

CAN A PATIENT-CENTERED ETHOS BE OTHER-REGARDING? OUGHT IT BE?

*Theodore W. Ruger**

The American health care system is built on a significant conceptual tension that grows more intense with each passing year; it devolves primary authority over medical decisions to individualized physician-patient transactions, while increasingly embodying notions of group solidarity and systemic interconnectedness in its overall design. The passage earlier this year of the landmark Patient Protection and Affordable Care Act (“PPACA”)¹ only sharpens this tension. Many of the PPACA’s most important measures reflect the principle of group solidarity. For instance, insurers will be restricted in their ability to thinly slice risk pools by practicing age and gender rating and by enforcing preexisting-condition exclusions.² The individual mandate to purchase insurance will drive more healthy Americans into larger private risk pools, and the prices they pay will in many cases be higher than is appropriate for their own age- and health-adjusted actuarial risk; this mandate will effectively result in a redistributive tax on youth and good health.³ On the public-finance side, the PPACA’s substantial expansions of Medicaid coverage will be funded primarily by higher taxes on affluent federal taxpayers, reflecting an unprecedented commitment to guarantee coverage for virtually every American below or near the poverty line.⁴ For all of these reasons and more, individualized patient and physician choices about utilization will, when aggregated, reverberate through an increasingly integrated system struggling with profound cost and quality concerns.

Despite enforcing a more robust (and in my view long overdue) principle of collective solidarity in the overall health insurance

* Professor of Law, University of Pennsylvania Law School.

1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

2. See § 1201, 124 Stat. at 154–61 (defining exclusive permissible rating criteria for individual and small-group markets).

3. See §§ 1501(a)(2)(G), 124 Stat. at 243; 10106(a), 124 Stat. at 908.

4. See Theda Skocpol & Vanessa Williamson, *Obama and the Transformation of U.S. Public Policy: The Struggle for Health Reform*, in SUPPLEMENT: HEALTH CARE REFORM UPDATE 1, 5 (Mark A. Hall ed., 2010) (describing the PPACA as “a bill that draws resources from the privileged to spread access to affordable health insurance to most of the U.S. citizenry”).

system design,⁵ the PPACA does little, in the short term at least, to address the individualistic variation in treatment decisions and utilization rates that many scholars and policy makers have pegged as a major problem in the American system. High-profile examples of this feature of health care delivery abound. A set of studies has found dramatic variations in the Medicare cost per patient in different regions of the country, even after controlling for all relevant health, population, and price-index variables.⁶ The studies concluded that differences in regional medical practice and utilization patterns cause these cost variations.⁷ Another study found that physicians' willingness to prescribe expensive cox-2 inhibitors to Medicaid patients for chronic pain relief varied from a low of eleven percent of applicable patients in one state up to seventy percent in another.⁸ Many scholars cite such therapeutic variations as the source of major cost and quality concerns.⁹

There is nothing new about this preference for individualization in American medicine, or about the correlative resistance to therapeutic standardization among providers and patients. This norm has deep epistemological roots in the American medical profession, and has been preserved and entrenched by constitutional and legal structures of American health law until recent decades. Medical historians, such as John Harley Warner, have described the prevalence of a "principle of specificity" among American physicians as the profession coalesced and sought enhanced status in the mid-nineteenth century.¹⁰ For American physicians seeking to distance themselves from the ideas of the major European medical centers, as well as from universalist therapeutic regimes like Thomsonianism and homeopathy, the notion of individualistic variation in treatment became a central intellectual precept of the profession. So, for instance, a Boston physician writing in 1861 claimed that "[i]diosyncrasy, or the peculiarities of the individual, are as anomalous and impossible to reduce to rule and measure, as the

5. See § 10106(a), 124 Stat. at 908.

6. See DARTMOUTH MED. SCH., *THE DARTMOUTH ATLAS OF HEALTH CARE* 1998 (John E. Wennberg & Megan McAndrew Cooper eds., 1998); Elliott S. Fisher et al., *The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care*, 138 *ANNALS INTERNAL MED.* 288 (2003); W. Pete Welch et al., *Geographic Variation in Expenditures for Physicians' Services in the United States*, 328 *NEW ENG. J. MED.* 621 (1993).

7. See DARTMOUTH MED. SCH., *supra* note 6, at 2; Fisher et al., *supra* note 6, at 288; Welch et al., *supra* note 6, at 625–27.

8. See Michael A. Fisher et al., *Medicaid Prior-Authorization Programs and the Use of Cyclooxygenase-2 Inhibitors*, 351 *NEW ENG. J. MED.* 2187, 2187 (2004).

9. See, e.g., Fisher et al., *supra* note 6, at 297–98.

10. See John Harley Warner, *From Specificity to Universalism in Medical Therapeutics: Transformation in the 19th-Century United States*, in *SICKNESS AND HEALTH IN AMERICA: READINGS IN THE HISTORY OF MEDICINE AND PUBLIC HEALTH* 87, 87–91 (Judith Walzer Leavitt & Ronald L. Numbers eds., 1997).

passage of the clouds."¹¹ Professor Albert Stille of the University of Pennsylvania claimed in a major lecture in 1884 that "[t]here is also an art of medicine [that] completely eludes, or . . . flatly contradicts science."¹² Likewise, according to a Boston physician writing contemporaneously, "No two patients have the same constitutional or mental proclivities," and thus, in language that clearly resonates with our own age's debates about cost-effective research and standardized practice protocols applied to medical care, "[n]o 'rule of thumb,' no recourse to a formula-book, will avail for the proper treatment even of the typical diseases."¹³

Like the recent *Dartmouth Atlas* studies reveal, in the past century such variation produced real and meaningful differences in treatment between otherwise similarly situated patients. In a study of hospital records from two mid-nineteenth-century hospitals, Professor Warner documented the dramatically different therapeutic protocols employed contemporaneously by doctors at a major Boston hospital and a major Cincinnati hospital.¹⁴ Physicians at the latter site were much more likely to employ invasive techniques, like purging (induced by calomel or tartar emetic) and bloodletting (venesection), often with adverse results for the patient.¹⁵

That this conceptual preference for therapeutic individualization persisted for over a century and became successively more entrenched in the medical arena is no accident. Individual physician authority was a key intellectual foundation of American medicine in the nineteenth century, and its staying power through much of the twentieth century was fostered in no small part by the regime of American health law that arose contemporaneously. The judicial doctrines that composed American health law from the middle of the nineteenth century until the last decades of the twentieth built on this diffused structure of medical authority that prevailed among American physicians. Whereas liability rules and private institutional ordering might have operated over time to blunt or counteract the tendency toward diffused authority, the rules that courts framed from the middle of the nineteenth century until the middle of the twentieth only sharpened the individualistic and atomized nature of medical

11. David W. Cheever, *The Value and the Fallacy of Statistics in the Observation of Disease*, 63 BOS. MED. & SURGICAL J. 449, 483 (1861).

12. Alfred Stille, Professor of the Theory & Practice of Med., Univ. of Pa., Address to the Medical Classes of the University of Pennsylvania on Withdrawing from His Chair (Apr. 10, 1884), in 44 MED. NEWS 433, 435 (1884).

13. See Editorial, *Routine Practice*, 108 BOS. MED. & SURGICAL J. 42, 43 (1883).

14. See generally John Harley Warner, *Power, Conflict, and Identity in Mid-Nineteenth-Century American Medicine: Therapeutic Change at the Commercial Hospital in Cincinnati*, 73 J. AM. HIST. 934 (1987).

15. See *id.* at 941.

authority. As I explain in a longer work still in progress, the legal rules that operated in this way are numerous—ranging from the basic American constitutional structure that devolved authority over medicine, to the laws of myriad state governments, to the weak pressures for standardization imposed by state licensure regimes and liability rules that permitted multiple schools of thought and variation based on locality and practice setting.¹⁶ In the early twentieth century, other doctrines such as the bar on “corporate” practice of medicine worked to preserve therapeutic diversity by stunting the development of institutional forms of control over medical practice.¹⁷ Though many of these core doctrinal rules have been modified or abandoned today, health law played a major role in the care and feeding of medicine’s devolved authority structure well past the middle of the twentieth century, and relatedly contributed to its normative entrenchment today even as formal doctrinal levers have receded.

In the past several decades, American medicine has become dramatically more patient centered, but hardly less individualistic. The substantial transformation of authority within the individual therapeutic relationship, which has been produced in the past several decades by the emphasis on patient autonomy and informed decision making,¹⁸ has not altered the orientation of medical authority. Though the relative decisional authority of doctor and patient may have shifted, and the norms of communication and self-determination have expanded in dramatic ways,¹⁹ the legal and ethical changes fostered by the informed-consent ideal have done little to reduce the diffused character of medical decision making in the United States. Medical decisions are now binary rather than unitary, but remain devolved to the most particularized level of the delivery system. If medical authority was atomized before, it is now molecular. Although couched in a complex set of systems for delivery and payment, medical decision making remains centered on individual doctors and patients.

Recent events illustrate the deeply entrenched nature of this authority structure. One of the iconic images of the recent health-reform debates was the U.S. Secretary of Health and Human

16. The working title of this article, which I expect to be published in 2011, is *The Ghosts of Health Law Past*.

17. See Nicole Huberfeld, *Be Not Afraid of Change: Time To Eliminate the Corporate Practice of Medicine Doctrine*, 14 HEALTH MATRIX 243, 249–53 (2004) (describing the rise of corporate practice doctrine).

18. See, e.g., Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899, 900–05 (1994) (describing the rise of the informed-consent doctrine after 1957).

19. See Christine Laine & Frank Davidoff, *Patient-Centered Medicine: A Professional Evolution*, 275 JAMA 152, 152–53 (1996) (describing the “striking” change in physician attitudes toward patient awareness and involvement in treatment decisions).

Services, Kathleen Sebelius, appearing on television in November 2009 to quell a growing uproar over the new recommendations for breast cancer screening that were promulgated by a little-known body called the United States Preventive Services Task Force (“Task Force”).²⁰ The Task Force, comprised of a dozen independent medical experts under the auspices of the Federal Agency for Healthcare Research and Quality, is authorized by federal statute to “conduct[] scientific evidence reviews of a broad range of clinical preventative health care services [and to] develop recommendations for primary care clinicians and health systems.”²¹ In this instance, the Task Force found that the risks and uncertainties associated with regular mammograms for healthy women under age fifty outweighed the therapeutic benefit of earlier screening, and so recommended against such regular screenings for women in their forties.²² The recommendations were grounded in sound science—large-*N* studies from multiple countries—and were unanimously supported by the physicians and scientists who staffed the Task Force.²³

Still, despite the fact that this recommended standard of care was entirely nonbinding on providers and payers, the Task Force’s action provoked an intense and immediate backlash from physicians, patients, and members of the broader public.²⁴ Although a fraction of this opposition articulated a reasonable difference of opinion regarding risk assessment, much of the uproar was more fundamental, responding to a perceived intrusion by a centralized federal agency into a decision that had traditionally been vested in an individual patient and her physician.²⁵ Members of the public, physicians, and politicians claimed that the Task Force was part of a broader effort to restructure American medical authority and to

20. See Stephanie Condon, *Sebelius: Mammogram Recommendations Won't Set Policy*, CBS NEWS (Nov. 18, 2009), http://www.cbsnews.com/8301-503544_162-5698251-503544.html.

21. See *U.S. Preventive Services Task Force (USPSTF)*, U.S. DEPARTMENT HEALTH & HUM. SERVICES, <http://www.ahrq.gov/clinic/USpstfix.htm> (last visited Oct. 14, 2010).

22. U.S. Preventive Servs. Task Force, *Screening for Breast Cancer: U.S. Preventive Services Task Force Recommendation Statement*, 151 ANNALS INTERNAL MED. 716, 716–17 (2009).

23. See Dan Eggen & Rob Stein, *Mammograms and Politics: Task Force Stirs Up a Tempest*, WASH. POST, Nov. 19, 2009, at A1.

24. See Valerie Richardson, *Sebelius Shuns New Mammogram Report*, WASH. TIMES, Nov. 19, 2009, <http://www.washingtontimes.com/news/2009/nov/19/sebelius-shuns-panels-advice-on-mammograms/>.

25. See, e.g., *Alexander Cautious of New Mammography Guidelines Released by Government Task Force*, CONGRESSMAN RODNEY ALEXANDER (Dec. 3, 2009), <http://alexander.house.gov/index.cfm?sectionid=25&parentid=23§iontree=23,25&itemid=568> (“With these new guidelines, it is even more apparent to me that health care decisions need to be made by patients and their doctors. We need to reinforce this important relationship, not weaken it with government intrusion.”).

bureaucratize treatment decisions.²⁶ The Task Force's tentative effort to standardize practice in this area had threatened the longstanding authority structure in American medicine, characterized by diffuse and individuated medical authority.

Secretary Sebelius and others in the Obama administration were keenly aware of the deep roots and latent power of these structures and of the general resistance to medical centralization held by Americans, even if they may have been surprised at the intensity of this particular reaction. Within a few days of the Task Force's recommendation, Sebelius went to the media to expressly distance the administration from the panel and, more pointedly, from its epistemic assumption that medicine could be, or ought to be, standardized through collectivized expert agencies.²⁷ Calling the Task Force an "outside independent panel of doctors" who "do not set federal policy," Sebelius proclaimed that decisions on appropriate breast cancer testing, like other medical decisions, were appropriately devolved to the individual judgment of physician and patient.²⁸ She told the nation's women to "[k]eep doing what you have been doing for years," and to "[t]alk to your doctor . . . and make the decision that is right for you."²⁹

In repudiating the Task Force and urging women to make the decision "right for" them, Sebelius clearly opted for a patient-centered conception of decisional authority, as opposed to the tentative standardization proposed by the Task Force. Although such a statement quelled the public outcry in the short term, the normative clash between these two visions of medical expertise is bound to recur in a system that is becoming increasingly interconnected, particularly given the scholarly and bureaucratic interest in giving greater prominence to expert cost-effectiveness research and best-practices standardization. In a medical economy growing at unprecedented rates,³⁰ and with cost increases driven in part by patient- and physician-driven therapeutic variation,³¹ the question is whether we can afford such heavily patient-centered medicine.

A key question in light of these potentially conflicting visions is

26. See, e.g., Whitney Pitcher, *Bureaucratization of Breast Cancer Screening?*, THEPALINATION.COM (Nov. 20, 2009, 7:49 PM), <http://www.thepalination.com/2009/11/bureaucratization-of-breast-cancer.html>.

27. See Press Release, U.S. Dep't of Health & Human Servs., Secretary Sebelius Statement on New Breast Cancer Recommendations (Nov. 18, 2009), available at <http://www.hhs.gov/news/press/2009pres/11/20091118a.html>.

28. *Id.*

29. *Id.*

30. See Thomas J. Parisi, *How Much Did You Pay for Your Heart: Is a Centralized Entity Performing Health Technology Assessment with Cost-Effectiveness Analysis the Answer to the Rising Costs of Healthcare?*, 46 JURIMETRICS 285, 287 (2009) (documenting the rising costs of health care).

31. See Molly Cooke, *Cost Consciousness in Patient Care—What Is Medical Education's Responsibility?*, 362 NEW ENG. J. MED. 1253, 1253–54 (2010).

whether a “patient-centered” approach to medical care is inevitably in conflict with an approach grounded in collective solidarity and advancement of system-wide cost and quality goals. Put differently, is a well-meaning focus on the patient necessarily and entirely individualistic, or can a patient-centered ethos of medical care incorporate concern for broader systemic goals? The challenge for the U.S. health care system in the coming decade and beyond will be to moderate the excesses of a decentralized authority structure, while retaining sensitivity to individual patient need and individual physician judgment. I speculate briefly about whether such a dichotomous framing of authority is possible.

At one level, of course, there are inevitable trade-offs. Creating a system in which therapeutic choices are more sensitive to systemic externalities (whether resource-related or otherwise) inevitably involves some reorganization of authority. Though not a zero-sum game, as discussed below, efforts to meaningfully standardize treatment protocols necessarily make incursions on the substantial decisional choice that has traditionally characterized American medicine in recent decades. These incursions go beyond mere resource constraint (though they might occasionally manifest as resource constraint) and also threaten the independent value that physicians and patients place on choice itself. As such, even regimes in other countries that have operationalized global budgets and cost-effectiveness analysis still profess deference to individual physician judgment and the best interests of individual patients. In Great Britain’s National Health Service, for instance, the National Institute for Health and Clinical Effectiveness (“NICE”) has been empowered to recommend against the use of new technologies that are too costly relative to their returns,³² but its recommendations contain the cautionary language that they cannot “over-ride the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient.”³³

The increasing interconnectedness of the U.S. health insurance system going forward will increase pressures to standardize allocation of resources, thus implicating a clash of normative values, given the entrenched individualized authority structures that exist. It is unlikely that an approach grounded in centralized budgeting or allocation will gain traction in the United States in the short- or medium-term. The alternative to this extreme is to explore methods to reshape existing therapeutic relationships—and the law and financial arrangements that shape those relationships—to achieve greater sensitivity to values beyond those of the immediate patient

32. See David J. Kerr & Mairi Scott, *British Lessons on Health Care Reform*, 361 *NEW ENG. J. MED.* e21(1), e21(2) (2009).

33. *R. v. Nat’l Inst. for Health & Clinical Excellence*, [2009] EWHC (Admin) 2722 (Eng.).

seeking treatment. Whether such other-directed medical ethics and law can be made consistent with a “patient-centered” view of medicine is a crucial question that remains open.

Building on existing law, policy, and scholarly commentary, I raise here three intermediate paradigms that may serve to point the way forward. The first two conceptual reforms retain the specific physician-patient interaction as the fulcrum of medical decision making, but aim to modify the financial arrangements and legal duties that contextualize that relationship and exert influence on physician-patient decisions. The traditional method of paying physicians for specific medical procedures (fee-for-service medicine), and the traditional fiduciary-duty doctrine that emphasizes loyalty to the patient above all other values, have both contributed to the fragmentation and individuation that characterizes American medicine.³⁴ Although reforms on both fronts create uncertainty and grounds for concern, reforming payment policies and fiduciary laws are necessary steps toward a more balanced approach to medical care in the United States.

It is hardly new to suggest the necessity of meaningful payment reform as a step in updating the American system of medicine—such reforms are the centerpiece of much recent scholarship³⁵ as well as a component of the recent PPACA.³⁶ A common feature of most of the ideas for payment reform that currently proliferate is the goal of shifting payment models away from the traditional stochastic per-procedure basis, which incentivizes individual physicians and patients to collude to obtain more expensive care by shifting costs of procedures to private or governmental insurance pools.³⁷ Accordingly, the common impulse is to restructure payment models to compensate providers for something more comprehensive than an unbundled set of health care inputs (procedures and therapies). So, for instance, some reform models would pay physicians and hospitals “per episode” of care, while others would

34. See François de Brantes et al., *Building a Bridge from Fragmentation to Accountability—The Prometheus Payment Model*, 361 NEW ENG. J. MED. 1033, 1033 (2009); Eike-Henner W. Kluge, *Resource Allocation in Healthcare: Implications of Models of Medicine as a Profession*, MEDSCAPE GEN. MED., Mar. 21, 2007, at 57, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1925021/>.

35. See Meredith B. Rosenthal, *Beyond Pay for Performance—Emerging Models of Provider-Payment Reform*, 359 NEW ENG. J. MED. 1197, 1197–98 (2008) (describing various payment-reform models).

36. See Sara Rosenbaum & Jonathan Gruber, *Buying Health Care, the Individual Mandate, and the Constitution*, 363 NEW ENG. J. MED. 401, 403 (2010) (“In the end, the [PPACA] is all about altering individual economic conduct, and its importance lies in the way it changes the when and how of health care purchasing.”).

37. See David M. Cutler & Richard J. Zeckhauser, *The Anatomy of Health Insurance*, in 1A HANDBOOK OF HEALTH ECONOMICS 563, 576–88 (Anthony J. Cuyler & Joseph P. Newhouse eds., 2000) (discussing moral-hazard problems in traditional health insurance payment relationships).

bundle episodes together and pay providers on an annual capitated basis for each patient in their care.³⁸

The question of whether such bundled payment arrangements are, or can be made to be, compatible with a patient-centered model of care is hotly debated.³⁹ To the extent that newer payment models disrupt the traditional autonomy that patients and physicians have traditionally enjoyed—autonomy that allows them to employ any procedure justified under the capacious “medical necessity” standard—they may initially appear to be less patient friendly. But it bears emphasis that neither the classical fee-for-service model nor the fully capitated model is, at the extreme, intrinsically more matched to patient interests. Both models contain the seeds of misaligned interests between providers and patients—the former by encouraging too much and too invasive medicine, the latter by incentivizing too little care. That only capitation is regarded as dangerous is a testament to the medicalization of American health care—with its heavy focus on interventions and procedures—and to the continued entrenchment of that model today.

Under any payment model, it is important to have a legal or bureaucratic backstop so that physicians squeezed by financial incentives will not shirk on patient care. The traditional duty of due care offers one such backstop, as does the related duty of loyalty. Physicians bear fiduciary duties of loyalty and care (the malpractice standard) to their patients,⁴⁰ and courts have made clear that innovative payment arrangements do not alter or release physicians from these baseline obligations.⁴¹ Courts have characterized the physician’s duty of loyalty as an “implied promise” that the patient should “be able to trust that the physician will act in the best interests of the patient thereby protecting the sanctity of the physician-patient relationship.”⁴² To the extent that this standard encourages physicians to take account of patient preferences and to be solicitous of patient interests, it is clearly aligned with a “patient-centered” view of medicine. But to the extent that it prioritizes fidelity to patient interests at the expense of all other systemic considerations, such a standard appears anachronistic in a regime of

38. See, e.g., Harold D. Miller, *From Volume to Value: Better Ways To Pay for Health Care*, 28 HEALTH AFF. 1418, 1419–20 (2009); Rosenthal, *supra* note 35, at 1199.

39. See, e.g., Yunjie Song et al., *Regional Variations in Diagnostic Practices*, 363 NEW ENG. J. MED. 45, 46 (2010).

40. See *Hammonds v. Aetna Cas. & Sur. Co.*, 243 F. Supp. 793, 799 (N.D. Ohio 1965) (recognizing the physician’s duty of care and duty of loyalty); Michael A. McCann, *Message Deleted? Resolving Physician-Patient E-Mail Through Contract Law*, 5 YALE J.L. & TECH. 103, 109–10 (2002–2003) (same).

41. See, e.g., *Pegram v. Herdrich*, 530 U.S. 211, 236–37 (2000) (declining to expand fiduciary liability under the Employee Retirement Income Security Act, despite an innovative payment arrangement, because of the overlap with traditional malpractice liability).

42. *Petrillo v. Syntex Labs., Inc.*, 499 N.E.2d 952, 961 (Ill. App. Ct. 1986).

greater interconnectedness and solidarity.

Accordingly, another key challenge for retaining patient-centeredness in a world of payment and delivery reform may be reframing the retention and modification of these baseline liability rules on physician conduct to be both patient focused and sensitive to broader values. For those steeped in medical law and ethics, it may seem incongruous, even oxymoronic, to contemplate a “duty of loyalty” that is other-directed at all; traditionally the duty has been framed in terms of the specific patient or perhaps clearly identifiable third parties. But looking beyond the four corners of health law to other fiduciary contexts offers some analogies. Long-established principles of trust law acknowledge that a trust might have multiple beneficiaries, and these principles have thus imposed on fiduciaries duties of balance and even-handedness in dealing with beneficiaries.⁴³ Importantly for the possible extension to medical care, this duty of fairness does not mean that all beneficiaries’ shares of trust assets must be precisely equal; instead, trust principles permit trustees to allocate greater shares to one beneficiary in response to his or her greater need.⁴⁴ But at all times the fiduciary duty runs collectively to all beneficiaries, rather than individualistically.

This impulse is occasionally reflected in positive statements of environmental law. For instance, the National Environmental Policy Act contains as one of its precepts for governmental action the duty to “fulfill the responsibilities of each generation as trustee of the environment for succeeding generations.”⁴⁵ That Act imposes a fiduciary duty on federal agencies with respect to environmental protection, but frames the duty of loyalty in broader terms that include an intertemporal duty to generations not yet existing. Under no conceivable formulation of a health care provider’s duty is a similarly broad fiduciary mandate thinkable, but a smaller measure of other-directedness is perhaps not out of the question for medical law and ethics in the future.

I am skeptical that such an endeavor will, or ought to, dislodge medical ethics from its individualistic focus. If that is the case, we might invert the question posed here: rather than make medical ethics more other-regarding, can we enhance sensitivity to patient concerns on the part of the public and private institutions that in future decades will exert more standardizing and collectivizing

43. See RESTATEMENT (THIRD) OF TRUSTS § 79 (2007).

44. See *id.* cmt. b (“It would be overly simplistic, and therefore misleading, to equate impartiality with some concept of ‘equality’ of treatment or concern—that is, to assume that the interests of all beneficiaries have the same priority and are entitled to the same weight in the trustee’s balancing of those interests.”).

45. National Environmental Policy Act of 1969, 42 U.S.C. § 4331(b)(1) (2006).

pressures on the individual therapeutic relationship? Here I think various existing design features are worth pursuing, in terms of the composition of such panels and agencies (to include patient representatives and decision rules permitting transparent dissent); in the design of the metrics used to evaluate “effective” care (to include patient-centric variables beyond merely optimal health status outcomes); and in the review of the decisions of such bodies by democratic processes and by an independent judiciary. Consider, for instance, the rather tone-deaf promulgation of the mammography guidelines by the Task Force discussed above. Would the agency actions or communications relating to those ill-fated guidelines have been different if the Task Force had included patient representatives or ethicists in addition to physician experts? The question is significant enough to merit spending significant time thinking about ways to make the new standardizing institutions of American health care more consistent with a patient-centered ethos, even as inevitable tensions will remain.