupation. It did not go unchallenged. The United States Supreme Court in 1889 upheld state legislation requiring a diploma from a reputable medical college in order to practice medicine claiming such legislation "was intended to secure such skill and learning in the profession of medicine that the community might trust with confidence those receiving a license under authority of the state."[41] The state recognised that a specialized body of knowledge had to be mastered in order to practice medicine.[42] Rather than define the standards itself, the state passed this responsibility on to the professions and gave them the power to enforce their standards. US trends were followed at about the same pace in Canada.

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[40]See generally E. Friedson, *Profession of Medicine*, (New York: Dodd, Mead and Co., 1970), and D. Coburn, G.M. Torrance & J. M. Kaufert, "Medical Dominance in Canada in Historical Perspective: The Rise and Fall of Medicine?"(1983) 13 International J. Health Services 407.

[41]*Dent v. State of West Virginia*, 129 U.S. 114 (S.C. 1889), 9 S.Ct. 231 [hereinafter Dent].

[42]Yet, the development of the scientific body of knowledge at the heart of orthodox medicine was in its early stages of identifying, through scientific research, specific causes of disease. Most of the improvements in the health of the population related to social changes such as improved nutrition and sanitation, and a rising standard of living. See P. Conrad and R. Kern, *The Sociology of Health and Illness*, (New York: St. Martin's Press, 1990) at 137. The major advances in medical treatment began in the early 20th century. The 1920s were especially active as the discovery of insulin gave new confidence to the medical profession. See G. Sharpe, *The Law and Medicine in Canada*, 2d ed. (Toronto: Butterworths, 1987) at 2.

Obligations accompanying professionalism

The granting of a monopoly to orthodox physicians was less a recognition that they had superior skill and more a decision that this was the best way to organise increasingly valuable services. Thus, "[p]rofessionalism as a concept was developed and joined to the tradition of the healer as a means of organizing and supporting the provision of complex services to the population."[43] As the US Supreme Court acknowledged, the community needed to be able to trust medical practitioners and needed to be protected from any random treatment or approach to health being called medical care.[44]

In the mid 19th century, as medical associations were being given their professional status, society's interest in medicine was limited. The 'science based' healing power of medicine was in its infancy. Moreover, medical care, though more prolific, was still viewed as an individual's responsibility and not the state's. It was an individual's choice to consult a physician and pay the fees. State interest in ensuring the services of physicians was limited to extreme, marginal members of society, namely psychiatric patients. Even care for indigent people was not a major social priority at this stage.

The state intervened, as a consumer protection or public trust matter, to protect society's interest in quality care so

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[43]R.L. Cruess & S. R. Cruess, "Teaching Medicine as a Profession in the Service of Healing" (1997) 72 Academic Medicine 941 at 943.
[44]*Dent supra* note 41.

individuals could trust medical practitioners. They needed to know that if they did consult a physician they would receive good quality care. Medical societies were not given the power to control licensure and standards of education in order to improve people's access to care. This might have been better served by having more physicians of diverse training. The medical profession entered into a contract with society. State and provincial medical societies received the mandate to establish and maintain the standards of practice in order to serve society's interest in assured quality care.

It is important to highlight here that professional status was *granted* by society- a social contract or mutual covenant. As Friedson states, "The profession's privileged position is given by, not seized from, society, and it may be allowed to lapse or may even be taken away."[45] The profession of medicine claimed to serve the public. Self-regulation was portrayed as "a measure calculated to protect the interests of the public, as well as to advance the progress of medical science; ...these it is proposed to effect, by the organisation of the profession into a body;..."[46] The public must believe that the profession serves the public interest or it may limit or revoke professional autonomy, as happened in Canada when the state took over control of the health care market place to ensure public

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[45]E. Friedson, *Profession of Medicine*, (New York: Dodd, Mead & Company, 1970) at 73.
[46]"The Medical Bill", I (June, 1851) Upper Canada J. of Medical, Surgical and Physical Science 112, quoted in Hamowy *supra* note 33 at 59.

accessibility. It is clear that the power to self-regulate was sought by the profession to advance its own interests.[47] Nonetheless the public, or the policy-making elite, had to perceive some benefit from this arrangement as well. This is a key point as it affects the physician's duty today. Physicians must meet public expectations or lose status, control, and autonomy.

Justifying the trust

The dramatic rise of the medical profession since its legislative recognition resulted from a combination of self-promotion and the advancement of the body of knowledge and services it controlled. At the time of the 'professionalisation' of medicine in North America, there was a huge variety in the quality of medical training and care offered. Many medical schools, run as profit-making institutions by physicians, offered a poor quality training to their students.[48] This was precisely what the state and the public wanted to eliminate, the inadequate

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[47]The profession's writings from that period do not disguise the self-serving desire behind the calls for self-regulation. In 1851 a piece in the Upper Canada Journal of Medical, Surgical and Physical Science stated the following: "...medical men are the hardest worked, have the least leisure allowed them for domestic enjoyment, are the most grudgingly remunerted, have their services the least appreciated, and are the worst protected and least encouraged by the State of all other classes of men, let their profession or calling be what it may.... We want mutual and cordial co-operation to protect ourselves and our interests. And how is this to be [accomplished?] ...It is obvious as it is simple: to obtain from the legislature, by means of an Act of Incorporation, the power to regulate our own affairs- to manage our own concerns." I (April 1851) 28 quoted in Hamowy *supra* note 33 at 57.

[48]Nancarrow Clarke *supra* note 16 at 207.

training of physicians. The public could not judge one physician's training from another. Yet the consequences of not knowing could be lethal.

Medical associations, by restricting licensing to reputable colleges and applying standards in curricula, attempted to correct some of these deficiencies. However, it was not until 1912, with the Flexner report that the medical profession took drastic steps to regulate the quality of medical education in the United States and Canada.[49] The report reviewed medical education in North America. It recommended substantial changes leading to a major improvement in the quality and standardization of medical education. The profession succeeded in its mission of raising the standard of care.

Securing its status

Through its monopoly on the provision of health care services, the medical profession strengthened its own social status and power. Physicians were regarded as the supreme authority in the field of health, dominating the other health service providers. They controlled the market, setting fees and dictating availability of services. They enjoyed remarkable functional autonomy.[50]

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[49] *Ibid.*

[50] Friedson *supra* note 45.

As Coburn has documented, the medical profession controlled the agenda of health care. Health policy was formulated largely by the medical community. Physicians held key positions in health bureaucracies and directed or heavily influenced health policy from the early 20th century to the 1960's.[51]

The greatest sign of their dominance was the degree to which physicians shaped the notions of health, illness, and cure in our society. "The medical profession has first claim to jurisdiction over the label of illness and anything to which it may be attached, irrespective of its capacity to deal with it effectively."[52] Medicine built a model of itself for the public based on clinical interventions and a focus on individual patients rather than responsibility to the community or general public.[53] It upheld the tradition of the Hippocratic healer reinforcing the patient-centred individualism of health care.

Yet, behind the scenes, the medical profession was the primary source of authority capable of representing the public's interest in health care. Physicians formulated health care policy and determined distribution of services. However, as the public's interest in health care evolved from the original desire to have

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[51]Coburn *supra* note 34. See also D. Coburn, G.M. Torrance and J.M. Kaufert, "Medical Dominance in Canada in Historical Perspective: The Rise and Fall of Medicine?" (1983) 13 International J. Health Services 407.

[52]Friedson *supra* note 45 at 251.

[53]Conrad & Kern *supra* note 41 at 188.

assured standards of training and medical care, the medical profession did not respond. Accordingly the state intervened to shape a health care system that more accurately reflected society's changing interests.

Chapter 2

Society's Evolving Interest in Health Care

Having analyzed the physician's role as healer and medical professional, and the relatively recent expansion of duties, we now examine the developing health care landscape. This chapter considers specifically how society's evolving interest in health care has affected the medical professional's obligations, eventually causing the dilemma of double agency.

Autonomy reined in

The medical profession's unbridled autonomy did not last. As health care became more important to citizens and society as a whole, public interest in the field of health care awakened. Across the Western world throughout the 20th century, social welfare legislation began to grow regulating or ensuring everything from education to old age pensions to medical insurance. West Germany passed the first health insurance legislation in the 1880s. Great Britain introduced universal medical insurance in 1912. Canada began public discussions of universal health insurance soon after.[54]

At that time, medical care was becoming much more effective exemplified in the 'medical miracle' insulin. In a remarkably

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[54]Nancarrow Clarke *supra* note16 at 189.

short period of time, medicine gained significantly increased power to save, extend, and improve lives. "[T]he efficacy of the doctor became firmly established in the public mind."[55] Health care began to be perceived as a fundamental moral right meeting a basic human need.[56] It became a major part of the social fabric and social security system of most Western nations. A greater level of health for most people was attainable with the help of modern medicine. From a state of 'good' health, individuals were better able to take full advantage of what choices society offered. Individuals plagued by ill-health were at a disadvantage that in many cases was preventable. Thus, the moral importance of health care sprang "from its effect on the normal range of opportunities available in society."[57]

During and after the depression in North America, society began to see that medicine's control of health care and its market place had not led the health care system to evolve at a pace with the public's interest. More people wanted medical care but it lay beyond their grasp. This was most evident during the depression; many could not afford it. Responding to public demand, the Canadian government introduced universal

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[55] *Ibid.* at 188.
[56] R.F. Badgley & S. Wolfe, "Equity and Health Care" in Naylor *supra* note 20 193 at 194.
[57] This interpretation is attributed to Norman Daniels and discussed in R. Priester, "A Values System for Health System Reform" (1992) Health Affairs 84 at 88.

health insurance.[58] It imposed this against physicians' wishes- the first major blow to medicine's control of health care.[59] The government recognised that the cost of illness was not just an individual tragedy. As a nation, the loss to the economy due to illness was substantial.[60] A family member's illness meant lost of wages and imposed the cost of medical treatment. This lead to a breakdown of the household economy. Illness also deprived the workplace of workers and injured the economy. As the healing power of medicine grew, so did the cost of not having access to medical care.

The publicly funded Canadian health care system emerged as part of a series of social-security measures enacted for the purposes of the elimination of poverty among Canadians.[61] The initial federal legislation, the 1968 National *Medical Care Insurance Act*, specifically recognised "the fundamental principle that health was not a privilege but rather a basic

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[58]The national insurance plan followed the enactment of universal hospital -insurance plans in five provinces, led by Saskatchewan. The provinces took the initiative but quickly pressed the federal government to share the costs of health insurance. See generally Vayda & Deber *supra* note 20 at 125.

[59]During the depression, physicians also faced salary insecurity as patients were unable to pay for care. The CMA officially supported universal health insurance so long as physicians remained firmly in control of the programme. The stage was set for universal insurance. After WWII, a stronger economy in North America secured physician's salaries and they felt less need to consider universal insurance, particularly if it would infringe upon their control of the health care system. For a discussion of this point see Nancarrow Clark *supra* note 16 at chap. 8.

[60]Badgley *supra* note 56 at 194.

[61]Canada, *House of Commons Debates* (5 April 1965) 2, cited in Badgley *supra* note 56 at 193.

right which should be open to all."[62] The focus was on universal access- a public interest medicine had ignored.

This was a crucial stage in the evolution of the North American medical profession. Canadian and US physicians took separate paths. In the US, health care was not viewed as a universal right but rather something to be bought. This reflected a more individualistic culture.[63] The patient-centered Hippocratic tradition remained the core of a professional values framework. The physician's responsibility, as the patient's advocate, narrowly and almost exclusively centered on the individual patient. A culture of 'ethical individualism' focused on encounters between an individual practitioner and an individual patient. Respect for patient autonomy became the guiding principle for provider/patient relationships (in theory if not always in practice). The impact of the individual's treatment choice on the distribution of health care resources or its effect on the interests of others was largely irrelevant.[64]

In partial contrast, Canadian society embraced more communitarian values. Health care became a moral right by virtue of permanent residency, governed by the universal access principle.[65] When the medical profession in Canada

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[62]Badgley *supra* note 56 at 194.
[63]Priester *supra* note 56 at 90.
[64]*Ibid.*
[65]*The Canada Health Act*, R.S. C. 1985, c. C-6, would later set out the five governing principles of Canadian health care: universality,

ignored this, it lost control over the health care market. The profession's influence over health policy slipped into the hands of government bureaucrats.[66]

The medical profession remained a powerful force nonetheless. Physicians still defined illness and controlled individuals' access to the care that was available. In this sense physicians had a management role in the health care system. This role complemented their responsibilities as patient advocates. Their commitment to the individual patient - rooted in the Hippocratic tradition- was in keeping with their professional duty to promote society's interest in quality care and universal access. The physician was still committed to quality care for individual patients and to ensure high standards of practice within the profession. In Canada, however, the public valued accessibility of care such that the health care system aimed to give the best quality care reasonably possible to all Canadians. Physicians as managers of the system assumed partial responsibility for this goal. The public in the United States did not establish health care as a moral right. Accordingly, the US medical profession did not receive a mandate to manage a 'public good' from the society whose interests it represented.[67]

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accessibility, portability, comprehensiveness, and public administration.

[66]Coburn *supra* note34 at 130. The medical profession in the United States also lost some of its power several decades later, but it was largely ceded to the private sector.

[67]As healers, physicians still had an obligation to help those in need and promote care for the poor. However they were not motivated by the same public goal to provide care for everyone regardless of social status.

Thus, as Canadian society's interest in health care changed, the content of the medical profession's mandate to advance society's interest evolved. The commitment to the patient, however, was constant in the physician's ethics.

The rising cost of health care

Until the radical 1960's, the medical profession had managed the health care system free largely from external intervention or supervision. It built a system in which the physician was the dominant figure acting in the patient's best interests. With the advent of a publicly funded health care system, another player appeared- the public. But it was this same 'public' who, a century earlier, had 'insisted' that the medical profession be empowered to build and control the health care system. In the 1960's the government reclaimed some control of the system. It asked physicians to ensure the best care reasonably possible for *every* citizen. The public was no longer simply an entity to be protected. It became a stakeholder- a payer and a player in a position of power.

By the 1970's, however, early warning bells rang. The health care system's structure became skewed. The public had to foot an increasingly large bill. Some argued medical power had distorted the system.[68] Physicians had sought to advance the

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[68]Coburn *supra* note 34 at 132.

interests of their patients while promoting access to care regardless of long-term costs and implications.

In fact, there were multiple causes for rising health care costs. Space precludes exploration of causes here. But it is pertinent to identify the dynamics among the three parties in the system, and particularly the physician's role in the rise in costs. First, universal health insurance sheltered the patient from the cost of her health care choices. Patients were not concerned with treatment costs. Physicians, promoting patients' interests, provided services generously. If in doubt of a service's potential benefit, it was usually provided.[69]

Second, advances in medical technology, drugs, therapies, and cures substantially increased the range of services and the cost of intervention. Physicians fulfilling their duties to patients, and to the public interest in universal access to quality care, offered more services to more patients increasing the total cost of care. In fact, the rising cost of health care far outpaced the growth of the economy. The result was that a greater allocation of public funds to health care squeezed investment in other social priorities. Consequently spiraling costs required control.

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[69]E.B. Hirshfeld, "Should Ethical and Legal Standards for Physicians be Changed to Accomodate New Models for Rationing Health Care" (1992) 140 U. Penn. L. Rev. 1809.

It is clear that greater investment in health care might not be the best way to improve health. For example, draining funds from education or job training programmes may worsen overall population health by increasing poverty.[70] Thus, unlimited spending on health care is not necessarily in society's best interests. Canada's response to the escalating costs is unique as it has a single payer system. The federal government began cutting transfer payments, in particular those for health and post-secondary education, to the provinces in the early 1990's, forcing provincial governments to cut their global budgets, including the largest item- health care spending. While the general principles of the 1984 Canada Health Act still serve as a baseline guide for provision of services, general allocation decisions have been left to the provinces.

However, the specific allocation of resources within the overall health care budget established by each provincial government is left largely up to the physicians who are still the dominant figures in the health care system. As Tuohy notes, "[t]throughout this process, the clinical discretion of individual physicians- the ability of the individual physician to exercise his or her clinical judgment in individual cases according to professionally determined standards- has remained virtually

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[70] See J. W. Frank, "The Determinants of Health: a new synthesis" (1995) 1 Current Issues in Public Health 233; M. Angell, "Privilege and Health- What is the Connection" (1993) 329 NEJM 126. See also Daedalus 1994 123: 4.

untouched."[71] Physicians in Canada have experienced relatively little second-guessing of their clinical decisions. Thus, "within gross over-all constraints, the clinical autonomy of the individual physician, and of the profession as a whole, has been maintained."[72]

Thus, physicians, responsible for the allocation of over two thirds of health care expenditures, suddenly faced pressure to rationalize and restrain the upward surge in health care costs. They were held accountable for the use of public funds. Suddenly, the healer's commitment to advance the patient's welfare clashed with the medical professional's mandate to manage and ration health care resources in society's interests. The dual role of patient advocate/healer and medical professional responsible for the public's interest had the potential to pull the physician in opposite directions.

An inherent conflict of interest

Since the 1970's, calls for greater accountability of the medical profession have increased. Physicians still uphold their

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[71] C. Hughes Tuohy, "Principles and Power in the Health Care Arena: Reflections on the Canadian Experience" (1994) 4 Health Matrix 205 at 226.

[72] *Ibid.* at 227. While political and market forces have impinged relatively less on physicians' clinical autonomy, other sources may increasingly do so. Pharmaceutical formularies are an example of another profession asserting its expertise. The classification of pharmaceutical substances and their uses may play a greater role in regulating the use and access to increasingly important and costly treatments.

primary commitment to the patient.[73] In almost all current codes of medical ethics, the first principle confirms an obligation to place the welfare of the patient first. The tradition of the healer remains strong and is still a role the patient expects of a physician. This expectation is backed up by both ethics and law.

Medical professionals are also expected to be responsible for society's health interests. Angell believes that this dual obligation "is a recent construct, which arose out of the economic difficulties of the large third-party payers."[74] Essentially she asserts that when third party-payers, the state in Canada, began to feel the pressure of increasing costs, they demanded that physicians be more accountable to them and represent their interests, thereby imposing a new role on physicians.

I believe that this dual role is inherent in the tradition of professionalism and in the structure of the health care system in which the healer delivers services as a member of a self-regulating profession which, in turn, manages the health care system in the public interest. However, it was only when resource constraints and health care cost control became visible and a stark public interest that these two roles came into conflict. The interests of society in efficient and universally

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[73]The basis for distinguishing primary from secondary duty will be explored in later chapters.
[74]Angell *supra* note 1 at 280.

accessible health care, whose cost did not unduly encroach on other social priorities, might conflict with the interests of individual patients seeking medical care.

Once universal access to health care became such a part of the culture that many Canadians could not imagine their society without this safety net, concern turned to the cost of this right and its efficient management. Today's physician has moral commitments to two distinct groups, the patient and society, and must fulfill the expectations of each. This creates a conflict that makes many physicians uncomfortable.[75] Unless we restructure our health care system, the physician's 'double agent' dilemma will continually require a balancing and calibration of competing duties. The physician's role in our current system and the strains this conflict of interests is causing within the profession and for the public will be explored next.

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[75]Williams & Beresford *supra* note 10 at 125.

Chapter 3

Double Agent Dilemma in Today's Health Care System

Our modern health care system was shaped by the circumstances of its birth in the 1960's social-welfare movement. It emerged from a desire to improve people's health and thus improve their lives. Canadian Medicare was universal- a social programme for all citizens. The system was built on communitarian values to further just distribution of opportunity and resources.

The major public investment in health care also reflected our commitment to individual autonomy self-determination. We are at our core also an individualistic society. We aim to empower individuals promoting their ability to live according to their values and accept the consequences of their choices. Health is "envisaged as a resource which gives people the ability to manage and even to change their surroundings."[76]

Thus, even in the founding goals of our health care system there is a tension between the individual and society as a whole. Within the framework of a public resource designed to further justice and equality in our society, we foster individualism. In structuring the provision of health care

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[76]J. Epp, "Achieving Health for All", in Baylis *et al.*, *supra* note 10 at 80.

services such that independent professionals respond to individual demand, we cemented an individualistic approach to health care, rights to treatment, and responsibilities for one's own health.

In this chapter, I will explore the physician's dilemma as double agent in our modern health care system. I start by considering an underlying cause, the tension between individualism and communitarian goals created by the insulated patient-physician relationship in a public health care system. I then discuss how this tension may be balanced by interwoven yet distinct levels of decision-making representing different priorities. Next, I examine the limited circumstances when physicians, normally representing the individual best interests of each patient, must act as social advocates in rationing health care resources. Finally I discuss the need to protect the physician's commitment to the patient and define the extent of the competing duty to represent society's interests in the public health care system.

The patient-physician relationship within a public health care system

The patient-physician relationship in the Canadian health care system has three characteristics that contribute to its insularity within the health care system: authority, trust, and the concept

of others.[77] These traits reinforce the individualistic nature of the patient-physician relationship. They also increase the tension between individualistic and communitarian goals, particularly when the physician seeks to achieve both.

Authority

The health care system is founded upon the patient-physician relationship. This is its basic unit. The physician is the most authoritative person whom the patient is likely to encounter. In hospitals, nurses have more contact with the patient and often know the patient better than the physician. Nurses make strong patient advocates. However, the patient-physician relationship has traditionally been the locus of decision-making.[78] Further, the physician represents the patient to any higher hospital or regional health authorities.

Health care resources are distributed on the basis of medical need. Canadian legislators have determined that health care providers shall decide which persons are medically needy.[79] Thus, physicians have primary responsibility for a patient's

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[77]The confidential nature of the relationship also contributes to its privileged status in our system.

[78]We are increasingly embracing a more integrated approach to decision-making that may involve other members of the health care team, family, and friends.

[79]E. S. Gioiosa Dillabough, "An Ethical Approach to Health Care Reform in Canada: A Comparative Analysis." (1997) 25 Manitoba Law Journal 153 at 166.

medical treatment plan, not, for example, review committees or health care policy-makers.

This might contribute to the individualism of the therapeutic relationship as it appears on the surface, very self-sufficient. There are only two individuals involved in the decision-making. For example, payment or third party payers are not usually direct factors in the Canadian system as the physician bills the government. The whole health care infrastructure which enables the patient and physician to interact fades deep into the background. Accordingly, the many bonds that link the physician to the health care system and society, and the patient to his community may be forgotten.[80] It becomes more difficult to accommodate the claims these demands impose on either party, such as to ration resources or consider a family's well-being.

Trust

Trust is intricately linked to authority in the characteristics that define the therapeutic relationship in our health care system. First, as discussed earlier, physicians were given a self-regulating monopoly in the provision of health care

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[80]This phenomenon may also contribute to the difficulties encountered in dealing with patients' family and friends in decision-making situations. Feminist medical ethics have challenged the individualistic nature of the therapeutic relationship calling for a recognition that the patient may define herself more by relationships with others, necessarily making those "others" an important part of the therapeutic relationship as well.

services to ensure that citizens could trust their physicians.[81] Second, the patient must place trust in many health care workers. Nurses and pharmacists are only two examples. Yet, it is the physician the patient consults because she has the most decision-making authority to act in the patient's best interests. However, if the patient withdraws trust, perhaps expressed through consent to care, the physician has no power concerning that patient.[82]

Thus, trust is arguably more important than authority. It is the foundation of the physician-patient relationship. Its content is defined as:

> the expectations of the public that those who serve them will perform their responsibilities in a technically proficient way (competence), that they will assume responsibility and not inappropriately defer to others (control), and that they will make patients' welfare their highest priority (agency).[83]

To maintain this trust, the physician must act as a patient advocate, advancing the interests of her patients to the best of her ability.[84] In an ever changing health care environment, the patient-physician relationship must be protected as much

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[81]See *supra* notes 40 and 41 and accompanying text.

[82]This, of course, does not apply to emergency situations where consent cannot be obtained.

[83]D. Mechanic & M. Schlesinger, "The Impact of Managed Care on Patients' Trust in Medical Care and Their Physicians" (1996) 275 JAMA 1693 at 1693.

[84]*Ibid.* Before the 1960's physicians were viewed more as patient protectors, perhaps implying a more passive role for patients. The role of patient advocate may incorporate a greater sense of the patient as an individual with interests and needs which may, and should, be expressed.

as is reasonably possible from encroaching pressures which would undermine that trust. Decisions or actions that jeopardize it should preferably be taken by someone who is not directly involved in that relationship.

For example, a patient's consent to participate in a research protocol should not be secured by the treating physician but by someone outside of this relationship.[85] The patient must be able to trust that his physician will advance his interests without a competing allegiance to a research protocol. This might imply that the patient-physician relationship be immune from any competing obligations of social agency. Others should be responsible for ensuring the just and efficient allocation of resources. As Susan Wolf states, "t]he physician knows there are others set to question and sometimes deny patients treatment."[86]

Others

It is this concept of others that is troubling. According to this view, the patient-physician relationship operates in the eye of the hurricane that is the whole health care system and its

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[85]The Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans, article 2.4 e specifies that "[t]o preserve and not abuse the trust on which many proessional relations reside, researchers should separate their role as researcher from their roles as therapist, caregivers, teachers, advisors, consultants, supervisors, students or employers and the like." Medical Research Council of Canada (1998).
[86]S.M. Wolfe, "Health Care Reform and the Future of Physician Ethics" 1994 2 Hastings Centre Report 28 at 36.

bureaucracy. The patient-physician relationship is supposed to be sheltered from the winds and storms of health care policy and practice. The inherent characteristics of authority and trust encourage this sense of insularity. This trust relationship, however, exists within the system, and cannot be isolated from it.

The health care system has many links. Rare is the part that can operate in isolation from the whole. The just allocation of health resources is society's concern yet it is also a part of the patient-physician relationship. Decisions made within the patient-physician relationship affect the availability of resources for others. John Stuart Mill in his essay *On Liberty* recognises that while supporting the greatest possible freedom for individuals, there are some restraints necessary by virtue of membership in a society: "The only part of the conduct of anyone for which he is amenable to society is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute."[87]

A patient's health care does concern others. It uses finite public resources. However, the patient is often in a vulnerable position and understandably self-regarding. If we relied primarily on patients to have regard for the just use of society's health resources, we would encounter a problem

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[87]J. S. Mill, *On Liberty*, ed. by David Spitz, (New York: W.W. Norton & Company, 1975) at 11. There are, of course, other philosophical approaches which are more communitarian.

similar to the "global commons" first identified in relation to global environmental resources. Few will be willing to curb use of free resources in order to protect accessibility for all. Yet if everyone overexploits limited resources there will be none for all.[88]

Interwoven yet distinct levels of decision-making

Society's interest in the just allocation of health care resources cannot simply be addressed by government bureaucrats or hospital administrators either. Setting medical goals and priorities requires medical knowledge, an understanding of available resources, likely outcomes of allocation choices, the needs of the population and special groups, the political structure and climate affecting funding, and finally the values that form the basis of our society from generation to generation. Allocation decisions require the input of patients, physicians, citizens, and other health care providers.

Who then should actually make such decisions and how? There is no shortage of opinions on these questions. Should hospitals institute policies limiting the provision of services to treatments whose cost is worth the perceived benefit? Should the government leave access to more treatments to be

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[88]See D. Naylor & A. Linton, "Allocation of health care resources: a challenge for the medical profession" (1986) 134 Can. Med. Assoc. J. 33 at 335, discussing G. Hardin, "The Tragedy of the Commons" (1968) 162 Science 1243.

governed by the market place by insuring fewer services. Should physicians have ultimate responsibility for regulating access to specialists, therapies, and other health care resources? Do the values and expectations of the public influence such decisions?

There are at least three levels at which allocation or rationing decisions may be made. Macro rationing refers to government policies and allocation of public funds. Meso rationing designates the activities of hospital administrations, including setting operating budgets and service priorities. Finally, micro rationing is carried out by individual physicians involved in patient care.[89] This last level is also referred to as bedside rationing. It is the most controversial stage for resource allocation decision-making. We all expect governments to prioritize between competing social needs. We assume hospitals divide up their budget to best meet the needs of all the patients they serve. Many, however, are surprised and

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[89]Kluge identifies three levels of health resource allocation decision-making as well yet distinguishes them by the group being considered in the decision, not by the decision-makers. I separate the levels by decision-makers as it is easier to distinguish a government administrator, from a hospital administrator, from a physician rationing at the bed-side, in part by the very location of the decision. The importance of the decision-making lexus is particularly acute in bedside rationing where the consequences of a decision may be felt directly in the patient's treatment. As Kluge points out, the "impact of a particular decision is here as immediate as it is apparent. Such immediacy carries great psychological weight." See E-H.W. Kluge, *Biomedical Ethics in a Canadian Context* (Scarborough: Prentice-Hall Canada, 1992) at 221.

uncomfortable to think that their physician might also be balancing their needs against others'.[90]

These levels are distinguished from each other on the basis of proximity to the patient. They also reflect different goals. At each level the health and well being of individuals should be the more compelling priority. However, at the macro level, decision-makers generally act on behalf of society as a whole or communities. At the meso-level, the constituency becomes smaller, limited to the population served by the institution. At the micro level, the physician is primarily representing the patient's interests.

Currently, allocation of health care resources occurs at each of these levels. The federal government allocates funds to each province based on a formula which factors *inter alia* total population and the province's wealth. The provincial government sets resource allocation to health in its general budget. Hospitals and other health care institutions receive funding from the regional health authorities. They must allocate this among their various departments and services. Finally, physicians facing patients and assessing their medical needs must balance these with the available resources and competing needs of other patients.

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[90]The problems that arise with bedside rationing will be discussed in greater detail later on in the paper.

While this separation of decision-making helps balance the competing needs of the different constituencies, by a geographical 'sleight of hand', it is not an absolute separation, nor necessarily a fair one. The dilemma of double agency arises specifically because, in certain circumstances, the physician must embrace the goals of the institution or society. Health care rationing raises this dilemma most acutely because it cuts across the three layers of decision-making. We now turn to the challenge of appropriately locating the decision-making lexus for health care resource allocation.

The decision-making lexus for health care rationing

The challenge to the decision-making structure posed by health care rationing is not unique to Canada. In the United States governments, hospitals, and individual physicians all participate in health care resource allocation. However, many allocation decisions reside in private sector market forces, largely health maintenance organisations (HMO's). The United Kingdom's National Health Service shows greater resemblance to the Canadian system. In the UK a limited health care budget is given to regional health authorities and rationing occurs within an environment more accepting of such limits. Micro rationing in the UK's NHS is a major force in resource allocation.[91] The UK, however, also has a private, market-

[91]See K.C. Calman, "The ethics of allocation of scarce health care resources: a view from the centre" (1994) 20 J. of medical ethics 71.

driven second tier health care system. This facilitates rationing in the NHS, particularly at the bedside. Physicians and patients involved in the limitation of care in the NHS know there may be another chance to seek that care.

In the US and the UK, those who can afford better or more service are free to seek them privately. These individuals are the most likely to resist rationing policies imposed upon them. In Canada there is no escape or second tier for patients to turn to if restricted by rationing policies.[92] Rationing decisions are essential to allow public participation and facilitate public acceptance of the fact that resources are limited and difficult choices must be made.

Regardless of the health care system's structure, physicians clearly have a role in allocating resources. They enter in as healers with specific knowledge, as professionals responsible for their individual patients and the health care system, and as citizens concerned about social programmes and the resources of the state. The AMA's Council on Ethical and Judicial affairs has given extensive thought to this issue. "On a societal level,

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[92] The Canada Health Act *supra* note 65, established that federal funding could be withheld from any province which did not adhere to the five basic principles in its provincial health care system: universality, accessibility, comprehensiveness, portability, and public administration. The last of these principles essentially prevents a province from establishing a 'second tier' or privately funded and administered parallel health care system. The United States serves in part as a second tier for the Canadian system. It is possible for those who can afford it to seek treatment, not available in Canada, south of the border. However, this is a limited second tier due to geography and gross difference in expense.

physicians have a great deal to offer those who are defining the adequate level of health care. For the public to express its preferences, for example, it must have a solid understanding of the benefits, risks, and costs of the different kinds of health care that can be funded. Physicians have a responsibility to participate and to contribute their professional expertise to safeguard the interests of patients in any decisions made at the societal level regarding the allocation or rationing of health resources."[93]

The preference of the AMA and many others writing about health care allocation is that wherever possible allocation choices should be made at the macro or meso level.[94] There is much debate on how these decisions should be made even at the meso and macro levels. But that is a subject for another paper. Suffice it to say that such decisions would require wide consultation to help establish priorities in treatments, goals, and values.[95]

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[93]Council on Ethical and Judicial Affairs, American Medical Association, "Ethical issues in Health Care System Reform" (1994) 272 JAMA 1056 at 1061.

[94]For debate on this issue, see David Naylor and Adam Linton *supra* note 88; D.J. Roy, B.M. Dickens & M. McGregor, "The choice of contrast media: medical, ethical, and legal considerations"(1992) 147 Can. Medical Association J. 1321 [hereinafter Roy *et al.*]; Wolfe *supra* note 86; A. Detsky & I.G. Naglie, "A Clinician's Guide to Cost-Effectiveness Analysis"(1990) 113 Annals of Internal Medicine 147.

[95]Allocation decisions should be made in a public forum with accountability to those affected, and include an appeal mechanism. This openness, however must be balanced against the need to ensure that decision-makers are not held hostage to the most vocal special interest groups and lobbying forces. Public policy makers might seek to measure likely outcomes and success rates of particular treatments, severity of the disability being treated and impact on quality of life. These are all very difficult and controversial factors. There is a large

Without attempting to suggest a procedure for public policy makers to allocate health care resources, I believe it is important to note that government policies on some of the most controversial issues usually require a social consensus which is slow to develop. Strong government leadership would be needed to address openly health care rationing and establish priorities. This process might be held hostage to election timetables. Further, legislators can be even slower to respond to emerging social norms. Thus, the law in this and similarly complex and contested areas usually follows major developments rather than leads them. I raise these concerns here only to highlight the need for decision-making on other levels or in other fora to deal with rationing issues more quickly and perhaps more flexibly.

The physician as social advocate

Another valuable actor in decision-making is the judiciary. The judiciary has an important role to play in protecting the rights of patients and individuals caught in the allocation process. It may help clarify the legal principles which apply to new situations. These are discussed later.[96] At this point, when evaluating the physician's conflict of duty to patient and to

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body of literature addressing the setting of priorities in the allocation of health care resources, particularly surrounding the state of Oregon's health insurance plan.

[96]See chapters 7-10.

society in light of other potential actors, it is worth remembering that the judiciary's role arises only after a conflict has arisen. The reality, as stated by two former members of the Royal College of Physician and Surgeons of Canada's Biomedical Ethics Committee , is that "...physicians cannot wait for the emergence of a social consensus on the allocation of resources for health care. Physicians are faced daily with patient care decisions that require a balancing of the patient's best interests and the need for society, hospitals and physicians to ration limited resources."[97]

The two radiological dyes described on page one exemplify the typical dilemma physicians encounter.[98] The emergence of competing interests, that of the individual patient's comfort, and that of other patients served by the limited resources is also illustrative.

In one large teaching hospital, radiologists had been performing their exams using the standard cheaper dye, aware of the risks it posed. In the early 1980's a new dye was introduced into the hospital as part of a clinical trial. It proved to be better.

At the end of the trial, the new dye was no longer provided free of charge by the pharmaceutical company which

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[97]Grunberg & Williams *supra* note 10 at 311.
[98]See chapter 1.

developed it. However, the hospital's physicians had become used to it and preferred it to the standard one. Like most new products, the new dye was commercially available at a high price. Physicians continued to use the new dye on their patients. This caused a substantial increase in the radiology department's operating costs.

As this level of spending could not be maintained, the director of professional services asked the radiologists to suggest ways to incorporate the new dye where most needed to reduce risk, yet stay within the budget. Eventually, with the physicians' advice, the hospital administration established guidelines for physicians' use of the two dyes. Risk categories were crafted. Only patients judged to be in the higher risk category could receive the new dye. Patients were to be informed of this policy and its rationale.[99]

As this case illustrates, initially physicians had to make decisions concerning a new treatment. Considering the best interests of their patients, they chose what they perceived to be the best treatment. Had all radiologists continued to use only the new dye, the care of the other patients the department had to treat would have suffered due to financial

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[99]Discussion with Dr. Sylvia Cruess, Director of Professional Services, Royal Victoria Hospital, 1980-95, April, 1999. This is simply one hospital's approach to such a situation. Others may have handled the allocation decision differently, including allowing the newer dye to be available at a higher price for patients who could pay such that they might fund its use for more patients without the means to pay for it.

constraint. Thus, the physicians came under pressure to restrain their use of the more expensive dye. There might then have been a variation in the response of different physicians to the new pressure leading to different treatment patterns, until the hospital policy was established.

This scenario took place in a teaching hospital which had ample warning that a new treatment was available. Still, physicians were faced with decisions requiring them to balance the immediate needs of their patients with the needs of all the patients treated by the department. Guidelines established at the meso, or hospital administration, level took the pressure off the physicians. The guidelines were also drafted with the benefit of thorough knowledge of outcome differences between the two dyes, as well as objectivity.

Nonetheless, even in these ideal circumstances, physicians had to be aware that their choices had consequences borne by others.[100] Ultimately it was for the physicians to recognise a duty to ensure the most just distribution of resources amongst all the patients under the department's care. This could not be achieved if every physician pursued any beneficial treatment

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[100]Physicians in community practice or smaller hospitals would face similar dilemmas as new treatments or technology spread from the academic centres to all health care centres. These physician's however would deal with de facto rationing caused by the absence of resources in these regions, especially new technology. Additionally, they would not have as substantial peer review.

considering exclusively the best interests of her immediate patient.

As the radiological dye case illustrated, a physicians' instinct is to offer the best possible treatment to patients. This is an instinct to foster and protect. Introducing an obligation to act as a social agent in promoting just and equitable allocation of resources is inevitable. It is an added burden on physicians and a role they may feel ill prepared for.

However, physicians have been balancing obligations to society as a whole with their duty to their patients for a long time. When a patient poses a risk to others, the physician must act to protect others even if this is not in the patient's best interests. Whether warning of risks posed by patients with infectious diseases, or informing licensing authorities that an elderly driver poses a safety risk to self and others, physicians, by virtue of their position of responsibility and as the only ones able to know and protect society in relation to certain risks, must, on occasions, act on behalf of society as a whole.[101] We see here the emergence of a balancing act physicians must perform- harm to patient versus harm to others. This theme will be revisited in later chapters discussing methods to balance competing duties.

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[101]See for example, *Ontario Child and Family Services Act* S.O. 1984. c. 55 under which it is an offense punishable by a fine of up to $1000 to fail to report suspected child abuse. See also H.G. Coopersmith, *et al.*, "Determining medical fitness to drive: physicians' responsibilities in Canada" (1989) 140 Can. Med. Assoc. J. 375.

Similarly, physicians, by virtue of their position as the ultimate allocators of health care resources, must consider society's interests when these are pressing as well. When harm may be done to other patients by a failure to prioritize or restrain use of some health services, physicians must acknowledge their duty to society and the consequences of their actions.

The grave danger in this, is that patients may suffer harm, even die by virtue of physicians conserving resources for other patients or treatments. Trust may also be sacrificed. Patients expect their physician to put them first. If they believe a physician may be withholding services due to concern for the overall health care system, patients will have lost their ally in promoting health.

The AMA warns of an additional danger associated with micro rationing. "Bedside rationing can result in arbitrary decision making in which a patient's care depends on the values of the physician providing care rather than on generally accepted values"[102] However, the danger of this happening from micro-rationing is no greater or lesser than that of care in general. Every patient is to some degree subject to the treating

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[102]Council on Ethical and Judicial Affairs *supra* note 93 at 1061. It is interesting to note that the CMA's code of ethics does not address micro-rationing as explicitly as does the AMA's code. In the two distinct health care systems, the motivations to micro-ration are different. In Canada, with a single payor, there is no personal gain for rationing of services. Thus, as discussed earlier, the restraint on placing private interests over those of patients does not apply.

physician's values. Quality of care is assured despite great room for clinical discretion in most areas of medicine by ensuring good teaching, access to information, and self-regulation through peer review.

This points to a fundamental weakness in the structure of our health care system. The physician's secondary role of social agent leads to obligations in our modern society for which physicians are ill-prepared. The trap is what Veatch termed "the fallacy of generalization of expertise."[103]

It is a mistake to assume that because physicians have to allocate health care resources, they are adequately trained to make such decisions. For a physician to participate in the just allocation of resources she must understand the needs of her immediate patient, competing priorities or the known needs of others, available resources, and likely outcomes. The average Canadian medical student receives 4-16 hours of formal ethics training over a 4 year programme. While completing rotations in hospitals, students may witness role models balancing the claims of patient advocate with social agent. However, studies show physicians are ill at ease with this double agency.[104]

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[103]R.M. Veatch, "Generalization of expertise" (1973) 1 Hastings Center Studies, 129 , quoted in, Baylis *et al. supra* note 10 at 158.
[104]Williams & Beresford *supra* note 10. See also a study done in Norway indicating very similar sentiments among physicians faced with the role of social agent; T. Arnesen & S. Fredrikson, "Coping with obligations towards patient and society: and empirical study of attitudes and practice among Norwegian physicians" (1995) 21 J. Medical Ethics 158.

They are thus, less likely to be teaching students appropriate methods for balancing and resolving this dilemma.

Despite inadequate preparation for this responsibility, physicians do act in limited ways as social agents. Allocation decisions must be made when a budget crunch is felt before an institutional policy is developed, as with the radiological dyes. While physicians do not view themselves as primarily social agents, it is clear that they often do so act. A Canadian study analyzing the views of 25 physicians found four ways in which they function as social advocate: "by voluntarily restraining their use of health care resources, by working with their colleagues to distribute the available resources fairly, by educating their patients not to make excessive demands, and by refusing unreasonable patient or family requests."[105]

The need to define the physician's duty to society

This study highlights the need to establish the content and limits of the physician's role as social advocate. First we must eliminate or minimise the physician's role in rationing health care resources, where possible. I briefly mention several means to do this as this is an important part of defining the extent of the physician's social advocacy role. However, in this paper I am focusing on the limited circumstances in which

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[105]Williams & Beresford *supra* note10.

physicians must participate in health care rationing and the balancing of the competing interests of patient and society.

In an analysis of the ethical challenges posed to the health care system by the two radiological dyes, Roy, Dickens, and McGregor concluded:

> There is a necessary tension between the different and complementary functions and responsibilities of health care administrators and of physicians. That tension needs to be maintained, because without it health care administrators may allow their responsibility for the common good to be compromised by compassion for individual sufferers; alternatively, physicians may compromise their primary responsibility to individual patients because of an assumed higher responsibility to the good of the community.[106]

These two roles may complement each other but neither are they entirely separate. There is clearly some overlap as treating physicians feel the need, or the pressure, to act as social agents.

Wolf also suggests a separation of the roles. Meso-level decision-making or institutional policies are the place for social advocacy to protect the patient-physician relationship. "To deliver good patient care a health care organization must support physicians' efforts to establish strong relationships with their patients, leaving it to the broader organization (or

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[106]Roy *et al. supra* note 94 at 1322.

higher authorities) to impose limits on the physician's success in seeking potentially beneficial treatment for the patient."[107]

Where possible this is an ideal solution to the double agent dilemma. Institutional policies may develop in response to specific catalysts such as individual physicians lobbying as patient advocates, patients complaining of lack of treatment, or budgetary constraints due to new, expensive treatments. Guidelines will be set. However, so long as clinical discretion has a place at the bedside, physicians will have two roles, as patient and social advocate.

To manage this double agency, one must understand the forces and principles underlying the physician's role. Disagreement persists over the extent of the physician's role as a social agent. Most of the sources of guidance for physicians give mixed messages as to the physician's obligations. Clarifying the issue and exposing the lack of congruity may help us decide what tools or principles should guide the treating physician.

If physicians are expected to assume some responsibility for rationing health care services as part of their responsibility to society, this must be understood by all and its extent known. Aaron and Schwartz found that physicians in the UK. offered medical reasons to withhold beneficial treatment from patients

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[107]Wolfe *supra* note 86 at 38.

rather than say the resource was scarce or unavailable.[108] This may preserve physician-patient relationship on the surface, but it indicates either dishonesty, lack of understanding, or discomfort with the professional role. This may be something we wish to prevent to avoid perverting clinical judgment and the abuse of clinical autonomy. It is clear that Canadian physicians need guidance on this issue and the UK's example has relevance here. However, guidance may come from many sources. The contribution of ethics, professionalism and the law in resolving this dilemma and offering guidance to physicians is the subject of the next chapter.

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[108] H. Aaron & W.B. Schwartz, *The Painful Prescription: Rationing Health Care* (Washington: The Brookings Institute, 1984), quoted in J. La Puma & E. F. Lawlor "Quality-Adjusted Life-Years" (1990) 263 JAMA 2917 at 2918.

SECTION III

Chapter 4

Balancing the Double Agency: Sources of Guidance

The physician's dilemma as double agent may be cast as an ethical issue, a medical problem, even a legal question. In fact, it is a social issue encompassing each of these elements. To resolve this dilemma, one must analyze each of these components. In this chapter, I briefly discuss the contribution of ethics, medical professionalism, and the law as sources of guidance in resolving this issue. This will set the stage for a deeper discussion of the actual guidance offered by each of these in later chapters.

It is important to understand and recognise the part that each source plays in both defining the physician's competing duties to patient and society and in building a balancing mechanism. The medical profession controls both training for and entry to the profession. The profession establishes the standards of accepted practice; few outside the profession can challenge these. Such is the character of an autonomous, self-regulating profession. Medicine, however, is also practiced within a community, a society, and a set of norms which govern it implicitly and explicitly. These norms arise from many sources such as professional ethics and professional traditions; academic research from disciplines outside of medicine

including bioethics, sociology, philosophy, and health economics; society's expectations; and the law. To craft a comprehensive solution to the social issue of physician participation in health care rationing we must draw on many of these sources of norms.

Ethics

Health care ethics has been defined as "concerned with the identification and investigation of ethical problems that arise in the realm of health and health services."[109] Beauchamp and Childress described bioethics, of which health care ethics is a part, as an applied normative ethics in which we apply general moral action-guides to biomedicine.[110] This source of norms, in its applied form in medicine, has matured from a fringe discipline to a well established force in health care policy over the past two decades. 'Ethics' has the ability to formulate general guiding norms and apply them to entirely new situations.

There are many sources from and through which a profession's ethics may be crafted. In medicine the most obvious one is the professional code of ethics. However, medical journals, bioethics literature and scholarly writing from other disciplines

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[109]Baylis, *et al. supra* note 10 at 4.
[110]T.L. Beauchamp & J.F. Childress, *Principles of Biomedical Ethics* 2d ed.(New York: Oxford University Press, 1983) at 9.

such as philosophy and religion continually contribute to the development of medical ethics.

A code of ethics of a self-regulating profession is central in the formation and governance of professional behaviour and attitudes and objectives of the profession. It is usually an essential requirement of professionalisation imposing duties beyond the self. It serves both as a "checklist for the initiated members of the profession of the standards and limits of practice," and as a "quality assurance guarantee to society".[111]

Medical codes of ethics have changed as society has changed; but some of the core principles have remained remarkably consistent considering the radical changes in society, the delivery of services, and the role of physicians since the Ancient Greek physicians vowed to uphold the Hippocratic Oath.[112] The continued use of the medical code of ethics speaks to the lasting power of ethics in the formation of professional norms.

Principles of ethics operate on various levels with varying degrees of enforceability. As a public affirmation, a code of ethics creates public expectations and in theory becomes a part

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[111] P. Sohl & H.A. Bassford, "Codes of Medical Ethics: Traditional Foundations and Contemporary Practice" (1986) 22 Social Science and Medicine 1175 at 1175.

[112] For commentaries on the evolution of codes of medical ethics, see Sohl & Bassford *supra* note 111, and R. Crawshaw & C. Link, "Evolution of Form and Circumstance in Medical Oaths" (1996) 164 Western J. Medicine 452.

of an individual's personal code of values. In Quebec, the government requires all physicians seeking a license to swear the medical oath in front of a table carrying "a Catholic bible, a Protestant bible, a Jewish torah, and the Koran."[113] As part of the licensure process, the code also becomes part of the definition of unprofessional conduct. Additionally, medical oaths and codes of ethics are part of the socialization of physicians occupying an informal position of influence as they may be enforced simply through peer pressure or public censure.

In Quebec, uniquely in Canada, the code of ethics of the Collège des Médecins du Québec has the force of positive law (government legislation and precedent-setting court decisions), as it is passed in the form of a provincial regulation. The Canadian Medical Association's code may also be considered indirectly to have the force of law. Common law jurisdictions may look to it to determine the standard of care established by the profession to which each individual physician should adhere.[114]

Thus, ethics as a source of guidance offers a set of general guiding principles and codes of conduct which may help define the physician's duties to the patient and society. It may also help set the parameters of acceptable conduct. In highlighting

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[113]Crawshaw & Link *supra* note 112 at 454.
[114]See Sharpe *supra* note 41 at chap. 12.

the principles and fundamental values at stake, the discipline of ethics may raise awareness or warn of the potential conflict of duties and contribute to the foundations of a balancing mechanism. This will be discussed in chapter 5.

Professionalism

The obligations of professionalism, like codes of ethics, establish a physician's responsibilities. Unlike codes of ethics, professional obligations are crafted by society not the profession itself. The medical profession must of course interpret these duties. Examining the obligations of professionalism and the ways medicine has embraced these illustrates how physicians understand their role as professionals in our society. The positions they have assumed, particularly as expressed in medical literature, indicate what some of the leaders of the profession believe is within their domain of competence, as mandated by society.[115] Is there a consensus from them? Are medical organisations saying the same thing as academics, private clinicians, and rural physicians? These questions are important as medicine is an autonomous profession within the limits set by society. Its own perception of its role will carry greater weight in determining the norms of conduct than will the self-perception of non self-governing occupations.

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[115]The questions and issues addressed in the medical literature also indicate what the academic leaders believe is of interest to the profession.

Nonetheless, it is also important to understand society's expectations of the profession? Society gave physicians the professional status from which physicians grew into the role of the dominant figure in health care. If society's expectations are not met, self-governing professional status may be revoked or severely restricted by government legislation forcing physicians to meet the perceived obligations to society.[116]

Despite the potentially valuable contribution of an analysis of professionalism in resolving the physician's conflicting duties, this problem, like many medical issues, is largely studied under the lenses of ethics, philosophy, or law. As discussed in the first two chapters, the concept of professionalism, adopted to structure and organise the delivery of medical care, has a played a significant role in setting up these competing duties to patient and society. Moreover, the obligations inherent in professional status mandate that the medical profession assume leadership in defining the conflict of duties and in seeking a balancing mechanism. Chapter six explores this.

Law

In health care issues the law is often a follower of society's norms rather than a leader. However, once legal principles are

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[116]See R.L. Cruess, S.R. Cruess & S.E. Johnston, "Renewing Professionalism: An Opportunity for Medicine" (1999) 74 Academic Medicine 878. See also Friedson *supra* note 45 at 73.

established, they may set an enforceable and public standard. Law relating to the medical profession often relies on the profession itself to set the standard.

The courts can help the norms governing the medical profession evolve with society's expectations. The evolution of the doctrine of informed consent is an example. "Over the years, perhaps as a result of what some have perceived as a deterioration of the physician-patient relationship and a concomitant testing of the heretofore sacrosanct trust-bond, the adage that the 'physician knows best' has been supplanted by patient demands for greater knowledge."[117] Through two decisions, *Hopp* v. *Lepp*[118] and *Reibl* v. *Hughes*[119], the Supreme Court of Canada articulated the doctrine of informed consent as part of a physician's duty of care. Further the scope of disclosure of risks was to be judged by the standards of a reasonable patient in similar circumstances. This was a major change in the approach to the exchange of information in the patient-physician relationship, pioneered by the courts. As we consider in chapter nine, the court responded to evolving social values and forced the medical profession to do likewise.

Legislation is also a manifestation of society's will or government's interpretation of it. It too should guide the

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[117]Sharpe *supra* note 41 at 34. See also Pellegrino *supra* note 11, for a review of the impact of social trends on medical ethics.
[118][1980] 2 S.C.R. 192, 112 D.L.R. (3d) 67.
[119][1980] 2 S.C.R. 880, 14 C.C.L.T. 1.

profession. Recently, legislation is playing an increasingly important role as it encroaches on professional autonomy.[120]

The judiciary's role in defining a physician's duties is especially important in evolving dilemmas as judges can respond to each new challenge on a case by case basis. We discuss the role of Canadian common law in chapters seven and eight.

What we must remember in crafting a solution to the double agent dilemma, is that these sources of guidance- ethics, professionalism, and the law- often overlap or complement each other. The judiciary, in developing common law, still relies heavily on the medical profession to present evidence of accepted medical practice. In Quebec, the physician's code of ethics is legislated as a government regulation.[121] In Saskatchewan, the *Medical Profession Act* offers concrete examples of unbecoming, unprofessional and improper conduct taking on more of the role of a code of ethics.[122] Thus, the government is assuming a greater role in defining acceptable conduct for the profession

Sharpe points out that "[s]uch legislation is, to an extent, an encroachment on the self-government of the profession, for once standards are incorporated into legislation, the provincial

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[120]The significance of this will be discussed later as it affects professionalism.
[121]Professional Code R.S.Q., c. C-26, s.87
[122]Sharpe *supra* 41 at 223.

licensing authority loses some of its traditional flexibility in interpreting and applying those standards in the light of changing conditions and circumstances."[123] A solution to this question will require input from each of these sources. We examine the part of the solution that we may derive from ethics next.

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[123] *Ibid.* at 224.

Chapter 5

Ethics of the healer

Consider this statement in a 1980 letter to the New England Journal of Medicine:

> "A physician who changes his or her way of practicing medicine because of cost rather than purely medical considerations has indeed embarked on the 'slippery slope' of compromised ethics and waffled priorities."[124]

In contrast consider Alan Williams' response more than a decade later:

> "...anyone who says that no account should be paid to costs is really saying that no account should be paid to the sacrifices imposed on others. I cannot see on what *ethical* grounds you can ignore the adverse consequences of your actions on other people. You can do so on bureaucratic or legalistic grounds, of course, by saying 'they are not my responsibility', but we all know into what an ethical morass that line of defence leads."[125]

There are conflicting views from within the profession itself. The following chapter will identify some of the ethical arguments related to the physician's double duty. It will consider the ranking of duties or priorities assigned by the ethical literature as a possible solution to the double duty. A

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[124]E.L. Loewy, "Cost should not be a factor in medical care" [letter] (1980) 302 NEJM 697, discussed in A. Williams, "Cost-effectiveness analysis: is it ethical?" 1992 18 J. Medical Ethics 7.
[125]Williams *supra* note 124 at 7.

balancing mechanism of separating the goals of each decision-maker will be explored. Finally it will point out the major contribution of ethics in raising and clarifying the competing values to be balanced.

Conflicting views

Former members of the Biomedical Ethics Committee of The Royal College of Physicians and Surgeons wrote during their tenure, "...physicians cannot wait for the emergence of a social consensus on the allocation of resources for health care. Physicians are faced daily with patient care decisions that require a balancing of the patient's best interests and the need for society, hospitals and physicians to ration limited resources."[126]

Others, like Detsky and Naglie, hold the view that clinicians may not share the health care resource allocator's objective of maximizing the net health benefit for a target population derived from a fixed budget. Clinicians, individually "are appropriately concerned solely with the effectiveness of a specific intervention for their patients and are not concerned with the benefit derived from spending those resources on other patients in the target population."[127] "A clinician making individual allocation decision for his or her patients has

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[126]Grunberg & Williams *supra* note 10 at 311.
[127]Detsky & Naglie *supra* note 94 at 147.

the sole objective of maximizing his or her patients' health status "regardless of the effect of those decisions on other patients and resources. Clinicians may not be concerned about the constraint of a fixed amount of resources and the effect that using scarce resources for their patients will have on other patients."[128]

As these two arguments demonstrate, the ethical responsibilities of a physician can be interpreted in starkly different ways. This may be both the strength and weakness of the field of ethics. It recognises that several different principles may guide our actions. In fact the debate flushes them out so we may know what principles and values are at stake and the ethical consequences of our choices.

A ranking of priorities

We must now search for a ranking of values or priorities from within the debate. The CMA's code of ethics, adopted by all the provincial medical associations except Quebec, establishes that the patient's welfare is a physician's *primary* obligation (my emphasis). Yet, as already mentioned, it also recognises a physician's obligation to share a part of the profession's responsibility for the just use of society's resources. The CMA's code of ethics is less clear than, for example the AMA or the equivalent physician's organisation in France, L'Ordre

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[128] *Ibid.*

national des médecins, in defining a physician's role faced with a conflict of duties owed to patient and society.

The AMA stated in its code of ethics that: "a physician has a duty to do all that he or she can for the benefit of the individual patient."[129] While it recognises that allocation policies may limit the ability to do so it maintains that "[t]he treating physician must remain a patient advocate and therefore should not make allocation decisions."[130]

This is the AMA's latest opinion. In 1957, section 1 of the AMA's medical ethics principles stated that "the primary objective of the medical profession is to render service to humanity with full respect for the dignity of man." In the 1994 edition described above, a narrower patient-centred ethic is advanced but a responsibility to society is nonetheless acknowledged.[131]

In contrast, L'Ordre national des médecins en France[132] distinguishes itself from the Anglo-Saxon nations and their tradition of physicians serving humanity. It highlights the difficulty North American ethics has had in establishing a clear

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[129]Code of Medical Ethics and Current Opinions of the Council on Ethical and Judicial Affairs, American Medical Association, article 2.06, 1994 edition.
[130]*Ibid.*
[131]Priester *supra* note 57.
[132]The professional organisation charged with the responsibility to ensure ethical and professional conduct and to uphold the code of ethics.

hierarchy. In its introduction to the code of ethics, the Ordre specifies that the individual always comes before the collectivity. "*Depuis Montaigne, l'individu s'est émancipé et il prime aujourd'hui la collectivité, du moins en France et dans un nombre croissant de pays: le médecin a pour mission de soigner une personne avant d'avoir à défendre la santé publique.*"[133]

While lacking the clarity and conviction of the French code, the CMA's code, like most ethical positions advanced in this debate, acknowledges that patient welfare is the physician's priority. The Canadian code of ethics does not go as far as the American one in restricting physician participation in allocation decisions and it certainly is not as explicit as that of the French. The reality for Canadian physicians, as reported by Williams and Beresford, is that good, caring physicians do feel pressure to make allocation decisions and alter their behaviour in certain respects accordingly.[134] There is a ranking of values in the ethics literature, placing the patient's welfare as the physician's primary consideration. However, we may still question how the duty to the patient is interpreted so that it is deemed fulfilled when less than is possible is done for one patient in order to save resources for others?

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[133]Since Montaigne, the individual has been emancipated and now comes before the collectivity, at least in France and in a growing number of countries: the physician's mission is to heal a person before defending public health. (author's translation) L'Ordre national des medecins en France, code de déontologie, Introduction aux commentaires du code, http://www.ORDMED.ORG/

[134]Williams & Beresford *supra* note 10.

A partial solution

One solution proposed to the conflicting ethical messages is to give physicians their own clear ethics. Wolf suggests distinguishing between the ethics of institutions and the ethics of professionals. This may allow us to "differentiate individual goals from collective ones. The defence attorney seeks acquittal in a system that seeks justice, and the physician may work to optimize patient care in a system trying to distribute health care fairly."[135]

Physicians are part of the system. Like lawyers, they must share their part of the profession's obligation to society. A physician's ethics must be guided in part by an understanding of the moral basis for the duty to represent society and make allocation decisions as well as the limits of this obligation. While bound by the duties of solicitor-client privilege, a defence attorney must agree to uphold a system's goal of promoting justice, cannot withhold material evidence in his or her possession, and cannot encourage a client to lie under oath.[136]

However, an important part of resolving the dilemma of the physician as double agent is recognising the distinct primary

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[135]Wolfe *supra* note 86 at 37.

[136]The dilemma of witholding material evidence, like health care rationing, challenges the limits of established professional ethics. It falls into a grey zone. An attorney must balance the primary obligation of defending her client's interest, particularly with respect to solicitor-client privilege, whith the obligation not to obstruct justice.

goals of each actor in the health care system. As Wolf suggests, it is important to separate these goals and assign decision-making to the appropriate actors. This may serve to minimize the conflict of duties a physician faces in advocating for the patient and society. It will not, however, eliminate this conflict in the Canadian health care system.

As discussed in chapter three, the difficulty arises when responsibility for particular goals cuts across traditional divisions of authority. A hospital cannot allocate resources fairly without an element of physician participation. Physician discretion is essential in limited circumstances, for example before a formal institutional policy is developed to distribute scarce resources, and in each individual case to some extent.

Clarifying the competing values

The ethical opinions advanced on this issue remind us of the various moral duties and values at stake. They challenge us to consider each value and the consequences of how we act on them. Ethics gives primacy to the obligation to the patient as we recognise an individual's right to health care and the physician's fundamental role in securing that right. It also recognises a secondary duty to advance society's interest in a just distribution of resources.

An argument like that offered by Detsky and Naglie suggests we protect the principles of loyalty and beneficence. Alan Williams argues that a physician cannot ignore the impact or potential harm of her choices on others. She must be guided by the principle of non-maleficence. Detsky and Naglie, like Wolf, propose that separate ethics should guide different actors. Others offer the argument or practical necessity; physicians must participate in rationing to a certain degree.

In clarifying the principles at stake, we may come one step closer to resolving the dilemma. The argument of practical necessity begs the question: this may be the situation, but is this what we want? Can we change the circumstance which places physicians in the position of double agent? Perhaps we must recognise that different decision-makers should be guided by different goals and accordingly minimize physician involvement in representing society's interest in distributing health care resources justly. This does not bar us from also recognising that in limited circumstances this is not possible and physician's must also represent society's interest in the health care system.

A solution to the double agent dilemma will not come from ethics alone. Ethics may clarify the competing values and raise the questions we must consider in crafting a solution. A balancing mechanism is still required. We consider the medical profession's role in developing such a mechanism next.

Chapter 6

Tradition of Professionalism

In the following chapter I outline the crucial role the medical profession must play in resolving the double agent dilemma. First, professional obligations have, in part, created this conflict of interests. The profession is granted autonomy and a monopoly in exchange for advancing society's interest in health care. Society has a strong interest in preserving the 'sacred' patient-physician relationship and the most just distribution of health resources. The medical profession has the most authority in the system and must work to advance both of these goals to maintain its status. Second, this professional autonomy allows physicians to set the standards of conduct for their occupation. If physicians fail in satisfying public expectations, their autonomy will be constrained.

There are three steps the profession can take. First it must acknowledge openly that this conflict of interests for physicians arises in certain circumstances. Second it must attempt to define the conflict, specifically the limits of the professional's role as social advocate and patient advocate. Third is methodological- how the profession should take the first two steps: gathering empirical evidence of the conflict, and consulting widely, particularly patients. In doing this, the

profession may be able to identify mechanisms to resolve the conflict of duties owed to a patient and to society when it arises in health care rationing.

Autonomy for representation

The public granted the medical profession autonomy to regulate its activity.[137] In return for professional status, the healer/physician became accountable to society.[138] In regulating its activity the profession has come to control much of the health care domain.[139] As earlier discussed, the profession justified its position of power in the field of health care claiming, like all professions, to have a service orientation, working for society's best interests.[140]

The profession has fought to maintain its autonomy. Naylor and Linton suggest that in accepting the burden of making allocation decisions, the medical profession has preserved its professional clinical autonomy.[141] Barer and Evans point out that, "[r]eferral for diagnostic work, specialist care, or hospital services is under the control of physicians themselves, and they do the 'rationing.' In effect, physicians in Canada run an internal 'utilization review and management' system, within

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[137]Friedson *supra* note 45 at 73.
[138]*Ibid.*
[139]*Ibid.* at 82. See also Coburn, Torrance & Kaufert *supra* note 51.
[140]See chapter one.
[141]Naylor & Linton *supra* note 88.

the externally set constraints on capacity."[142] As discussed in the first two chapters, this autonomy comes at the price of representing society's interest in health care.

Society has a strong interest in the just distribution of limited public resources invested in health care. The modern health care system was born as a social programme from a desire to secure universal access to health care.[143] Society also has a strong interest in protecting trust in the patient-physician relationship from any threats such as posed by micro-rationing.[144] This physicians' dilemma is created by their own tradition of professionalism. Physicians' have the autonomy to regulate their profession and in return must represent society's interests. In limited circumstances, the physician must represent competing interests when called upon to ration health care resources. This conflict then becomes a significant social concern. It is one that affects individual physicians who look to the profession for guidance. Moreover, society will expect those with the authority in the system to propose solutions to it. The profession must clarify or define its interpretations of its professional obligations.

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[142]M.L. Barer & R.G. Evans, "Interpreting Canada: Models, Mind-Sets, And Myths" (1992) 44 Health Affairs 61.
[143]See chapter 2.
[144]Mechanic & Schlesinger *supra* note.

In fact, the profession should already be addressing this conflict more directly as it goes directly to the standard of care or accepted practice within the profession. Each province has its medical act setting out the duties of the profession and its professional association to regulate its affairs. In Ontario, for example, the 1991 Regulated Health Professions Act lists the objectives for the professional regulatory bodies such as the College of Physicians and Surgeons of Ontario including the following:

1. to regulate the practice of the profession;
2. to develop and maintain programs and standards of practice to assure the quality of the practice of the profession; and
3. to develop professional ethics for its members.[145]

Additionally, as Dickens points out, the governing council of each regulated profession has the power to make regulations "prescribing what constitutes a conflict of interest in the practice of the profession and regulating or prohibiting the practice of the profession in cases where there is a conflict of interest."[146] The profession has the duty to set the standard for participating in rationing of health services and balancing a duty to the patient and to society.

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[145]Section 3 of the Health Professions Procedural Code which is schedule 2 of *The Regulated Health Professions Act*, S.O. 1991, c. 18.

[146]*The Regulated Health Professions Act*, S.O. 1991, c. 18, sched. 2, amended by S.O. ch. 37 (1993) (can.), as quoted in B.M. Dickens, "Conflicts of Interest in Canadian Health Care Law" (1995) 21 Am. J.L. Med. 259, at 259.

As further evidence that it is the medical profession which must define this conflict and establish the acceptable limits of double agency, even government regulations concerning professional misconduct rely on the profession's interpretation. According to the Ontario regulations governing the medical profession, professional misconduct includes "[a]n act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded *by members* as disgraceful, dishonourable, or unprofessional...[and] [c]onduct unbecoming a physician."[147] Dickens points out that courts can show great judicial deference to a profession in identifying a conflict of interest. He cites a decision rendered by the Ontario Divisional Court:

> In delegating to the college the power to define the activities that constitute a conflict of interest, the legislative assembly recognized that conflict of interest varies from calling to calling and that it can best be recognized by those intimately familiar with the particular profession and the subtleties and realities of their own market-place.[148]

Addressing the double agent dilemma

Having established that its own tradition of professionalism mandates that the profession play a vital role in resolving the dilemma of the physician as double agent, we now turn to how.

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[147]R.O. 856/93, cl. 1(1)(33)(1993), as quoted in Dickens *supra* note 146 at 268. Emphasis added by author.

[148]*Cox* v. *College of Optometrists of Ontario*, (1991), 65 O.R. 2d 461 (Ont.Div. Ct.), cited in Dickens *supra* note 146 at 270.

First is to acknowledge the conflict. This may not be easy. Physicians are not comfortable participating in health care rationing.[149] However, if the profession is to assume responsibility for resolving this dilemma, it must start with openly acknowledging the potential conflicting interests represented by physicians.

The profession must define its understanding of a physician's duty to society to ensure the just allocation of resources. Defining this means establishing the extent and limits of this duty. As part of defining the conflict and the physician's duties, the profession must take the initiative to understand the problem. The profession must gather evidence of rationing practices and how individual physicians cope with pressures to ration society's health care resources and craft principles of best or preferred practice. In doing so the profession will educate practitioners and the public as to the extent of the conflict.

To define the extent of the medical professional's role in rationing resources, the profession must consult the public to understand what role society wishes physicians to play. To obtain a response from society, the profession must first educate the public about the physician's double agent dilemma. This reinforces the need for evidence and data concerning the extent of rationing practices among Canadian physicians. There

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[149]Williams & Beresford *supra* note 10.

will certainly not be a consensus within the profession or society as a whole. However, only through discussion, and suggestions of balancing mechanisms, however, will a resolution emerge.

This underlines the importance of other fora to deal with this issue- ones which might facilitate a wider representation of interests- namely meso and macro fora as discussed in chapter three. Williams points out, however, that meso-rationing allows managers and administrators to make key decisions which may, in fact, impinge on clinical autonomy. As mentioned earlier, the AMA's ethical opinions recognise this, stating that such meso rationing may limit a physician's ability to be patient advocate or in fact impinge on clinical judgment as to the patient's best needs.[150]

Williams points out that this may be more in keeping with society's values;

> ...it is those involved in the art of health service management who are resolving the conflicts, rather than the doctors. And since issues of community-wide 'just dealing' between patients will go beyond the scope of any one doctor's realm of action, it could be argued that if the judgments made by a particular doctor (exercising his clinical freedom) clash with those of someone with authority from the community to allocate scarce resources across rival claimants, the clinical freedom of the doctor

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[150]Code of Medical Ethics and Current Opinions of the Council on Ethical and Judicial Affairs *supra* note 129.

> has the weaker moral claim, and can legitimately be constrained accordingly.[151]

Advocating meso rationing requires accepting greater limits on clinical autonomy. Physicians individually seem ready to give up some autonomy in favour of guidance on these issues and lessen the allocation burden on their shoulders. A study of Norwegian physicians asked them directly about their role as manager of society's health resources. It found that "[e]ven though it would represent a reduction in their influence, the majority of the doctors wanted to be relieved of the responsibility of setting difficult priorities."[152]

While more activity at the meso level in rationing would alleviate some pressure, the fact remains that physicians will still be faced with conflicting duties: to the patient and to society. Physicians may relinquish more clinical autonomy by establishing another authority to micro ration. An outside review body might consider requests for new therapies or expensive treatment. Greater reliance on peer review or submission of treatment requests to public accountability might relieve some of the allocation decision-making pressure. The question is how much the profession is willing to surrender its clinical autonomy to avoid responsibility for difficult decisions that challenge the principal commitment to the patient.

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[151]Williams *supra* note 124 at 8.
[152]Arnesen & Fredriksen *supra* note 104 at 160.

Professions are given autonomy and entrusted to *serve* rather than *determine* the public interest.[153] The patient and physician together determine the patient's best interest.[154] Similarly, the public in consultation with physicians, should determine the public interest in health care.[155] However on the front-line, before law and policy is made, physicians must recognise the need to promote justice in the allocation of resources. As a citizen and as the only professional with the power and position to make the initial judgments, physicians cannot shirk this responsibility.

Failure to set the standard

If physicians do not take the initiative to set the standard of conduct with respect to the allocation of resources, the government may limit their authority to do so. At present physicians define medical need and allocate resources based on this need. This autonomy could be forfeited if on site utilization review committees which review treatment plans to ensure the most efficient use of resources, are implemented. Further, pre-utilization review committees which must give pre-authorization for the use of certain health care resources

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[153]Friedson *supra* note 45 at 381.

[154]Unless there is conflict between them when, in most cases, the patient should prevail.

[155]In the case of a conflict between physicians and the public, one might query which side would prevail. The public interest prevailed over the issue of national health insurance.

could be implemented. There are others who could take over the burden for allocating resources. These others however, do not share a commitment to the patient's best interests. While this commitment is the very source of the dilemma, it is also a safe guard in the system to ensure that while rationing decisions will hurt some patients they are carried out within a framework of a strong commitment to patient interests.

It is imperative that the profession attempt to educate the public and draw on other sources of guidance in resolving this dilemma. As Wolf points out, "...the medical profession cannot sit as final arbiter of its own obligations to the broader citizenry and its place in health care reform. That requires collective decisions."[156] Hence the importance of encouraging other fora to make allocation decisions and to discuss the physician's role. Another important forum to deal with this issue is the law, specifically the courts, to which we now turn.

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[156]Wolfe *supra* note 86 at 34.

Chapter 7

Legal Recognition of the Physician's Duty to Society to Ration Health Care Resources

In the next four chapters I consider the role of the law in reconciling a potential conflict between the physician's duties to the patient and to society. This analysis is based on Canadian common law with some reference to the civil law of Quebec and American case law for the purpose of comparison.

In this chapter, I discuss how this conflict fits into a general legal framework and, more specifically, our current law of torts. In the following chapter, I examine how the law of torts might be reformed. I then consider how the doctrine of informed consent might influence this conflict. Finally, I discuss the impact of fiduciary obligations on a physician's dual advocacy role.

I limit my legal analysis to tort law for the sake of space. Contract law is another possible lens under which to examine the patient-physician relationship.[157] However, the legal liability of physicians has been largely defined and dominated by tort, in particular negligence, for the past century and a half.

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[157]For reasons of space, I do not consider contract law further.

Accordingly, this chapter focuses on the tort of negligence. There has been surprisingly little judicial consideration of the physician's double duty and role in health care rationing. The British Columbia Supreme Court touched upon this issue, though only in dicta, in one judgment discussed below. Two American cases from California courts are discussed for comparative purposes. I then turn to discuss whether the law should explicitly recognise a physician's secondary duty to society. I propose that the law should formally recognise the physician's limited but inescapable role in health care rationing as part of her duty to society.[158]

Before considering law's contribution to resolving this dilemma, it is essential to clarify the basic legal issues. There is a large body of case law considering the physician's duty to the patient in tort law and increasingly under fiduciary obligations. I ask whether the law recognises the physician's duty to society to ration health care resources in limited circumstances? Then, I query whether the law provides any mechanism to balance this latter duty with the primary duty to advance the patient's best interests? No physician has been directly charged with failing

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[158]This will be a difficult duty to define both professionally and legally. Like the issue of abortion, rationing of health care services cuts to the core of individuals' beliefs and values. We will have to decide whether the duty to ration should be recognised in the form of a defence to conduct that would otherwise be negligence, or whether it is an enforceable duty. At this stage, enforceability is difficult. Accordingly, while the medical profession has not defined the role itself and the public has not addressed the issue of physician dual advocacy, legal recognition should be in the form of an immunity or justification for conduct that would otherwise be negligence rather than an enforceable duty.

to meet her duty to a patient by prioritizing society's needs through rationing. Thus, this issue has not been subjected to a rigorous legal analysis by Canadian courts. Accordingly, much of the following discussion is anticipatory. This is nonetheless a valuable exercise as such a discussion may help clarify the legal principles that should guide the resolution of this conflict.

Cost containment: an analytical bias

Reviewing the legal literature, a reader might note that it addresses health care rationing primarily from the point of view of cost containment pressures corrupting clinical judgment. Hall, for example, phrases the issue as follows: "The empirical/descriptive question is whether the legal standard will in fact change to accommodate cost-sensitive treatment decisions; the normative issue is whether the standard should change, and, if so, how."[159]

Legal writers discuss rationing as a new pressure facing physicians rather than, as I argue, a part of their professional responsibility and the evolution of that responsibility. Treating the rationing of health care resources as a new phenomenon makes it easier to reject this role for physicians. The legal literature assumes there was a period before cost containment was an issue, during which the physician faced no such conflict

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[159]M.A. Hall, "The Malpractice Standard under Health Care Cost Containment" (1989) 17 L. Medicine & Health Care 347.

of duties. Viewing rationing as a part of the medical professional's role to represent society encourages us to look at the system that has fostered this role and question not simply health care rationing but the structure of authority and implications of limiting or encouraging professional autonomy. Health care rationing is a systemic issue not simply a new pressure on physicians and should be considered accordingly in the legal literature.

Relevant legal areas

The physician's double agent dilemma may be addressed through three areas of legal responsibility: the tort of negligence, contract law, and fiduciary obligations. The law of tort sets a standard of care required of the physician. Failure to meet this standard may constitute negligence. Most patient-initiated actions against physicians are based on the tort of negligence.[160] In the last few decades, the patient-physician relationship has also come to be seen as containing some fiduciary obligations by virtue of the power inequality and the trust inherent in the relationship. This is also recognised in Quebec's Civil Law.

There is much debate about which area of the law will be applied to the double agent dilemma. Irvine suggests that

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[160]E.I. Picard and G.B. Robertson, *Legal Liability of Doctors and Hospitals in Canada* ,3d ed. (Toronto: Carswell, 1996) at 2.

courts are most likely to address the physician's double agency through tort law in an action on informed consent or through proceedings for breach of fiduciary obligations.[161] He also believes that this issue is unlikely to be resolved in court because few people will bring a suit against a physician for parsimonious (or less than the best) treatment in Canada.[162]

Caulfield, in contrast, suggests that a physician's role in cost containment "will likely result in an adjustment of 'medical customs'- which are relevant to establishing the standard of care..."[163] Thus he places the issue squarely under tort law actions in negligence. Dickens, also proposes that an action against a parsimonious physician would likely be brought in negligence.[164]

The consensus is that should an action against a physician who rationed health care resources come before the courts, it would most likely be addressed through the tort of negligence and the development and enforcement of fiduciary obligations. None of the authors reviewed considered this scenario under the principles of contract law. Thus, I only explore the double agent dilemma under the lens of tort law.

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[161]Irvine *supra* note 3 at 347.
[162]*Ibid.* Irvine also suggests such an action would fail on causation as a patient would have difficulty proving with certainty that he would not have suffered the injury had another treatment been offered.
[163]T.A. Caulfield, "Health Care Reform: Can Tort Law Meet The Challenge?" (1994) 32 Alberta Law Review 585 at 698.
[164]Dickens *supra* note 145.

Tort law in Canada at present

Fleming defines a tort as "a civil wrong, other than a breach of contract, which the law will redress by an award of damages."[165] Conduct is designated as tortious by the courts and is only a tort when the law defines it as such.[166] It requires first a duty of care owed by the defendant to the plaintiff. This is usually imposed on a physician when she agrees to treat the patient who has requested the services.[167] Second, for tortious negligent conduct, there must be a failure to meet the standard of care set by the law in the circumstances.

The standard of care expected of physicians was largely established in the 1950's through several Supreme Court of Canada cases. In *Wilson v. Swanson*, the Court held that the degree of care and skill required of a physician is "that which could reasonably be expected of an average practitioner of the same specialty in similar circumstances."[168]

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[165] J.G. Fleming, *The Law of Torts*, 8th ed. (Sydney: Law Book, 1992) at 1.
[166] A.M. Linden, *Canadian Tort Law*, 5th ed. (Toronto: Butterworths, 1993).
[167] See Picard *supra* note 15p at 7.
[168] *Wilson* v. *Swanson*, [1956] S.C.R. 804, 5 D.L.R. (2d) 113. See also *Crits* v. *Sylvester*, [1956] S.C.R. 991, 5 D.L.R. (2d) 601. There is debate about the meaning of 'average practitioner'. More recent case law refers to the reasonably prudent and competent practitioner.

The courts usually rely on the medical profession to allow them to determine what are reasonable practice patterns. Expert evidence offered by physicians is used to establish accepted practice. Judging the reasonableness of a medical decision or procedure often requires specific knowledge and an understanding of the medical facts. Accordingly, the medical profession is expected to fill this evidentiary role. This evidence is used by the court to set the standard. Sometimes, although not often, the judiciary does reject the medical profession's interpretation of the reasonable standard of care, and sets the standard simply on the basis of its own assessment.[169]

Canada's test case

Simice

Does the legal standard of care expected of physicians guide them to balance competing obligations: first to act as a patient advocate securing access to care, and second to act as social advocate rationing health care resources? The closest Canadian courts have come to a ruling on this issue was an action in negligence before the British Columbia Supreme Court in *Law Estate* v. *Simice* [*Simice*][170]

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[169]*ter Nuezen* v. *Korn*, [1995] 3 S.C.R. 674 [hereinafter *ter Nuezen*], and *Chasney* v. *Anderson* [1950] 4 D.L.R. 223 (S.C.C.) [hereinafter *Chasney*].
[170](1994), 21 C.C.L.T. (2d) 228 (B.C.S.C.), [1996] 4W.W.R. 672 (C.A.).

There an action was brought against four physicians in British Columbia for alleged negligence in their provision of care. The plaintiff claimed, inter alia, that the defendants had failed to provide timely and competent diagnoses. During the trial, several physicians testified that their ability to provide these was restricted by the standards of practice set by the British Columbia Medical Insurance Plan and the British Columbia Medical Association.[171] The court upheld the plaintiff's action against several of the physicians involved.

In its dicta, the court recognised that there were budgetary constraints on the physicians: "those constraints worked against the patient's interest by inhibiting the doctors in their judgment of what should be done for him. That is to be deplored."[172] The judge was clear on the issue of a physician's conflict of duties. "[I]f it comes to a choice between a physician's responsibility to his or her individual patient and his or her responsibility to the medicare system overall, the former must take precedence in a case such as this."[173]

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[171]Anecdotes supporting the claim that physicians feel this pressure are increasing. Recently, the emergency room physicians at a leading teaching hospital in Montreal tendered their resignations to protest the pressure the provincial medical insurance agency put on them to offer less care. The insurance agency claimed the physicians had a higher billing rate than other emergency rooms. The physicians, mostly specialists, claimed that due to their specialist training they were able to offer better and more extensive examinations and care. Further, the physicians taught while they examined patients, as they belong to the largest emergency medicine teaching programme in Canada. See "Vic ER Doctors Resign", *The [Montreal] Gazette* (June 22, 1999) A1.
[172]*Simice supra* note 170 at 240.
[173]*Ibid.*.

With respect, I disagree with the court. This dicta was limited to the circumstances of the case. However, it was based on a balance of harms approach. As discussed later, this approach may in fact also open the door for legal recognition of the balancing act required of physicians through the rebuttable defence of economic duress. The court stated that the effect of financial constraints on a patient's treatment should be considered by those who provide the care and those who finance it, essentially passing off responsibility for resolving this dilemma. It was not prepared to consider the effect of such constraints on the standard of care expected of physicians.

Further, the court weighed the harm to the patient who goes undiagnosed against that to the Medicare system if one more CT scan procedure is ordered and shows no condition needing medical treatment. Clearly the harm to the patient is greater. However, this is a short-sighted and unrealistic view. Financial constraints imposed on physicians do not arise because of one extra procedure. They arise because of practice patterns that cannot be sustained by the budget. The harm to the Medicare system is not the cost of one procedure but the aggregate cost of all the CT scans ordered. Nonetheless, *Simice* does show judicial reluctance to expose the patient-centred standard of care to any threats from third party pressures.

US test case

Wickline

The physician's double agency was also first raised before the California Court of Appeal in 1986 in *Wickline* v. *State of California* [*Wickline*][174]. There, the plaintiff patient brought an action in negligence against the defendant state alleging that the negligent discontinuance of her Medi- Cal state insurance eligibility resulted in her injury. The patient who underwent corrective surgery was to be discharged just five days after the procedure, according to the state's medical insurer's policy for such a procedure. Thus, the patient's stay in hospital would only be covered by her insurance policy for the five days. The doctors believed it was medically necessary for the patient to remain in hospital for an additional eight days. The insurance agency rejected an application for an eight day extension and allowed funding for a four day extension. The senior physician testified that "at the time in issue he felt that Medi-Cal[175] consultants had the state's interest more in mind than the patient's welfare and that belief influenced his decision not to request a second extension" of the patient's stay in hospital.[176] The patient suffered complications while she was at home and had to return to the hospital to have her leg amputated.

The court concluded that the treating physicians had an obligation to stand by their clinical judgment and insist on a

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[174]192 Cal. App 3d 1630 (Ct App. 1986).
[175]The state medical insurance agency for the poorest state residents.
[176] *Wickline supra* note174 at 1649.

second extension of stay for their patient. The court did not question Medi-Cal's limitation of care in the interest of minimizing public expenditure on health care. It found fault with the physicians who allowed their medical judgment to be influenced by non-clinical considerations. "While we recognise realistically, that cost consciousness has become a permanent feature of the health care system, it is essential that cost limitation programs not be permitted to corrupt medical judgment."[177] The court was explicit: "...the physician who complies without protest with the limitations imposed by a third party payer, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care."[178] Accordingly the court did not find the insurance agency negligent.[179]

US test case

Wilson

The same court that decided *Wickline* also heard the case of *Wilson v. Blue Cross of Southern California* [*Wilson*][180] four years later and effectively disarmed the *Wickline* proposal of

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[177] *Ibid.* at 1663.

[178] *Ibid.* at 1660.

[179] This case raises another debate currently raging in the United States regarding the liability of insurance companies and the medical nature of their decisions. Recently, California passed legislation allowing patients to seek punitive damages for harm suffered as a result of an HMO coverage decision. This is an important issue but due to limited space must remain a subject for another paper. See "California Law To Let Patients Sue H.M.O.'s", *The New York Times*, vol. CXLIX, no. 51,659(28 September 1999) A1.

[180] 271 Cal. Rptr. 876 (Ct. App. 1990).

an obligation to protest third-party limitations. In *Wilson*, a patient checked himself into a hospital for psychiatric treatment. The attending physician recommended a three-to-four-week inpatient stay. The patient's insurer determined that only eleven days of inpatient treatment were necessary and informed the patient that insurance coverage would cease after eleven day's stay.

The psychiatrist discharged the patient to his family's care when the benefits ceased as the patient and his family were unable to pay for continuing hospital care. The psychiatrist wrote that the patient had to leave hospital treatment early because of pressure from the utilization review firm hired by the insurance company to evaluate treatment plans. Twenty days after his discharge, the patient died from either a drug overdose or suicide. The patient's parents sued the insurance company and the utilization review firm for breach of contract and wrongful death, alleging that their conduct resulted in the premature termination of needed medical treatment.[181]

In *Wilson*, the court rewrote much of *Wickline*, essentially neutralizing its earlier decision.[182] The *Wilson* court stated that the suggestion in *Wickline* that civil liability for a

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[181]Contract law may play a greater role in mitigating disputes between patients and insurance agencies than it does with the patient-physician relationship.

[182]J.J. Frankel, "Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures" (1994) 103 Yale Law Journal 11297 at 1308.

discharge rests solely within the responsibility of a treating physician in all contexts was dicta.[183] The *Wilson* court essentially limited the assertion in *Wickline* that physicians should not comply with third-party limitations on care without protest, to the facts of that case. It rejected the lower court's summary judgment issued against the physician who failed to follow the insurance company's informal policy of appealing initial decisions for reconsideration. This is a clear step back from the absolute commitment to patient advocacy and allows for a more comprehensive assessment depending on the circumstances. This is nonetheless, a long way from judicial acceptance of a physician's participation in health care rationing.

Irvine summarizes the law's de facto position as follows: "the physician's responsibility- not his primary responsibility but his only responsibility for the time being- is to do his best for his patient."[184] Courts may recognise the economic reality that some treatments or facilities may not be practically available.[185] However, the courts will not sanction a physician to exercise his or her discretion to withhold potentially beneficial treatment because of a concern for society's resources.

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[183]Wilson *supra* note 180 at 880.
[184]Irvine *supra* note 3 at 356.
[185]*Bateman* v. *Doiron* (1992), 8 C.C.L.T. (2d) 284 (Q.B.), 118 N.B.R. (2d) 20 [hereinafter *Bateman*].

Should the law recognise a physician's duty to society?

The law is a powerful force in shaping our society. It passes on and protects the values that are essential to our society from generation to generation. The judiciary protects fundamental freedoms and rights against encroachments by the majority or current public sentiment. The law also helps society to evolve, sometimes leading public opinion and values, other times consolidating or following them. The courts, in particular, may take a leadership role in difficult social issues or policy dilemmas when the legislature cannot or will not.[186]

The courts' input on issues as fundamental as a physician's duty to patient and society is important. It may preserve the age-old patient first ethic of the healer in our society. Alternatively, the courts may assist the profession in meeting its evolving obligation to society and encourage society to recognise the changing environment of health care. We now turn to the legal and policy question of whether the courts should recognise a physician's duty to society to participate in health care rationing, through an amended standard of care.

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[186]For example, the Supreme Court of Canada has assumed a leadership role in recognising the rights of homosexual couples and encouraging legislators to do so as well. See "Landmark gay ruling could affect 1000 laws", *The National Post* [Toronto] (21 May 1999) A1.

An outdated standard of care

As discussed above, the courts have opted for the former, protection of the healer's commitment to the patient. The courts have based their decisions on a legal standard of care which many now call unrealistic or outdated. Caulfield, writing in Canada, suggests that the legal standard of care was developed in an atmosphere of the ideal situation that the patient's best interest could be the all-encompassing motivational force, with little "government limitation, or utilization control, on the treatments covered by health insurance."[187] Physicians were free to prescribe whatever treatment they deemed necessary and set the standard of care accordingly.

Frankel asserts that today's medical malpractice law in the United States holds physicians to a standard of care set without regard to cost.[188]

> Medical malpractice law is built upon a definite cultural conception of health care delivery, one in which physicians have sole authority to define appropriate health care outcomes for society and are obligated to do so without reference to patient (or system) resources. Efforts to contain medical costs by forcing physicians to alter their practices to take account of economic concerns cut directly across the grain of this ideal. Plans for cost containment thus risk direct collision with the tort system.[189]

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[187]Caulfield *supra* note 163 at 689
[188]Frankel *supra* note 182 at 1302.
[189]*Ibid.*

These authors and others propose that it is inappropriate to hold physicians to such a standard of care in our current environment of budget cuts and health care resource use limitations. Roy *et al.* suggest that:

> "...medical and ethical limitations on the use of costly health care technologies cannot be sustained if the legal definition of standard medical practice is based on the illusion of unlimited resources. However, there is little evidence that the courts are inclined to enforce illusion-based standards of practice on hospitals and the medical profession."[190]

There are calls to change the standard. The difficult question is how?

The practical reality

Surprisingly little attention has been given to studying a physician's practice patterns and participation in the rationing of health care resources. What information there is indicates that across the country, good, caring physicians are doing this.[191] We are in an era of increasing medical capability and limited resources to match that capability. Few would deny that we must seek to control rising costs to some degree.

Morreim assesses the issue as follows:

> "Successful cost containment cannot occur without the systematic cooperation of physicians, who control some 60 to 80% of health care spending through their decisions about which services and

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[190]Roy *et al.* *supra* note 94 at 1323.
[191]Williams & Beresford *supra* note 10.

> products to order for which patients. Therefore, for the first time, hospitals and health care payers are pressuring physicians to do less for their patients, to perform more procedures on an outpatient basis, and to discharge hospitalized patients earlier."[192]

Unless we radically restructure the health care system, severely limiting clinical autonomy of judgment, physicians, like those in the radiological dye case, will be faced with dual obligations. Physicians are clearly implicated in health care allocation decisions by virtue of their power position. They have the specialized knowledge to judge the medical value of treatments and compare them to possible alternatives or other uses of resources.

This is only one part of the decision-making base required to assess whether a certain treatment should be offered to a patient. The rationing of health care resources requires more than medical knowledge. Physicians are not experts in social values. Clearly physicians are not the only one's who must be involved in rationing decisions. Nonetheless, the social agent role is part of the professional mandate and the standard of behaviour physicians have assumed. Accordingly, physicians should be required to meet this obligation rather than continuing with outdated practice patterns which ignore the cost of health care to society. It is time we accept that the

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[192]E. H. Morreim, "Cost Containment and the Standard of Medical Care" (1987) 75 Cal. L. Rev. 1719 at 1723.

physician's role is wider than just serving the patient's interest.[193]

Urging the courts to acknowledge the evolving role of physicians in our health care system does not address the many ways they may do so. Nor does it deny that there are dangers associated with such a development.

Why the law should not recognise the physician's duty to society

As with many of the new issues arising in health care today, there is a fear of letting the camel's nose into the tent. What may follow may bring the whole tent down. Each new challenge risks moving us away from our traditional values- the patient-centred foundation upon which our health care system is built. Some argue that to recognise as ethical a physician's competing duty to society is the thin edge of the wedge allowing physicians to put a price on life.[194] We want our physicians to be healers not health care rationers. Accordingly, the courts should hold the line and prevent our society from going down that road. If necessary the courts

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[193]M.A. Rodwin, "Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System" (1995) 21 Am. J. L. Med. 241 at 254.

[194]See Angell *supra* note 1. See also Caulfield *supra* note 163; tort law should not allow physicians to avoid responsibility for cost containment decisions leading to harm as this may be the only mechanism by which patients may obtain compensation for injuries resulting from substandard health care.

may have to call us back from a path on which we have already embarked.

Irvine suggests that, at least for the present, physicians should leave cost containment to administrators and hold the patient as their only concern.[195] The law should not recognise the rationing of health care resources as part of a physician's role because such a major policy shift should be made by society and legislators. "There is no reason whatever to suppose that the law - the judge-made and judge-evolved principles of 'common law and equity' - is about to mutate and admit the propriety of non-clinical influences in the physician's dealings with her patient."[196] That should be a political decision requiring legislation. Rightly, the cost and the burden should be borne by politicians not physicians.[197]

The courts are a public forum. Nonetheless, they are not the best place to form public policy. They are adversarial, and in tort actions require the finding of fault and injury and crafting remedies appropriate to the parties to the action. If the courts are to recognise a physician's duty to society and balance it against the primary duty to the patient, they will have to consider variables such as hospital budgets, competing medical

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[195] Irvine *supra* note 3 at 356.
[196] *Ibid.* at 357.
[197] *Ibid.*

priorities, and more generally, social priorities for which the court may be ill-equipped to judge.[198]

Similarly, many of these variables are not best dealt with by physicians either. Nonetheless, simply because there are better fora for such considerations does not preclude less appropriate fora from assuming that burden in the interim, before more appropriate ones act. It is only a matter of time before the courts must consider this issue directly. As *Simice* shows, this issue is already being raised in legal actions.

The political process should grapple with the major resource allocation issues. However, many of these decisions have led to a health care environment in which the physician feels pressure to ration health care resources.[199] Further, public opinion may be measured in many different ways but media reports over the last few years indicate that the public is critical of the government for failings in the health care system, not health care providers.[200]

The inescapable fact remains. At a certain point, as new treatments and technology enter the system, and as people live

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[198]Conditions under which the courts might have to consider such factors will be discussed in the following chapter.

[199]See *supra* note 171.

[200]A recent nurses strike in the province of Quebec provides a stark example of this. On the third day of the strike, following two previous 24 hour walk outs only a month earlier, a poll which surveyed over 1000 Quebecers found that 61,5% of the public supported the nurses illegal strike as a pressure tactic. See "Cabinet Set to get Tough with Nurses", *The [Montreal] Gazette* (28 June 1999) A1.

longer, physicians must accept some responsibility for cost containment before official policies are set. If they do not, hospitals will find they are over budget and have to cut planned services. A part of the responsibility for cost-containment falls on the front-lines. Rather than deny it, we might better spend our energy delimiting this role by ensuring institutions respond quickly and appropriately to evolving treatment options.

Finally, whether or not the courts accommodate the need to ration resources in the standard of care, strong forces constraining the health care sector from abandoning its patient first credo exist within the profession itself, namely, professional ethics and professional prestige.[201] The legal standard of care relies heavily on medical custom and the profession's own code of conduct. Thus, it is essential for the profession itself to assess its role and establish the limits of its role in rationing health care services.

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[201] Hall *supra* note 159 at 352.

Chapter 8

The Standard of Care and a Physician's Double Duty

The call for the courts to recognise the physician's obligation to participate in health care resource allocation has grown louder over the past decade. Nonetheless, there is much debate over how this might be done. Two general approaches to incorporate rationing into the standard of care are possible. First, acknowledge a different or lower standard of care effective in instances of particular financial constraint. Second, maintain a uniform standard of care but allow a defence of economic duress.

In this chapter I discuss a range of legal doctrines that adopt one of these approaches; namely the locality rule, substandard care, a rebuttable presumption for a uniform standard of care which allows for a defence of economic duress, and finally the respected minority principle. These will each be considered as possible mechanisms for the law to recognise a physician's role in health care resource rationing.

Reasonable standard of care

Before considering any reform of the standard of care in Canadian tort law we must examine what role economic constraints play in the current standard. The standard of care

expected of physicians, as stated earlier, is based upon reasonable expectations.[202] It is thus possible that "reasonable expectations" might be interpreted to include consideration of resource constraints and the physician's role in dealing with these. This approach has been used in evaluating the standard of care expected of hospitals. In the 1992 case *Bateman v. Doiron*, the court held that "[a] hospital has an obligation to meet standards reasonably expected by the community it serves in the provision of competent personnel and adequate facilities and equipment."[203] The notion of 'reasonable community expectations' may be an attempt to recognise the reality of health care resource limitations.[204] Picard and Robertson claim that "it is appropriate for the Court to take into account the scarcity of resources in assessing whether the facilities and equipment were reasonable in the circumstances."[205] Roy *et al.* also suggest courts might recognise "resource constraints as an essential part of defining the acceptable level of technology use."[206]

Recognising that economic considerations may play a part in reasonable standards of care expected of hospitals, is a long way from recognising that it is reasonable for physicians to take into account concern for cost containment in their

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[202]See *supra* note 168.
[203]See *supra* note 185 at 290.
[204]Irvine *supra* note 3 at 355.
[205]Picard & Robertson *supra* note 160 at 207.
[206]Roy *et al. supra* note 94 at 1323.

treatment decisions. Caulfield suggests that, though in *Bateman* the courts recognised that a physician might have to work with inadequate resources and might adjust the standard of care down to accommodate that reality, "this judicial discretion would only be applied in circumstances where the equipment was inadequate due to circumstances beyond the clinical decision making power and control of the physician in question."[207]

This case does not address whether the standard of care might take into consideration a physician's conflicting duties and be reduced accordingly because of obligations to others or the system as a whole. Thus, where a higher standard of care was possible, a parsimonious physician might not be immune from liability for taking cost into account and offering good, but less than the higher standard.[208]

Substandard Care

The standard of care does not acknowledge the resource constraints within which a physician operates. One approach to legal recognition of a physician's duty to participate in health care rationing might be to state that substandard care was given due to economic pressures and a physician's responsibility to society. Instead of arguing that a

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[207]Caulfield *supra* note 163 at 702.

[208]The doctrine of informed consent may have a crucial role in such a situation. This will be explored in chapter nine.

parsimonious physician offered the required standard of care, which does not take resource constraints into account, here one candidly admits a lower standard was applied. The courts would then be asked to recognise the financial pressures physicians operate under such that they may have to offer less than optimal care in order to promote a just allocation of resources.

This approach would, effectively, ask a court to "impose a social policy on an injured individual seeking compensation."[209] It also asks the courts to value society as a whole, or the needs of unnamed patients, over a harmed individual in a specific case.[210]

Further, this would be a difficult defence to build. It would require the court to judge social values and economic pressures. "A defendant would need to document the economic circumstances present at the time the substandard care occurred and establish that they were such as to justify the quality of care provided."[211] This would require a great deal of financial information as to regional and hospital budgets.[212] Such a defence would further expand the scope of, and burden of, malpractice litigation.

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[209]Caulfield *supra* note 163 at710.
[210]*Ibid.* at 708.
[211]*Ibid.* at 710.
[212]*Ibid.*

It is unlikely that the courts will assume such a heavy role in policy formation. Roy *et al.* suggest the courts are more likely to leave the task of developing and monitoring economic health policy to the political process. [213] As already discussed, the *Simice* court went so far as to pass off this responsibility to physicians and health care funders.[214]

Lowering the Standard of Care

The courts do not usually accept a lower standard of care. They recognise deviations from the accepted standard where these deviations lead to better care, such as improved medical technology.[215] The courts, however, may be reluctant to acknowledge a duty to society where it might lead to a downward trend in the standard of care

Shuck observes that courts may be more patient centred than the profession- "plus royalistic que le roi". "If rationing is desirable, it is probably fatuous to expect courts in malpractice cases to legitimate it without the benefit of a statute."[216] Caulfield also suggests that the courts may have an obligation to maintain a standard of care which ignores rationing pressures, despite evidence of accepted practice, or the views

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[213]Roy *et al. supra* note 94 at 1323.
[214]See *Simice supra* note 170, and accompanying text.
[215]Morreim *supra* note 192 at 1733.
[216]P. Shuck, "Malpractice Liability and rationing of Care" (1981) 59 Texas L. Rev. 1421 at 1421, quoted in Caulfield *supra* note 163 at 707.

of a respected minority, to the contrary. Courts do not have to uphold professional custom.[217] Caulfield cites the Ontario Supreme Court's 1982 decision in *Hajgato v. London Health Assn.* as an example:

> I do not accept, however, that the court has no active role in determining the outcome in such matters. I accept that the evidence of approved practice is most helpful and persuasive and I fully recognize an absence of expertise in medical matters on the part of the court. In my view, however, a court has a right to strike down substandard approved practice when common sense dictates such a result. No profession is above the law and the courts on behalf of the public have a critical role to play in monitoring and precipitating changes where required in professional standards.[218]

The courts will be reluctant to legitimize a lower standard of care. Judicial acceptance of physician participation in health care rationing will not simply require recognition of a different standard of care, but of a lower standard. The plaintiff in each case will present evidence of the highest standard of care requiring the defendant to justify the 'lower' one offered.[219] It is possible that courts will show their traditional deference to the profession in setting the standard, hesitating before second-guessing. Again, this would require a strong standard or opinion coming from the profession itself clarifying the role of physicians in health care rationing. However, as a general

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[217] *ter Nuezen supra* note 169.
[218] (1982), 36 O.R. (2d) 669 at 692 (H.C.), aff'd (1983) 44 O.R. (2d) 264 at 693, quoted in Caulfield *supra* note 163 at 707.
[219] Caulfield *supra* note 163 at 708.

principle of legal history, when courts challenge a profession's standards, it is to raise them.[220]

Locality rule

The locality rule is a persistent thread throughout the history of Canadian medical law. Its premises are worth briefly mentioning because we seem to be unable to lay them to rest. This rule, recognised by Canadian courts at the end of last century[221], acknowledges that there may be great differences in the health care resources available in rural versus urban settings.[222] It established that "the standard against which a physician is to be judged is that of a reasonably prudent practitioner "in good standing in the community in the same line of practice."[223] The rule was largely abandoned as improved technology and communication overcame the difficulties rural practitioners had in maintaining up-to-date skills. The recent revival of this rule is still tenuous. However some courts have decided the standard of care required in a given case with reference to the practitioner's locality. [224]

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[220] For example, *ter Nuezen supra* note 169 and *Chasney supra* note 169, as discussed in Caulfield *supra* note 163 at 709.

[221] *Zirkler* v. *Robertson* (1897), 30 N.S.R. 61 (C.A.).

[222] Picard *supra* note 160 at 204. This was accounting primarily for lack of educational opportunities to improve and maintain skills.

[223] Caulfield *supra* note 163 at 703, quoting A. Meagher *et al.*, *Doctors and hospitals: Legal Duties* (Toronto: Butterworths, 1991).

[224] See *Davidson* v. *Connaught Laboratories* (1980), 14 C.C.L.T. 251 (Ont. H.C.). Picard suggests the locality rule's reemergence over the last 15 years reflects the fact that it refuses to die. Nonetheless, it is having little effect on the outcome of the cases in which it is raised. See Picard *supra* note 160 at 205.

The locality rule acknowledges the resource restrictions that affect the quality of health care provided in certain geographical regions. It might allow courts to adjust the standard of care to take into account tight budgets and the pressure physicians face to ensure the most just and efficient use of resources because the standard required must be reasonable in the circumstances.

The important point is that the locality rule recognises a difference in the standard of care that exists due to factors beyond the physician's control, namely lack of resources. This rule, however, does not address the physician's role in rationing health care resources or the element of professional discretion. It addresses the somewhat rare situation where resources truly are unavailable.[225]

The issue in the physician's dual agency is not the actual availability of resources but the exercise of the physician's discretion and factors that may be taken into account in offering care. Morreim rejects the locality rule because in order to use it for guidance,

> ...we would have to expand the locality rule to cover both the unavailability of resources and conscious decisions to refrain from using available resources. Here, the physician forgoes an intervention not

[225]This is truly a rare situation. Even when resources are not available in this country patients may be sent to the United States for treatment deamed medically necessary.

> because it cannot be procured or because the patient would not benefit, but because of a priority decision that this patient's benefit would not be certain enough or substantial enough to justify depriving other, needier patients. Such an extension of the locality concept would not be a reasonable extension of its original meaning.[226]

Rebuttable presumption for a unitary standard of care

The law currently holds physicians to a uniform standard of care such that they owe all patients the same basic quality of care. Rather than seek a lower standard of care, Morreim proposes a rebuttable presumption for the unitary standard of care. She suggests that "the law should offer economically pressed physicians some opportunity to rebut this presumption where the diminution of care arose by necessity [not of the physician's making] and not by negligence."[227] She warns that a simple balancing of the patient's interest against those of society or the public would not suffice. Strong and specific proof of the economic pressures or constraints a physician faced would be required.[228]

What is most interesting about this proposal, as Morreim notes, is that it recognises that the physician is a part of the resource allocation process.[229] However, it is only upon very strong

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[226]Morreim *supra* note 192 at 1730.
[227]*Ibid.* at 1767.
[228]*Ibid.*
[229]*Ibid.* at 1758.

proof of financial constraints that the physician's primary role of patient advocate can be lessened.

Morreim believes this defence upholds the principles of fairness and furthers the purpose of tort law which is to prevent needless injury.[230] Incorporating cost containment into a reasonable standard of care is not a gross distortion of the law. As Morreim points out, "[r]easonableness is determined by weighing the seriousness and likelihood of harm we wish to avoid against the burdens or costs incurred to avoid such harm."[231] The rebuttable standard acknowledges that in allocating a limited public resource, it is not simply the individual patient who may be harmed by a physician's decision but other patients who have claims on that resource and who may be equally dependent upon our limited resources.

Morreim's proposal might help to bring the law into line with current practice, while still ensuring the vigilance of the law protects patients. The standard of care is still a uniform one. A physician charged with negligence for limiting or withholding treatment due to costs to the system would have the opportunity to explain the pressures that led to this course of action. Such a presentation takes a very real social condition into an open public forum.

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[230] *Ibid.* at 1757.
[231] *Ibid.* at 1759.

The courts would then have responsibility for establishing the guidelines by which a physician must balance a patients' interests and those of society. The judge would set the bar for the level of economic duress which allowed society's interests to outweigh those of the patient. This is a decision that should be addressed in legislation as is, for example, the responsibility to report child abuse in many provinces. The courts may turn to the profession itself for guidance in establishing such a bar, even on a case by case basis. Thus, the profession might still participate in addressing this question for itself.

Hall disagrees with Morreim's proposal. He says if we allow for a rebuttable unified standard of care and for a defence of lack of resources to be raised, we require the courts to "shift the inquiry from the prevailing custom to a direct assessment of the net social welfare of performing a particular test or procedure."[232] Courts would have to decide if cost-constraint truly justified lowering the standard of care.

Morreim proposes that a physician or hospital defendant in a negligence action provide information on "the needs of the plaintiff-patient compared with other patients' needs at the time, the policies developed within the hospital and elsewhere to cope with fiscal limits, and perhaps even the pressures that

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[232]Hall *supra* note 159 at 351.

have been personally applied to the physician defendant."[233] She acknowledges that this might require the courts to engage in difficult judging of the value of one therapeutic intervention over another.

Morreim recognises that resource allocation questions are best addressed by society as a whole and not the judiciary. However, bringing this issue into court takes it one step closer to a public forum where society as a whole may deal with it.[234] Hall counters that such a process would overburden the malpractice system when insurance premiums are already skyrocketing.[235]

Overburdened or not, the courts will have to resolve this dilemma case by case until the legislature offers a solution. Morreim's proposal allows the courts to consider the social reality and judge whether a physician's conduct was tortious in those circumstances. It also affirms the standard of care as the best reasonably expected. thus it upholds the principle that patients should receive the best care reasonably possible from their physicians. It is the exception rather than the rule that can offer less than this standard of care.

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[233]Morreim *supra* note 192 at 1756.
[234]*Ibid.* at 1762.
[235]Hall *supra* note 159 at 352. While this is especially true in the United States, this is also a concern in Canada.

Respectable minority rule

Hall does not believe that we need a new doctrine or need to lower the standard of care in certain instances. He suggests that the legal standard of care already allows for considerations of cost containment to be taken into account. Specifically, the standard is taken from the custom that prevails in the industry. Yet, within the health care industry, there are huge variations in practice patterns. The law recognises this to a small extent with the respectable minority rule.

To establish this doctrine as a defence in a malpractice suit, a physician must show that the care offered or practice "is followed by at least a respectable minority of competent practitioners in the same field."[236]

Hall argues that with the huge variations in accepted practice between different regions, major cost cuts and limits on treatment could be carried out in certain regions and still fall well within currently accepted practice. He offers the example of New Haven, Connecticut, which could cut coronary bypass procedures by half and still be within the acceptable practice standard for the New England region.[237] Hall believes a custom-based legal standard can accommodate cost-containment incentives in the provision of care and still provide sufficient protection of quality of care. Where there

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[236]Picard *supra* note 160 at 278.
[237]Hall *supra* note 159.

are strong economic pressures the standard of care could be lowered and still be within accepted practice. The accepted standard of care is determined in each circumstance and is not based on general regional statistics or averages. Further, the institutions which feel the greatest financial constraints may already offer care considered below the 'statistical average'. Physicians serving in these institutions or regions are not likely to be helped by Hall's approach.

The precursor to an amended standard of care

Both Hall and Morreim base their propositions on an "accepted practice" incorporating cost-containment. This may be difficult to apply because to date the approach to resource allocation, and the methodology describing and implementing it varies from institution to institution and physician to physician. There is little cohesion in the field of a physician's duty to society and no clear minority opinion, or even accepted practice, as to how a physician should balance the duty to patient and society. An academic opinion in support of a physician rationing health care would require more than colleagues saying they would have acted in a similar manner.[238] While many physicians clearly feel pressure to act as social agents and alter their behaviour accordingly, there is no consensus on how it should be done or which steps to take.

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[238]Caulfield *supra* note 163 at 706.

Thus there is no minority or majority yardsticks against which to measure a physician's actions.

This highlights a powerful point. Physicians largely set the standard of care allowing for evolution of practice patterns. However when practice patterns evolve not because of advances reported in medical journals, but because individuals recognise a responsibility or feel pressure and respond according to their own conscience with little cohesion, a clear standard does not develop. The resulting wide variety of coping strategies may not be the best for patient care or society. Can the courts do better? Can they help establish a more uniform approach or offer guidelines as to how physicians must balance these competing obligations? Morreim's rebuttable unified standard is a start. Yet the courts would have an easier job if the medical profession initiated debate and worked towards establishing a consensus from within first.

Exploring these various methods to incorporate the physician's duty to participate in the rationing of health care resources into the legal standard of care is still speculation. The courts have not shown any readiness to adjust the standard of care. Irvine advises "that the proper course for physicians generally, at this juncture in medico-legal history, is to leave the task of cost containment strictly to the administrators, wherever such strategies come into actual or potential conflict with the best

interests of the patient."[239] This may be wise advice but some physicians feel they cannot heed it. At this juncture, physicians are vulnerable and receiving mixed messages. It is time to bring the law into harmony with the social reality and the medical professional's roles in our system.

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[239]Irvine *supra* note 3 at 356

Chapter 9

Informed Consent

There is another doctrine within the tort of negligence that is intricately linked to the issue of the physician's double duty-informed consent. This doctrine places an obligation on the physician as part of the required standard of care. Through this obligation to adequately inform a patient, any duty conflicting with that of advancing the best interests of the patient is likely to be exposed. The importance of this doctrine is less in the guidance it might offer to physicians as to how to balance competing duties, or to courts as to whether to legally recognise a duty to society. Its greater value lies in its ability to illuminate the conflict of duties and provide a lens for the conflict's judicial consideration.

I believe this doctrine is the most likely vehicle for consideration of the physician's double duty dilemma. But I deliberately discuss this issue after considering the obligations of professionalism and an amendment to the standard of care in the tort of negligence. To analyze a disclosure duty concerning rationing decisions, we must first understand how a physician's obligation to ration health care services fits into the standard of care. Is it a legally recognised duty or accepted practice within the profession? If yes, what are the limits on this duty? Only then may we ask whether there is a disclosure

duty. Therefore, before the physician's double duty may be considered through the lens of informed consent, leadership from the medical profession and legal analysis is required to provide answers to the first two questions above.

In this chapter, I examine how the doctrine of informed consent impacts the double agency. Specifically, I review the conflicting opinions in the legal literature concerning the duty of disclosure and rationing. I then discuss the concepts of material information, autonomy, and a patient centred standard to conclude that, on the balance, these concepts point to a duty of disclosure. I then suggest a policy of openness concerning a physician's duty to society. I recommend initiatives to educate physicians, patients, and society on the physician's role in rationing health care to facilitate public debate and patient-physician discussion.

Informed consent

I start with an attempt to define the ever-evolving concept of informed consent. Its content is determined by each case's circumstances. The concept refers to the physician's obligation to provide adequate information to the patient.[240] It is a tool the courts developed to protect patients' autonomy and ability to make decisions concerning their own welfare.

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[240]Picard *supra* note 160 at 110.

Through this obligation, courts attempt to redress the inequality of power in the patient-physician relationship in which the physician holds the specialized knowledge.[241] Competent patients must be informed of all material information relevant to a decision whether or not to pursue a proposed course of treatment.[242] Material information is judged as that which a reasonable patient in that particular situation would deem relevant. It includes potential risks, harms and benefits of reasonably indicated treatment, including foregoing treatment, that the physician knows or ought to know would be relevant to a patient's decision to undertake a particular treatment.[243]

This doctrine begs the question: if a physician has a legally recognised duty to society to ration health care resources in limited circumstances, does that physician have an obligation to tell the patient of this duty's extent? Must the physician inform the patient when she has exercised her discretion to limit treatment or services which might have some medical benefit? Does the patient have a right to know of existing treatment options which are not available? The conflict of duties a physician faces is most clearly exposed when considered under the lens of informed consent.

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[241] *Ibid.* at 111, discussing *Hollis* v. *Dow Corning Corp*, [1995] 4 S.C.R. 634, 129 D.L.R. (4th) 609. This doctrine's contribution to resolving the double agent dilemma will be discussed in the final chapter.
[242] See *Reibl* v. *Hughes supra* note 119.
[243] *Ibid.*

This would be a very difficult discussion. In the UK., where physicians have played a more active role in rationing health care resources, physicians have developed a pattern of avoiding discussing their role in limiting treatment. They find medical reasons for the limitation of treatment rather than acknowledge the clinical discretion involved. [244] This indicates physicians are not comfortable discussing treatment limitations with their patients.

Conflicting opinions on duty of disclosure

Despite such discomfort, a physician's duty to inform the patient is not confined to the risks of a given procedure or treatment. Material information which a reasonable patient would want to know may include treatment options not available due to cost-containment pressures. There are conflicting opinions on this issue in the legal literature. The arguments discussed below represent a range of the views on this subject. At present, they are largely speculation.

Morreim, who asserts that the law must recognise the cost-containment pressures under which physicians operate, suggests that requiring physicians to disclose all medically reasonable options, even those not available because of cost containment, may harm the trust relationship with the patient. Such an obligation might "require the physician- unavoidably a

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[244]Aaron & Schwartz *supra* note 108.

pivotal agent of allocation decisions- to inform the patient that the physician himself is withholding some desirable intervention because of cost or of other patients' greater need."[245]

Roy *et al.* support this view. However, they further specify that when treatment is withheld as a result of cost containment measures, patients need only be informed if they can be expected to seek such treatment out at private expense. If a treatment not available due to cost containment is clearly beyond a patient's personal means, failure to inform the patient of this treatment does not affect the legal validity of that patient's informed consent. The existence of this treatment, or knowledge of its existence, will not have an effect on the patient's decision to undergo the available treatment.[246]

Roy *et al.* point out that if it is legal and ethical to restrict access to treatment then it is legal and ethical for a physician not to have to inform a patient of treatment options not available.[247] The legality and ethics of such policies belong in the public realm. "[T]he diagnostic couch is not the place for a one-on-one patient referendum on the hospital's policy."[248]

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[245]Morreim *supra* note 192 at 1737.
[246]Roy *et al. supra* at 1323. However, consider that vocal or 'difficult' patients may receive different treatment. See W.B. Schwartz & H.J. Aaron . "Rationing Hospital Care: Lessons from Britain"(1984) 310 NEJM 52.
[247]Roy *et al, supra* note 91 at 1323.
[248]*Ibid.*

In contrast to Morreim and Roy *et al.*, Caulfield and Ginn suggest that disclosure of cost-containment policies and treatment restrictions is necessary. This is particularly pertinent in light of the courts' emphasis on patient autonomy.[249] Roy *et al.* and Caulfield and Ginn refer primarily to institutional cost containment policies. Individual physician judgments exercising a social advocacy role are somewhat different and more difficult. This highlights the importance of having institutional backing of physicians' efforts to control costs and consensus within the profession, as will be discussed later.

Material information

In the context of health care rationing, the doctrine of informed consent may be analyzed primarily in light of what constitutes material information. In the initial scenario described concerning the radiological dyes, the decision to offer the less expensive dye also increased the chances of mild to moderate side effects. Is the existence of the more expensive dye, and the increased risk of discomfort associated with the cheaper dye, material information?

What exactly constitutes a material risk or material information is not a clear fact. A 1: 100 000 risk of a fatal

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[249]Caulfield *supra* note 163 at 330.

reaction to a radiological dye, was held to be a material risk.[250] For patients to consent to the use of the cheaper but higher risk dye, would they need to be told that their risk of discomfort is higher than with the more expensive dye? Caulfield and Ginn suggest that " a cost containment policy must be disclosed where it might add to the material risks of a given treatment program; for example the use of less expensive drugs with more side effects".[251]

US case law is a valuable and more ample source to explore how the courts have treated this issue. In 1972 the California Supreme Court held in *Cobbs v. Grant*[252] that in addition to the requirement to inform patients of the risks inherent in their treatment, "patients must also be informed about 'the risks of a decision not to undergo the [proposed] treatment."[253] Risks resulting from a treatment being withheld might be considered in the same light. The decision to withhold a more expensive treatment and thereby increase the potential risks might well be considered material information by a reasonable patient in such a situation.

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[250] *Meyer Estate* v. *Rogers* (1991), 78 D.L.R. (4th) 307 (Ont. Gen. Div.) discussed in Caulfield *supra* note 163 at 330.
[251] Caulfield *supra* note 163 at 330.
[252] 502 P.2d 1 (Cal. 1972), discussed in F.H.Miller, "Denial of Health Care and Informed Consent in English and American Law" (1992) 18 Am. J . L. Med. 37 at 63. .
[253] *Ibid.* In *Truman* v. *Thomas* 611 P.2d 902 (Cal. 1980), the California Supreme Court also found a physician negligent in failing to properly inform his patient as to the risks of foregoing treatment. Discussed in Miller *supra* note 252 at 63.

Autonomy through Information

The right to full information has become an increasingly well developed and protected element of medical law. It is only through information that a patient may exercise true autonomy in choosing the best treatment option. Information allows a patient to consider treatments in light of his own values of which the physician can have only limited knowledge.

In addition to requiring disclosure of material risks, the doctrine of informed consent also requires that a patient be informed of alternative treatments to ensure she is able to choose the best one for her.[254] Caulfield and Ginn suggest that this might require disclosure of all treatments even those not available because of cost containment policies since there is no economic qualification to this legal requirement.[255] We might use the standard of the reasonable patient to ask if such a patient in this situation would want to know of any services withheld due to rationing policies? If a patient would want to know about any such potentially beneficial treatment not offered before making a decision concerning the proposed treatment, then the rationed treatment should be discussed. Depending on the nature of the treatment, it is possible that some patients might consider pursuing the treatment privately or challenge the decision to withhold the treatment. Informed

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[254]See *Reibl v. Hughes supra* note 119.

[255]Caulfield *supra* note 163 at 330.

consent from such patients would require that they be informed of the services withheld.

Quebec's legislation, *The Health Services and Social Services Act* specifies: "Every person is entitled to be informed of the existence of the health and social services and resources available in his community and of the conditions governing access to such services and resources."[256] This is the first provision under the section on the rights of those who use the health care system. Information concerning rationing policies or decisions might fall into conditions governing access to services. Disclosure of this information would be required.

While at first this legislative initiative appears clear, it is still open to different interpretations. Specifically, that legislation does not specify that patients are entitled to be informed of treatment options which are not available. If courts recognise the need to ration resources then a rationing policy may make certain resources legally unavailable to certain patients.[257] Roy *et al.* suggest that if it is legal for a physician to ration care, such services are legally not available. Alternatively, however, we might view this provision as implying that a 'legal' rationing scheme is a condition governing access to care and must be disclosed.

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[256] *An Act Respecting Health Services and Social Services*, R.S.Q, c. S, 4.2, s4.

[257] This begs the question: will legal recognition of the need to ration be interpreted as establishing no legal right to certain services, or simply offer legal immunity to physicians who withold those services.

In some instances it is clear that physicians would be under a duty to disclose the existence of rationed off treatment. A physician must provide an honest answer to any questions a patient asks.[258] If a patient inquires about a treatment, the physician must explain why it is not available. This responsibility, however favours those patients who have better access to information independent of their physician. More educated patients might be more inclined to research their illness, follow news coverage of medical developments, or talk with other patients or informed persons. Such patients would be more able to question their physicians about treatment alternatives.

If the duty to disclose the existence of rationed off treatment rests solely on the obligation to answer specific patient questions, then the most educated patients will clearly benefit. A patient who knew there were two types of radiological dye available might be able to ask about the difference between the two and challenge a decision not to provide the more expensive dye. Alternatively, such a patient could go to another hospital where the more expensive dye would be made available. A patient who had no prior knowledge of the less risky dye, or who was more timid, would not ask a question and would not have no opportunity to seek the rationed off treatment through other means. Two standards of care would

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[258] *Reibl v. Hughes supra* note 119.

arise based upon a patient's access to information outside of the patient-physician relationship. Therefore, concern for the principle of equality, just distribution of resources, and non-discrimination favours requiring disclosure of rationing decisions and policies.

The Reasonable patient

The very nature of informed consent as established by the Supreme Court of Canada in 1980 in *Reibl v. Hughes* [259]is based upon what a reasonable patient would want to know. If this standard for the content of a physician's duty to disclose were applied to the case of rationed treatment it is very likely that the reasonable patient would want to know of rationed-off options. This begs the question, however, what would the reasonable patient want to know?

Roy *et al.* approach this question by suggesting that a patient who might be able to act on information about rationed off treatment would want to know. Other patients for whom the information would serve no practical purpose would likely not want to know.[260] This, however, implies that the only reason a patient would want to know about rationing decisions is to secure rationed off treatment. Patients might possibly want to know what their health care system truly offers.

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[259]*Ibid.*
[260]Roy *et al. supra.* note 94.

Further this adds to the physician's duties. It makes her responsible for estimating a patient's financial means. To make that judgment, the physician would have to know how concerned the patient was about increased risk factors associated with the offered treatment such as the cheaper radiological dye, and the extent he would go to to avoid those risks. The patient might have family resources, community support, or savings to help him secure a less risky treatment. This would be difficult for a physician to assess without openly discussing the rationing decision with the patient.

On the other hand, we cannot expect the physician to discuss every treatment option around the world. She has to make a judgment as to what treatments are most likely to be relevant to the patient's decision. The reasonable patient standard thus requires a very subjective approach as the physician must establish what a reasonable patient in the particular situation with the same fears, values, and available means, would like to know.

The Supreme Court of Canada specified that "[w]hat the doctor knows or should know that the particular patient deems relevant to a decision whether to undergo prescribed treatment goes equally to his duty of disclosure as do the material risks recognised as a matter of required medical knowledge."[261]

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[261] *Reibl v. Hughes supra* note 119.

This standard would favour discussion and seeking as much input as possible from the patient. There may be extreme cases as Roy *et al.* point out where disclosure of rationed-off treatment is not necessary. More often than not, however, the reasonable patient would like to know.

A policy of openness

At present, the better conclusion is that if the physician is required to act as a social advocate, the patient should be aware of this reality of our health care system. Like the legal standard of care, patients too have developed their expectations for their health care system in an era when cost consciousness was not a dominant factor- particularly since universal health insurance eliminated the immediate cost of care. If either patients or physicians are unhappy with this role, they should work for change. This may be an unfair burden on patients but it preserves trust. Patients will know the limits of their physician's advocacy mandate. The alternative is that patients will be ignorant of health policy that directly affects their own health.

If rationing decisions or treatment options not available are considered material information then a patient has a right to know about them. Further a physician has a duty to disclose this role. A blanket rule of disclosure is not appropriate. Rather, we might adopt a base presumption in favour of

disclosure, allowing for justified non-disclosure. Each case must be approached on its circumstances. If a physician believes that that patient would consider the existence of options not available as material to the decision to undergo treatment then discussion is warranted. This places the issue back into the realm of physician discretion. In the UK this has not led to much disclosure.

This highlights the difference between theory and practice. It is easier to say on paper that we should hold no secrets. In practice a physician may be reluctant to discuss rationing with an ill patient. Physicians will be put in an unfair position facing expectations that they are solely patient advocates, then having to explain that they are the system's gate keepers too.

If we are more public about our limits to treatment and the profession acknowledges this role and its limits, and educates patients and society, it may become easier for physicians to undertake rationing when necessary and accept this as part of their clinical duties in our health care system. This will require a new socialization of patients, citizens, and physicians. The medical profession, health care institutions, and society will have to offer physicians considerable support to help define the limits of this role and its necessity.

This simply underlines the need for more public discussion of health care resource rationing. We need to know what patients

want. We must ask them. In addition to public consultations, we need empirical studies of patients' and citizens' views to guide the informed consent doctrine.[262] For now, however, the doctrine's evolution rests in the court's hands. There is room, indeed urgency, for health care professionals, to take some initiative and help define informed consent through empirical research.

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[262]This is a challenge for policy makers and the medical profession. Public views on a hypothetical situation may differ from those on a real one. Nonetheless, this must not deter efforts to promote public discussion and consultation.

Chapter 10

Fiduciary Obligations

The doctrine of informed consent is the most likely vehicle through which the conflicts of duty owed by a physician will receive judicial consideration. However, the doctrine of fiduciary obligation drives to the heart of the conflict, exposing the fundamental principles at stake: trust and trusteeship. Recently there has been a renewed interest in the fiduciary nature of the patient-physician relationship. This is understandable in light of many of the new challenges facing the profession of medicine which touch directly upon these fundamental principles of fiduciary obligations.[263] Fiduciary principles may play an increasingly important role in defining the physician's duties within the therapeutic relationship. In an era of cost-containment and a potential conflict between the interests of the patient and those of society as a whole, the extent of a physician's fiduciary obligations to her patient and her responsibility to society may play a vital role in balancing the competing priorities for physicians.

In this chapter, I review briefly the concept of a fiduciary relationship and fiduciary obligations, highlighting their evolving nature. I consider the physician's role as fiduciary to

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[263] See chapter one and two for a brief discussion of some of those challenges.

the patient. I then explore the physician's obligations to society in certain circumstances. I conclude that the concept of fiduciary duty is useful in calibrating the balance between the primary obligation inherent in the trust nature of the patient-physician relationship and the secondary obligation arising out of the physician's professional duties to society.

The fiduciary relationship

A fiduciary relationship is one in which one party- the fiduciary- may exercise a discretion or power capable of affecting the legal or practical interests of the second party- the principal.[264] The fiduciary duty was developed in the early 1700s in the English Court of Equity "as a device by which a trustee's discretion over the legal interests of his or her *cestui que* trust could be controlled".[265] Where this duty exists, the fiduciary must exercise his discretion for the benefit of the principal and must avoid any conflict of duty or interest.[266]

Over the past two decades, Canadian courts have contributed to a growth in the concept of fiduciary obligations imposed on a wider variety of relationships. It is suggested that this

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[264]The Honourable Mr. Justice G.V. La Forest, "Overview of Fiduciary Duties" in Mr. Justice A. MacInnes & B.M. Hamilton, Co-Chairs, *The 1993 Isaac Pitblado Lectures: Fiduciary Duties/ Conflicts of Interest* (Manitoba: Manitoba Law Society, 1993) 3.
[265]*Ibid.* at 2.
[266]*Ibid.*

development is simply another legal tool which responds to "the Court's concern for the plight of the vulnerable individuals in transaction with others."[267] The evolution of the courts approach to the patient-physician relationship parallels an important development in the law, what Justice La Forest calls "...the rapprochement of contract, tort, fiduciary duties, and other concepts for the protection of the vulnerable, and a wider, more comprehensive and flexible approach to the law of civil obligations."[268]

Fiduciary obligations: a social construct

Like the doctrine of informed consent, the fiduciary relationship is a social construct of the court. Its obligations and limits are shaped by the court. As Rodwin points out, "the decision to hold any class or individual to fiduciary standards is a social decision."[269] Accordingly, fiduciary obligations may be extended to new parties by courts, legislatures and other means.[270]

Rodwin's comparison of automobile mechanics and physicians highlights the element of societal values inherent in the establishment of a fiduciary relationship. Mechanics give advice and have specialized expertise. Clients trust them and

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[267] *Ibid.* at 1.
[268] *Ibid.* at 2.
[269] Rodwin *supra* note 193 at 245.
[270] *Ibid.* at 245.

must rely on their knowledge. Nonetheless, the car owner-mechanic relationship is not a fiduciary one. What is at stake- the health of the car- is deemed less important and the dependent party less vulnerable than a patient whose physician may hold direct life or death power.[271] Therefore, mechanics are not held to owe fiduciary obligations to their clients. They do not have to promote their clients' best interests above their own. Nor do they owe their clients a duty of loyalty.

Few people can adequately monitor the quality of their mechanic's service. Similarly, patients are in a poor position to monitor physicians.[272] Yet, the courts are more vigilant in protecting patients from conflicts of interest which might affect the standard of care offered to them because their health and life may be at stake.

So sacred is the patient's trust, that courts do not even require malicious intent to find a breach of a fiduciary duty. Where a fiduciary duty exists, a breach of that duty does not "necessarily involve self-interest, deceit, or dishonesty on the part of the fiduciary."[273] The question then arises, where does a fiduciary duty exist and what is the extent of this duty. To this we now turn.

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[271] *Ibid.* at 245.
[272] *Ibid.* at 246.
[273] The Honourable Mr Justice G.V. La Forest *supra* note 264 at 3. He discusses this development in light of his judgment in *Canson Enterprises Ltd.* v. *Boughton & Co.*, [1991] 3 S.C.R. 534.

Physician as fiduciary to the patient

In light of these aspects of the fiduciary duty it is possible to see why the patient-physician interaction contains elements of the fiduciary relationship and yet is not a pure example. First, a physician clearly holds power over the patient's legal or practical interests- namely health and life. Second, a physician cannot be a pure fiduciary as there has always been a potential conflict of duties owed to the patient and to society, highlighted in cases of highly contagious diseases, dangerous psychiatric patients, elderly drivers, or most recently cost containment policies. Accordingly this hybrid relationship has been called 'of a fiduciary nature' and not entailing a fixed set of fiduciary obligations.[274]

We consider the Canadian courts' interpretation of the physician's fiduciary obligations to the patient. The trust inherent in the therapeutic relationship has been recognised in Canadian common law for over one hundred years.[275] In 1956 the Ontario High Court specifically defined the patient physician relationship as both fiduciary and confidential in *Henderson v. Johnston.* "It is the same relationship as that which exists in equity between a parent and his child, a man

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[274]R. Novek, "Fiduciary duties: Patients and Healthcare Professionals", *The 1993 Isaac Pitblado Lectures: Fiduciary Duties/ Conflicts of Interest*, *supra* note 264 at 131.
[275]*Ibid.*

and his wife, an attorney and his client, a confessor and his penitent, and a guardian and his ward."[276]

More recently, in 1992 in Norberg *v. Wynrib*[277], the Supreme Court of Canada demonstrated that the patient-physician relationship can be characterized under tort, contract or fiduciary principles. That case, concerned sexual relations between a physician and his patient. Justice Sopinka observed that "certain obligations that arise from a doctor-and-patient relationship are fiduciary in nature; however, other obligations are contractual or based on the neighbourhood principle which is the foundation of the law of negligence. Fiduciary duties should not be superimposed on these common law duties simply to improve the nature or extent of the remedy."[278] However, there are signs that the fiduciary nature of the relationship may rise to prominence. While Justice McLachlin in *Norberg* stated that the doctor-patient relationship can be conceptualized as a creature of contract or of tort, she added that its most fundamental characteristic, rooted in the trust inherent in the relationship, is its fiduciary nature.[279]

She described the distinctions as follows:

> The foundation and ambit of the fiduciary obligation are conceptually distinct from the foundation and ambit of contract and tort. ... In

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[276]*Henderson* v. *Johnston*, [1956] O.R. 789, at 799, (Ont. H.C.), aff'd (1959), 19 D.L.R. (2d) 201 S.C.C..
[277][1992] 2 S.C.R. 226, 12 C.C.L.T. (2d) 1[hereinafter *Norberg*].
[278]*Ibid.* as quoted in Dickens *supra* note 146 at 261.
[279]*Norberg*, *supra* note 277 at 268

> negligence and contract the parties are taken to be equal actors, concerned primarily with their own self-interest. Consequently, the law seeks a balance between enforcing obligations by awarding compensation when those obligations are breached, and preserving optimum freedom for those involved in the relationship in question. The essence of a fiduciary relationship, by contrast is that one party exercises power on behalf of another and pledges himself or herself to act in the best interests of the other.[280]

That same year in *McInerney v. Macdonald*[281], the Supreme Court of Canada confirmed the fiduciary nature of the patient physician relationship while specifying that it should not be thought of as "a fixed set of rules and principles [which] apply in all circumstances or to all obligations arising out of the doctor-patient relationship."[282] However, the court did specify that "certain duties do arise from the special relationship of trust and confidence between the doctor and the patient. Among these are the duty of the doctor to act with utmost good faith and loyalty.'[283]

Irvine suggests that the fiduciary duty of undivided loyalty in *McInerney* and in *Norberg* prevents physicians from advancing the interests of state, hospital or career over patients as this would breach their fiduciary duty.[284] No matter how noble or

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[280]*Ibid.* at 272
[281][1992], 2 S.C.R. 138, 12 C.C.L.T. (2d) 225 [hereinafter *McInerney*].
[282]*Ibid.* at 148.
[283]*Ibid.* at 149.
[284]Irvine *supra* note 3 at 353.

professional it is to represent society, courts have set a high standard for loyalty to the patient in the public interest.

Novek, however, suggests that the law's attention to the fiduciary nature of the physician-patient relationship has focused primarily on information and confidentiality duties.[285] She summarizes a physician's four fiduciary obligations arising from the recent judicial consideration of the medical relationship:

1. To act with utmost good faith and loyalty.
2. To hold information received from a patient in confidence.
3. To make proper disclosure of information to a patient.
4. To act in the best interest of the patient.[286]

According to her, the law is unsettled as to whether fiduciary obligations will be extended beyond these duties.[287] Thus we can only speculate how the courts would interpret the fiduciary obligations of loyalty and acting in the best interests of the patient in light of scarce resources and pressures on physicians to participate in rationing health care resources.

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[285]The focus on information reinforces my belief that informed consent will be the vehicle through which the conflict of duties is analysed by the courts.
[286]See Novek *supra* note 274 at 133.
[287]*Ibid*, at 133.

Physician as social agent

While the process of clarifying the extent of a physician's fiduciary obligations is a continuous one, it is clear that physicians are not held to be complete fiduciaries as are trustees.[288] As discussed earlier, physicians do fulfill roles where patient interest is not always their primary concern.[289] Similarly, lawyers are fiduciaries and yet at times are also responsible to other parties, such as the court. Lawyers are expected to be zealous advocates for their clients yet they also serve as officers of the court, and protect the integrity of the judicial system. [290] For physicians, safety and public health have long been held to override absolute loyalty to a patient's interests in certain circumstances.[291]

Physicians are, in limited circumstances, society's agents. It is a fundamental part of their professional status to represent society's interest in health care. The medical professional's duty to society is secondary to that of loyalty to the patient. Yet it is an obligation which should be met. Might cost containment and the need for a just allocation of health care resources also override absolute loyalty to the patient in certain circumstances?

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[288]Rodwin *supra* note 193 at 251.
[289]For examples of some of these roles, see *Ibid.*
[290]*Ibid.* at 256
[291]See *supra* note 101.

The fiduciary obligations of physicians might be extended to include securing maximal access to health care resources for each patient. This would then forbid physician participation in health care resource rationing. This would, in effect, set up a "*Wickline*" style of duty for physicians to protest limits on their patents' access to care.

However, the same court which decided *Wickline*, later neutralized that duty to protest.[292] Further, it is interesting to note that even in *Simice* the court set up a framework of balancing the patient's interest against that of society, rather than assume an overriding duty to the patient.. The responsibility to the patient had to take precedence over responsibility to the Medicare system because *the severity of harm that might occur to the patient far outweighed the severity of harm to the system.*[293] In this case the secondary duty to society did not outweigh the primary duty to the patient. In *Simice*, the Court did not take the opportunity to extend a physician's fiduciary obligations to bar a duty to society to ration health resources where appropriate.[294]

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[292]See chapter 7.
[293]*Simice supra* note 170.
[294]It might be argued that the action in *Simice* was brought in negligence. thus the courts had no need to consider fiduciary obligations. However, in *Norberg*, the plaintiff brought the action in negligence as well, yet the court still considered the implications of fiduciary principles.

Dickens also points out that fiduciary law is flexible in this area.[295] In *Hodgkinson v. Simms*[296], the court stated that "[t]he existence of a fiduciary duty in a given case will depend upon the reasonable expectations of the parties, and these in turn depend upon factors such as trust, confidence, complexity of subject matter, and community or industry standards."[297] This favours a physician's fiduciary duty to take reasonable steps to secure maximal access to care rather than a strict obligation to secure maximal access.

In considering reasonable expectations, existing standards, and resulting reasonable steps, the court might acknowledge that the Canadian Medical Association's own code of ethics requires physicians to promote fair access to health care resources and to use these resources prudently.[298] Further, physicians currently feel pressure to advance society's interests through cost containment, in some cases altering their behaviour.[299] Thus, it is possible that the court's finding of whether or not a fiduciary duty to put a patient's interests first exists may depend on the competing interests.

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[295]Dickens *supra* note 146.
[296][1994] 3 S.C.R. 377; 117 DLR 4th 161.
[297]*Ibid.* at 178.
[298]*Supra* note 9 articles 31 and 32.
[299]Quebec's College des Medecins in its code of ethics specifies that the physician's primary duty is to protect the health and well-being of his patients, both individually and *collectively*. *Professional Code*, (R.S.Q., c. C-26, s. 87) art 2.02.01.

Balancing competing duties

The challenge before the courts, physicians, and society as a whole is to define the balance between a physician's primary duty to the patient and secondary duty to society. The physician is in the best position to act as a patient advocate. Further patients have little power to influence cost containment decisions. When a hospital refuses to provide an expensive treatment to conserve resources for other patients there is little the affected patient can do as in Canada there is no private system. Thus a physician's cost containment actions directly affect patient welfare without a real remedy for any patients who may be wronged.[300] The primary duty to the patient must be strong.

However, we cannot escape the social reality that we have limited health care resources. Institutions and public policy must set guidelines governing access to health care resources. Nonetheless, in limited circumstances, front-line physicians must exercise discretion in rationing health care resources. Establishing the extent of fiduciary obligations in this area will demand that the courts protect the duty of loyalty upon which the trusting relationship rests while being careful not to impose unrealistic duties on physicians.

Rodwin suggests that "[t]he law could hold doctors accountable to patients for specific goals while holding doctors accountable

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[300]Dickens *supra* note 146 at 276.

to other parties for other goals. As a result, physicians would be subject to greater oversight and more stringent standards of conduct."[301] This would require the courts to take a more active role in defining the medical professional's role in regards to specific goals. I believe that this is the approach the courts will and should take. However, in defining specific goals and accountability, the courts will need input from the medical profession on its own interpretation of its role and goals, as well as from society on what the public expects of its physicians. This leads us into a concluding discussion of possible solutions which will incorporate judicial, professional and societal contributions.

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[301]Rodwin *supra* note 193 at 256.

SECTION IV
Conclusion

Let us return to our initial scenario. A physician performing a radiological exam faces a choice, dye A or dye B, the first more costly but potentially entailing fewer side effects She must consider the best interests of her patient and those of society as a whole. How does she do this? She needs a new framework requiring reform from the medical profession, the law, public policy and society's understanding. This reform may be summarized in these three fundamental observations to form a new framework.

I We must recognise the physician's double agent dilemma. Physicians are trained to serve their patients and consider first the well-being of their patients. However, Canadian physicians work within a publicly funded system with finite resources. They make many micro-allocation decision daily in the course of treating patients. Physicians cannot ignore the consequences their decisions have on the system and the overall allocation of health care resources to all patients and citizens.

II We must understand the origins of this double duty. The healer in Western society has a long tradition of acting in the best interests of her patients. The Canadian medical professional's obligations to represent society's interest in

medicine goes back over a century. During the course of that century, health care and the Canadian health care system have evolved dramatically. So too has the content of the medical professional's obligation to represent society. We have the ever-increasing ability to prevent, cure and treat disease, yet finite resources to devote to health care. Therefore, difficult allocation choices must be made. In limited cases these choices will fall to the front-line treating physicians.

III We must find a way to reconcile these two duties and establish a means to balance them which affords sufficient protection for the interests of individual patients and enables the most just and equitable distribution of limited health care resources.

To build this new framework, five interlocking changes, captured in the following recommendations, are necessary: leadership from the medical profession; public acknowledgment of the double duty; establishment of a new legal standard; judicial leadership in recognising this new standard; and finally public policy initiatives.

1. Leadership from the medical profession

The medical profession must clarify and define both the extent of, and limits on, the physician's duty to society. Physicians are a self-regulating profession. They must assume the initial

burden of establishing the standard of care expected of the profession. The medical profession's own standards carry great weight. Individual physicians may seek guidance from the profession's policies, codes of ethics and published debates or discussions. This is especially important with the current challenge to develop a more uniform approach to rationing rather than individual coping strategies.

Additionally, the common law often relies on the medical profession to inform it when it sets the standard of accepted practice. Finally, the obligations inherent in professional status require physicians to educate the public on health issues including the health of the system. Discussing the reality of limited resources and the physician's role in allocating resources certainly falls within the domain of health issues of interest to the public. Thus, it is imperative that the medical profession take a leadership role in tackling this difficult issue. Its aim must be to reach a consensus on the physician's role in rationing health care that might be taken as evidence of accepted practice.

The profession's own medical expertise, however, will not be sufficient to solve what is also a social issue. The profession is supposed to serve, not determine, the public interest.[302] Accordingly the profession must take the initiative in prompting society, policy makers, and patients to think about

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[302]Friedson *supra* note 45 at 381.

this issue and offer input. Physicians must act as representatives of society's interests, not simply members of a union. The profession must encourage the establishment of meso and macro fora to debate and make rationing decisions. It is through these that a wider representation of interests may be heard and the physician's duty to society most appropriately addressed. While physicians are those most keenly aware of the double agent dilemma, it affects society as a whole and challenges many of our values.

2. Public acknowledgment of the double duty

Having established what the profession must do and why, we now turn to how it must do it. It is important that the profession address this issue directly and openly. There are many linked issues, such as adequate funding for the entire health care system, futile treatment, and experimental treatment, to name only a few. However, to truly define the physician's role in rationing medical care, the profession must consider the narrow question of how to balance duty to the patient and duty to society faced with limited resources, patient need and no established institutional or other policies governing access to a particular treatment. It is imperative that the profession study this question and gather evidence of conflicts and coping strategies to uncover the scope of the dilemma.

The medical profession must address this issue in its code of ethics with less ambiguity than its does at present. The profession must seek to educate its members, encouraging debate and discussion in medical journals, professional conferences, and education seminars. Additionally, the profession must reach out to the public through more accessible media. It must establish its stance on the issue such that this may be taken as accepted practice within the profession for legal purposes and may inform the public.

3. Establish a new legal standard of care for physicians

If we accept the physician's duty to society, and the physician's role in rationing health care, we must amend the law to reflect this new reality. First we must clarify the fiduciary obligation principle. Second we must amend the standard of care in the tort of negligence. Third we must refine the legal principle of material information for informed consent.

We must recognise that physicians are fiduciaries to the patient for certain obligations and are responsible to society for others. We must establish that the fiduciary duty to the patient does not bar the physician from acting as a social advocate where this is warranted.

The standard of care in the tort of negligence for physicians should be amended to include a rebuttable defence of economic

duress which caused them to make a rationing choice. This would acknowledge that physicians may have to participate in the rationing of health care services to further the just allocation of resources. Allowing physicians to prove that limited resources or financial pressure must be taken into account in establishing the standard of care reasonably expected in those circumstances will help bring the law into accord with the social reality.

The final step is to reform the doctrine of informed consent. Rationing decisions or policies should be included in the material information necessary for informed consent. This step will likely be the catalyst for other reforms as the doctrine of informed consent is the most likely vehicle for the issue of a physician's double duty landing in court.[303]

Informed consent may in fact be the best venue through which to consider this issue in court. This doctrine deals with the face to face interaction between doctor and patient. Thus, it is more difficult to hide a conflict of duties. Such a conflict, particularly where it leads to a rationing decision affecting a patient's treatment will most likely be considered material information by most patients.

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[303]If the courts address this issue directly through the doctrine of informed consent, the procedure for change will be the reverse of the one suggested here. The courts will redefine the standard of care and the profession will have to respond.

Establishing a policy of honesty may be easier in theory than it is to implement in practice. Patient-physician discussions over rationed treatment will be difficult. For it to be possible, we must educate physicians and patients, and provide institutional and societal backing for physicians. Again, this will only come after the medical profession shows leadership in addressing this issue.

4. Judicial leadership in recognising a new standard of care

The judiciary has a crucial role in developing a solution to the double agent dilemma. If the standard of care is to be amended to accommodate a physician's duty to society, the courts will have to do so. The courts must address this issue explicitly should it come before the courts, not simply as *dicta.*

Fiduciary obligations and the tort of negligence are constructs of the court. Accordingly, the judiciary will be responsible for interpreting the new standard of care. This will further serve to put this issue in the public domain. The judiciary may take initiative on its own to define the extent of the physician's duty to society and participation in health care rationing. However, it usually draws on the medical profession's own debates and is always open to being overruled by the legislature. Further, the judiciary can only take on such a role after a conflict has arisen and legal proceedings are launched. This might be a long time

coming. Meanwhile, each physician adapts her own solution to the double agent dilemma. Redefining the standard of care requires the medical profession's prompt input and efforts to develop a consensus.

5. Public policy initiatives

In advocating a strong role for the medical profession and the judiciary in crafting a solution, I am not contemplating a dictatorship of the professions. A physician's duty to society is a public policy issue. Ideally it should be dealt with through the legislature not by appointed judges or 'cartelized' physicians. However, I believe that a change in public policy will require initiative from other sources, particularly to spark a debate and provide evidence of the extent of the conflict.

It is unrealistic to expect public policy to take a leadership role on this issue. Where individual life is at stake, over issues such as abortion, euthanasia, and the rationalization of health care, public policy has great difficulty offering concrete solutions. Democracies often struggle with these issues. The stakes are so high that no one may be prepared to compromise. It can become difficult to find an acceptable solution. Others must help fill the policy vacuum or offer it material upon which to build a solution.

In sum, physicians must take a leadership role on this major societal health care issue. Their professionalism mandates this. Judges develop, and interpret legal doctrines allowing for evolution in social norms, while adhering to fundamental principles. Judges can fasten upon professional responsibility to society as accepted and defined by the medical profession. Public policy should guide this issue but it will require a catalyst.

Professionalism, law, and the social reality

If we embrace these recommendations, we will bring the law into harmony with professionalism and the social reality of limited health care resources. These are the three points of the triangle which must guide our approach to reconciling the physician's duty to the patient and to society. Physicians owe a primary duty to the patient. However this duty is framed by the obligations of professionalism, the law, and the social reality in which patient and physician interact.

The law will have come full circle to embrace the professional responsibility it originally assigned to the profession. Both professionalism and the law recognise a duty to society but place the patient as the physician's first concern. They accept that medical professionals cannot serve only their patients as lawyers cannot defend their clients' interests at all costs. All must function within the system which supports them.

In conclusion, I return to the original question, how does the medical professional reconcile a duty to the patient and a modern duty to society? First by recognising and defining the secondary duty to society. Second by incorporating this understanding into the profession's standard of conduct, the law's standard of care, and society's expectations. This is essential for physicians to continue to operate as autonomous professionals offering the best care reasonably possible to their individual patients and to society as a whole within the limited resources allotted to health care. The mantle rests on the shoulders of the medical profession to take the lead in raising this issue, and providing the foundation for a solution.

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