

Must We Forgo Informed Consent to Control Health Care Costs? A Response to Mark A. Hall

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SHOULD PHYSICIANS DISCUSS OPENLY WITH THEIR patients the economic influences on their recommendations for care? Mark A. Hall argues that disclosure of alternative treatments precluded by patients' insurance coverage is not required by the law of informed consent. Morreim (1991), in contrast, looks to patients' rights to self-determination, physicians' contractual obligations toward patients, and the fiduciary relationship that defines the doctor-patient interaction as bases for a contrary conclusion.

Before exploring some aspects of this debate, two preliminary points are worth clarifying. Although Hall frames his discussion in terms of whether informed consent law *would* require disclosure, his argument is more than a mere prediction of how the courts will apply existing law. Legal doctrine is the embodiment of policy. When the courts created the law of informed consent, and as they subsequently modified it, they acted in pursuit of a set of policy goals that were partly directed toward altering the balance of power in physician-patient relationships (Appelbaum, Meisel, and Lidz 1987). If judges believe that disclosure of economic effects on treatment decisions is desirable, they will extend the law of informed consent to require such disclosure. Thus, I understand Hall's argument as prescriptive: that the courts *should* not apply consent law to require case-specific disclosure of economic constraints on medical recommendations.

Further, although the motivation for this position may be obvious, I do not find it stated overtly in Hall's article. When Hall and others argue against physicians' disclosure of options they have not recommended on economic grounds, they do so out of concern that such a requirement would undercut the effectiveness of reforms aimed at limiting health-care expenditures. Patients repeatedly confronted with real-life restrictions on treatment, in this view, would create irresistible demands for additional coverage that would undo any cost controls. Hall's suggestion that case-specific discussions be replaced by general disclosure of limitations on care at the time of enrollment in a health plan is designed to bolster the prospects of health reform, leaving patients unaware that they are being denied potentially beneficial care.

The worth of this decidedly utilitarian proposal depends on the correctness of several underlying presumptions, including the proposition that consumer ignorance is the only basis on which health care reform can rest. I focus, however, on two other issues that I find key to evaluating the reasonableness of this approach: the effectiveness of "global disclosure of rationing mechanisms at the time of enrollment"; and the likely effects of a failure to disclose economic components of decision making at the time a course of treatment is recommended.

Because there is substantial danger in allowing the discussion of health care reform to become too abstract, it may be useful to consider the following real-life case, around which the discussion can be structured:

Ms. Wickline, a woman hospitalized for vascular surgery, suffers several postoperative complications. As the period of hospitalization approved by her insurance plan draws to a close, her surgeon requests the insurer's approval for an additional eight days of inpatient care. Only four days are approved; the surgeon later maintains his belief that he had no choice but to discharge the patient after that period elapsed. Within a few days of leaving the hospital, the patient's leg begins to hurt and turn blue. She is not seen by a physician for nine days, by which time her leg requires amputation.¹

Ms. Wickline's surgeon—as best I can tell from the reports of the case—appears not to have informed her that, in his judgment, four additional days of hospital care were desirable. Because the announcement of her insurer, California's public Medi-Cal program, that it would not

¹ *Wickline v. State*, 228 Cal. Rptr. 661 (Cal. App. 2 Dist. 1986).

pay for the extra days was the determining factor in the surgeon's decision, this would seem to be just the situation that Hall's proposal addresses. It is a "rationing decision," in his terms, because it involves a "decision to decline potentially beneficial care on account of excessive costs." Hall presumably would support the surgeon's failure to discuss the basis for his decision to discharge the patient as long as certain disclosures had been made at the time Ms. Wickline enrolled in the insurance plan.

Effectiveness of Disclosure at Time of Enrollment

What information, assuming it had been provided to Ms. Wickline prospectively, would have justified her surgeon's behavior? The answer, of course, depends on the goals of requiring that anything at all be disclosed to patients about the basis for physicians' recommendations. Informed consent law has been charged by different theorists with varying tasks, but the least controversial probably is to ensure that patients receive sufficient information to enable them to play a meaningful role in treatment decision making, if they so choose. What prospective disclosure would have allowed Ms. Wickline to function in this way?

Insurers currently offer limited information to subscribers about how decisions will be made on coverage of medical treatment. Some interventions (e.g., cosmetic plastic surgery) may be excluded outright; others (e.g., psychiatric hospitalization) often are subject to blanket caps on a calendar year or lifetime basis. In general, though, subscribers are told that all "medically necessary" care will be covered (Hall and Anderson 1992). Medical necessity, however, is a term that obscures as much as it reveals. Ms. Wickline's surgeon initially believed that eight additional days of hospitalization were medically necessary. Only when the insurer, with clear pecuniary interests of its own, disagreed, did the surgeon relent. Thus, at least in this case, medical necessity seems vulnerable to reinterpretation on the basis of economic pressures.

Clearly, some additional information must be provided to a subscriber like Ms. Wickline if she is to understand that the possibility of benefit to her medical condition—the plain meaning of medical necessity—is not a sufficient basis for decisions regarding her care. What might that information be? Havighurst (1992), who has struggled with

this question, suggests two general approaches. The first would “assist consumers in economizing by surrendering legal rights that systematically induce or excuse excessive spending by physicians.” Thus, subscribers might be told that their insurers and physicians would depart from customary treatment when to do so would not be unreasonable in benefit/cost terms, or that their rights to sue were limited to situations in which gross negligence could be demonstrated. Havighurst’s second broad option would be to refer subscribers to sets of practice guidelines that would define the treatments for which insurers would be liable. Insureds might then know with some certainty what treatment they could expect to have covered.

Hall’s approach to this question appears in greater detail elsewhere (Hall and Anderson 1992). He recommends that disclosure at the time of enrollment include enumeration of excluded treatments, general standards that would guide determinations of coverage, and the specification of entities that would apply these standards to medical treatments in general and to specific cases, like Ms. Wickline’s, in particular.

To what extent would such disclosures help Ms. Wickline, lying in her hospital bed, to understand the basis for her surgeon’s decision sufficiently for her to play a meaningful role in the outcome? Note that postulating an effect of disclosure at the time of enrollment depends on an interrelated set of highly questionable propositions: that disclosure is made in language sufficiently clear for a layperson to understand; that subscribers are alerted to the importance of the information, such that they attend to its presentation, whether oral or written; that persons unsophisticated about medical concepts are able to appreciate the implications of the information for their future (unanticipated) medical conditions; and that, when faced with the need for medical treatment at some point in the indefinite future, subscribers are able to recall the provisions of their policies with clarity.

Even were all these desiderata to be achieved—an accomplishment students of informed consent in the real world would recognize as little short of miraculous—considerable doubt would remain as to whether patients still would grasp the impact of economic factors on their care. If Ms. Wickline, in a formidable act of will, had been able to recall that her insurer and physicians were authorized to depart from customary standards of care when warranted by benefit/cost considerations, would she have had any idea that her surgeon’s initial recommendation for an extended stay had been modified in response to economic concerns? If

practice guidelines covering vascular surgery, along with hundreds of other medical conditions, had been included by reference in her insurance contract, again assuming she read and recalled them, would they have been of sufficient detail to inform her of limits on length of stay in her peculiar circumstances, which involved several postoperative complications? If the policy had specified standards for determining when coverage was available and established independent bodies to apply them, would she have had any way of knowing that the discharge decision, among all others, had been affected by this process?

Only a cockeyed optimist is likely to respond to these queries in the affirmative. Moreover, most discussions of contractual mechanisms for limiting disclosure about and provision of potentially beneficial care assume, as does Hall, that patients' autonomy will be protected by allowing them to select among insurance plans, choosing the plan that provides the optimal combination of disclosure, coverage, and cost. Because options for health insurance are dwindling, however, as existing plans merge, this is increasingly unlikely to be the case. Indeed, many employers offer their workers only a single choice of plan, and Ms. Wickline, who relied on a public insurance program, also had no alternative but to accept the limitations imposed on her. Even with a choice of plans, the information costs of comparing plans according to provisions that are likely to affect discrete medical decisions will be, in almost all circumstances, prohibitive.

I conclude, therefore, that disclosure at the time of enrollment of an insurer's limitations on coverage based on economic considerations is unlikely to leave subscribers meaningfully informed about the ways in which their doctors' recommendations are being affected by concern over costs. Thus, whether one views their acceptance of enrollment as "prior consent" to rationing or as a "waiver" of consent, it is an action that for almost all persons will be taken in profound ignorance of its implications. Indeed, this should not be a surprising conclusion because keeping patients in the dark about the basis for particular rationing decisions is the motive force behind such proposals.

Even granting the ineffectiveness of prospective general disclosure, however, Hall and other advocates of this approach might well retort that the information in question will make little difference in any event—or, in legal terms, that it is not material to the patient's decision. If the insurer will not pay for the procedure, why require disclosure of particular rationing choices?

Effects of Failure to Disclose at Time of Treatment

Hall himself offers a partial response to this question, noting that patients may elect to pay for treatment out of pocket if they are told that their physicians believe it is indicated. Moreover, patients might use such information to decide to switch doctors or insurance plans, or, Hall might have added, to advocate for alternative approaches to cost controls on medical care. As Hall notes, "Few nontreatment decisions would clearly escape these standards of materiality."

If I understand Hall's counterargument to these contentions, it is that physicians cannot be expected to inform patients of all the factors that influence the many decisions they make in the course of patient care. In addition, as physicians incorporate economic considerations into their decision making, they may not even be aware of the extent to which such influences are operative. These arguments have the feel of straw men. No one would contend that every factor entering into a treatment recommendation be disclosed to patients. But surely that is not the same as asking that physicians inform patients when, in their medical judgment, further treatment for which the patient's insurer will not pay is likely to be beneficial.

Nor have we exhausted the arguments that might be made in favor of such a practice. Although many patients, including Medi-Cal-insured Ms. Wickline, will not be able to pay out of pocket for noncovered care, they will always have the option of appealing the denial of benefits to the insurer. This was a step Ms. Wickline's surgeon, absent pressure from his patient, failed to pursue. The likelihood that appeals, particularly if supported by the physician, will be at least partially successful is demonstrated by advice given to insurers and managed-care companies to authorize care for an interim period while additional review (perhaps by a neutral third party) takes place (Hinden and Elden 1990).

Other beneficial effects may ensue from a discussion between physician and patient regarding the reasons why the additional, uncompensated care was thought desirable. Ms. Wickline, for example, neglected to seek medical attention after discharge, despite symptoms suggesting thrombosis in her leg. One can only speculate about the reasons for her inaction, but knowledge that her surgeon believed her condition warranted further hospitalization would have reinforced in her mind the importance of seeking follow-up care if complications developed.

Perhaps the most potent argument for disclosure at the time economic rationing decisions are made involves the probable effects of failure to disclose on the physician–patient relationship. The essence of that relationship always has been thought to be what Fried (1974) referred to as “personal care,” the primary allegiance of the physician to the patient’s well-being. It is undoubtedly true that this orientation is not absolute. Physicians long have been held to have obligations to protect the public health (e.g., by reporting communicable diseases), even when such action might be to the detriment of their patients. By and large, however, patients seem to understand and tolerate these uncommon exceptions to the general principle.

Were physicians, however, routinely to conceal their opinions that patients would benefit from additional medical care not covered by their insurers, the core of the physician–patient relationship would be in jeopardy. Patients legitimately would suspect all recommendations made by physicians, always concerned that they were being deceived regarding the care they needed. The medical treatment setting would be fully adversarialized, with wealthier patients seeking outside opinions of independently retained physicians on all matters of medical import. Indeed, even Hall is willing to compromise a bit here, allowing physicians to respond fully to questions patients ask—unwilling evidently to tolerate affirmative prevarication—although not forcing them to volunteer the information on their own. (Does this, by the way, not undo the entire effect of Hall’s proposal? What is left of his plan once every patient learns to ask, “Are there any other treatments that you think would be beneficial for me, but are not recommending because of their cost?”)

Conclusion

Although presented under the rubric of “prior consent,” Hall’s and similar proposals in fact sacrifice patient consent altogether. Subscribers are unlikely to understand or appreciate information provided at the time of enrollment, or to recall it when decisions are being made. Denying patients disclosure of the basis for medical recommendations therefore undermines any possibility of their playing a meaningful role in treatment decision making, with all the deleterious consequences outlined above. Is such institutionalized deception essential to cost-conscious health reform? I certainly hope not. At a minimum, however, there is no small

irony in informed consent—a legal doctrine whose genesis and development were based on the desire to enhance patients' autonomous participation in medical decision making—being recruited for this purpose.

References

- Appelbaum, P.S., A. Meisel, and C.W. Lidz. 1987. *Informed Consent: Legal Theory and Clinical Practice*. New York: Oxford University Press.
- Fried, C. 1974. *Medical Experimentation: Personal Integrity and Social Policy*. New York: American Elsevier.
- Hall, M.A., and G.F. Anderson. 1992. Health Insurers' Assessment of Medical Necessity. *University of Pennsylvania Law Review* 140: 1637–1712.
- Havighurst, C.C. 1992. Prospective Self-denial: Can Consumers Contract Today to Accept Health Care Rationing Tomorrow? *University of Pennsylvania Law Review* 140:1755–1808.
- Hinden, R.A., and D.L. Elden. 1990. Liability Issues for Managed Care Entities. *Seton Hall Legislative Journal* 14:1–63.
- Morreim, E.H. 1991. Economic Disclosure and Economic Advocacy: New Duties in the Medical Standard of Care. *Journal of Legal Medicine* 12:275–329.

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