



2001

The Market for Medical Ethics

Maxwell Gregg Bloche

Georgetown University Law Center, bloche@law.georgetown.edu

This paper can be downloaded free of charge from:
<https://scholarship.law.georgetown.edu/facpub/929>

26 J. Health Pol. Pol'y & L. 1099-1112 (2001)

This open-access article is brought to you by the Georgetown Law Library. Posted with permission of the author.
Follow this and additional works at: <https://scholarship.law.georgetown.edu/facpub>



Part of the [Bioethics and Medical Ethics Commons](#), [Health Economics Commons](#), [Legal Ethics and Professional Responsibility Commons](#), [Social Welfare Commons](#), and the [Social Welfare Law Commons](#)

The Market for Medical Ethics

M. Gregg Bloche

Georgetown University Law Center and
John Hopkins University School of Public Health

At the core of Kenneth Arrow's classic 1963 essay on medical uncertainty is a claim that has failed to carry the day among economists. This claim—that physician adherence to an anti-competitive ethic of fidelity to patients and suppression of pecuniary influences on clinical judgment pushes medical markets toward social optimality—has won Arrow near-iconic status among medical ethicists (and many physicians). Yet conventional wisdom among health economists, including several participants in this symposium, holds that this claim is either naïve or outdated. Health economists admire Arrow's article for its path-breaking analysis of market failures resulting from information asymmetry, uncertainty, and moral hazard. But his suggestion that anticompetitive professional norms can compensate for these market failures is at odds with economists' more typical treatment of professional norms as monopolistic constraints on contractual possibility.

Arrow acknowledged that all industrywide norms of conduct limit the options for economic exchange (Arrow 1972). For some commentators, the fact of such limits is proof enough of the perniciousness of professional norms from an efficiency perspective. Richard Posner (1993) treats the common "ideology" of guild members concerning matters of quality and craftsmanship as a tool for cartelizing production in order to serve the self-interest of members.¹ Guild *ideology*, in this view, deceives both its own adherents and the public concerning members' furtherance of their own

1. Guild *ideology*, so interpreted, discourages would-be defectors and free riders by persuading them that guild cooperation serves the public good and by shaming deviant guild members as self seeking.

interests at society's expense, and guild norms that express this ideology do not deserve the law's deference. To the contrary, suppression of competition through guild norms ought to be the object of legal attack.

Nowhere did Arrow deny that physician adherence to the ethic of fidelity to patients and suppression of pecuniary influences at the bedside serves the medical profession's self-interest. Indeed, implicit in Arrow's account is a short-term/long-term tradeoff: physicians resist bedside financial temptation case-by-case² in order to reap reputational (and financial) rewards from the profession's perceived adherence to this ethic. The norm of fidelity to patients is, by this account, a product of the marketplace. Arrow and critics who view this and other professional norms as pernicious from a social welfare perspective differ not over whether these norms reflect professional self-interest, but over whether they yield welfare gains or welfare losses by comparison with a hypothetical absence of such self-constraint.

This difference of opinion is not merely academic. The question of how health care policy and law should treat professional ethics is key to a variety of ongoing legal controversies. To the extent that health policy and law strive toward optimality in resource allocation, the social welfare impact of professional norms, including the ethic of fidelity to patients and suppression of pecuniary influences at the bedside, is an important public policy matter.

The effect of professional ethics norms on social welfare is most visibly an issue in antitrust law. Over the past twenty-five years, antitrust doctrine has come to treat professional norms with skepticism, as so-called naked restraints on trade (see Havighurst in this issue). Yet ethics norms have survived antitrust scrutiny through a variety of doctrines that enables defenders of these norms to argue that they advance consumer welfare or other public purposes,³ and the U.S. Supreme Court recently signaled an increased willingness to entertain such arguments.⁴

2. As other participants in this symposium have noted, Arrow was also a realist about the extent of professional adherence to this ethic, which he acknowledged was sometimes honored in the breach. But it surely has *some* influence on clinical judgment, he insisted, and to the extent that it does it moves medical resource allocation in different directions than would physician decisions driven purely by short-term financial incentives.

3. These doctrines include the *worthy purpose* exception, which permits open-ended arguments for the public policy value of a restraint; the *rule of reason*, which nominally calls for analysis of a restraint's effects *on competition* but in practice entails assessment of a restraint's effects upon consumer welfare; and the *market failure* defense, which allows restraints to stand if they represent welfare-enhancing responses to informational or other malfunctions in competitive markets. (See Havighurst in this issue.)

4. In *California Dental Association v. Federal Trade Commission*, 119 S. Ct. 1604 (1999), the Court overturned an FTC ruling against a professional association's ethical rules governing

The implications of professional ethics norms for social welfare are at issue in other areas of law marked by tension between these norms and the market paradigm. Conflicts over the lawfulness of financial rewards to physicians for frugal practice, the authority of treating physicians versus health plan managers to determine medical need, and the supervisory powers of plan managers over clinical practitioners pit professional norms against immediate market pressures.

If the goal of health care policy and law is to maximize the social welfare yield from medical spending, consideration of the place of professional ethics norms in health policy requires that we pose three questions. First, how can we distinguish between professional norms that enhance social welfare (even if “anticompetitive” in some sense⁵) and therefore merit our deference (and perhaps even some legal protection) and norms that reduce welfare? Second, when we conclude that a professional norm is socially undesirable, how should we go about choosing among regulatory and legal strategies and deference to markets as means for dissolving the norm? Third, when we conclude that a professional norm is socially desirable, how should we go about preserving it? Should we defer to market outcomes — and perhaps shield select forms of professional collusion from antitrust intervention? Or should we defend this norm actively, through legal and regulatory intervention?

This essay focuses on the first of these three questions, since it is the subject of Arrow’s article. From a public policy perspective, however, the second and third are just as important. It is hardly obvious that a socially undesirable norm should be targeted by judges or regulators rather than left to wither in the marketplace; nor is it clear that a socially desirable norm needs legal or regulatory support to survive.

Arrow and the Market for Medical Ethics

The idea that actors’ unrestrained pursuit of self-interest sometimes reduces social welfare was well accepted among economists in 1963, as Arrow noted in his article. But economists were disinclined to acknowl-

members’ claims to the public about low fees and discounts. The justices offered a “market failure” rationale, arguing that consumers are at high risk for misunderstanding professionals’ advertising claims and that ethical restraints that make such claims easier for consumers to grasp can therefore be “procompetitive.”

5. I employ the word *anticompetitive* here *not* in its antitrust law sense, as a term of art to convey a mix of judgments about a practice’s effects upon both competition *and* consumer welfare (Hammer 2000), but in a more literal sense, to convey proscription of alternative competitive strategies inconsistent with professional norms.

edge that ungoverned self-interest, without negative externalities or monopoly power, could yield socially suboptimal results. The notion that, absent externalities, competing producers without market power might sometimes better advance social welfare by suppressing their self-interest boldly challenged conventional wisdom.

Arrow's explanation for the ethic of suppression of self-interest in medicine put information problems front and center. Indeed, from the perspective of academic economists, Arrow's principal contribution in this article was his path-breaking analysis of information asymmetry and uncertainty as causes of market failure—and thus as reason for restraints on economic actors' pursuit of self-interest. Arrow argued, in brief, that patients' uncertainty about the effectiveness of medical care is a barrier to the marketability of medical services. The classic market response to uncertainty and risk, he noted, is the offering of *insurance* against undesired outcomes, but for an array of technical reasons, a market for insurance *for the outcomes of medical treatment* has not developed and is unlikely to emerge soon.

Without such insurance, Arrow contended, consumers who might benefit from medical care but are disinclined to bear the risk of poor results will demand medical services at socially suboptimal levels. Here is where the professional ethic of fidelity to patients and suppression of self-interest comes in. By making medical advice more trustworthy, Arrow suggested, this ethic compensates to some degree for consumers' uncertainty about clinical outcomes and for their inability to purchase insurance against disappointing results. It thereby moves clinical demand toward socially optimal levels.

The means by which this professional ethic is forged and sustained were nebulous in Arrow's account. Arrow proposed that “when the market fails to achieve an optimal state, society will . . . recognize the gap, and non-market social institutions will arise attempting to bridge it” (947). He pointed to government as the classic example of such an institution⁶ but held that “in some circumstances other social institutions will step into the optimality gap” (947) and that medicine's anticompetitive norms and organizational forms are illustrative. Arrow, however, offered no theory to explain how *nonmarket* bridging occurs—to explain *who* identifies optimality gaps (based on what incentives) and *how*, consciously or unconsciously, these gaps are closed without the intervention of market forces.

6. In so doing, Arrow aligned himself against what later came to be known as *public choice theory*, which treats government as an alternative market venue and public policy as the outcome of bidding and negotiation among competing private interests, not as the product of a disinterested quest to identify and compensate for market failures.

Later in his article, however, Arrow offered a different account, along more classic economic lines. Having presented the ethic of fidelity to patients and suppression of self-interest as a *nonmarket* response to consumer ignorance and uncertainty, he recharacterized professional commitment to this ethic as, in essence, a long-term marketing strategy. Physicians make this commitment in order to win their patients' confidence: thus this ethic is "part of the commodity the physician *sells*" (965; emphasis added).

Arrow's parallel, market-based explanation presents physicians' commitments to professional standards of care, suppression of self-interest, and avoidance of "the obvious stigmata of profit-maximizing" as signals of their "intentions to act as thoroughly in the buyer's behalf as possible" (965). Because prospective buyers respond to these signals by purchasing medical care at increased levels, professional norms that reinforce such conduct and commitment are in physicians' *long-term*, collective self-interest. These professional norms, in other words, reflect and reinforce a rational trade-off strategy that forgoes short-term opportunities for exploitation of consumer ignorance in order to win consumer trust and to thereby increase consumer demand over the long term. And because consumer reliance on medical advice yields net benefits (something Arrow was inclined to presume but that current commentators tend to question), physicians' anticompetitive professional norms also enhance social welfare, Arrow held.

This hard-nosed account of physicians' anti-competitive norms has fared better over time with health policy commentators than has Arrow's almost-mystical story of inexorable optimality-seeking by "nonmarket social institutions." The rise of public choice theory — and of cynicism about the public-regarding potential of government in particular and other social institutions more generally — created an unfavorable intellectual climate for the proposition that nonmarket institutions can do other than function as venues for pursuit of private self-interest. Public choice theory denies that anything about the operation of these institutions tends toward social optimality, except by coincidence. Arrow's failure to propose a mechanism in support of his contrary claim that such institutions detect and bridge optimality gaps may have made this claim more difficult to sustain in the face of public choice theory's prevailing wind. On the other hand, Arrow's market-based account of trust-inducing professional norms as "part of the commodity the physician sells" has taken root among scholars of health care law and policy. Not only did this interpretation fit the fundamental economics premise of pursuit of self-interest by rational actors; it squared

with historical accounts of the medical profession's success, during the first half of the twentieth century, at suppressing practitioners' commercial behavior, committing them to higher standards of care, and thereby winning greater consumer confidence (Starr 1982).⁷

Arrow's Doubts

Although Arrow's account of physicians' anticompetitive norms stressed their social welfare-enhancing effects, he cautioned that noncompetitive physician behavior ensuing from adherence to these norms could interfere with the pursuit of optimality. "The social adjustment towards optimality," he wrote, "puts obstacles in its own path" (947). With this caveat, Arrow acknowledged a thing often discounted in economics commentary: that institutions and mores understandable in functionalist terms, as adjustments tending toward efficiency, can exhibit adaptive inflexibilities, or structural constraints,⁸ that reduce social welfare. Such constraints can arise from human cognitive shortcomings, institutional rigidities, and the coherence of systems of social and moral belief.

Arrow said nothing in his article about the ways by which the medical market's anticompetitive features, including the professional ethic of suppression of self-interest and the institutions that reflect and reinforce this ethic, might interfere with progress toward optimality. Such interference was, for Arrow, a footnote to his story about the overall social welfare gains from this professional ethic. Yet during the generation or so that followed publication of Arrow's essay, this footnote became one of the principal storylines in health care economics and law, eclipsing in influence Arrow's case for the social welfare benefits of anticompetitive professional norms.

7. Law-and-economics scholars broadened Arrow's story about the marketing of indicia of trustworthiness as a response to consumer inability to assess results. Henry Hansmann (1980) interpreted the nonprofit form as an answer to what he termed "contract failure"—the diverse inabilities of patrons (whether charitable donors or paying customers) to knowledgeably monitor a firm's performance to assess its compliance with patrons' expectations. For Hansmann, the nonprofit form's essential feature was its bar against distributing money (aside from compensation at market rates) to stakeholders—a prohibition analogous to the professional ethic of suppression of financial self-interest. Along similar lines, Robert Cooter treated the law of fiduciary obligation as a tool for reinforcing principals' confidence in agents' reliability when principals cannot closely monitor agents' exercise of discretion (Cooter and Freedman 1991).

8. Neoclassical economists pursue functionalist explanations of social phenomena—that is, they seek to interpret behavior and institutions as adaptive responses to the environment—just as classical evolutionary theorists sought to explain the anatomy and physiology of organisms entirely in terms of adaptive purposes served. In economics, as in biology, there is a growing realization that adaptation to environmental pressures is often incomplete, due to limits (i.e., structural constraints) on the social and biological possibilities for change.

The Rising Tide of Skepticism

Since the 1970s, a growing number of commentators from across the ideological spectrum has cast the ethics of the medical profession as a program for self-interested restraint of trade. Arrow himself, as I noted earlier, acknowledged that all industrywide behavioral norms restrain trade by putting some contractual alternatives off limits (Arrow 1972). Whether a given restraint on commerce reduces (or enhances) social welfare is, as Arrow realized, a separate question. But some commentators seem to presume that mere “discovery” that an ethical norm limits buyers’ and sellers’ options (and benefits sellers) is enough to establish the norm’s social undesirability.

More sophisticated critics of professional ethics offer powerful arguments for the inefficiency of particular anticompetitive norms, including prohibitions against advertising, price competition, and contractual lowering of clinical standards of care (Blumstein 1994; Havighurst 1995). These critics tie the norms they target to lost opportunities for consumers to learn more about the quality and prices of alternative providers, to obtain equivalent services more cheaply, and to act on their own cost-benefit trade-off preferences by choosing lower levels of care at lower cost. These arguments have had large real world impact. Invoking antitrust law, courts have rejected collaborative price-setting and ethical proscriptions against professional advertising as impermissible restraints on trade. A variety of legal protections for professional self-governance, including the rule against the “corporate practice of medicine,” have fallen by the wayside, and use of financial incentives to both promote and deter physician utilization of clinical services has become widespread.

Consideration of the social welfare implications of professional norms can now draw upon a new body of research and scholarship that aspires to explain the origins and persistence of informal, nonlegal norms in myriad settings. Robert Ellickson’s (1991) theory of welfare-maximizing norms—his hypothesis that “members of a close-knit group develop and maintain norms whose content serves to maximize the aggregate welfare that members obtain in their workaday affairs with one another”—is arguably consistent with portrayals of physicians’ ethical norms as self-serving restraints on trade. Ellickson and his followers have studied a variety of close-knit groups, from Shasta County cattlemen in California to diamond traders in New York, identifying governing, nonlegal norms and offering persuasive arguments for these norms’ efficiency within these communities. The medical profession to some degree resembles these close-knit

groups, which sustain their nonlegal norms through peer feedback, gossip, and reputational sanctions. But divisions among physicians arising from specialization, geography, status, and institutional arrangements make sustenance of self-serving norms through informal feedback, gossip, and sanctions more problematic. These informal behavior control mechanisms are crucial to close-knit groups' ability to maintain norms that maximize members' aggregate welfare, in Ellickson's account. Groups insufficiently cohesive for these mechanisms to work thus fall outside the ambit of Ellickson's model.

There is good reason to suspect that the medical profession has become less cohesive since publication of Arrow's article. Physicians practice today within much more diverse institutional and financial contexts. Multispecialty group practices, myriad arrangements with health plans and provider networks, and highly variable economic incentives exist alongside the solo and small group fee-for-service model that was the norm in 1963. A more tangible sign of the profession's diminished cohesiveness is the increased willingness of physicians to testify against their peers, on plaintiffs' behalf, in medical malpractice suits, which were rare before the 1960s in large part because of physicians' distaste for testifying against each other. If Ellickson is right about the crucial role of group cohesion in the creation and maintenance of norms that maximize a group's aggregate welfare, then the medical profession may no longer be capable of sustaining ethical norms that maximize its welfare.

The medical profession's internal cleavages also cast doubt on the notion that any one set of norms can maximize the welfare of all or most physicians. The profession has become a complex mix of overlapping subgroups with both shared and competing interests. Norms that might maximize one subgroup's common interests might yield less desirable results for another subgroup or for the profession as a whole. Conversely, norms that maximize interests shared by most of the profession might yield unwanted results for particular subgroups.

It is thus hardly clear that traditional physician ethics—including the norm of fidelity to patients and suppression of financial self-interest—maximize the medical profession's aggregate welfare, let alone society's. Recent efforts to explain the persistence of nonlegal norms in terms of their expressive function cast further doubt on the thesis that physician norms maximize the profession's (or society's) welfare. It has been suggested that people often abide by social norms to signal their cooperative nature, and thus their desirability as potential partners in collaborative effort, irrespective of whether the norms being followed and thereby sus-

tained yield benefits that outweigh their costs (Posner 1998). Once a norm is fixed in place, by common understanding, as such a signal, it is difficult to dislodge even if it is wasteful in the aggregate to the group that abides by it as a signal—and even if adherence to an alternative norm could, in theory, perform this signaling function at lower cost. To the extent that physician norms perform this signaling function, their persistence cannot be taken as evidence that they maximize the profession's welfare; it may merely reflect the difficulty of shifting to an alternative, agreed-upon symbol.

The upshot is that recent thinking about the social welfare impact of physicians' anticompetitive norms is deeply skeptical of Arrow's assertion that these norms have desirable welfare effects. Indeed, contemporary law-and-economics models for the creation and sustenance of social norms invite doubt about whether physicians' anticompetitive norms further *the medical profession's* aggregate welfare. On the other hand, these models do not support the sweeping conclusion that physicians' anticompetitive norms, including the ethic of fidelity to patients, are socially wasteful *per se*. I turn next to some ideas about how we might sort out this confusing picture for some of the anticompetitive medical ethics norms most at issue today.

A Dynamic Model of the Market for Medical Ethics

I start with a premise favorable toward economic analysis: that it makes no sense to speak, without explanation, of a tendency for nonmarket means, including ethical norms, to emerge and to fill optimality gaps that ensue from market imperfections. Arrow's contribution toward our understanding of professional ethics was not his almost-mystical invocation of "non-market" forces tending toward optimality; it was his bold but down-to-earth proposition that an ethical commitment to fidelity to patients and suppression of pecuniary self-interest is "part of the commodity the physician sells." Whether or not one accepts Arrow's further claim that "sale" of this commitment moves society toward optimality, his account of a market for ethical commitment as a response to consumer uncertainty about medical outcomes is intuitively appealing and compatible with the premise of self-interested actors. It is also consistent with the medical profession's success, during the late nineteenth and early twentieth centuries, at increasing its prestige, credibility, and income as it restrained practitioners' commercial excesses.

Indeed, Arrow arguably underestimated consumer demand for professional commitment to an ethic of devotion to patients and suppression of self-interest. In looking exclusively to consumer uncertainty about medicine's biological efficacy as the source of consumer demand for professional trustworthiness, Arrow neglected the affective dimension of patients' experience of illness—their yearnings for support and comfort, reassurance, and credible explanation of frightening developments. To the extent that sick patients value trusting relationships with their doctors as a way to cope with these emotional needs, Arrow's exclusive focus on consumer information deficits undervalues consumer desire for the ethical commitment he seeks to explain.

Arrow's characterization of this ethical commitment in static terms, as part of a market equilibrium, missed dynamic features of the market for medical ethics that play a large role in ongoing health systems change. Over the past hundred or so years, physician commitment to the ethic of suppression of self-interest for the sake of patients has fluctuated considerably, almost certainly in response to changing demand-side pressures. At the dawn of the twentieth century, competing clinicians were hardly reserved about their entrepreneurial pursuits and claims for remedies. The raucous commercialism parodied in George Bernard Shaw's *The Doctor's Dilemma* undermined consumers' belief in the value of what the healing professions had to offer. But by the second decade of the twentieth century the medical profession was responding aggressively to its image problem by closing proprietary medical schools, cracking down on clinical commercialism, and presenting its ethical commitments as evidence of superiority over other kinds of clinical practitioners (Starr 1982). By the time Arrow published his article, patient confidence in the medical profession had risen from an abysmal low to a historic high. Physicians, in short, identified and met a previously unfulfilled consumer "demand" for trustworthiness.

Yet having won consumers' confidence, American physicians were, by 1963, under less market pressure to "prove" their trustworthiness. Many took opportunistic advantage by acquiring ownership interests in hospitals, clinical laboratories, and other health care businesses. Anticommercial norms that Arrow treated as part of a lasting equilibrium fell by the wayside as physicians advertised aggressively and stopped providing free and discounted care to the poor. The profession, in short, began to drift back toward the commercialism of the late nineteenth and early twentieth centuries.

I have suggested elsewhere that growing consumer awareness of this

drift (and consumer skepticism about claims that physicians are little motivated by money) opened the way for managed health plans to be explicit, in the 1980s and 1990s, about financial rewards to physicians for limiting care (Bloche 1998). The managed care revolution has transformed the market for medical ethics. The involvement of health care payers in clinical decision making introduced a cost-sensitive buyers' perspective that differs from the vantage point of sick patients. From the payers' perspective, physician responsiveness to financial incentives is not problematic, either ethically or clinically, and division of physician loyalties between health plans and patients is acceptable, even desirable (Berenson 1991). On the other hand, the managed care "backlash" of the last few years suggests growing consumer unhappiness over economic arrangements that are at odds with the ideal of undivided physician loyalty to patients. Whether the medical profession will respond to market pressure for a return to more robust professional commitment to this ideal remains uncertain. What is clear, though, is that the constellation of ethical norms that Arrow's article treated as a market equilibrium arose, in fact, through a dynamic process in which both physician willingness to suppress self-interest and consumer concerns about doctors' trustworthiness changed over time.

This dynamism remodels medical ethics in response to changing market pressures and market actors' shifting perceptions. The landscape of ethical obligation has changed dramatically since 1963. Physicians now routinely advertise, accept discounted fees from managed health plans, take ownership interests in facilities financially affected by clinical utilization patterns, and sign contracts that reward them financially for withholding care. Yet many physicians at least say they remain committed to the ethic of undivided loyalty to patients (Sulmasy et al. 2000). A difficult but pertinent question is whether the constellation of anticompetitive norms Arrow identified should be treated as indivisible — as tied together by deep cognitive, cultural, or other structures that make the preservation of some of these norms impossible if others are allowed (or even encouraged) to erode. For example, is the ethic of suppression of self-interest when making clinical recommendations undermined by robust price competition, elimination of prohibitions against advertising, or frank manipulation of financial incentives to influence utilization of services? Arrow treated ethical proscriptions against advertising and price competition as critical signals of the profession's commitment to suppression of self-interest in matters of clinical judgment. But the meaning of signifiers is often in flux, and we lack an empirical basis for distinguishing systems of norms that are cognitively, culturally, or otherwise indivisible.

Conclusion: The Efficiency of Suppression of Self-Interest

The market pressures that continually remodel medical ethics are not acknowledged in contemporary law-and-economics treatments of professional ethics that portray these norms as monopolistic restraints on trade that serve professional elites at consumers' expense. There is surely failure, to some degree, in the market for medical ethics: third-party payment and consumer ignorance about the efficacy of clinical services are spawning grounds for opportunism. But market pressures from both consumers and health care purchasers constrain this opportunism, and the growing availability, to consumers and purchasers, of information about treatment efficacy and financial arrangements is boosting these actors' countervailing power.

Acknowledgment of a market for medical ethics, and of the power of purchasers and consumers in this market, should push debate over the social implications of the ethic of undivided loyalty to patients and suppression of pecuniary self-interest away from the presumption (among many economists) that professional unwillingness to depart from this ethic produces a welfare loss. Sustenance of this ethic under current market conditions, in the wake of the breaking of professional price cartels and the proliferation of information about medical prices and quality, augers favorably for this ethic's desirability to consumers.

With almost forty years of hindsight, we are able to tell a more nuanced story than Arrow offered about the social welfare effects of physician commitment to this ethic. One might argue, for example, that this ethic ascends in importance for patients as their health deteriorates and their clinical choices and prospects become more complicated and frightening. Essentially healthy people who face simple, low-stakes therapeutic choices for minor ailments tend to have more emotional and cognitive resources (and time) for information-gathering than do sicker people, and their information needs are comparably modest. Information asymmetries between such patients and their doctors may therefore also be modest, even trivial, and the social welfare gains, if any, from physician trustworthiness may be minimal. At the affective level as well, the welfare advantages of physician trustworthiness may be small for such patients, since they are typically not in much psychic distress and therefore not in great need of emotional support and reassurance.

For the seriously ill, however, clinical alternatives are typically much more complicated and frightening. Their information needs for informed,

reflective choice are large. Meanwhile, these patients' cognitive and emotional resources are under extraordinary strain. Information asymmetries between these patients and their physicians therefore tend to be enormous, and the social welfare gains from physician trustworthiness are likely to be large. These patients' emotional needs, for support, comfort, and credible explanation for their frightening life circumstances, also are likely to be high, yielding further welfare gains from trustworthiness at the bedside.

From a legal and policy perspective, therefore, it might make sense to distinguish between situations that place very different emotional and cognitive demands upon doctors and patients. Anticompetitive ethical norms that call upon physicians to suppress their short-term self-interest when exercising clinical judgment may yield net welfare gains, and net losses, in different clinical and institutional circumstances. That Arrow did not tease out the ramifications of his reasoning for diverse clinical and institutional circumstances is hardly a criticism of his work. His seminal contribution, from a medical ethics perspective, was his account of ethical commitment as a market-driven phenomenon. This basic idea has stood the test of time.

References

- Arrow, Kenneth J. 1963. Uncertainty and the Welfare Economics of Medical Care. *American Economics Review* 53(5):941–973.
- . 1972. Social Responsibility and Economic Efficiency. *Public Policy* 21:303–317.
- Berenson, Robert. 1991. A Physician's View of Managed Care. *Health Affairs* 10: 106–119.
- Bloche, M. Gregg. 1998. Cutting Waste and Keeping Faith. *Annals of Internal Medicine* 128:688–898.
- Blumstein, James. 1994. Health Care Reform and Competing Visions of Medical Care: Antitrust and State Provider Cooperation Legislation. *Cornell Law Review* 79(6):1459–1506.
- Cooter, Robert, and Bradley J. Freedman. 1991. The Fiduciary Relationship: Its Economic Character and Legal Consequences. *New York University Law Review* 66:1045–1075.
- Ellickson, Robert. 1991. *Order without Law: How Neighbors Settle Disputes*. Cambridge, MA: Harvard University Press.
- Hammer, Peter. 2000. Antitrust beyond Competition: Market Failures, Total Welfare, and the Challenge of Intramarket Second-Best Tradeoffs. *Michigan Law Review* 98:849.
- Hansmann, Henry B. 1980. The Role of Non-Profit Enterprise. *Yale Law Review* 91:835–901.

- Havighurst, Clark C. 1995. *Health Care Choices: Private Contracts as Instruments of Health Reform*. Washington, DC: American Enterprise Institute Press.
- Posner, Eric A. 1998. Symbols, Signs, and Social Norms in Politics and the Law. *Journal of Legal Studies* 27:765–798.
- Posner, Richard A. 1993. The Material Basis of Jurisprudence. *Indiana Law Journal* 69(1):35–37.
- Shaw, George Bernard. 1996. *The Doctor's Dilemma*. Studio City, CA: Players' Press.
- Starr, Paul. 1982. *The Social Transformation of American Medicine*. New York: Basic Books.
- Sulmasy, Daniel P., M. Gregg Bloche, Jean M. Mitchell, and Jack Hadley. 2000. Physicians' Ethical Beliefs about Cost-Control Arrangements. *Archives of Internal Medicine* 160:649–657.