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THE RISE AND FALL OF MANAGED CARE: A PREDICTABLE “TRAGIC CHOICES” PHENOMENON

DAVID ORENTLICHER*

I. INTRODUCTION

Once touted as the answer to defects in fee-for-service health care insurance,¹ managed care has seen its fortunes rise and fall over the past decade. Initially, managed care techniques became widespread, and they slowed the growth in health care costs. Indeed, premiums for health care insurance went from double-digit increases in the late 1980s to a less than two percent increase in 1996.² More recently, however, public dissatisfaction with managed care has led insurers to jettison key cost-containment strategies of managed care, including closed panels of doctors,³ primary-care gatekeeping⁴ and pre-admission authorization.⁵ As insurers have abandoned these hallmarks of managed care, health care costs have resumed their rapid growth.⁶

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1. In fee-for-service medicine, physicians bill for every service they provide. In contrast, under managed care, physicians are more likely to be paid a salary or to be given a flat annual fee per patient (capitation) regardless of how many services the patient receives during the year.

2. Vernon K. Smith, *State Budgets and Health Care Coverage: What Happens If the Money Runs Short*, Presentation for Alliance for Health Reform (Nov. 8, 2001), at http://www.allhealth.org/recent/audio_11-08-01/VsmithPresentation.ppt.

3. Closed panels refers to the practice once common among health maintenance organizations (HMOs) of making available to patients a limited number of physicians from whom patients could choose for their care. With an open panel, patients can go to any physician that they like. Preferred provider plans charge higher co-payments when patients see physicians who are not included on the plan's list of doctors.

4. With primary care gatekeeping, patients are unable to receive coverage for seeing a specialist (for example, a cardiologist, neurologist, or ophthalmologist) without a referral to the specialist from the patient's primary care physician (for example, an internist, pediatrician, or family physician).

5. Under pre-admission authorization programs, insurers will not cover the costs of non-emergency hospital stays unless physicians have obtained the insurer's approval for the patient's admission in advance of the admission.

6. While employer health care costs increased by only 0.5 percent in 1996, they resumed their double-digit growth in 2001. AETNA, *HEALTH CARE COSTS*, at <http://www.aetna.com/>

Scholars have attributed the fall of managed care to a number of factors including imperfections in the market for health care insurance,⁷ the use by some managed care plans of egregious strategies for cutting costs⁸ and a lack of consumer choice⁹ or voice¹⁰ in the operation of managed care. In the view of some scholars, for example, managed care lost the public's trust because it deceived the public about its practices. Patients were told they would receive the same level of care as they had under fee-for-service insurance when, in fact, managed care restrained costs by providing fewer services.¹¹

This article offers a different explanation for the rise and fall of managed care. Managed care has failed not because of market imperfections, a bad design, or because its design was poorly executed. Rather, the United States' experience with managed care illustrates what happens when society tries to ration health care resources, regardless of the mechanism used for rationing. In this view, problems with the health care market or the design and implementation of managed care might have affected how quickly managed care failed, but they did not affect *whether* managed care would fail. As a method for making the "tragic choices" involved in health care rationing, managed care's failure was inevitable, as predicted by the analysis of Guido Calabresi and Phillip Bobbitt in their book, *Tragic Choices*.¹²

public_policy_issues/Prthehealthcarecosts.htm (Mar. 2002). Similarly, at health maintenance organizations (HMOs), double-digit premium increases had returned by 2001. *2001 HMO Intercompany Rate Survey*, MED. BENEFITS, Dec. 15, 2001, at 1, 2.

7. David A. Hyman, *Regulating Managed Care: What's Wrong with a Patient Bill of Rights*, 73 S. CAL. L. REV. 221, 233-34 (2000); Russell Korobkin, *The Efficiency of Managed Care "Patient Protection" Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1, 6 (1999).

8. David Mechanic, *Managed Care as a Target of Distrust*, 277 JAMA 1810, 1810-11 (1997) (citing "gag rules" that prohibited doctors from giving full disclosure to patients and policies for early discharge from the hospital after a woman gives birth to a baby).

9. Alain C. Enthoven et al., *Consumer Choice and the Managed Care Backlash*, 27 AM. J.L. & MED. 1, 3 (2001) (hypothesizing that "consumers are much more likely to be satisfied with their health plans, including HMOs, if they are given a choice of plans, especially a choice menu that includes a wide-access plan").

10. Mark A. Rodwin, *The Neglected Remedy: Strengthening Consumer Voice in Managed Care*, AM. PROSPECT, Sept.-Oct. 1997, at 45, 46 (calling for a more direct voice for consumers in the operation of managed care organizations), available at <http://www.prospect.org/print/V8/34/rodwin-m.html>. See also Eleanor D. Kinney, *Resolving Consumer Grievances in a Managed Care Environment*, 6 HEALTH MATRIX 147, 149 (1996) (proposing procedures to facilitate the resolution of patients' grievances under managed care).

11. Even with the provision of fewer services, patients have not necessarily had poorer outcomes. Overall, patients do about as well under managed care as under fee-for-service insurance. Some sub-groups of patients do better under managed care; others do better with fee-for-service insurance. R. Adams Dudley & Harold S. Luft, *Managed Care in Transition*, 344 NEW ENG. J. MED. 1087, 1088 (2001); David Orentlicher, *Health Care Reform and the Patient-Physician Relationship*, 5 HEALTH MATRIX 141, 162-66 (1995).

12. GUIDO CALABRESI & PHILIP BOBBITT, *TRAGIC CHOICES* (1978).

As I will discuss in greater detail in the next section, Calabresi and Bobbitt explain that the difficult life-and-death choices entailed in rationing can only be made by hiding them from public scrutiny.¹³ Managed care provided a method for disguising rationing. However, write Calabresi and Bobbitt, when the hidden “tragic choices” are exposed—as they ultimately will be—the method for making those choices becomes discredited, and the public demands a new method.

II. THE “TRAGIC CHOICES” MODEL¹⁴

In *Tragic Choices*, Calabresi and Bobbitt observe that, if societies are faced with the need to allocate critical, but scarce, resources, fundamental values will come into conflict.¹⁵ When resources for life-saving treatment are limited, for example, physicians could allocate the treatment to those who are the sickest, thereby satisfying the value of treatment according to need. However, the sickest patients will often realize less benefit from treatment than healthier patients. If someone has suffered from cirrhosis of the liver for many years and is now close to death from liver failure, a liver transplant may not prolong life very long because of the damage done to the rest of the patient’s body from the liver failure. In contrast, a patient with fairly recent onset of liver disease, who is not so close to death, will likely live much longer with a liver transplant.¹⁶ Treatment according to need, then, will undermine the important social value of allocating limited resources so that they will prolong life as much as possible. However, if treatment is allocated so as to maximize the prolongation of life, then society will have to sacrifice its goal of treating those who are most in need of care.

While it is impossible to avoid conflicts between fundamental values, it is also the case that open resolution of the conflicts is frequently not feasible. As Calabresi and Bobbitt write, societies often cannot resolve difficult life-and-death decisions explicitly.¹⁷ It would cause too much social turmoil to do so.¹⁸

Indeed, the U.S. health care system’s history with explicit rationing has generally been devoid of success. When kidney dialysis units were in short supply thirty years ago and dialysis treatment had to be rationed, the public became so uncomfortable with the process that Congress guaranteed funding to

13. *Id.*

14. Much of the following discussion is adopted from DAVID ORENTLICHER, *MATTERS OF LIFE AND DEATH: MAKING MORAL THEORY WORK IN MEDICAL ETHICS AND THE LAW* 123-131 (2001).

15. See CALABRESI & BOBBITT, *supra* note 12, at 18.

16. DAVID ORENTLICHER ET AL., *HEALTH CARE LAW AND ETHICS* 652 (6th ed., Aspen Law & Bus. 2003).

17. CALABRESI & BOBBITT, *supra* note 12, at 18-19.

18. *Id.*

ensure that dialysis would be available for anyone who needed it.¹⁹ The State of Oregon seemingly engaged in explicit rationing with the Oregon Health Plan in the early 1990s, a plan designed to expand the percentage of the indigent in the state that were covered by Medicaid by limiting the kinds of services that would be covered.²⁰ However, in the end, the State provided generous funding for the Plan to avoid any meaningful cuts in care. The State excluded some treatments from coverage, but the excluded treatments generally were those that provided little, if any, benefit.²¹ Moreover, the state offered some types of coverage that were not offered before under its Medicaid program, or not even offered by private insurance plans.²² In the end, Oregon financed its expansion of coverage only a little bit by limiting services, with more of the contribution to coverage expansion coming from the use of managed care to deliver services and, most importantly, from a tobacco tax and an increase in general state revenues used to fund Medicaid in the state.²³ In short, with two leading efforts at explicitly rationing health care, people have ultimately responded by increasing the resources devoted to the limited services rather than taking the difficult steps needed to implement a serious rationing policy.²⁴

Societies employ various methods to allocate their resources so as to minimize the appearance of conflict because it is impossible to avoid the conflict between fundamental values, and because open resolution of the conflict is often not feasible.²⁵ In other words, with the difficulty of engaging

19. Roger W. Evans et al., *Implications for Health Care Policy: A Social and Demographic Profile of Hemodialysis Patients in the United States*, 245 JAMA 487, 487 (1981).

20. See *infra* note 21. The Plan was supposed to be extended to other groups in the state, including employees of state government, but that has not happened.

21. Howard M. Leichter, *Oregon's Bold Experiment: Whatever Happened to Rationing?*, 24 J. HEALTH POL. POL'Y & L. 147, 148 (1999); Thomas Bodenheimer, *The Oregon Health Plan—Lessons for the Nation* (pt.1), 337 NEW ENG. J. MED. 651, 653-54 (1997). For example, there was no coverage for treatment of the common cold.

22. For example, while private health plans often cap the number of hospital days or physician visits for mental health care, Oregon's Plan had no caps on the duration of mental health services. Lawrence Jacobs et al., *The Oregon Health Plan and the Political Paradox of Rationing: What Advocates and Critics Have Claimed and What Oregon Did*, 24 J. HEALTH POL. POL'Y & L. 161, 166 (1999).

23. *Id.* at 165-66. Oregon was more successful than other states in expanding health care coverage of the poor, but its health care costs went up faster—its Medicaid expenditures in 1996 were 36 percent higher than those in 1993, compared to a national increase of 30 percent in Medicaid expenditures during the same time period. Bodenheimer, *supra* note 21, at 652.

24. Whether such a response was appropriate is difficult to know. The increase in resources may have been justified by the recognition that rationing was unnecessary, or resources may have been diverted from other public services that were more deserving of funding, but whose needs were less visible (or less popular).

25. CALABRESI & BOBBITT, *supra* note 12, at 18.

in explicit rationing, societies turn to implicit rationing to hide the decisions from public view.

For example, societies might rely, at least, in part, on market forces because they give the illusion that allocation decisions are made freely by individuals, acting in an autonomous and decentralized way. If allocation decisions are perceived as being made by autonomous individuals, then people would not blame society for imposing the allocation decisions on the public. In other words, the market shifts responsibility, at least, in part from the state to the citizenry.²⁶ Thus, when a young adult earns a low salary from an employer who does not provide health care insurance, and the employee does not purchase an individual insurance policy that would consume a substantial percentage of his or her annual income, other people often say that the worker chose to go uninsured, perhaps because the chances of sickness are small. However, the same young adult would enjoy health care coverage in Canada, Germany, Great Britain and other countries because those countries rely less on market forces than the United States does to allocate limited health care resources.

Indeed, historically, and in contrast to other industrialized societies, the United States has rationed its health care resources primarily through market forces. Patients who can afford private health care insurance on their own or who are employed by a company with health care benefits have the most access to medical treatment; patients who lack private insurance and who do not qualify for public assistance have the least access to medical treatment. However, markets have their limits, especially in tragic choice contexts. The allocation of health care by wealth in the United States has been sharply criticized, and a market has been firmly rejected for the allocation of organs for transplantation.

Market forces influence not only whether a person has insurance for medical care but also the extent to which the person's insurance is effective at providing coverage. Health care plans, including managed care plans, typically discourage visits to the doctor by raising deductibles and co-payments and lowering coverage caps.²⁷

In other words, there are two stages at which market forces influence the allocation of health care. The pricing of insurance premiums affects whether or not someone is insured. The use of deductibles, co-payments and coverage caps affects the allocation of health care among those who are insured.

26. *Id.* at 31.

27. Thus, note that as health insurers recently have abandoned some of the cost-cutting strategies of managed care, consumers have seen their deductibles and co-payments rise and their coverage caps fall. An example of a coverage cap would be a limitation on the number of outpatient visits allowed per year for mental health treatment.

Lotteries represent a second method sometimes used to disguise allocation decisions.²⁸ A lottery gives the appearance of not choosing, but of leaving matters purely to chance.²⁹ However, it is only an appearance, for the use of a lottery entails a choice to reject differences among candidates that might be relevant.³⁰ In a lottery to allocate a scarce medical treatment, any two patients would be given the same opportunity to receive treatment even though one might be sicker or the other might have a better chance at benefiting from the treatment.³¹ Because lotteries frequently go too far in their egalitarianism, they play a limited role in life-and-death decisions in medicine.³²

Other important methods for hiding tragic choices include the use of technical experts to make the decisions (for example, physicians or other scientists) and the transformation of the decision from one of allocation (that is, an assessment of relative merit or worth) to one that seemingly involves an assessment of absolute worth such that everyone who is worthy is given the life-sustaining good.³³ Because these two methods have been prominent in managed care and other approaches to the rationing of health care, I will now discuss both of the methods in greater depth.

By resting authority for tragic choices in the hands of technical experts, society can create the illusion that the decisions are based on neutral, objective data. This helps to avoid concerns about a sacrifice of important social values.³⁴ For example, if the United Network for Organ Sharing's (UNOS) guidelines for organ allocation give one person a kidney transplant, but deny a kidney transplant to another person, there would seem to be no violation of principles of equality since the differential treatment would presumably reflect real and objective medical differences between the two persons. The person receiving the kidney is the medically appropriate recipient. However, this is only an illusion because, even if medically based, the UNOS guidelines must ultimately reflect judgments about the appropriate way to balance competing moral values, rather than serving as an objective value-free enterprise. Medicine cannot tell us whether to give priority to patients who will live the longest with a new organ, to those who will die soonest without a transplant, or to patients who have been waiting the longest time for a transplant. Medical science can only identify which patients meet our moral criteria, once those

28. The military draft has been an important example of a lottery used to make the tragic choice of who must risk their lives in combat.

29. CALABRESI & BOBBITT, *supra* note 12, at 41.

30. *Id.* at 42-44.

31. *Id.*

32. *Id.* On occasion, pharmaceutical companies have allocated a new drug in limited supply by lottery. See also Diane Naughton, *Drug Lotteries Raise Questions; Some Experts Say System of Distribution May Be Unfair*, WASH. POST, Sept. 26, 1995, at Z14.

33. CALABRESI & BOBBITT, *supra* note 12, at 64-66.

34. *Id.* at 65-66.

criteria are established.³⁵ Nevertheless, when decisions about organ allocation are made according to medically-based guidelines, an impression is created that the decisions rest solely on objective and scientific factors.

Managed care has relied extensively on the tragic choices subterfuge of technical expertise. With primary care gatekeeping, for example, a patient's primary care physician decides whether and when a patient can see a specialist. Under fee-for-service insurance, visits to a specialist often arose upon a primary care physician's referral, but patients could also take the initiative to schedule an appointment with an orthopedic surgeon, cardiologist or psychiatrist. By requiring a primary care physician's referral to see a specialist, managed care companies can reduce the number, and, therefore, the cost of visits to specialists. Moreover, managed care plans have augmented the cost cutting effect of gatekeeping with financial incentives that reward primary care physicians for limiting referrals.³⁶

Primary care gatekeeping acts as a subterfuge because it is not promoted to patients as a method for cost containment. Rather, managed care companies justify gatekeeping in terms of its benefits for the quality of care. If the patient's primary care physician is responsible for referrals to specialists, the physician can better coordinate the patient's care and ensure that different doctors are not doing things that are inconsistent.³⁷ For example, problems have arisen when specialists in different fields (for example, neurology and cardiology) each prescribe a drug, and one drug interferes with the effectiveness of another drug. Gatekeeping, in short, has been promoted as an objective, medically-based exercise in judgment.

For instance, consider the practice of pre-admission authorization for hospitalization. Managed care plans ostensibly employ this practice to eliminate unnecessary hospitalizations of patients, and the plans characterize the authorization process as involving expert review of physicians' requests for hospitalization. However, a primary purpose of pre-admission authorization has been to reduce health care costs.

35. Defining death is a good example of how medicine can only identify when a patient meets moral criteria after the criteria are established on moral grounds. Whether someone is dead when their brain stops functioning or only once their heart stops beating is a philosophical decision that society must come to after weighing the relevant moral considerations. Once society decides that death occurs when the brain stops functioning, physicians can apply medical knowledge to determine that someone's brain has stopped functioning and that the person therefore is dead. *In re Welfare of Bowman*, 617 P.2d 731, 734 (Wash. 1980) (en banc); Alexander Morgan Capron & Leon R. Kass, *A Statutory Definition of the Standards for Determining Human Death: An Appraisal and a Proposal*, 121 U. PA. L. REV. 87, 92-94 (1972).

36. For a discussion of these financial incentives to limit care, see David Orentlicher, *Paying Physicians More to Do Less: Financial Incentives to Limit Care*, 30 U. RICH. L. REV. 155 (1996).

37. Dudley & Luft, *supra* note 11, at 1088.

This is not to say that the use of technical experts serves only the role of subterfuge. When subterfuges are used to hide tragic choices, they typically offer some real advantage other than perpetuating the myth that a tragic choice has been avoided.³⁸ Thus, as I indicated, primary care gatekeeping can also ensure that a patient's care from multiple physicians is well-coordinated.

In addition to the subterfuge of technical expertise, tragic choices are also hidden when they are characterized as involving assessments of absolute worth rather than relative worth.³⁹ When societies employ decisions that seem to reflect assessments of absolute rather than relative worth, the ostensible premise is that everyone's life can be saved, that society has committed sufficient resources so that no lives need be lost. For example, if there is a shortage of ventilators, society could concede that its resources are limited and that some patients in need of artificial ventilation will be given priority over other patients with such a need. The number of patients viewed as candidates for artificial ventilation would exceed the number of ventilators and difficult choices would have to be made. This approach would entail assessments of relative worth.

Alternatively, a society could raise the threshold for considering someone a candidate for artificial ventilation, such that the number of patients viewed as candidates would drop and come into line with the number of ventilators. In such a case, the society might claim that it has purchased ventilators for everyone who is medically qualified for artificial ventilation. When someone dies for lack of a ventilator, we might not see this as involving a tragic choice if we believe that the patients who are denied ventilation are not appropriate candidates for a ventilator. In other words, we try to hide the fact that some sacrifice of life is being made in favor of other values⁴⁰ by acting as if there is no meaningful sacrifice of life.⁴¹

In many situations, society translates decisions about relative worth into decisions about absolute worth by making it seem as if worthiness turns on individual behavior. That is, the idea is that everyone could demonstrate absolute worth if they only acted without fault. Criminal law frequently uses this approach. It is easier to blame criminals for their deficiencies than to

38. CALABRESI & BOBBITT, *supra* note 12, at 78.

39. *See id.* at 72-78.

40. For example, if we do not artificially ventilate permanently unconscious patients, we may be sacrificing the value of preserving life in order to save money for better funding of primary school education or environmental cleanup.

41. To be sure, the greater the consensus that little is being lost when life-sustaining treatment is denied, the fewer the people who will view the decision as tragic.

admit that much crime could be eliminated if all persons had access to decent levels of housing, education and other basic necessities.⁴²

Managed care's primary use of this subterfuge is its promise that patients will receive all medically necessary or all medically appropriate care—the same promise that patients receive from their fee-for-service insurers. With this guarantee, patients are told that any care withheld will be withheld because it does not serve a meaningful medical purpose. They are not told that some care will be withheld because it costs too much money.

III. WHITHER THE FALL OF MANAGED CARE?

As a tragic choice subterfuge for rationing medical care, it was inevitable that managed care would not be sustainable, at least in its initial formulation. To be sure, tragic choice subterfuges often are successful for a time. Eventually, however, as Calabresi and Bobbitt observe, the public recognizes that there is only an illusion that tragic choices have been avoided, and people demand that the subterfuge be rejected.⁴³

Scholars, consumer advocates and members of the media have exposed the rationing techniques of managed care. The public has become aware that managed care plans tried to contain costs by imposing strict limits on days of hospitalization,⁴⁴ providing financial incentives for physicians to limit care or blocking patient access to medical specialists. With greater awareness of the subterfuges, public criticism followed. In turn, managed care plans changed their practices voluntarily or changed them in response to legislative mandates.

With the recognition and abandonment of a tragic choice subterfuge, society must change its method of resolving the tragic choice. It must find a new way to allocate the limited resources at stake. However, it still is not possible to resolve the tragic choices openly, and so new subterfuges are adopted.⁴⁵ The United States will no longer employ managed care as we knew it to ration health care, but it will find another implicit method to contain health care costs.

In the short term, health care insurers have turned back to the subterfuge of market forces to hide the rationing decisions. Premium costs are rising, as are deductibles and co-payments. By shifting costs back to patients, society returns to the illusion that allocation decisions are made freely by individuals exercising their autonomy, when, in fact, a societal choice has been made to

42. CALABRESI & BOBBITT, *supra* note 12, at 74. It is undoubtedly no coincidence that levels of violent crime in the United States dropped during the 1990s with the expansion of the economy.

43. *See id.* at 18-26, 195.

44. For example, managed care plans were heavily criticized by public disclosures of policies for discharging women within 24 hours after childbirth.

45. CALABRESI & BOBBITT, *supra* note 12, at 18-19.

allocate medical resources on the basis of wealth rather than medical need or likelihood of receiving benefit.

Changing subterfuges does not eliminate the conflict of values, but it allows for the possibility that a society will give priority to different values over time, thereby ensuring that all important values are both favored and disfavored.⁴⁶ An organ allocation system may give greater weight to medical need at one time, but then give greater weight to likelihood of benefit at another time.⁴⁷ Thus, long-term ineffectiveness may, in fact, be a virtue rather than a vice of tragic choice subterfuges. It is better that societies have to change the values that are disfavored rather than disfavoring some values all of the time.⁴⁸

IV. LESSONS FOR THE FUTURE

Considering managed care as a tragic choice phenomenon yields some other important insights about the fall of managed care and about its future. First, managed care cannot be saved by greater disclosure to patients of managed care's techniques for containing health care costs, and, indeed, managed care's downfall could not have been averted even if managed care plans had been more open about its rationing techniques. Managed care did not fail because it betrayed the public trust. As the tragic choice analysis indicates, managed care succeeded only because its efforts at rationing were hidden from public view. If managed care plans had publicized their strategies for limiting health care spending, managed care would never have gotten off the ground, or it would have failed more quickly. Tragic choice subterfuges cannot thrive in an atmosphere of openness.

If managed care as we knew it is beyond redemption, what comes next? As I have indicated, health care insurers have turned back to the rationing subterfuge of market forces in the short term. By raising premiums, co-payments and deductibles, health care plans have increased the extent to which medical care is allocated on the basis of wealth.

However, there are real concerns with making access to medical care turn on people's ability to pay, and we can expect a swing back to other kinds of tragic choice subterfuge. In this regard, we might see practice guidelines for physicians play an increasing role in health care rationing.⁴⁹ By "practice guidelines," I am referring to guidelines developed for physicians that give

46. *Id.* at 196-97. Of course, it may also be the case that the same values are favored even as different tragic choice subterfuges are used.

47. The liver allocation policy of UNOS, for example, has changed in recent years to give greater weight to medical benefit and less weight to medical need. WILLIAM J. CURRAN ET AL., *HEALTH CARE LAW AND ETHICS* 774 (5th ed. 1998).

48. CALABRESI & BOBBITT, *supra* note 12, at 196-97.

49. Kathleen N. Lohr, *Guidelines for Clinical Practice: What They Are and Why They Count*, 23 J.L. MED. & ETHICS 49, 54 (1995).

recommendations for the diagnosis and treatment of specific medical problems. For example, a practice guideline for chest pain would indicate when it is a good idea to evaluate the pain with an electrocardiogram (EKG) and when it is not necessary to do so.

Practice guidelines incorporate the tragic choice subterfuges of both technical expertise and measures of absolute worth. As to the subterfuge of technical expertise, practice guidelines are typically developed by medical experts who justify their conclusions in terms of medical research and their own experiences caring for patients. The guideline drafters give the impression of relying on objective, medical considerations, but they also incorporate value judgments about the best way to allocate health care.⁵⁰

As to employing measures of absolute rather than relative worth, practice guidelines purport to identify when a patient is a qualified candidate for care. They do not typically suggest that some qualified candidates are more deserving of care than other qualified candidates.⁵¹

V. CONCLUSION

As with other tragic choice subterfuges, managed care was destined for temporary success but also doomed to ultimate failure. Greater openness by managed care might have been fairer to patients, but it would not have prevented the downfall of managed care. Rather by exposing the rationing subterfuge more quickly, openness would only have quickened the public's desire to rid itself of managed care.

50. David Orentlicher, *Practice Guidelines: A Limited Role in Resolving Rationing Decisions*, 46 J. AM. GERIATRICS SOC'Y 369, 369-70 (1998).

51. It is not uncommon for a practice guideline to admit to a degree of uncertainty. For example, a surgical practice guideline might identify some patients as clearly benefiting from surgery compared to non-surgical treatment, other patients as clearly benefiting more from non-surgical treatment, and a third category of patients for whom it is unclear whether surgery or non-surgical treatment is more advantageous. American College of Cardiology/American Heart Association Task Force on Assessment of Diagnostic & Therapeutic Cardiovascular Procedures, *Guidelines and Indications for Coronary Artery Bypass Graft Surgery*, 17 J. AM. C. CARDIOLOGY 543 (1991).

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