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The Ethical Health Lawyer: When Doing the Right Thing Means Breaking the Law - What is the Role of the Health Lawyer?

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What happens when being a good doctor requires being a bad citizen? What should a doctor do when living up to the requirements of a professional code of ethics or staying true to deeply held personal values requires breaking the law? What should a health care professional do when the appropriate conduct in a particular case is inconsistent with a more generalized principle that has been incorporated into law? Further, what is the role of the ethical health lawyer who advises a health care provider facing such a dilemma?

As health care lawyers advising individuals and institutions, is it our job to advise our clients of all the options available to them, and all the potential legal consequences, or is our role simply to keep our clients acting within the law? Are we information providers, policy counselors, risk managers, or some combination of these? If we can distinguish among our various roles, can our clients? These are questions that most lawyers have not discussed with their clients, but they ought to be explored before the most difficult inquiries arise.

When a doctor is confronted with the dilemma of choosing between the path authorized by law and a seemingly more appropriate path, the derivative question posed to the ethical health lawyer is an even more difficult one. Except for those ethically narrow lawyers who believe that there can never be a reason for violating any law, the question of how to advise health care providers with values of their own is fraught with complexity and ambiguity.

The simple answers to most of these questions are insufficient. It is not sufficient to tell doctors to do what they conclude is ethically sound: to first of all, do no harm, whatever the law may require. The health care lawyer mantra, "Good medicine makes good law," is, alas, not always true. There are times when society should be able to trump the personal judgments of individuals. That is the very reason for law; if individual values always led every individual to the right act, law would be unnecessary. If lawyers do not take the law seriously, how can we expect others, including our health care clients, to do so?

On the other hand, the decision to obey an unjust and immoral law may undermine the value of law itself. Several theories, such as concepts of natural law, justify ignoring the civil law under some circumstances.[1] If we are worried about authorizing disregard of the civil law, we might turn to mechanisms that at least caution individuals who consider violating conventional legal requirements and obligations. Perhaps the ethical health lawyer should declare that there is an obligation to uphold even bad law, but at the same time, seek to change it. Perhaps the ethical health lawyer should adopt the principles that were applied to justify civil disobedience by the most famous generators of social change.[2] These principles require the person violating the law to do it openly and publicly, and to be willing to suffer any penalty imposed for doing so. Perhaps, though, that is too great a burden to put on a physician who may face years in prison for helping an otherwise helpless patient, as illustrated by the following case study.

A Case Study: Treating a Person not Legally in the Country at a State University Health Clinic

It may help us to understand these issues if we look at a common legal dilemma faced by health care providers:

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About this Column

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Your client, a primary care physician at a state university hospital clinic, observes that a thirteen-year old Spanish speaking boy, suffering from apparent severe bronchial infection, has come to the clinic with his cousin's Medicaid card. The physician knows something is improper regarding the eligibility card because she has also treated the cousin as a patient. Your client suspects that the boy with the bronchial infection is using the cousin's card because the boy is not in the country legally, and thus he is not eligible for virtually any non-emergency care at a state funded facility. Because the boy seen in your client's clinic lives with his cousin (the doctor's "real" patient, the one to whom the Medicaid card was issued), failure to treat the boy will result in substantial risk to the cousin due to the likelihood of spread of the infectious disease to the boy's close contacts. It is a felony to fraudulently use someone else's Medicaid identification card to obtain payment for service, and it is a felony to aid or abet someone who is using the card illegally. Your client has left the examining room to call and ask you what she should do under these circumstances. What should you tell her?

The Obligation of the Physician

First, consider the case from the perspective of the physician. Assume that the physician is a clinic staff physician without authority to "give" the use of the state university hospital-owned examining room, or the antibiotics that will certainly be required, to the person she is seeing, even if she can donate her time. In fact, under the Personal Responsibility and Work Opportunity Reconciliation Act,[3] arguably it would be illegal for the hospital to "give" anything of value, including any non-emergency medical services, to someone in the country illegally.[4] That physician faces a choice between denying care, in accord with the law, even though doing so would do terrible harm to both of her patients, and violating the law by providing care (and, probably, writing a prescription she knows will be fraudulently filled at some outside pharmacy). The choice is between beneficence – doing what is best for the patient – and adherence to principles of distributive justice that require these kinds of decisions be made by rule, not arbitrarily in individual cases.

The physician could well feel morally obliged to provide the treatment. A long-standing ethical guideline is that the physician "first of all, do no harm."[5] That principle of nonmaleficence is commonly accompanied by the principle of beneficence – the obligation to do good.[6] For example, the American College of Physicians' respected *Ethics Manual* provides that, "the physician's primary commitment must always be to the patient's welfare and best interests...."[7] Addressing the "Changing Practice Environment," the American College of Physicians directs that "the physician's first and primary duty is to the patient. Physicians must base their counsel to patients on the interests of the individual patient, regardless of the insurance or medical care delivery setting in which physicians find themselves..."[8]

On the other hand, there is not much ambiguity in the law, and there is little room to justify the provision of health care under these circumstances. The patient waiting in the examining room is defrauding both the state and federal governments. The physician who lives up to the ethical precepts just described will be doing a highly valuable act, but also will be aiding and abetting a felony (or, more likely, two felonies), and that is likely to be a felony (or two) as well.[9]

If there is no ambiguity about what ethics require (i.e., that the patient be treated) or about what the law requires (i.e., that the patient not be given any non-emergency medical care), there is certainly a great deal of ambivalence about what the physician ought to do. Dr. Bernadine Healy, former director of the National Institutes of Health, appeared on a CBS News *Healthwatch* segment in 1999 to discuss American Medical Association and Kaiser Family Foundation research which found that doctors and patients would happily collaborate in lying about a wide range of cases if doing so were necessary to get an insurance company or managed care organization to pay for necessary health care. She commented, "I think it is heroic for doctors to step up and admit they have been doing something terrible, which is lying."[10] But which is it? Were they heroic, or were they doing something terrible? Is lying heroic when the end is beneficent? Like the rest of us, and like the doctors about whom she was commenting, Dr. Healey could not make up her mind. Doing something terrible, it appears, was the heroic choice. In another news account of an analogous situation in which a physician was required to admit a patient for an unnecessary hospital stay to get approval for the care that patient needed as an outpatient, a physician (who, perhaps wisely, asked that his name not be used) said, "It's a lie.... What I would call a white lie.... I don't know what the right answer is."[11]

So, what is a doctor to do? The American College of Physicians' *Ethics Manual* contemplates this, too, and it recognizes the value of the law as well as the reasons for challenging it:

> The law is society's mechanism for establishing boundaries for conduct. Society has a right to expect that those boundaries will not be disregarded. In instances of conflict, the physician must decide whether to violate the law for the sake of what he or she considers to be the dictates of medical ethics. Such a violation may jeopardize the physician's legal position or the legal rights of the patient. It should be remembered that ethical concepts are not always fully reflected in or adopted by the law. Violation of the law for the purposes of complying with one's ethical standards may have significant consequences for the physician and should be undertaken only after thorough consideration and, generally, after obtaining legal counsel.[12]

Even with the strategic, intentionally ambiguous use of the passive voice (who is supposed to remember that ethics is not always "fully reflected" in law?), this paragraph may provide

some direction to physicians who face this issue. First, do no harm. But wait! Before a physician carries out that directive, before a physician engages in beneficent or non-maleficent conduct, at least in these cases, obtain legal counsel. But what is that attorney supposed to tell his client?

The Role of the Ethical Health Lawyer

The ethical health lawyer could tell the physician client to advocate for a change in the law so that others will not be caught in the unfortunate and arguably unjust position in which her patient found himself. The ethical lawyer could also tell the physician what she must do under these circumstances, or what the law requires of her, or how to meet the ethical obligations of her profession (which are also likely to be incorporated into the requirements of her state licensing statute). Her counsel could tell the physician that she has an obligation to do what will maintain the patient's (or the patients') trust in the physician and the health care system, or what might happen – in criminal court, in a civil action, or in an administrative proceeding – if the physician does, or does not, provide care. The lawyer could describe the physician's required conduct, or recommend particular conduct, or just lay out all the possibilities and all of their consequences.

What should the ethical health lawyer do? Describe all these alternative legal roles, and ask which the client would prefer? The middle of a legal consultation is too late to start informing clients of the alternative roles health lawyers can play in providing advice. Perhaps the counsel has an obligation, as a representative of the law and as someone who is bound to uphold the law, to limit the alternatives described to those that are permitted by the law.

Would a lawyer who tells his client that legal sanctions are unlikely under the circumstances, or who shows his client how to avoid legal consequences ("don't let anyone know you had any suspicion...."), be liable as a conspirator to commit fraud?[13] On the other hand, doesn't the ethical health lawyer have some obligation to advance the interests of those who need health care? Why else would attorneys choose to practice health law? Perhaps the ethical health lawyer really has an obligation to point out that a failure to provide care will adversely affect the level of trust between the physician and her patient.[14] Is it also appropriate for the lawyer to tell the physician about her obligation to advocate for this group of patients? Perhaps political advocacy is yet another new function that has been added to the traditional provider functions of diagnosis and treatment, like informing patients of treatment risks, benefits, and alternatives (added as a professional duty of health care providers in the "informed consent" days of the 1970s),[15] and advocating for patients within managed care organizations (added as a duty of physicians in the 1990s).[16]

Perhaps, in the end, the ethical health lawyer must look at himself as a technical and informational resource to his client, just as his physician client sees herself as a technical and information health care resource to her patient. For the most part, in these cases, the ethical health lawyer may be obliged to give the client the information she needs to make a decision for which only the client will be responsible.

But does the ethical health lawyer have any obligation to tell the client about pursuing illegal alternatives as a form of civil disobedience? Of course, in this case the consequences of civil disobedience may be a felony conviction and a very long jail term, as the highly principled but civilly disobedient Jack Kevorkian found out.[17] Thoreau's famous defense of civil disobedience described the one night he spent in a rural Massachusetts jail for failing to pay taxes to support the Mexican War.[18] However, a doctor who knowingly treats an alien who fraudulently produces a Medicaid card may be facing many more years of imprisonment – a term during which that physician will be unable to provide care to other needy patients.[19] As the American Medical Association says in describing the relationship between law and ethics,

> Ethical values and legal principles are usually closely related, but ethical obligations typically exceed legal duties. In some cases, the law mandates unethical conduct. In general, when physicians believe a law is unjust, they should work to change the law. In exceptional circumstances of unjust laws, ethical responsibilities should supersede legal obligations.[20]

To make the disconnect between law and medicine clear in both directions, the AMA's Judicial Council adds, "The fact that a physician charged with allegedly illegal conduct is acquitted or exonerated in civil or criminal proceedings does not necessarily mean that the physician acted ethically."[21] And how is the physician supposed to know when the law is sufficiently, exceptionally unjust to allow it to be superseded by ethics? Is that the kind of question one would expect a lawyer to be able to help answer? Is that the kind of question on which the lawyer's advice would be useful in the least, or is it entirely dependent on the values of the doctor?

Other Conflicts between Law and Ethics

The not-so-hypothetical problems described above illustrate just one context in which the ethical health lawyer will encounter serious difficulties when the ethical obligations of a physician may conflict with that physician's legal obligations. Historically, bioethicists have been most interested in conflicts between the principle of autonomy and the principle of beneficence rather than conflicts between the principle of beneficence and the requirements of distributive justice. Physicians who seek to end a patient's suffering by ending that patient's life have confronted laws that criminalize conduct they believe is ethically justified, or even ethically compelled. Some studies suggest that most physicians who routinely treat dying patients (oncologists, geriatricians and others) have given lethal doses of medication to some patients even though those physicians knew that it was forbidden by law.[22] They did so because they believed their obliga-

tion to relieve the suffering of their patients, and the principle of beneficence, demanded it.

Outside of Dr. Kevorkian, none of those who have engaged in this conduct for entirely altruistic reasons is serving a criminal sentence, even though many of their acts are likely to constitute homicide. Prosecutors, too, have been sufficiently ambivalent that they have decided not to pursue criminal actions. How should the ethical health lawyer react when asked about whether an oncologist can knowingly prescribe a lethal dose to a patient in intractable pain? Perhaps the legal opinion should be that the act would constitute a technical murder (and a premeditated one at that), but that it would be unlikely to be prosecuted, and that it would be an act of ethical merit. Should the lawyer add ways of concealing the doctor's acts from the coroner or other investigators, or should the counsel advise his client that such conduct would constitute another crime?

Probably the most academically discussed area in which the ethical health lawyer confronts conflict between the client's legal and ethical obligations concerns the forgiving of copays, and the analogous practice of physicians lying to third party payers in order get healthcare that they believe their patients need.[23] While many physicians seem comfortable with the conclusion that these lies, which constitute legal fraud on the third party payer, are justified by the benefits they bring to their patients, their lawyers probably have an obligation to inform them that forgiving a woman's copay so that she can buy food this month also constitutes fraud.

The practice of forgiving copays is not always ethically justified, and sometimes its justification is unclear. As authors writing in the *New England Journal of Medicine* almost twenty years ago recognized, this conduct "encompasse[s] a spectrum of activities ranging from kindness to fraud."[24] A physician may altruistically forgive a copay to relieve an impoverished patient from financial burden. On the other hand, a physician may forgive a copay for marketing reasons – a patient is likely to return to a doctor who gives her a discount by not collecting the copay. Lawyers will be able to structure doctor's gifts to patients (through the creation of a nonprofit organization that makes copays for the poor) so that they are more likely to pass the legal test. Is it appropriate for ethical health lawyers to do that? Should they suggest it to their clients? Is it just one of the ways that ethical health lawyers serve the interests of the health care system by making ethical obligations and legal requirements consistent?

Legal counsel must tell the health care client of the applicable legal requirements in each instance. But does the ethical health lawyer's obligation go beyond that? As a legal advisor, the lawyer may tell her client about all the options, including those not clearly authorized by law, and the likely outcome of each.

Conclusion

Legal counsel must tell the health care client of the applicable legal requirements in each instance. But does the ethical health lawyer's obligation go beyond that? As a legal advisor, the lawyer may tell his client about all the options, including those not clearly authorized by law, and the likely outcome of each. The decision then made by the physician is beyond the scope of the role of legal counsel. But as an ethics and policy advisor, a role regularly played by lawyers, prudent counsel is called upon to work with the physician to determine the ends of medicine, and to determine how the law can be evaluated to assure that the physician is acting to serve those ends. In taking this last role, the ethical health lawyer will also serve the ends of medicine. If the role of ethical and policy advisor is a difficult one, it is because all of us – doctors, lawyers, and others – are ambivalent about so many aspects of our health care system. Health lawyers, like all lawyers, are bound to respect the law. They are also bound to help their clients serve the needs of their patients – that is the reason health lawyers have respect for the work they do. In serving this role, the ethical health lawyer recognizes that a good doctor, like a good lawyer and indeed like any good person, is sometimes drawn to do what the law forbids.

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2. See J. M. Brown, *Gandhi and Civil Disobedience: The Mahatma in Indian Politics*, 1928-34 (Cambridge: Cambridge University Press, 1977) for an account of historically justified civil disobedience.
3. 42 U.S.C. § 1305, Pub. L 104 – 193 § 1 et seq., August 22, 1996.
4. S. M. Dawson, "The Promise of Opportunity – and Very Little More: An Analysis of the New Welfare Law's Denial of Federal Public Benefits to Most Illegal Immigrants," *St. Louis University Law Journal* 41 (1997): 1053-1079; Note, "Welfare Reform – Treatment of Legal Immigrants – Congress Authorizes States to Deny Public Benefits to Noncitizens and Excludes Legal Immigrants from Federal Aid Programs," *Harvard Law Review* 110 (1997): 1191-1196. The law does make some exceptions for outpatient prenatal care and some services provided to children under some limited circumstances, and for services paid entirely by state resources in states that have explicitly authorized those payments by formal legislative action taken after the effective date of the Personal Responsibility and Work Opportunity Reconciliation Act. Our client, alas, does not fall squarely within the relevant exceptions.
5. The Latin *"Primum non nocere"* was never part of the venerable Hippocratic Oath, but seems to have been a principle expressed by Galen. Today the Oath of Geneva prepared by the World Medical Association expresses a related principle: "The health of my patient will be my first consideration." World Medical Associa-

tion, *International Code of Medical Ethics, available at* <http://www.wma.net/e/policy/c8.htm> (last visited June 9, 2006).

6. The American Medical Association's *Principles of Medical Ethics* were amended in 2001 to add a new principle that reflects this notion: "A physician shall, while caring for a patient, regard responsibility to the patient as paramount." *American Medical Association's Principles of Medical Ethics* VIII (2001).
7. See American College of Physicians, *Ethics Manual* (5th ed.); *Annals of Internal Medicine* 142, no. 7 (2005): 560-582, at 561.
8. *Id.*, at 571.
9. See 18 U.S.C. § 2 (a) ("Whoever commits an offense against the United States or aids, counsels, commands, induces, or procures its commission, is punishable as a principal.")
10. "Lying Doctors," *CBS News: This Morning*. October 21, 1999.
11. D. Hilzenrath, "Ethics: The Moral Dilemmas of Managed Care," *Washington Post*, April 9, 1998, at H1.
12. See *Ethics Manual*, *supra* note 7, "Medicine and the Law."
13. For a general discussion of this possibility, see W. R. LaFave, *Criminal Law* (St. Paul: West, 2003): at 631.
14. For a discussion of the value of this trust, and its explicit recognition, see M. A. Hall, "Law, Medicine and Trust," *Stanford Law Review* 55 (2002): 463-527.
15. See, for example, *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972) (adding the obligation to arrange for "informed consent" to the physician's obligation to diagnose and treat).
16. See, e.g., *Wickline v. State*, 192 Cal.App.3d 1630 (1986) (suggesting that yet another additional obligation of a physician might be to advocate for a patient to arrange for payment for medical care, at least under some circumstances).
17. D. Johnson, "Kevorkian Sentenced to 10 to 25 years in Prison," *N. Y. Times*, April 14, 1999, at A1.
18. H. D. Thoreau, *Political Writings*, Nancy L. Rosenblum, ed. (New York: Cambridge University Press, 1996).
19. See 42 U.S.C. §§ 1320A-7b.
20. See *American Medical Association's Code of Medical Ethics*, Sec. E-102, in *Code of Medical Ethics: Annotated Current Opinions Including Principles of Medical Ethics, Fundamental Elements of the Physician-Patient Relationship and Rules of the Council on Ethical and Judicial Affairs* (Chicago: American Medical Association, 2004).
21. *Id.*
22. See D. E. Meier, C. Emmons, T. Quill, and C. K. Cassel, "A National Survey of Physician-Assisted Suicide and Euthanasia in the United States," *New England Journal of Medicine* 338 (1998): 1193- 1201.
23. A. Federman, "Can't We Just Drop the Copay?" *Virtual Mentor* 8 (2006): 130-134, *available at* <http://www.ama-assn.org/ama/pub/category/15948.html> (last visited June 9, 2006).
24. M. S. Lachs, J. L. Sindelar, and R. I. Horwitz, "Forgiveness of Coinsurance: Charity or Cheating?" *New England Journal of Medicine* 322 (1990): 1599-1602.