

# Informed Consent to Rationing Decisions

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**T**O RATION HEALTH CARE SPENDING AMONG competing medical and societal uses raises profound legal and ethical dilemmas. Previous discussions analyze whether rationing is permissible in any form (Fuchs 1984; Relman 1990), whether patients, physicians, or insurers (government and private) should be the primary rationing decision maker (*University of Pennsylvania Law Review* 1992), the proper criteria for rationing (Kilner 1990; Blank 1988; Churchill 1987), and the effect of cost containment on malpractice liability (Hall 1989). Neglected in most of this legal-ethical discussion is the foundational doctrine of informed consent. There is little systematic analysis of how the physician's obligation to discuss the course of treatment and tailor it to individual patient desires is affected by public or private insurance that calls for the denial of marginally beneficial care because of costs. (Morreim [1991] and Miller [1992] are the most notable exceptions.) The issue is a compelling one regardless of whether, and to what extent, physicians are forced to make rationing decisions by rules or are induced to do so by educational, professional, or financial incentives. In all events, the messenger who delivers the bad news is under a fiduciary obligation of candor, which the law of informed consent is designed to enforce.

Disclosure of rationing decisions can occur at two distinct points. General rationing rules and incentives can be disclosed to subscribers of health maintenance organizations (HMOs) and other limited insurance plans at the time of enrollment. Alternatively, particular, case-specific decisions not to contract for potentially beneficial care owing to excessive costs can be disclosed at the time of (non)treatment. This discussion addresses both stages, but the primary focus is on the second. A number of commentators have presented convincing arguments that enrollment disclosure should be required, even though no existing statute or case decision says so (Levinson 1987; Hirshfeld 1990; Figa and Figa 1990). Therefore, I will not elaborate on this position here, except to state my opinion that this glaring legal deficiency is inexcusable. HMO subscribers are clearly misled by the advertising slant that emphasizes their utopian features without mentioning the built-in incentives and constraints that can lead to the denial of beneficial care (Mechanic, Ettel, and Davis 1990; Brett 1992).

Although it is easy to agree on some global disclosure of rationing mechanisms at the time of enrollment (even if a consensus is lacking on exactly what to disclose and how to do it), we are still left with the thornier question of whether individual treatment options that are potentially beneficial but expensive must be disclosed precisely at the time the physician declines to order them, and, if so, whether the patient has a right to insist that the treatment be given. Beginning with James Blumstein's analysis (1981), every commentator to consider the issue except two (Jacobson and Rosenquist 1988) has concluded that the law indeed requires rationing decisions to be disclosed at the time of treatment (President's Commission 1982; Rolph 1991; Miller 1992; Morreim 1991; Menzel 1990; Kapp 1984; Mehlman 1985a), and several argue that it would constitute abandonment to deny beneficial care the patient desires (Morreim 1989; Macdonald, Meyer, and Essig 1985; Louisell and Williams 1960; Mehlman 1985b).

This article explores whether the law in fact demands stringent adherence to individual patient autonomy or, instead, whether it is capable of absorbing economic constraints and how it would go about doing so. I begin by describing the technical requirements of existing law, and then proceed to analyze how these requirements could be adapted to the demands of limited forms of insurance. The essence of my analysis is to inquire whether adequate global disclosure at the time of enrollment (or re-enrollment) suffices to satisfy legal requirements of informed consent,

either because it constitutes a prior consent to the bundle of nontreatment decisions implicit in a more conservative (i.e., cost-sensitive) treatment style or because it constitutes a valid waiver of the right to informed consent. I do not presume that, at present, such global enrollment disclosure in fact is adequately performed (indeed, I have just noted that it is not), nor do I attempt to articulate in any detail what such disclosure should contain. I mean only to lay the legal and analytic framework for constructive discussion of these important matters, in order to take us beyond the present extremes of requiring no disclosure on the one hand or, on the other, stipulating that only treatment-specific disclosures will suffice.

### The Law of Informed Refusal

To focus the discussion a bit more, suppose a 42-year-old, otherwise healthy male with high blood pressure asks his HMO primary-care physician for testing to determine the extent of his possible heart disease. The doctor orders a static electrocardiogram (EKG), which is an inexpensive test done on the spot. The test results are negative. Two months later, the patient suffers a nonfatal heart attack while jogging. His lawyer discovers that many respectable cardiac specialists would have performed a more accurate exercise stress test that costs far more and requires referral to a specialized facility; however, the prevailing standard of care allows only the simpler test for a younger, asymptomatic patient who is at low risk. Assuming that the patient has no legal basis to claim conventional malpractice, does he nevertheless have a valid informed consent claim for failure to disclose the existence of the more expensive alternative? Also, had the alternative been disclosed, could he have demanded that it be done and paid for by the HMO?

### *An Overview of the Law*

On the surface, economically motivated decisions to decline marginally beneficial treatment do not readily appear to fit informed consent doctrine. That doctrine arose from battery law, a branch of tort law that compensates for harmful or offensive *touchings*. Therefore, it does not easily reach decisions not to treat. Moreover, the traditional focus of the negligence branch of informed consent law has been on *medical risks*,

not economic costs. Thus, several courts have concluded that informed consent liability is "limited to those situations where the harm suffered arose from some affirmative violation of the patient's physical integrity such as surgical procedures, injections or invasive diagnostic tests."<sup>1</sup> (See also Shultz 1985.)

Nevertheless, a more fully developed version of informed consent doctrine and its rationale is easily capable of embracing a requirement that physicians disclose each decision to bypass, for economic or other reasons, a potentially beneficial treatment option. The central purpose of informed consent law is to enhance personal autonomy over decisions that affect physical and mental well-being. As Shultz (1985) has thoroughly and cogently argued, a medical decision can be equally vital regardless of whether it leads to treatment or nontreatment. As for the nature of the risk factors disclosed (medical versus economic), the California Supreme Court has held that the "concept of informed consent is broad enough to encompass . . . whether a physician has an economic interest that might affect the physician's professional judgment."<sup>2</sup> Other courts have held that physicians must disclose their alcoholism or their HIV-positive status.<sup>3</sup>

### *The Law's Potential*

Informed consent law has not yet reached its full, logical extension, however, because it remains tied to its traditional doctrinal moorings of battery and negligence. Battery law, as noted, requires some physical contact, whereas negligence law employs professional custom, not patient interests, as its standard for liability. In order for informed consent doctrine to shape itself into a fully actualized "dignitary tort," one that would thoroughly protect a patient's right to be involved in all forms of medical decision making, it would have to free itself from these constraining elements of traditional tort law.

Several commentators have argued for such an extension, observing

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<sup>1</sup> *Karlsons v. Guerinot*, 57 A.D.2d 73, 394 N.Y.S.2d 933 (1977).

<sup>2</sup> *Moore v. Regents of the University of California*, 793 P.2d 479, 483 (Cal. 1990).

<sup>3</sup> *Hidding v. Williams*, 578 So.2d 1192 (La. App. 1991); *Behringer v. Princeton Medical Center*, 592 A.2d 1251 (N.J. Super. 1991).

that this is the logical end point of the path along which the informed consent doctrine has developed (Shultz 1985; Katz 1977, 1984; Capron 1974; Meisel 1988). They argue, first, that a full legal embodiment of patient autonomy requires the standard of care to be elevated from simple disclosure of risk to one of true, epistemological understanding of the information conveyed (heightened duty). They also argue that plaintiffs should recover “dignitary” damages even though no physical harm resulted (no injury), even though it could not be shown they would have made any other decision if fully informed (no causation), and, most critical to our analysis, even though no treatment was rendered (no touching).

These arguments for an unprecedented extension of tort law have been partially successful only with respect to the touching element, which is the one most critical for the present inquiry. A handful of decisions have recognized a right of “informed refusal”—a right to be informed of the medical risks entailed in declining a proposed test or treatment. In the leading case, the patient died from cervical cancer that could have been detected had a pap smear been administered earlier.<sup>4</sup> The doctor testified that he had recommended the test to the patient several times over the course of six years, but she declined, stating she could not afford it. Nevertheless, the court made the doctor stand trial under an informed consent theory because he failed to disclose all the benefits of the test and the risks of its refusal. This decision has been followed in a number of other cases,<sup>5</sup> including one in which the plaintiff recovered \$733,000 when a tiny mole on his ear lobe, which he mentioned to his doctor in passing, turned out to be cancerous.<sup>6</sup> Incredibly, the court held that it was not sufficient for the doctor, a general practitioner, to “strongly recommend [seeing] a specialist” or even to warn him that “all pigmented skin lesions are suspicious in nature” until removed and studied microscopically. The court reasoned that the doctor should have specifically mentioned the risk of cancer and its consequences.

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<sup>4</sup> *Truman v. Thomas*, 611 P.2d 902 (Cal. 1980).

<sup>5</sup> *Gates v. Jensen*, 595 P.2d 919 (Wash. 1979); *Chrisher v. Spak*, 122 Misc.2d 355, 471 N.Y.S.2d 741 (Sup. 1983); *Battenfeld v. Gregory*, 247 N.J. Super. 538, 589 A.2d 1059 (1991).

<sup>6</sup> *Moore v. Preventive Medicine Medical Group*, 233 Cal. Rptr. 859, 861, 863–4 (Cal. App. 1986).

Even if the traditional touching requirement is retained, informed consent requirements reach treatment refusals when the nontreatment option is an alternative to the course of actual treatment. Conventional informed consent doctrine requires not only the disclosure of risks that attend the primary intervention, but also the alternatives to that treatment and their risks and benefits (Annotation 1985). Unless a physician decides to forgo all treatment, it will almost always be possible to conceive of any omitted test or procedure as an alternative to some affirmative medical intervention that was chosen (Faden and Beauchamp 1986). In the example given at the outset of this discussion, a treadmill EKG is an alternative to the resting EKG.<sup>7</sup>

### The Law of Economic Abandonment

These cases can be distinguished, however, by the fact that, in all of them, the patient either had full insurance or paid entirely out of pocket. Therefore, it might be possible to argue that, under the contractual or statutory terms of the new forms of limited coverage under consideration here, the patient has no right to insist on free treatment that is deemed unnecessary by his physician or by practice guidelines (Hall and Anderson 1992; Havighurst 1992). This presents the possible legal defense that disclosure of expensive omitted treatment *not covered by insurance* is immaterial to the patient's legal and practical options; if the patient is unlikely to be able to afford the treatment on his own, disclosure is not only pointless, but it can also be cruel (see Hilfiker 1985).

To assert this defense is to assume, however, that care may be denied when payment has ceased. To the contrary, a number of commentators have argued that the law prohibits economic abandonment (Morreim 1989; Macdonald, Meyer, and Essig 1985, § 20.01[2][b]; Louisell and Williams 1960, § 9.01); in their view, "under the doctrine of abandonment . . . courts reject the defense that refusal to treat is justified by the patient's inability to pay" (Mehlman 1985b). A closer look at abandonment law is necessary to determine whether this simplistic exposition is accurate.

It seriously misconceives abandonment doctrine to argue, per se, that

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<sup>7</sup> *Keogan v. Holy Family Hospital*, 622 P.2d 1246 (Wash. 1980).

treatment may not be stopped for economic reasons. Properly construed, the law contains no such generic prohibition; indeed, abandonment law imposes few substantive limitations of any kind. Abandonment law is thus much more forgiving than is usually recognized. The only explicit restraint on the legality of abandoning a patient is the *procedural* one of notice. So far as abandonment law is concerned, a doctor may, with proper notice, stop treatment because he wants to retire, because he wants to go on vacation, or simply because he dislikes the patient.

Thus, in several cases, courts have rejected abandonment charges, usually as a matter of law, despite the presence of economics in the physicians' motivation.<sup>8</sup> In the cases frequently cited to the contrary where abandonment liability was found possible, the economic motivation for ceasing treatment was beside the point; those cases turned solely on the adequacy of notice, not the patient's inability to pay.<sup>9</sup> The decision cited most often is based on a sad case in which the patient ended up losing his arm from complications caused by a barbed-wire cut on his hand.<sup>10</sup> His doctors abandoned him because of past due bills, but did so while he was at the hospital in the midst of being prepared for an operation to drain and clean his infection and without providing any referral alternatives.

Some confusion about the precise requirements of abandonment law may exist because of the custom adhered to by physicians of taking affirmative steps to arrange for substitute care if they can no longer attend a patient or they are temporarily absent. This practice, which is followed both for patient convenience and in order to avoid any question of impropriety, may create the impression that notice is not sufficient unless the patient can actually find a replacement, which is difficult for an uninsured patient to do. However, the little existing case law on this point holds that actual substitution is not a requirement.<sup>11</sup> Hirshfeld (1992) accurately states that "the physician does not have to care for the patient

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<sup>8</sup> *Cox v. Jones*, 470 N.W.2d 23, 26 (Iowa 1991); *Surgical Consultants, P.C. v. Ball*, 447 N.W.2d 676, 682 (Iowa App. 1989); *Carroll v. Griffin*, 96 Ga. App. 826, 101 S.E.2d 764 (Ga. 1958).

<sup>9</sup> *Meiselman v. Crown Heights Hospital*, 285 N.Y. 389, 34 N.E.2d 367 (1941); *Le Juene Road Hospital, Inc. v. Watson*, 171 So.2d 202 (Fla. App. 1965).

<sup>10</sup> *Ricks v. Budge*, 64 P.2d 208 (Utah 1937).

<sup>11</sup> *Payton v. Weaver*, 131 Cal. App. 3d 38, 182 Cal. Rptr. 225, 229 (1982).

after the notice period is over if the patient has not been able to find another physician. Therefore, a physician can withdraw . . . if a patient runs out of financial resources and can no longer afford to pay for care” (p. 1840; see also Gregory 1990).

Still, the conclusion that economic abandonment is not, per se, inappropriate, even for patients still in need of treatment, does not establish that economic abandonment is per se *legitimate* either. Abandonment law imposes a disclosure requirement of its own force, which might substitute for informed consent law. However, notice of abandonment is required only if *all* treatment is ceased; no abandonment occurs simply where the physician chooses a less aggressive course of treatment. Even in total cessation cases, abandonment law requires notice only where the patient is in a “critical condition.”<sup>12</sup> Properly designed rationing mechanisms applied in a responsible fashion should eliminate only marginally beneficial, not critical, care. In contrast, in the cases I have mentioned where abandonment has been found, the cessation was so abrupt, and the plaintiff’s condition so critical, that abandonment exposed the patient to severe suffering and extreme endangerment.

### *Materiality of Disclosure Reconsidered*

Having dispensed with the tangential analysis of abandonment law, we must return to the main line of analysis to inquire again whether the absence of insurance for an economically motivated treatment refusal makes disclosure immaterial to the patient’s deliberations. As Menzel (1990) and Morreim (1991) have argued, it does not because the patient might pay out of pocket or seek to solicit donations. Even apart from the short-term possibility of acquiring the particular treatment, the information might be material to a longer-range decision of whether to switch doctors within the plan or to switch insurance plans at the next open-enrollment opportunity. Finally, nontreatment information might be considered material, even if it objectively has no effect on any medical decision, simply because the patient would want to know purely for the sake of knowledge. Few nontreatment decisions would clearly escape these standards of materiality.

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<sup>12</sup> See note 8, *Surgical Consultants, P.C. v. Ball*.

## Cross Currents in the Law

Despite the theoretical support developed in the forgoing analysis for extending informed consent law to reach rationing decisions, the law has not yet fully taken this step, and several currents in the law are decisively opposed to such a requirement. As noted above, a few jurisdictions retain the battery law limitation that requires a harmful touching. Others are cautious about using the alternative-treatment requirement to circumvent this limitation. There are very few decisions that have squarely rested liability on failure to disclose alternatives, and some courts have narrowly construed this requirement to distinguish “additional” from “alternative” treatment, or to apply it only to entirely different courses of case management rather than to simple variations in the chosen course.<sup>13</sup>

Even California, the most demanding jurisdiction, has retreated somewhat from its informed refusal theory of liability. *Truman v. Thomas* was a split decision decided by a single vote, and subsequent lower courts have restricted it in a manner that precludes its application to rationing decisions. Several California decisions have ruled that, consistent with its facts, *Thomas* applies only to nontreatment decisions made by the patient *contrary to* the doctor’s medical advice.<sup>14</sup> These conditions characterize each of the cases that have followed *Thomas*. Therefore, no existing precedent, even in the most liberal jurisdictions, squarely supports a right of disclosure for physician- or insurer-initiated treatment refusals.

## Prudential Constraints on Economic Informed Consent

The law’s ambivalence about extending informed consent requirements to rationing decisions may be caused by the deleterious effects that lia-

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<sup>13</sup> *Kalsbeck v. Westview Clinic*, 375 N.W.2d 861, 869 (Minn. App. 1985); *Madsen v. Park Nicollet Medical Center*, 431 N.W.2d 855, 859 (Minn. 1988).

<sup>14</sup> *Munro v. Regents of the Univ. of Cal.*, 263 Cal. Rptr. 878, 885 (Cal. App. 1989); *Scalere v. Stenson*, 260 Cal. Rptr. 152 (Cal. App. 1989); *Jamison v. Lindsay*, 166 Cal. Rptr. 443, 446 (Cal. App. 1980).

bility would cause for the practical workings of treatment relations under constrained insurance. Taken to its logical extreme, informed refusal law would require physicians to engage their patients in elaborate explanations for each discrete step in a complex tree of diagnostic and treatment options for even the most minor of ailments. In deciding to employ a single test, a physician might explicitly or elliptically pass over a dozen options. If informed consent theory applied with full vigor, doctors would have to engage their patients in an extensive, 14-point dialogue about each of these alternatives (Comment 1981), periodically stopping along the way to test for full comprehension and videotaping these encounters (Jones 1990) to ensure proof of their sufficiently "prolonged conversation" (Burt 1979) and "shared decision making" (Katz 1984). This would have to be done for each branch in the decision tree, including every conceivable alternative encountered in a complex course of treatment.

Thoroughgoing disclosure of all economically motivated nontreatment decisions at the time they are made is also inconsistent with the nature of clinical judgment and the manner in which financial constraints are likely to be considered by physicians. Physicians are humans, not computers. Their judgmental processes are often more elliptical and heuristic than they are methodical and calculated (Schwartz and Grubb 1985). Like any other professional engaged with a complex body of knowledge and experience, physicians are subliminally affected by countless influences. Therefore, it has been observed that their practice styles develop more from habit and learned tradition than from rigorous, deductive logic (Freidson 1970). As resource constraints become more manifest, they are likely to induce physicians to alter their practice styles more or less subconsciously so that they engage in what is referred to as implicit rather than explicit rationing (Luft 1982). Thus, physicians will not overtly consider that they are making marginal sacrifices in medical benefit. As demonstrated by the British experience, they will adjust their views of proper practice to fit within the constraints they face (Aron and Schwartz 1984). Because implicit rationing will often occur without conscious deliberation, it is unrealistic to require physicians to disclose thought processes they in fact are not overtly engaged in.

Elsewhere, informed consent doctrine frequently compromises ideal theory to accommodate similar prudential concerns of administration in real world settings. This is witnessed even in the law's core standards of materiality and causation. Despite the purpose of informed consent law

to actualize individual autonomy fully, the law employs an "objective test" of whether "reasonable" people would have viewed disclosure as important and whether the disclosure would have changed the "reasonable" patient's decision. The law compromises its purely subjective values in order to prevent injured plaintiffs from playing unduly on the sympathies of a lay jury by asserting their after-the-fact regrets.

Even more telling is the fact that informed consent is routinely practiced in real-world settings only for invasive procedures and at major junctures in the treatment relationship, such as at the point of hospital admission. Despite the law's literal application to any treatment or non-treatment decision, and despite the defensive tendencies caused by physicians' hypersensitive liability concerns, rarely is written informed consent obtained to prescribe medication or perform a routine test (President's Commission 1982, 108). Never is it obtained for the multitude of injections, bodily inspections, and manipulations, midnight awakenings, and other personal invasions one encounters during the course of hospitalization. It is simply felt that, in practice, it is not worth carrying informed consent requirements to their logical extreme for minor, non-invasive steps, even on pain of the physician's liability or the patient's risk of harm (Appelbaum, Lidz, and Meisel 1987; Lidz and Meisel 1982).<sup>15</sup>

Even more so would it be infeasible to apply informed consent literally to the vast multitude of nontreatment decisions. Great Britain has avoided this path (Miller 1987, 1992),<sup>16</sup> partly out of recognition that "the economics of the British National Health Service could not tolerate" total patient sovereignty (Schwartz and Grubb 1985). Even some of the commentators who advance the most stringent versions of informed consent *ethics* concede that the *law* is too blunt an instrument for behavioral control to strictly enforce ethical ideals through liability rules (President's Commission 1982; Katz 1984).

However, as convincing as this pragmatic reasoning may be, it still fails to supply a principled legal basis for suspending informed consent requirements. Filling in this analytic void will require developing a new theory of economic informed consent, which the remainder of this article undertakes in broad, conceptual outline. In the conclusion, I suggest

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<sup>15</sup> *Novak v. Texada, Miller, Masterson and Davis Clinic*, 514 So.2d 524 (La. App. 1987).

<sup>16</sup> *Sidaway v. Board of Governors*, 2 W.L.R. 480 (1985).

some of the parameters that should shape the more detailed implementation of this legal theory in real-world settings but I leave this further explication to future development.

### Prior Consent to Rationing

A proper theory of economic informed consent requires us first to understand how patient autonomy, the fundamental value underlying informed consent, relates to economic constraints. Patient autonomy would be perfectly preserved despite resource constraints if there were no health insurance at all because patients would be free to purchase as much health care as they could afford, being fully informed along the way about the various options and their relative cost effectiveness. However, the exigencies of poor health and the anxiety of having to think about money when a patient or a family member is sick make the desire for some form of insurance compelling. The existence of insurance requires that, to some degree, spending decisions be delegated to treating physicians or to governing entities (whether corporate, government, professional, or consumer-oriented). This delegation of spending authority creates the dilemma that insured patients will lose control over rationing decision making.

Menzel (1990) and others (Emanuel 1991; Mechanic 1986; Begley 1986) have suggested the concept of prior consent to health care rationing as a way to reconcile the demands of patient autonomy with the need to preserve an affordable form of insurance. Prior consent reasons that enrolling with an HMO constitutes blanket advance consent to the subsequent denials of marginally beneficial care created by the rules, procedures, and incentives disclosed at the outset (and periodically reaffirmed through annual open enrollment decisions); thereafter, additional disclosure at the time of treatment is unnecessary.

### *Presumed Consent Distinguished*

Prior consent should not be confused with presumed consent, a separate concept that Menzel develops. Presumed consent reasons that consent requirements are satisfied if it can be shown that, had the patient been asked, he or she would have consented. Menzel argues that presumed consent is an adequate substitute when actual consent is impossible or

prohibitively costly as, for instance, where the patient is incompetent and in emergent need of care. He extends this absolute incapacity argument to the relative disabling effect that insurance has on economic rationality, or what economists call "moral hazard." In Menzel's view, the inability of insured patients to assess rationally which medical benefits are worth the costs paid by insurance is a form of incapacity that allows the invocation of presumed consent. Because the ideal vantage point from which to gauge patients' cost-sensitive treatment preferences is when they choose how much to spend on an insurance premium (Eddy 1990), Menzel argues for allowing rationing decisions that reflect what the patient would have agreed to if asked before becoming ill, at the time of enrollment.

This controversial position need not be defended here. Instead, the position I wish to examine is whether a fully informed decision to enroll in a limited insurance plan constitutes *actual* consent to the subsequent treatment decisions. Under this position, there is nothing fictitious about the consent. Actual consent can be viewed as resulting from informed enrollment, even if all of the multitude of possible nontreatment decisions and their particular risks and benefits are not described to the patient, because he or she is informed of and consents to the broad parameters of a rationing *mechanism*. Advance agreement to a set of rationing rules and incentives binds the insured person by the treatment decisions that result from these mechanisms, much as a principal is bound by the contracts his agent forms.

### *The Lack-of-Understanding Objection*

It might be objected that disclosure at the time of enrollment would rarely suffice to meet requirements of truly informed prior consent because the array of choices one must make at that stage are far too vast and complex for ordinary subscribers, let alone health policy experts, to comprehend adequately. Much the same objection can be made, however, about conventional applications of informed consent to invasive treatment decisions. Dozens of empirical studies have documented the frustrating reality that some people will never sufficiently comprehend the medical options they face regardless of how thorough the explanation because they simply lack the intellectual capacity or the experiential base (Meisel and Roth 1983; Office of Technology Assessment 1988). Despite this documented and persistent futility, we do not dispense with

informed consent practices altogether, nor do we prohibit the performance of the procedure owing to the lack of true understanding. Instead, we reason that autonomy values are promoted simply by giving patients the opportunity to understand or to make their own mistakes (Faden and Beauchamp 1986; Weisbard 1986).

However, this rationale provides no guidance on how much disclosure is required for consent to be truly informed because it concedes that being truly informed is largely a fiction and it argues that autonomy values are satisfied even in its absence. The sufficiency of patients' understanding and the rationality of their actual decision processes are not the talisman for the adequacy of disclosure. Instead, we decide when consent is sufficiently informed by a much more intuitive, pragmatic, and socially constructed judgment about how much effort at disclosure and education is appropriate in a given situation, for a specified range of decisions. In short, we do the best we can under the circumstances. In the present context, this means that the sufficiency of a global disclosure of rationing incentives, rules, and mechanisms at the time of enrollment can best be determined by examining how law and ethics regard similar instances of prior consent.

### *Recognized Examples of Bundled, Prior Consent*

Prior consent is the basis on which surrogates are allowed to refuse life-sustaining treatment. The patient's informed appointment of an agent satisfies consent requirements even for decisions as monumental as withdrawing life support. The argument here by analogy is that an informed enrollment decision in essence constitutes prior explicit consent to appointing the HMO medical director and the primary care physician as agents for a bundle of much less significant but nonspecific treatment refusal decisions. Although these agents may be affected by conflicting economic interests, so might family members, yet they are viewed as not only valid, but also as preferred agents for making explicitly life-and-death decisions.

Bundled consent is also how we conventionally view a single decision to be hospitalized or operated on as entailing consent to hundreds of discrete events of testing, medication, and bodily examination during the course of what may be a rather long and complex episode of treatment. Likewise, bundled consent applies to economically motivated re-

fusals of marginally beneficial treatment because, when an insurance subscriber knowingly enrolls in a rationing system, he buys into an entire cost-constrained medical philosophy and set of practices.

An even more direct application of this reasoning that is widely accepted in bioethics and the law applies to “futile” treatment: care that falls outside the prevailing standard of care more because it lacks medical benefit than because it presents a medical risk. The conventional thinking is that informed consent law cannot be used to force physicians to provide or even discuss care that, in their view of medical benefit, has no utility whatsoever, such as laetrile for cancer patients, antibiotics for a viral respiratory infection, or megadoses of vitamin C for a common cold. No one even considers that doctors should inform patients as they silently bypass such generally disapproved alternatives, even though some other doctors indeed believe in the utility of these treatments (Brett and McCullough 1986). It is generally agreed that physicians are free to limit themselves to their chosen school of practice so long as that school is accurately reflected in their representations to the general patient community. Here, this same representation is made explicit by the global economic disclosures that should be made at the time of enrollment in a rationed insurance plan.

### *The Malpractice Analogy*

This bundling concept is the analytic foundation from which the conventional malpractice standard of care is derived. The strongest justification for using professional custom as the basis for malpractice liability is that this is the duty that a provider implicitly promises when the contractual basis for a treatment relationship is formed (Epstein 1976, 1986). Rather than impose on patients and physicians the impossible contractual burden of specifying the minutiae of an explicit standard of medical practice, the law adopts the convention of customary practice. As economic constraints induce practice styles to shift, one or more cost-constrained professional standards will emerge as “respectable minority” positions to the inflated, fee-for-service standard that presently exists (Hall 1989). Thus, commentators envision that a separate HMO-custom standard will govern negligence suits brought by HMO patients (Bovbjerg 1975).

No one has ever complained that patients lack sufficient notice of the conventional professional custom standard. When patients choose gener-

alists over specialists, or choose nonphysician allied health professionals or practitioners of holistic medicine, it is taken for granted that a lower or different standard of care applies without the need specifically to warn patients that superior care may be available elsewhere.<sup>17</sup> Likewise, idealized informed consent requirements should not be allowed to negate the adoption of a cost-constrained practice standard (Jacobson and Rosenquist 1988), particularly where that standard is explicitly disclosed (in general terms) at the time of enrollment.

One particularly notable instance of this reasoning can presently be found in the area of “wrongful birth” suits brought by the parents of severely handicapped infants. These suits seek to hold obstetricians liable for failing to recommend diagnostic tests that might have revealed a genetic risk or birth defect in time to avoid conception or obtain an abortion. Wrongful birth is not reasoned on “informed refusal” grounds, however. Rather, proper genetic counseling is considered to be simply part and parcel of the obstetric standard of care, governed by professional custom.<sup>18</sup>

## Waiver of Informed Consent

It is perhaps easier to characterize an informed enrollment decision not as advance consent, but instead as a waiver of the right to be informed when a chosen rationing mechanism denies costly treatment of marginal benefit. Actual prior consent justifies silent rationing by arguing that global disclosure satisfies the primary informed consent duty; waiver invokes an affirmative defense to a prima facie violation of that duty. Under the waiver characterization, informed consent requirements are not satisfied—they are dispensed with at the patient’s request. A number of legal authorities and commentators have observed in passing that informed consent can be waived, for to rule otherwise would undermine the very value of personal autonomy that the doctrine is intended to enforce (Appelbaum, Lidz, and Meisel 1987; Meisel 1979). Allowing waiver is perfectly consistent with informed consent doctrine because the principal effect of consent is itself a waiver—of the right not to be touched. If the law is willing to allow the right of bodily integrity to be

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<sup>17</sup> *Mathis v. Morrisey*, 13 Cal. Rptr. 2d 819 (Cal. App. 1992).

<sup>18</sup> See note 1, *Karlsons v. Guerinot*, and note 14, *Munro v. Regents*.

waived, it should be (and is) willing also to recognize the waiver of the secondary right to *information about* a bodily invasion, so long as the waiver itself is informed and freely given.

### *Constraints on Free Choice*

The success of this argument depends on whether, in fact, patients would prefer not to be told of long-shot, expensive treatment options that are not covered by their insurance. Whether patients in a real-world setting will agree to waive economic informed refusal disclosures naturally depends on what their options are. Quite a few more will demand full disclosure if that option comes at no cost or inconvenience to them in their choice of insurance plans, but they will have to think about it much harder if they learn that the least expensive or most comprehensive insurance (or both) demands this concession. However, can it be said that the right to informed consent is freely waived if the decision is made on pain of a substantial sacrifice in health benefits or increase in premiums? What if the *only* insurance available requires an informed refusal waiver, so that the only means to obtain full disclosure of nontreatment is to pay out of pocket?

Ideally, patients would be allowed to pick precisely the degree of disclosure they desire from any provider with no consequence to themselves. This could be accomplished, as Engelhardt (1986) suggests, by asking “subscribers to insurance programs . . . to check which standard of disclosure they wished used in their treatment . . . [and to] review their choices semiannually or annually” (see also Green 1988). However desirable this may be, it may not be feasible, or, if it is, it is not required by the law. Doctors may find it difficult to employ multiple disclosure standards among their many patients and still satisfy the standard of proof required if their decisions are challenged in court. Doctors’ bedside manner, like their basic medical practice style, tends to be fairly uniform across patients. Presumably, the law is lenient enough to allow a doctor to employ a single disclosure standard for all of his or her patients so long as it is sufficiently disclosed at the outset of the treatment relationship, leaving patients free to choose another provider if they wish.

Can the same be said for a group of doctors organized into an insurance plan? Choice might still be preserved, if not within the plan, then among plans, if a private employer offers a range of insurance options or

a government program is administered through a managed competition system. We have already observed that a hospital can, without either violating fiduciary principles or being accused of coercion, insist that a patient cooperate with frequent, bothersome testing, medication, and other routine steps as a condition of treatment in that facility. Likewise, an HMO should be able to offer its services contingent on agreement to a reasonable disclosure standard, even one that is lower than the law ordinarily sets.

Some limitation of individual choice is particularly appropriate given the collective nature of insurance. An insurance subscriber joins a community of interest when pooling his or her risk with others. This necessarily requires a collective agreement on certain terms and conditions of coverage because demanding tailor-made insurance would destroy the risk-pooling function that makes insurance possible or affordable in the first place. Where the treatment function is integrated with the insurance function, as in HMOs, then subscribers necessarily must be bound by a collective agreement on certain aspects of the treatment relationship as well (Emanuel 1991). To insist on a greater degree of disclosure than the rest of the pool is willing to tolerate is no more ethically justified than insisting on more treatment than the subscriber has paid for. In short, individual-rights-based informed consent principles derived from a solo practice, third-party-reimbursement setting do not automatically apply to the new forms of health care delivery.

### *The Arbitration Precedent*

Still, what if silent rationing is the only form of insurance an employer or government program offers? Can it be said that the subscriber makes a willing waiver by acquiescing under the threat of losing insurance altogether? The closest guidance lies in the small collection of cases concerning agreements to arbitrate HMO malpractice suits. The leading decision upholds a binding arbitration agreement in a standardized HMO enrollment form, despite the subscriber's claim that she was unaware of the provision and never agreed to it.<sup>19</sup> The court noted that the subscriber was offered a number of health plans by her employer, some of which did not require arbitration. It is a matter of speculation whether this is

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<sup>19</sup> *Madden v. Kaiser Foundation Hospitals*, 17 Cal.3d 699, 552 P.2d 1178, 131 Cal. Rptr. 882 (1976).

an essential element of the decision (compare *Wheeler v. St. Joseph Hospital*<sup>20</sup> and Mehlman 1990 with Havighurst 1986), but it is reasonable to conclude that many courts will be hostile to informed-consent waivers if no other option is readily available to the subscriber.<sup>21</sup>

On the other hand, it is also reasonable to conclude that a partial waiver (one relating only to economic informed refusal, not to *all* forms of informed consent), negotiated as part of an employer-provided health plan, fully comports with fiduciary contracting rules if the subscriber is given some choice, either within the plan selected or among other available plans. Choice exists within the plan if the subscriber need not accept the waiver, even on pain of paying a higher premium. Choice exists outside the plan if other plans are available that do not contain the waiver, again even if they come at a higher cost or with lower benefits. Nothing in the law of fiduciary contracting prevents charging subscribers the fair price of the actuarial risks and administrative costs they choose to insure. As Faden and Beauchamp (1986) observe, "To chain informed consent to *fully or completely* autonomous decisionmaking stacks the deck of the argument and strips informed consent of any meaningful place in the practical world, where people's actions are rarely, if ever, fully autonomous" (240-41).

## Conclusion

This analysis has mounted a relentless attack on full-bodied application of informed refusal liability to all rationing decisions. In doing so, I do not mean to argue that no legal duty exists or that consent (or waiver) should be blithely found in any enrollment decision. Instead, I mean only to sketch a theory of economic informed consent that articulates the conceptual parameters for constructive debate about the precise circumstances and extent of disclosure. Some global disclosure of rationing incentives, rules, and mechanisms is required at the outset of enrollment, although this presently is not done, and the details of what should be disclosed still have to be worked out. However, if such a disclosure can be accomplished, it serves to validate at least some subsequent rationing

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<sup>20</sup> *Wheeler v. St. Joseph Hospital*, 63 Cal. App.3d 345, 133 Cal. Rptr. 775 (1976).

<sup>21</sup> *Broemmer v. Abortion Services of Phoenix*, 840 P.2d 1013 (Ariz. 1992).

decisions, either under a prior, bundled consent conception, or under a waiver of consent conception. The extent of the required initial disclosure and the extent to which it encompasses subsequent treatment decisions are matters that are too complex and situation specific to prescribe in the present analysis, but the answers to these important inquiries should be shaped by the general principles I have advanced.

This freedom to engage in silent rationing is tempered, however, by a number of additional limitations that this article only touches on or has not mentioned at all:

1. Subscribers should be told that their doctors will not always point out when potentially beneficial treatment is not being offered because of its costs.
2. For this understanding to be enforceable, private employers must offer more than a single health insurance option and, more radically, public programs must be operated under principles of consumer choice that are common only in private markets.
3. Patients must always remain free to ask questions and, when they do, they must be answered thoroughly, including suggestions for where to obtain second opinions or optional, uninsured treatment.
4. Finally, some nontreatment decisions are so dramatic and high-stake, such as pulling the plug on life support or declining a life-saving operation for a terminally ill patient, that, if the plan imposes them, they should be specifically disclosed at the time of treatment. This could result either from the extension of informed consent doctrine or as the application of abandonment law, but legislative enactment or regulatory oversight might be preferable to the common law for drawing a justiciable line between dramatic and ordinary treatment refusals.

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