

The Physician's Duty in the Age of Cost Containment

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I. INTRODUCTION

IN THE SHORT ARTICLE which precedes this, Professors Caulfield and Ginn discuss one aspect of an immense issue, an issue which seems predestined to dominate the interface of law, ethics and medicine for the remainder of this century. The issue is a stark one. To what extent can considerations of thrift, of cost containment, be allowed to influence the standard or level of care shown by Canadian physicians to their patients? 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? If such balances are struck, perhaps as a result of institutional pressures within a hospital, is the physician potentially exposed to liability? Is the hospital so exposed? Can governments be sued, indeed, as the medical profession is constrained to lower its sights from optimal patient care to some other standard of adequacy, set by reference to "what society can afford?"

II. DISCUSSION

THE CAULFIELD-GINN PAPER confines itself largely to one aspect of this enormous issue, the patient's right to know of therapies which for reasons of expense are "not on offer," at least from his or her present physician. I would respectfully suggest that the writers have made a very strong case, based on the current jurisprudence of "informed consent," for concluding that physicians do indeed owe a legal duty of disclosure in these circumstances. The refusal of the writers to engage the wider issues outlined above reflects, I fear, a prudent policy of reticence which I might be thought well-advised to adopt as well; especially since every leading textbook on tort law or medical jurisprudence, and virtually all the learned journals in the Commonwealth, fail to address these issues at all. Worse still, there is an

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almost complete absence of case law on these questions, even in the United States. Accordingly, even a tentative approach to the wider issues may be seen as an attempt to “make bricks without straw.”

The absence of case law will be considered, and I think to some extent explained, in the pages which follow. The quietude of the academic literature is quite another matter. After all, the problem of cost containment, thought perhaps more acute than ever, is hardly new. Every day, physicians decide, no doubt in good faith and no doubt with an equanimity borne of familiar custom, that there is little or no point in providing “heroic” and very expensive therapies to prolong marginally the lives of very elderly and chronically ill patients; conservative management and palliative care are seen not just as cheaper, but as entirely reasonable modes of patient care. By contrast, the quest for incremental gains in patient health, or small gains in patient life-expectancy, heedless of cost, is not, I would suggest, a usual phenomenon in our health care system, nor would the “reasonableness” of such attitudes by physicians be readily assented to as self-evident. Physicians, then, *do* on a daily basis, at least outwardly, weigh economic considerations against purely clinical or therapeutic ones when assessing therapies. They can, in doing so, point to the ordinary usage of reasonable fellow professionals as a strong, though not conclusive,¹ circumstance suggesting that they have discharged their duty of care to the patient in such circumstances. After all, physicians have never been held under our law of obligations to undertake to provide patients with the best and most advanced care available in the light of the technology of the day. “Reasonable” care and skill — nothing less, but nothing more either — has been the criterion, and I fear the rather unreflective formula, continually used by the Courts. Its incantation does nothing to resolve the necessary further inquiry: whether indeed the reasonableness of care is to be assessed by reference to purely medical or clinical considerations, or whether the ethical standpoints favoured by his or her professional peers, or the trading-off of therapeutic gains for apparently larger financial economies in “the system,” indeed render immune from suit the physician who conforms in *these* ways to the professional norms of his or her peers. If so, we may conclude at the very least that the commonplace of peer-evaluated “reasonable care

¹ Adherence to universal professional custom will not, of course, in every case preclude a court from adjudging that practice to be negligent: see *Anderson v. Chasney*, [1950] 4 D.L.R. 223 (S.C.C.), as considered most recently in *Pittman Estate v. Bain* (1994), 19 C.C.L.T. (2d) 1 (Ont. Gen. Div.).

and skill" is by no means as coherent a notion as our tests and case law have so long affected to presume. Rather, it embraces tensions, tensions between what is best and what is affordable, which in itself it does nothing to resolve.

It need not surprise us that these tensions have remained occult within the case law. In the days before government-financed health care, the remedies available to medical science were in general not of a sophistication suggesting awesome expense; and if a patient's means were not adequate to secure a recommended course of treatment, the physician could hardly be blamed, in the absence of a "third party payer" with "deep pockets," in failing to provide it. With the advent of universal health care coverage, Canadians have come, for better or worse, and realistically or otherwise, to expect from the system the best that money can buy, with treatment according to the highest standards of current scientific knowledge. The crisis which is now upon us stems from the realization of two distressing but obvious truths — that the pockets of government are not bottomless; and that new and valuable remedies can sometimes only be had, and the continued prospect of further improvements only be secured, at frightening and sometimes prohibitive cost. Now that the "crunch has come," and governments are exercising pressure upon hospitals, and hospitals upon physicians, to contain costs, it may be reasonable to expect these tensions to be addressed in the case law. Why, it may be asked, has this not happened already?

The answer, I would suggest, lies in the essentially reactive nature of the common law. The judges do not like to commit themselves to broad generalizations of principle or policy unless forced to do so by the exigencies of the case at hand, and it will be the rare case, I would argue, in which litigants will find it worthwhile to pursue their grievances to trial, when their principal complaint, at bottom, is that a physician has allowed parsimony to overbear concern for the patient's health.

If such litigation is going to occur, I think Professors Caulfield and Ginn are right in supposing that it will surface either in the context of "informed consent" suits, or of proceedings for breach of fiduciary duty. But even in those areas, I would expect actions to be few, and successful ones fewer still. Putting aside for one moment the still-nebulous issues of fiduciary responsibilities and the remedies which sustain and redeem them, I would venture to suggest that most negligence-based claims against the cost-conscious physician will be foredoomed to founder on the reef of causation-in-fact.

Take, for example, this scenario, which will be familiar to any cardiologist.² X, a patient with a history of threatening coronary episodes, is stricken with an acute myocardial infarction, and rushed to hospital, where he comes under the care of Dr. Y, an experienced cardiologist. Dr. Y realizes the urgent need to administer a thrombolytic (clot-dissolving) agent; and she has a choice of two available to her. She can prescribe streptokinase (SK), a familiar and well-accepted specific for such conditions. It is ready to be had, and is relatively cheap. Or she can choose a newer compound; tissue plasminogen activator (TPA). This is also available within the hospital, and while the various test and trial results differ in point of detail, it seems that TPA is measurably more effective (let us say, for the sake of argument, 3 percent more effective) in securing short-term survival of stricken patients. Unfortunately, it costs several times as much as SK; a matter of thousands of dollars per course of treatment. Let us now suppose that Dr. Y, well realizing that TPA would offer her patient a better chance, prescribes SK nevertheless. Why? Because the hospital administration has urged her to do so "in the interests of economy." It may be (though one would prefer that it not be so) that the institution has hinted that adverse career implications may attend any choice of the more expensive medication. Is Dr. Y potentially liable if she allows her clinical judgment to be displaced by these promptings?

Let us suppose that a Court can be persuaded to hold that in these circumstances, Dr. Y has broken her duty of care; in other words, that she has failed to show that reasonable standard of care which the law requires. The case against Dr. Y, advanced by the estate and dependants of X (whom SK, as you will have guessed, failed to save) will still almost certainly be lost. For incontrovertible, emphatic and recent authority at the highest level demands that the plaintiffs go further,³ and prove on a balance of probabilities that Dr. Y's breach of duty caused X's death; i.e. that had Dr. Y chosen TPA instead of SK, X would have lived. This must be established, to be sure, not as a matter of cast-iron, 100 per cent "scientific" proof, but on a more than 50 per cent preponderance of probabilities. And while the plaintiffs may find transient consolation in a Court's readiness to apply "robust and

² And is, I would add, a matter of earnest and scholarly debate among professionals in that field, who may find this account of their dilemma distressingly over-simplified as a result not only of the author's medical ignorance, but of his need to keep the example succinct.

³ *Snell v. Farrell*, [1990] 2 S.C.R. 311, 72 D.L.R. (4th) 289, 4 C.C.L.T. (2d) 229.

pragmatic" processes of inference to the proven facts, it seems plain that our plaintiffs will have a tough time persuading the Court that their loved one was *more likely than not* one of those 3 per cent of patients who would have been saved by prescription of the more expensive drug! Even if they can persuade the Court to shake off the tyranny of statistics,⁴ and conclude that in light of the patient's personal characteristics, physique and lifestyle he would have been 49 per cent likely to belong to the favoured 3 per cent, they will still recover nothing. The magic figure is 51 per cent and nothing less will do. Attempts to introduce into Canada a doctrine favoured in some European civil law systems, and to say that such a patient has proven the loss of a quantifiable *chance* of recovery, have come to naught,⁵ and seem unpromising of success in the immediate future. The result, as one eminent academic authority has written,⁶ is unfortunate:

In view of the uncertainties of medical diagnosis,⁷ this approach is apt to blunt the sanction against negligent medical treatment. It under-deters the guilty but overcompensates plaintiffs who succeed in mounting the 50% hurdle.

So the unfortunate dependents of X will probably be well-advised to refrain from suing Dr. Y. How does this conclusion in the particular instance bear upon the general issue?

I venture to suggest that it does so very extensively indeed. For most advances in medical science nowadays, at least in the provision of new therapies, are of the incremental, rather than the revolutionary kind. A new drug which can indeed increase the survival rate of patients by, say, three cases in one hundred is obviously a very important advance. But discoveries like that of insulin, which effect quantum leaps in survival rates of whole categories of patients, and give likely promise of healthful survival where before there existed only a sentence of certain death, are unhappily rare. Most patients, then, denied access to new therapies apparently by reason of expense, will find themselves met in our causation-in-fact which frustrated the claim of X's nearest and dearest, in our example.

⁴ Which are, after all, merely an extrapolation of group experience, and may conceal the existence within the sample of sub-groups for which the new treatment might always be a life-saver.

⁵ *Hotson v. East Berkshire Area Health Authority*, [1987] A.C. 750 (H.L.); *Laferrière v. Lawson*, [1991] 1 S.C.R. 541, 6 C.C.L.T. (2d) 119.

⁶ J.G. Fleming, *The Law of Torts*, 8th ed. (Sydney: The Law Book Co., 1992) at 227.

⁷ And, I would suggest, of the aetiology of medical conditions and cures.

I need hardly add that the same frailty, *mutatis mutandis*, besets the claims of those who, emboldened by arguments like those of Professors Caulfield and Ginn, advance their cause under the banner of "informed consent." Let us suppose that A is referred by his physician to Dr. B, a specialist in internal medicine, who correctly diagnoses a progressive disease and recommends a particular therapy, whether surgery or a course of drugs, which happens to be the best available in those hospitals to which he enjoys admitting privileges; indeed, the best available, let us say, anywhere in Canada. Let us further suppose, however, that Dr. B knows (or ought to know) of a new therapy, currently only available in New York, which according to all tests so far is free of collateral risks and has shown itself 10 per cent more effective than Dr. B's proposed treatment, in arresting the progress of the disease. Professors Caulfield and Ginn make a persuasive case for saying that as a matter of law, Dr. B has a duty to reveal this information to A, so that A may make what plans he can to avail himself of the new treatment if he so chooses. I agree that Dr. B owes that duty, but am unconvinced that any lawsuit by A, alleging the breach of that duty, would succeed. The court may well find that Dr. B's silence was a culpable breach of duty, and may even conclude that "a reasonable patient" in A's position, fully informed of the options available and the probable advantages and the special, material and unusual risks of each, would have declined the therapy offered by Dr. B, and booked a plane to, and a bed in the New York clinic, forthwith. But even then — and most "informed consent" litigants never get to this stage — we must remember that the plaintiff-patient has to prove yet one thing more. He must show — as always, on a balance of probabilities — that having declined the treatment offered by Dr. B, and chosen the New York technique instead, he would have been healthier as a result. Unless the New York treatment is infallible (a hypothesis which takes us into medical fantasy), our plaintiff will fail at this last hurdle, for a statistically proven 10 per cent increase in effectiveness will be well-nigh impossible to translate into a 51 per cent probability that this particular patient would have benefitted by choosing it.

I do not, however, contend that negligence actions, whether for negligent choice of treatments simpliciter, or for negligent failure to keep the patient appropriately informed, are entirely and in all circumstances foredoomed to fail. And even if a negligence action is unlikely of success in yielding a damage award, as I have tried to show, the ambit of the physician's legal duty is, I would suggest, still a matter of great importance, upon which physicians ought to be able

to look to their legal advisers for clear guidance. On the other hand, there are the grimly practical concerns of physicians who may have suffered adverse repercussions on their career prospects for refusing to compromise clinical judgments by considerations of institutional economy. On the other, there will be those physicians who see an ethical value in fidelity to law itself, and regard their legal duties as imperatives even though the law may for one reason or another forbear to attach the sanction of a damage award to their breach. As things stand at the moment, the authorities, both judicial and academic, stand largely mute in the face of such inquiries; and such a silence does no credit to our law.

The Canadian case law seems to afford us no clear guidance, but there is a single case in California which has attracted some academic attention in the United States, and may seem worthy of attention. I refer to *Wickline v. State of California*,⁸ decided in 1986. Mrs. Wickline, a lady covered by California's Medi-Cal scheme, was admitted to Van Nuys Community Hospital suffering from an advanced case of Le Riche's Syndrome, an occlusion (as I understand it) of the abdominal aorta. Corrective surgery was undertaken to excise the affected artery, and insert a teflon graft. Following surgery, Mrs. Wickline experienced a block-clot in the groin area of the left leg. It was removed, but her recovery was "stormy" and further intervention by way of a lumbar sympathectomy was attempted. Now she was due to be discharged from hospital just five days thereafter, according to the hospitalization scheme originally authorized and approved by Medi-Cal. The doctors, in light of her recent post-operative history, unanimously thought that this would be a bad idea: it was, they said, medically necessary that she remain in hospital for an extra eight days. A registered nurse filled in the applicable forms, the attending physician signed them ... and Medi-Cal rejected the application, allowing only four extra days — their reasons for doing so were never fully explained. Mrs. Wickline was discharged; none of her physicians made a renewed attempt (as they could have done) to secure an extension. The senior physician, Dr. P, with disarming candour, testified at the trial that, "he felt that Medi-Cal Consultants had the State's interest more in mind than the patient's welfare, and that that belief influenced *his* decision not to request a second extension of Wickline's

⁸ 228 Cal. Rptr. 661 (Ct. App. 1986).

hospital stay ... he felt that Medi-Cal had the power to tell him, as a treating doctor, when a patient must be discharged from hospital."⁹

Anyway, Mrs. Wickline was discharged. The condition of her leg deteriorated alarmingly. After nine days, the excruciating pain and distressing appearance of the leg necessitated her readmission on an emergency basis. And despite heroic efforts, her leg had to be amputated. She chose to bring action only against the State of California. The amiable and candid Dr. P again helpfully testified that, "to a reasonable medical certainty, had Wickline remained in hospital for the eight additional days ... originally requested ... she would not have suffered the loss of her leg."¹⁰

The plaintiff initially recovered judgment against the State of California, but this was overturned, and the plaintiff deprived of any remedy, in the California Court of Appeal. They reached this conclusion because the real fault lay, in their opinion, at the door of the treating physicians who had failed to stand by their clinical judgment and insist accordingly on the contained acute-care hospitalization of their patient.¹¹ Had they done so, the required extension would probably have been granted. Justice Rowen, speaking for the Court, pulled no punches, expressing himself in words which will convey little comfort either to physicians or government:

The patient who requires treatment and who is harmed when care which should have been provided is not provided should recover for the injuries suffered from all those responsible for the deprivation of such care, including, when appropriate, health care payors. Third party payors of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms as, for example, when appeals made on a patient's behalf for medical or hospital care are arbitrarily ignored or unreasonably disregarded or overridden. However, the physician who complies without protest with the limitations imposed by a third party payor, when his medical judgment dictates otherwise, cannot

⁹ *Ibid.* at 667.

¹⁰ *Ibid.* at 668.

¹¹ *Ibid.* at 670: "As to the principal issue before this court, i.e., who bears responsibility for allowing a patient to be discharged from the hospital, her treating physicians or the health care payor, each side's medical expert witnesses agreed that, in accordance with the standards of medical practice as it existed in January 1977, it was for the patient's treating physician to decide the course of treatment that was medically necessary to treat the ailment. It was also that physician's responsibility to determine whether or not acute care hospitalization was required and for how long. Finally, it was agreed that the patient's physician is in a better position than the Medi-Cal Consultant to determine the number of days medically necessary for any required hospital care. The decision to discharge is, therefore, the responsibility of the patient's own treating doctor."

avoid his ultimate responsibility for his patient's care. He cannot point to the health care payor as the liability scapegoat when the consequences of his own determinative medical decisions go sour.¹²

In conclusion, the judge added these remarks:

This court appreciates that what is at issue here is the effect of cost containment programs upon the professional judgment of physicians to prescribe hospital treatment for patients requiring the same. While we recognize, 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. We have concluded, from the facts in issue here, that in this case it did not.¹³

The *Wickline* case, then, seems unequivocally to support the view that clinical judgments cannot properly be suborned or "corrupted" by economic or otherwise extraneous influences, whatever their source; and that the physician who allows such distortion or deflection of her clinical judgment is potentially liable in negligence to the plaintiff who receives sub-optimal care (or rather, less than the ordinarily expectable standard of care) as a result. While the *Wickline* discussion of these matters is arguably *obiter*, and of course non-Canadian, it must be regarded as carrying powerful persuasive force, given the distinction of the Court which decided it. And it affords one answer to the physician who wants to know simply what his other legal obligations are, as distinct from what consequences may flow from disregarding them.

Another source tending to the same uncompromising conclusion is that helpfully adverted to by Professors Caulfield and Ginn — namely, the concept of the fiduciary duty, which has so enlivened the Canadian law of obligations in recent years. That every physician owes to his or her patient a fiduciary duty, arising out of their respective status, is clear beyond argument. This duty transcends the common law responsibilities to show reasonable care and skill, and has traditionally been regarded as involving a clear and uncompromising duty of undivided loyalty to the patient. It would seem to follow that the physician who allows that loyalty to be subverted by regard to the

¹² *Ibid.* at 670–1.

¹³ *Ibid.* at 672. Lest this parting observation seem surprising or inconsistent with the foregoing account, it should be explained that in the Court's opinion, Medi-Cal, far from "corrupting" Dr. P's medical judgment, had left his discretion — to press for longer hospitalization — intact. Far from overriding his medical judgment, Medi-Cal never had any opportunity to do so, due to Dr. P's passive and arguably inappropriate acquiescence in their initial administrative decision.

better interests of the hospital, the department or (perish the thought) his or her own career, is in breach of that fiduciary duty. The fiduciary obligation of loyalty or undivided fidelity has been betrayed, and an action for breach of fiduciary duty, conceptually quite distinct from an ordinary negligence action, will be available to the patient. If physical harm to the patient is to be redressed through fiduciary principles, it is true that the plaintiff will encounter the same roadblock, that of proving "probabilistic causation," as will usually frustrate an ordinary negligence action. But — and this is important — the betrayal by the physician will itself justify the Court, in a fiduciary context, in awarding at least nominal damages. And in cases of repeated, cynical or gross breaches of fiduciary responsibility, Courts have assumed in recent years the jurisdiction to "tack on" substantial sums by way of "punitive damages," as a means of renouncing the delinquent fiduciary's conduct, and deterring its repetition.¹⁴ I do not suggest that the physician who compromises clinical standards in the name of institutional thrift will lightly be visited with such retribution in the Courts. But it is a possibility which in extreme cases — verging on the corrupt betrayal of patients — might well be realized.

If I may summarize the foregoing argument, it goes like this. A physician owes a duty of reasonable care and skill to his or her patient, which if broken will potentially give rise to an action in negligence. One aspect of that duty of care in the obligation of care is to provide, if not the best care obtainable anywhere in the present state of medical knowledge, at least to *try* to secure the best treatment reasonably obtainable of which a reasonable fellow physician, reasonably attuned and receptive to current developments, would be aware. Failure to exert such effort, or any compromising of that effort by consideration of non-medical considerations such as cost containment, will be a breach of the legal duty of care and skill. In addition, any such dereliction of purely clinical judgment, whether in deference to considerations of the institution's well-being or the physician's own, will be a clear breach of that quite distinct obligation we call fiduciary. While the intransigent and daunting challenge of proving causation of harm will often, perhaps usually, frustrate any hope of securing damages in a negligence action, there may still be a hope of redress, even on a punitive footing, in an action for breach of fiduciary duty. And in the last analysis, even if the patient's hope of monetary redress seems unpromising or speculative, it is worth remembering that the

¹⁴ See *Norberg v. Wynrib* (1993), 12 C.C.L.T. (2d) 1 (S.C.C.), especially the judgments of McLachlin and L'Heureux-Dubé JJ..

physician who refuses to break a duty to the patient, whether an ordinary negligence duty, or a fiduciary one, or both, is thereby refusing a temptation or invitation to break the law — an argument which gives powerful leverage to the physician in any dispute with his or her hospital or its administrators.

Let me end this paper by considering briefly an obvious cognate question. Suppose that those responsible for the running of a hospital (and trying to balance its books) decide that their only option is to develop purchasing policies or guidelines which literally prevent the provision of high-cost care, by ordaining that costly medications or equipment shall not be acquired by or available through the institution. While that manoeuvre may insulate the physician from liability,¹⁵ fiduciary or otherwise, it prompts the question of whether the hospital itself may be liable in negligence to the patient whose care is adversely affected by such a policy. In recent years, Canadian law has come to recognize that hospital authorities may be liable not only for the wrongdoing of their employees (such as nurses and salaried physicians) but for their own shortcomings in meeting their *own* legal obligations. The matter was authoritatively dealt with in the leading case of *Yepreman v. Scarborough General Hospital*, a 1980 decision of the Ontario Court of Appeal,¹⁶ and is succinctly expressed in a recent pronouncement in a New Brunswick decision:

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 and also with respect to the competence of physicians to whom it grants privileges to provide medical treatment. It is not responsible for negligence of physicians who practise in the hospital, but it is responsible to ensure that doctors or staff are reasonably qualified to do the work they might be expected to perform.¹⁷

Use of the “reasonable community expectation” standard seems implicitly to recognize that rural and small-town facilities may be expected to furnish less opulent equipment, a less complete range of pharmaceutical, and a less complete array of specialized personnel than big teaching hospitals in major urban centres. Surely there is in this an acknowledgment of economic reality, and of the necessity that hospital authorities everywhere must temper their zeal for excellence by balancing it against the need to keep in touch with their budgetary

¹⁵ Subject, of course, to the probable obligation to inform the patient.

¹⁶ (1980), 28 O.R. (2d) 494, 13 C.C.L.T. 105, 3 L. Med. Q. 278.

¹⁷ *Bateman v. Doiron* (1992), 8 C.C.L.T. (2d) 284 at 290, *per* Creaghan J..

limitations. When those charged within a hospital's organization with the control of expenses decide after due and reasonable deliberation that "we simply can't afford to make drug X available, however much our specialists want it," they do not operate beyond the reach of a negligence suit by those patients who are ultimately prejudiced by this policy of cost containment. But the Courts — as they do with governmental agencies and all who disburse public money and exercise discretionary judgment in doing so — will sympathize with the institution's need to balance the demands of efficiency and thrift, and will not castigate as negligent any reasonable or defensible decision of this kind made after due and diligent consideration of those competing considerations.¹⁸

I would earnestly suggest 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. That is not to say that physicians should not be cooperative and diligent in the avoidance of waste, alert in the elimination of superfluous or duplicative procedures, and critically reflective in their attitude to "defensive medicine." But within the confines of what is available to them, what is obtainable upon request or insistence within the institution or by feasible referral to another institution, the physician's responsibility — not his primary responsibility but his *only* responsibility for the time being — is to do his best for his patient. It may be that because of financial constraints, institutionally imposed, that best effort will not be nearly good enough to satisfy the patient or the physician. But the physician who has maintained this undivided fidelity will be beyond criticism, legal or ethical, and will ensure that responsibility for the undeniably hard economic and political decisions which undeniably have to be made

¹⁸ Administrators cannot be blamed for stressing to hospital physicians the urgent need for economy, or trying to encourage them to withhold expensive therapies when cheaper ones would do just as well. But to trespass upon the doctor's clinical judgment by threatening or even hinting at the likelihood of adverse career implications, should the physician not compromise his or her clinical decisions, would be a highly improper interference in the physician/patient relationship, and might well be actionable at the suit of a patient adversely affected, as being a tortious "interference with fiduciary relations." This concept, as yet untried in the Courts and as far as I am aware overlooked entirely in the academic literature, would probably be recognized by the courts, given the analogies with "tortious interference with contractual relations," a tort long familiar to lawyers; and with the more esoteric principles governing trustees *de son tort*, in the equity jurisprudence. Legal scholars reading this paper may find this an engaging topic for speculation.

rest with those whose job it is to make them, and who are ultimately answerable directly or indirectly to the public through the democratic process.

If physicians, through inclination or duress, show complicity in the process whereby clinical standards are reduced or rationed, they automatically accelerate the process of decline. The tension between those who seek excellence in care, on the one hand, and those who say "yes, but only so long as we operate within the available financial means," is a necessary and healthy one. But if the medical profession does not hold the front trenches and constantly press to acquire the best available therapies for patients; if they yield to the pressure to become themselves (as Morreim has put it) "key agents of resource allocation;"¹⁹ then the struggle will be one-sided and short indeed, for as the same author has noted, "[c]ost containment has advocates aplenty; if the patient cannot count on the support of his own physician, he may have no one to protect his interests."²⁰

In the long run, it may be that our society's economic constraints will inevitably induce, if not a decline in health care standards, at least a distressing deceleration in the rate of advance. No legal doctrine of tort law, realistically, can stand in the way of what is economically inevitable, or abetted by the often questionable priorities of our society or governments. But physicians can, by continually pressing for the best for their patients, supply a tension to the process that would otherwise be lacking, and can point to their legal and fiduciary duties as fortifying arguments in so doing. 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. If that were to change, legislation would be required, and the political cost would be borne by those who made that political decision. So it should be.

III. CONCLUSION

AS THIS ALREADY OVER-LENGTHY paper draws to a close, I have the uneasy feeling that some readers — particularly those with a medical background — will object that my thesis is impossibly and impractically idealistic; that I occasionally seem to catch glimpses of the real

¹⁹ E.H. Morreim, "Cost Containment and the Standard of Medical Care" (1987) 75 Cal. L. Rev. 1719 at 1726.

²⁰ *Ibid.* at 1746.

world of cost-consciousness and compromise, only to lose my focus, again and again, on the fleeting vision. They will remind me of those day-to-day predicaments faced daily in every major hospital, and to which I referred in just my third paragraph, wherein physicians *do* withhold heroic treatment from, say, the elderly and the chronically ill because the anticipated benefits, to put it crudely, "would not justify the expense." I would suggest, and hope too, that in the vast majority of such cases, one or both of two patterns of reasoning is being adopted by the treating physician. Either she is reflecting that "to expend thousands of dollars in extending by a few days the painful and joyless existence of my elderly patient would serve no reasonable end, nor do him any real favour." Or the physician, depending upon the facts, may be saying, "the therapy which would help my patient must be denied to him because it involves the allocation of a resource (i.e. donated organs) for which the demand far exceeds the supply. Distasteful as I may find the conclusion, I can make no plausible case for putting my patient, situated as he is in life, anywhere above or even near the 'cut-off' line." Both those lines of reasoning involve responsible and humane engagement of difficult moral issues. In the former, the physician is in truth guided entirely by what is best for the patient, but sensibly does so remembering that the quality, as well as the duration, of the patient's life must be taken into consideration. If the physician loses that focus on what is best for the particular patient, however, and indulges in crude exercises of estimating cost-effectiveness, my argument would indeed tend to identify her as being in breach of her legal, equitable (and I believe ethical) duties. In the latter (scarce resource) scenario, the physician who does not provide the needed therapy acts not in disregard of his patient's rights, but in defence to the inexorable realities of an imperfect world. The law will not blame the physician for failing to provide help which is, on a realistic view, not available within the system. Rather, lawyers and judges will reflect thankfully that they are not called upon routinely to face dilemmas of such a magnitude.

Tiresome though it may seem to end with an inquiry, and a confession of bafflement, I would nonetheless invite the reflection and comments of readers upon one further issue. Both the Caulfield-Ginn article and my own response have considered the duties of physicians in their primary role as providers of medical care, dealing directly with patients. It must not be forgotten, however, that physicians discharge other responsibilities too, in modern Canadian hospitals. Many find themselves sitting, with fellow doctors, with other health care professionals and with hospital administrators, on those very

committees (i.e. pharmacy and therapeutics committees) which determine the allocation of resources and the prioritization of purchases; and which accordingly may influence directly the availability of therapies to patients. In this administrative role, is it the duty of the physician to suspend, for the nonce, his or her usual persona, and that undivided loyalty to the patient of which I have written; and to assume for the time being the persona of the responsible team-member, mindful of the institution's needs, and determined to balance even-handedly the desire for medical excellence and the countervailing demands of financial husbandry and thrift? It may be that such questions are implicitly addressed and resolved by the foregoing argument, or answered (to the same effect or otherwise) in case law which has eluded me.²¹ But the question, like all those I have tried to raise in this essay, seems to me to demand more attention from the Canadian legal academy than has so far been forthcoming.

²¹ Just as this article goes to press, the decision in *Law Estate v. Simice*, (1995) 21 C.C.L.T.(2d) 228 (B.C.S.C.) has appeared: *dicta* of Spence J. at 240 in that case lend strong support for the thesis here contended for.