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CHICAGO HOPE MEETS THE CHICAGO SCHOOL

Gail B. Agrawal*

MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS, AND ECONOMICS OF RATIONING MECHANISMS. By *Mark A. Hall*. New York: Oxford University Press. 1997. Pp. xii, 300. \$35.

Twenty-five years after the enactment of the Federal Health Maintenance Organization Act¹ and nearly five years after the failure of proposed federal health care reform, managed care² has come to dominate the medical marketplace. As a result, the relationships among patients, payers, and physicians have changed fundamentally and dramatically. In this market-driven environment, health care — how much it costs, who receives treatment, and who pays for it — may have surpassed the weather as a topic of everyday conversation at dinner tables and water coolers across the country. In the popular press, reports concerning managed care, usually derogatory, are surpassed in number only by news of the latest political scandals.³ Scholars, too, find health care a rich topic for discussion.⁴

Professor Mark Hall's⁵ new book, *Making Medical Spending Decisions: The Law, Ethics, and Economics of Rationing Mechanisms*, is the culmination of many years of his work⁶ on the "funda-

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1. 42 U.S.C. §§ 300e to 300e-17 (1994); see also 42 C.F.R. §§ 417.100-180 (1997).

2. The term "managed care" refers to a variety of health benefit designs that combine the financing and delivery of health care services and provide for the exercise of controls over both functions.

3. For an empirical study of media coverage of managed care, see Mollyann Brodie et al., *Media Coverage of Managed Care: Is There a Negative Bias?*, *HEALTH AFF.*, Jan.-Feb. 1998, at 9.

4. See, e.g., RICHARD EPSTEIN, *MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE?* (1996) (reviewed in this issue by Thomas Greaney, *How Many Libertarians Does it Take to Fix the Health Care System?*, 96 *MICH. L. REV.* 1825 (1998)).

5. Mark Hall is a Professor of Law and Public Health at Wake Forest University and Bowman Gray School of Medicine.

6. See Mark A. Hall, *Rationing Health Care at the Bedside*, 69 *N.Y.U. L. REV.* 693 (1994); Mark A. Hall & Gerald F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 *U. PA. L. REV.* 1637 (1992).

mental question" (p. 8) of who should make cost-based rationing decisions for health care services. Proceeding from the generally, although not universally,⁷ accepted premise that rationing of health care resources is inevitable, Professor Hall begins his analysis considering the role of three categories of potential decisionmakers for medical spending decisions:⁸ consumers of health care services, third parties external to the patient-physician relationship,⁹ and physicians at the bedside.¹⁰

After concluding that neither consumers nor any of the third parties are ideally suited for all types of medical spending decisions, Professor Hall turns to the role of the attending physician at the bedsides of individual patients.¹¹ Bringing together legal, political, economic, and philosophical thinking on the role of cost in clinical decisionmaking in the current market-based health care delivery system,¹² he ably establishes his thesis that a physician may in some circumstances and to some degree make cost-conscious clinical decisions at the bedside.

Professor Hall then turns to the next logical step in the analysis: the circumstances under which physicians may act as rationing agents to withhold "marginally beneficial" care (p. 118). Here, he relies extensively on conclusions he draws from a consumer's decision to obtain health care coverage through a limited insurance plan. A consumer's selection of a health plan benefit design dictates the allocation of spending authority for that consumer.¹³ The collective decisions of consumers about insurance coverage operate as market mechanisms to select the "best mix" of medical decisionmakers (p. 246). Under Professor Hall's theory of economic informed consent,¹⁴ HMO enrollees, if properly informed of the

7. See Arnold S. Relman, *Is Rationing Inevitable?*, 322 NEW ENG. J. MED. 1809, 1810 (1990).

8. In this book, Professor Hall uses the terms "medical spending decision," "rationing," and "allocation" interchangeably to mean the "implicit or explicit denial of marginally beneficial medical treatment out of consideration for its cost." P. 6.

9. Included in this category are insurers, government officials, and other centralized authorities. See discussion *infra* at section I.A.

10. I use the term "bedside" to include any clinical encounter between a physician and a patient, whether in an inpatient, outpatient, or office setting.

11. See discussion *infra* at section I.B.

12. No book review could describe completely Professor Hall's detailed and nuanced arguments. From the political viewpoint, he considers how each potential decisionmaker fares in current realities. His ethical analysis applies communitarianism, liberalism, and social contract theory, as well as professional ethics and bioethics. His legal analysis considers the doctrine of informed consent, case law, and legislative and regulation initiatives affecting health maintenance organizations and their physicians.

13. I use the terms "health plan benefit design" or "benefit design" to include both insured and self-insured plans and traditional indemnity as well as the myriad of managed care products.

14. See also Mark A. Hall, *A Theory of Economic Informed Consent*, 31 GA. L. REV. 511 (1997).

economic underpinnings of that form of coverage, are deemed either to consent, or to waive their right to give informed consent, to their physicians' cost-based clinical decisions to withhold some beneficial medical care (p. 211).

Although I disagree that insurance selection fulfills all the purposes assigned to it in this book,¹⁵ this is a self-contained limitation that warrants further thought, and not a fatal flaw in a sound analysis. In the final paragraph of this work, Professor Hall states that his "objective [in writing this book] will be met if the reader is convinced to avoid the attraction of absolutist taboos and simplistic-sounding solutions and instead is motivated to give this intractable problem hard thought" (p. 262). After reading Professor Hall's cogent analysis of this critical issue, the reader is unlikely to find any arguments left for the proposition that physicians must be entirely "cost blind" in their clinical decisionmaking. Professor Hall has thus taken an important step toward resolving the problem of allocating health care resources.

Yet the book also leaves me wanting more. While ably pointing out the weak underpinnings of an absolute prohibition on cost consideration, the discussion offers little positive analytical support in favor of physician bedside rationing. The book acknowledges the need for (p. 155), but does not provide, practical guidance on how the physician is to assume this new role as society's rationing agent at the bedside of individual patients or on what will replace the former ethical dictate that the physician be committed solely to the patient's medical well-being.¹⁶ Combining the physician's role as rationing agent with the proposed theory of economic informed consent for HMO enrollees has profound implications for the relationship between patient and physician. But these issues, too, go largely unexplored. In short, I wish that Professor Hall's book offered more to facilitate the translation of sound scholarly suggestion into practical health care reform. One book, however, cannot answer all questions. The desire for more should be seen as a tribute to the success of this work in convincing the reader of its basic premise that physicians are not bound to ignore cost in clinical decisionmaking.

With some trepidation, I accept Professor Hall's invitation to give this difficult problem "hard thought" and will add to Professor Hall's self-styled "analytical musings of an academic lawyer" (p. 261) the musings of a long-time practicing health care lawyer and

15. See *infra* text accompanying notes 70-88.

16. In an article published as this book review was going to press, Professor Hall begins to develop ethical guidance for physicians as medical-spending decisionmakers. See Mark A. Hall & Robert Berenson, *Ethical Practice in Managed Care: A Dose of Realism*, 128 ANNALS INTERNAL MED. 395, 399 (1998).

student of the health care delivery system who has recently entered the legal academy.¹⁷ Before I comment further on our areas of disagreement or on what Professor Hall does not address, I will describe the wealth of ideas and insights he shares with us in this book.

I. WHO SHALL DECIDE?¹⁸

A. *Patients, Payers, and Third Parties*

Chapters Two and Three are devoted to a discussion of potential nonphysician decisionmakers and their medical spending decisions. The analysis begins with the intuitively most obvious choice, the consumer-patient. Covering now-familiar territory, Professor Hall points out that in a perfectly functioning market for health care services, consumers making discrete decisions about their own medical care would lead to the optimal allocation of medical resources (pp. 20-22). Of course, observers of the health care delivery system have long known that the market for health care services is not perfect. Regulatory interventions such as mandated benefits and comprehensive health care insurance shield health care consumers from the actual costs of their decisions. Since health care insurance is itself subsidized through taxation, consumers who obtain health coverage through employer-based plans are likewise shielded from the full cost of their insurance choices. The advent of managed care has exacerbated consumers' insensitivity to the cost of care by eliminating the patient's financial responsibility for deductibles and co-insurance and requiring in their stead only modest copayments.¹⁹

Although some economists and policy analysts have argued that the market for health care services would properly allocate medical resources if consumers' price sensitivity could be enhanced through insurance reform,²⁰ Professor Hall explains that consumers will still not be ideal decisionmakers (pp. 23-34). First, even cost-sensitive consumers will not be ideal decisionmakers because when the more

17. Before I began teaching law full time, I practiced health law as a member of a law firm in New Orleans, Louisiana, and later as a senior-level in-house counsel with a major health insurer. During my career as a practicing lawyer, I represented integrated delivery systems, physician group practices, individual physicians, health care trade associations, and hospitals, as well as health maintenance organizations and other payers. I also lobbied on behalf of my clients in favor of and against state and federal legislative proposals affecting managed care organizations and health care providers, including so-called anti-managed care legislation. Although as a practicing lawyer I had access to materials of the type referenced in this book review, all of the sources cited here were obtained from public sources.

18. With apologies to VICTOR FUCHS, *WHO SHALL LIVE?* (1974).

19. See Bruce C. Vladeck, *From the Health Care Financing Administration: Managed Care and Quality*, 273 JAMA 1483 (1995). The paradox of managed care is that it enhances consumer demand for care by lowering cost barriers while simultaneously seeking to restrict access to care, or more precisely access to care at the managed care organization's expense.

20. See, e.g., CHARLES E. PHELPS, *HEALTH ECONOMICS* 199-200 (1992).

costly purchasing decisions must be made, patients are ill and, as a result, not well-suited or personally inclined to make cost-conscious medical decisions. Second, patients are uninformed decisionmakers, as they generally lack technical medical knowledge.²¹ Finally, putting a patient in a bargaining relationship with her physician about the cost of care is not conducive to the documented healing effects of the trust-based patient-physician relationship.²²

Having concluded that the seemingly obvious choice for making medical spending decisions is not always the optimal choice, Professor Hall turns to third parties external to the patient-physician relationship as potential medical spending decisionmakers. He divides these third parties into three categories: the "bureaucrats," the "technocrats," and the "democrats" (pp. 64, 73, 91). The category of bureaucrats includes those who are currently the decisionmakers in many instances: insurers, government regulators, and judges (pp. 64-73). Technocrats are yet-nonexistent panels of disinterested scientists and physicians armed with yet-to-be-developed comprehensive medical outcome measures and clinical protocols tied to hypothetical insurance contract language.²³ Democrats are another largely hypothetical category of representative citizen groups (pp. 91-99). Each category has its limitations as potential decisionmakers for medical spending decisions.

Professor Hall posits that insurers and regulators are reluctant decisionmakers (pp. 64-67). I might be inclined to quibble about any reluctance of insurers to assume this role; managing cost is an essential element of the product that managed care organizations sell to their employer-customers. That said, the current popular press makes abundantly clear that neither the general public nor

21. Pp. 35-39. Although these statements are generally accurate, the extent of patient reluctance to make these decisions varies based on individual characteristics of the patient and the nature of the illness. With the development of the Internet, patient support groups abound, and information is more readily accessible to patients than it once was when medical libraries, geared toward medical professionals, were the principal source of information. Many patients with chronic conditions maintain that they are more knowledgeable about their individual medical needs than their physicians, despite their lack of broad-based clinical educations. See generally Mark V. Pauly, *Is Medical Care Different? Old Questions, New Answers*, 13 J. HEALTH POL. POLY. & L. 227 (1988).

22. Pp. 39-43. Professor Hall refers to the importance of the healing effect of the trust-based relationship between patient and physician several times throughout this work. He maintains that the trust between patient and physician is born in part of necessity, and therefore is resilient. He also relies on the systemic trust that society accords the medical profession. Pp. 176-77. He does not persuade me that the implementation of his proposal — that physicians may withhold beneficial care from their patients without disclosing either the role of cost in that decision or the physician's personal financial incentives — will not over time undercut both the systemic trust society places in medicine and the trust that a patient accords her physician.

23. For proposed sample contract clauses and an excellent discussion of rationing through contract, see generally CLARK C. HAVIGHURST, *HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM* (1995).

the medical establishment is comfortable with the current system of payer as medical decisionmaker.²⁴ Regulators fear the wrath of the electorate or special interest groups for unpopular, difficult decisions.²⁵ Insurers fear a hostile judicial system when their decisions are challenged.²⁶ The judicial system, in turn, is time-consuming, expensive, reactive, driven by fact-specific precedent, and ill-equipped to investigate scientific questions.²⁷

Nonetheless, each of these groups makes some medical spending decisions. When developing health benefit designs, insurers decide which medical treatments will be included under the terms of coverage (p. 68). Legislators override insurers' coverage decisions that are perceived by the public as the most egregious, such as so-called outpatient mastectomies and drive-through deliveries.²⁸ Courts are frequently asked to intervene in decisions to deny coverage for treatments deemed experimental or investigational (pp. 68-73). Among the most recent spate of cases are those involving demands for autologous bone marrow transplants for advanced breast cancers and other malignancies.²⁹

Technocrats are not as self-interested as payers, nor as controlled by public opinion as regulators (pp. 73-91). As decisionmakers, however, technocrats are rule-based. While rules offer the advantages of simplicity and fairness, they cannot capture individual factors and values. They also tend to isolate the caregiver from the patient. Even establishing the rules is problematic. Although some clinical guidelines exist, we do not have available a comprehensive set of outcome measures that considers all the myriad individual clinical factors that might affect a caregiver's professional judgment. Creating a technocratic system for decision-

24. See GEORGE ANDERS, *HEALTH AGAINST WEALTH: HMOs AND THE BREAKDOWN OF MEDICAL TRUST* (1996). Anders, a reporter for the *Wall Street Journal*, recounts anecdotal evidence of poor care provided to HMO enrollees. For a critique of the book, see Sarah E. Idelson, Book Notice, *Health Against Wealth: HMOs and the Breakdown of Medical Trust*, 95 MICH. L. REV. 2090 (1997).

25. P. 66. Most medical-spending decisions made by legislators and regulators with respect to managed care enrollees are decisions to spend, rather than decisions to ration. See *infra* note 28.

26. See Mark A. Hall et al., *Judicial Protection of Managed Care Consumers: An Empirical Study of Insurance Coverage Disputes*, 26 SETON HALL L. REV. 1055 (1996).

27. For an insightful discussion of the role of the judicial system in health care policy, see Peter Jacobson, *The Role of Private Litigation in Monitoring Managed Care* (1998) (unpublished manuscript on file with author).

28. See, e.g., D.C. CODE ANN. § 35-1102.1 (1981) (inpatient postpartum treatment); 215 ILL. COMP. STAT. ANN. § 5/356t (West 1993 & Supp. 1998) (post-mastectomy care).

29. See, e.g., *Fuja v. Benefit Trust Life Ins. Co.*, 18 F.3d 1405 (7th Cir. 1994) (finding that high dose chemotherapy with autologous bone marrow transplant treatment fell within plan exclusion of coverage for treatment connected with medical research); *Adams v. Blue Cross/Blue Shield of Maryland*, 757 F. Supp. 661 (D. Md. 1991) (finding that high dose chemotherapy with autologous bone marrow transplant was not experimental and was covered by the plan).

making, therefore, would add cost to an already costly health care delivery system without eliminating the need for a bedside decisionmaker to determine when and how to apply the rules.

The final third-party category considered by Professor Hall is the democrats, representative citizen groups who would discuss and decide resource allocation. Like the ultimate consumers of health care services, members of the citizen groups would lack technical medical knowledge. Like technocrats, they suffer from the shortcomings of rule-based decisionmaking.

Professor Hall returns briefly to the role of each category of decisionmaker in the final chapter of his book, concluding that no category of decisionmaker is ideally suited for every kind of medical-spending decision (pp. 241-48). He describes how society, acting primarily through the market for health insurance, will determine the proper role and mix of decisionmakers. Professor Hall's analysis of who shall decide considers a wide range of undifferentiated medical spending decisions — from pure medical spending decisions, such as societal funding limits, to mixed spending-treatment decisions, such as medical treatment options for individual patients.³⁰ The analysis also eliminates from its scope any consideration of the "how" of making medical spending decisions — the criteria that will guide the decisionmaker and the means to enforce the decisions made (p. 7). If Professor Hall were inclined to prescribe roles for each category of decisionmaker, then, the analysis would have to be refined and expanded.

B. *Physicians and Bedside Rationing*

Despite its title, this book is principally concerned with physician decisionmaking at the bedside, the topic Professor Hall addresses in Chapters Four and Five. Professor Hall characterizes the dominant position in the medical community as "a nearly absolute moral prohibition" of any cost consideration in treatment decisions (p. 114), and the dominant view in the ethical and legal communities as "unanimously" against bedside rationing of health care re-

30. Managed care organizations point out that their medical spending decisions are intended to be decisions about whether the managed care organization will, or will not, pay for a course of treatment or a diagnostic test. Treatment decisions, in contrast to payment decisions, can only be made by the licensed professional who will provide and the patient who will receive the prescribed course of treatment. See, e.g., Blue Cross/Blue Shield of Arizona Insurance Contract, available in Appellants' Opening Brief app. A at 27, *Murphy v. Board of Medical Examiners of Arizona*, 949 P.2d 530 (Ariz. Ct. App. 1997) (No. 95-0327) ("THE FACT THAT A PHYSICIAN HAS PRESCRIBED, ORDERED, RECOMMENDED, OR APPROVED A SERVICE OR SUPPLY DOES NOT MAKE IT MEDICALLY NECESSARY OR MAKE THE CHARGE ELIGIBLE FOR BENEFITS This is not intended to alter or influence a Provider's clinical judgment in providing your care. It is intended only to outline the reimbursement guidelines which apply to this Benefit Plan.") (emphasis in original) (on file with author).

sources (p. 117). He refers to the prohibition of cost consideration in clinical decisionmaking as the "absolute quality ethic," under which "any marginal medical benefit, no matter how small, is worth absolutely any price. . . ."³¹ He also acknowledges two other viewpoints on physician consideration of cost. The first is that physicians may consider cost in clinical decisions as a means to avoid rationing by third parties, but that they must be insulated from any personal economic stake in their rationing decisions (p. 115). The second view, which Hall classifies as a minority view, is that physicians may engage in resource allocation under the influence of personal financial incentives (p. 115). Professor Hall embraces this last view.

Discussing this view, Professor Hall notes that no "moral and political defense" has been offered in its support (p. 115). Rather, it appears to arise from market realities. Although I anticipated that Professor Hall's task in this part of the book would be to articulate the positive case in support of physician rationing induced by personal financial incentives, he chooses to target the arguments in support of the absolute quality ethic. He reasons that to understand the "proper form and limits [of rationing]," the "ethical and legal taboo" associated with rationing must be overcome (p. 127).

Much of the analysis in this section of the book, therefore, is reactive. The near-mythical role of the physician with his exclusive focus on the well-being of his patient, without regard to cost, personal gain, or personal sacrifice, supplies the analytical target. Professor Hall insightfully critiques historical mainstream thinking, or at least oft-quoted rhetoric, that physicians are barred from any consideration of cost in clinical decisionmaking at the bedsides of individual patients. He addresses and rejects in turn both practical arguments, such as the potential for physicians to abuse the authority to ration (pp. 121-22), and theoretical arguments, such as those based on role morality (p. 133), professional ethics (pp. 128-29), and bioethics (pp. 137-43).

Professor Hall's discussion of professional ethical and bioethical support for the absolute quality ethic is the reader's first introduction to the analytical role of insurance selection.³² In Hall's view, a consumer who chooses a less costly, restrictive form of health insurance has expressed a value preference for "less than optimal medical benefit" in exchange for economic well-being.³³ Accordingly,

31. P. 115. While I believe that these characterizations overstate the prevailing objection to cost consideration, they do provide an effective foil for Professor Hall's analysis.

32. The organization of the book seems sensible, but perhaps unavoidably leads to some repetition of critical insights, given that the role of insurance selection underlies much of the analysis.

33. P. 137. See also discussion *infra* at Part II.

he maintains that neither physician beneficence³⁴ nor patient autonomy³⁵ requires that physicians ignore cost in clinical decisions if the patient has made this selection (pp. 135-42). Cost-conscious clinical decisionmaking fulfills the physician's obligation of beneficence, because it serves both the patient's medical and economic well-being. Viewing this choice from an ex ante perspective, Hall asserts that a physician is required by the patient's direction expressed through insurance selection to trade the patient's medical interest for the patient's economic interest at the time of treatment (p. 138). Professor Hall argues that it is only the ex post perspective, viewed at the time of treatment rather than the time of insurance selection, that leads to "erroneous thinking"; when physicians consider costs they are trading off the patient's welfare for the welfare of others in society (p. 138). On similar reasoning, Professor Hall maintains that respect for patient autonomy does not bar bedside rationing when a patient has selected a restrictive form of insurance (p. 143). A patient exercises her autonomy by selecting an insurance vehicle. Through selection of a restrictive benefit design, a patient delegates to her physician the authority to make cost conscious medical decisions for the duration of the insurance contract term.³⁶ Professor Hall concludes in this section that the absolute quality ethic is not in keeping with current economic and medical realities and is not required by the role that physicians are asked to play in society. It must therefore be rejected.

Exposing the analytical weaknesses of the arguments in support of the absolute quality ethic is a necessary step to establish that the absolute quality ethic is not viable. But it offers little understanding of the moral, legal, or ethical limits of physician rationing. To begin to explore those limits, the reader must compare Professor Hall's definition of bedside rationing with current clinical practice to determine how radical a change in physician conduct is required by this proposal.³⁷

34. Beneficence has its origins in the Oath of Hippocrates: "I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous." For one translation, see *Hippocratic Oath*, in 14 THE ENCYCLOPEDIA AMERICANA 218 (International Edition 1976).

35. Patient autonomy is a right to self-determination. The principles of beneficence and autonomy clash when the patient's choice would direct the physician to practice medicine in an unsound manner. For a discussion of the inherent tension between the two principles, see JOHN ENGLEHARDT, JR., THE FOUNDATIONS OF BIOETHICS 82-84 (1986).

36. Although I do not find these arguments entirely persuasive for the reasons I state in this review, I particularly enjoyed Professor Hall's analogy to the myth of Ulysses and the Sirens. Pp. 150-51.

37. Clinical practice varies widely by geographic region, physician, and clinical setting. See generally Jonathan Skinner & Elliott Fisher, *Regional Disparities in Medicare Expenditures: An Opportunity for Reform*, 50 NATL. TAX J. 413 (1997). I am not suggesting that clinical practice is static nor that current practices reflect an unchanging and unchange-

C. *A Problem of Definition and A Need for Direction*

Physician bedside rationing, Professor Hall asserts, consists of the "prudent trimming of incrementally beneficial services" (p. 118) to deny managed care patients marginally beneficial treatment when that denial is consistent with the prevailing standard of care. An explicit cost-benefit analysis is not a prerequisite to physician bedside rationing, as Professor Hall envisions it (p. 119). In practice, requiring a cost-benefit analysis at the bedside would easily defeat most bedside rationing, because medicine simply lacks the outcome measures that would enable this analysis to occur.³⁸

What services then would be encompassed in bedside rationing? Professor Hall's answer is somewhat unclear. The examples he offers in the book include an extra diagnostic test or day in the hospital, a more expensive drug, and a referral to a specialist when the stakes are low or when confidence in the diagnosis and prognosis is already high (p. 118). He goes on to caution that physicians should not make "high-stakes, high-drama rationing decisions without consulting their patients *or* relying on explicit regulatory or contractual authority," because of the "corrosive" effect on the patient-physician relationship.³⁹

Given the discussion that preceded the "high-stakes, high-drama" limitation, I was perplexed by Professor Hall's implicit suggestion that physicians could make such rationing decisions without patient involvement, even with explicit regulatory or contractual authority. Regulatory or contractual authority would not eliminate the corrosive effect that would inevitably result from a physician's making such a significant decision without patient involvement.⁴⁰ This cryptic statement goes unelaborated, although Professor Hall hints that physicians might engage in bedside rationing in circumstances that are decidedly not low stakes. For example, in his discussion of bedside disclosures, Professor Hall suggests that it would be "cruel" to tell a "Mississippi dirt farmer" that a treatment offered at Sloan-Kettering, located in New York City, had a one-in-

able commitment between medicine and society. Rather, my purpose is to explore the limits of bedside rationing by exploring Professor Hall's definition of that term.

38. The science of medicine is still too inexact and the individual factors too numerous for the development of a comprehensive set of guidelines that would make this cost-benefit analysis an informed one. Professor Hall discusses this point when he addresses rule-based spending decisions. Pp. 76-81.

39. P. 118 (emphasis added). Presumably, the kinds of cases that appear on the evening news would fall into the "high-stakes, high-drama" category: autologous bone marrow transplants for metastatic cancers, organ transplants, and other last-option treatments that are potentially lifesaving.

40. Would Hall consider an exclusion from insurance coverage contractual authority to make a medical-spending decision to withhold expensive life-prolonging treatment without the patient's express concurrence in that decision? If so, that would be a larger step away from patient autonomy than I am prepared to take.

one-thousand chance to cure his cancer (p. 199). This example suggests that marginally beneficial care might also include care that has a low probability of very significant benefit in a life-or-death situation. Including such care within the definition of marginally beneficial care that a physician is authorized to withhold from HMO enrollees on the basis of insurance selection would, in my view, be decidedly more controversial and more troubling than Professor Hall's explicit statements that the physician's ability to withhold marginally beneficial care encompasses small increments of care in low-stakes, high-confidence situations.

Assuming that the more moderate examples accurately reflect Professor Hall's proposal, how is bedside rationing different from ordinary clinical judgment exercised by physicians as they go about ruling out alternative explanations for a patient's symptoms? Professor Hall's work leaves one uncertain of the answer. He points out a number of circumstances in which physicians currently engage in bedside rationing, as he defines that term (pp. 121-25). Among those he discusses are medical triage in emergencies,⁴¹ the cost-conscious treatment of uninsured and underinsured patients,⁴² and practice within resource-constrained environments, such as public hospitals. Many other medical decisions to forego or delay care would fall into Professor Hall's category of "nonstandard, unethical, or unprofessional" care (p. 125). For example, a physician exercising sound medical judgment need not acquiesce to a patient's request for medical testing merely intended for reassurance.⁴³ To borrow from Professor Hall's analysis, no matter how strong an otherwise asymptomatic patient's fear of malignancy, a reasonable physician would not feel compelled to comply with the fearful patient's request to order a whole body CT scan, or monthly Pap smears for the female patient. We may have a medical marketplace, but it is not a supermarket where unlicensed consumer-

41. This is an example of absolute scarcity of resources, which is different from the type of incremental decisions Hall cites. The decision is not based on cost of case, but on unalterable resource limits. See Maxwell Mehlman, *The Patient-Physician Relationship in an Era of Scarce Resources: Is There a Duty to Treat?*, 25 CONN. L. REV. 349, 380-81 (1993).

42. From an ethical standpoint, a physician's task is easier when her patient's own interests dictate cost-conscious decisionmaking, as they do when the patient is under- or uninsured or otherwise lacks financial resources to pay for her care. The physician is asked to follow the traditional ethical dictate that she consider her patient's interests superior to any other interest. She is not asked to balance her patient's interests against the interests of others in making a cost-based, clinical decision to withhold marginally beneficial care. See generally Marcia Angell, *The Doctor as Double Agent*, 3 KENNEDY INST. OF ETHICS J. 279 (1993).

43. See Allan S. Brett & Laurence B. McCullough, *When Patients Request Specific Interventions*, 315 NEW ENG. J. MED. 1347 (1986).

patients can shop for and purchase the medical technology of the moment, regardless of the source of payment.⁴⁴

Like Professor Hall's bedside rationing model, ordinary clinical judgment also encompasses an incremental approach to patient testing and treatment. Professor Hall offers a not entirely factual example of his wife's ankle injury, where her physician decided to wait and watch rather than order an expensive MRI to rule out an unlikely possibility of serious injury (p. 117). A physician's decision not to recommend a test or treatment because it has a low probability of providing a healthy patient any significant benefit would be consistent with both a physician's traditional duty to exercise sound professional judgment on the patient's behalf and with a broader duty to serve society's need to control medical expenditures.⁴⁵

Organized medicine, while rejecting calls for bedside rationing, accepts the cost-benefit analysis that is a part of standard clinical judgment.⁴⁶ Physicians are instructed to advocate with managed care organizations on behalf of their patients for care that is of "material benefit."⁴⁷ A lot of medical territory falls between an extra diagnostic test and an organ transplant. Is the admonition that a physician withhold marginally beneficial care a difference in kind or a difference in degree from everyday decisions made by physicians?

If withholding marginally beneficial care envisions only ordinary clinical judgment about small increments of additional care, as seems to be suggested in some parts of the book (pp. 117-18), the proposal might be too modest to have a significant impact on health care spending or on health insurance premiums. If more than withholding small increments of care is intended, as the case of the Mississippi dirt farmer obliquely suggests, the limits were not disclosed. Readers are left to ponder the qualitative, or quantitative, differences between marginal benefit, cost-benefit, and material benefit, and to wonder whether, or how much of, this debate about cost-

44. *Id.* at 1347 (noting that protection of the public health dictates that society impose barriers to acquisition of potentially harmful medical commodities and services).

45. Mammograms for twenty-year-old patients who are not otherwise at enhanced risk for breast cancer would fall into this category.

46. "Any broad allocation guidelines that restrict care and choices — which go beyond the cost/benefit judgments made by physicians as a part of their normal professional responsibilities — should be established at a policy-making level so that individual physicians are not asked to engage in bedside rationing." AMERICAN MEDICAL ASSOCIATION, CODE OF MEDICAL ETHICS: CURRENT OPINIONS WITH ANNOTATIONS Opinion 8.13(2)(A), Managed Care, at 126 (1996-1997 ed.). The AMA does not further define its use of the term "bedside rationing."

47. *Id.* at Opinion 8.13(2)(B) ("Regardless of any allocation guidelines or gatekeeper directives, physicians must advocate for any care they believe will materially benefit their patients.").

conscious clinical decisionmaking is based on differing definitions of key terms.

Given the centrality of the concept of marginally beneficial care to physicians' ability to act on the proposal set forth in this book — that the physician may withhold marginally beneficial care without their patients' informed consent — scant attention is paid to its parameters.⁴⁸ Future analyses of the benefit component of the cost-benefit analysis for marginally beneficial care should address the relative weights of the probability of medical benefit from an additional treatment or diagnostic intervention, the significance of the probable benefit to the individual patient, the physician's confidence in her clinical judgment, and the availability of alternative treatments or diagnostic interventions.

Physicians need guidance however, on more than matters of definition. A disappointing gap in this work is its lack of any direction for physicians' behavior as they act as rationing agents at individual patients' bedsides. The absolute quality ethic supplied a physician's general objective, the means to serve that objective, and imposed a limit on physician behavior. It was intended to focus physicians solely on the medical needs of patients through a cost-blind method of clinical decisionmaking. In the broadest sense, its ethical directive was a condemnation of physician self-serving behavior.⁴⁹ If we abandon the absolute quality ethic, as Professor Hall argues persuasively that we should, what will replace it? In a sense, whether physicians may consider cost in clinical decisionmaking is the easy question: they already do so, absolutist taboo notwithstanding. This work supplies neither the objective, the means, nor the limitations on physician rationing conduct. Thus, the hard questions go unanswered here.

D. *Motivating Physicians with Financial Incentives*

Having concluded that physicians are not bound by an absolute quality ethic to ignore the cost of care, Professor Hall's analysis turns to whether an absolute prohibition against the use of financial incentives to motivate physicians to make rationing decisions is justifiable (p. 172). Physicians have long been identified as the principal culprits in the current state of affairs of ever-escalating health care spending, for they have long controlled most health care

48. My suggested modification of Professor Hall's proposal envisions more disclosure to and discussion with the patient. The significance of the concept of marginally beneficial care is lessened when patients are aware that a rationing decision is being made.

49. See Deborah A. Stone, *The Doctor as Businessman: The Changing Politics of a Cultural Icon*, 22 J. HEALTH POL. POLY. & L. 533, 534-35 (1997) ("The entire organization and ideology of the profession was meant to show that doctors' decisions and recommendations were dictated by the best interests of the patient and by science — and distinctly not by the pecuniary interests of the doctor.").

spending through their prescriptive practices. Patients are admitted to the hospital, receive expensive procedures, and undergo surgery upon physicians' orders. If we assume that physicians gave those orders acting under a perceived directive that they could not, and should not, be cost-conscious, will disabusing them of that notion have a significant effect on future ordering practices? Incentives to change have to be created.

In Chapter Five, Professor Hall discusses the law of fiduciary responsibility and the agency cost theory of economics in concluding that the use of financial incentives is a permissible method to motivate physicians to make resource-allocation decisions. The conflict of interest between patient and physician that is created by giving physicians personal financial incentives to withhold care is cured by patient consent to the conflict.⁵⁰ By reference to the now-familiar insurance selection, Professor Hall suggests that a patient who has been properly informed about rationing mechanisms through the insurance selection process "may rationally agree to a set of strategically crafted incentives that induce doctors to act as both their medical treatment and their economic purchasing agents" (p. 172).

Legal oversight through direct regulation of financial incentives or through tort law can guard against financial incentives that work too well and cause physicians to withhold too much care.⁵¹ In addition, Professor Hall argues that managed care organizations can provide oversight of the effects of financial incentives by monitoring care through the peer review process and grievance proceedings. Finally, he opines that the "physicians' own internalized ethic of patient beneficence guards against corrupting influences" in the role as rationing agent (p. 180).

I agree with Professor Hall's general conclusions that properly informed patients can consent to the conflict of interest created by financial incentives to withhold care. Although such disclosures are now rare, recent legislative initiatives should make disclosures more

50. Although financial incentives to withhold care could create a conflict of interest between physician, as fiduciary, and patient, as beneficiary, conflicts of interest are not absolutely barred in fiduciary relationships. Conflicts can be cured by proper disclosure, in many circumstances. Professor Hall examines but finds nothing inherent in the particular relationship between patient and physician to suggest that disclosure cannot cure physician conflicts of interest. Pp. 178-79. For a contrary view, see MARC A. RODWIN, *MEDICINE, MONEY, AND MORALS: PHYSICIANS' CONFLICTS OF INTEREST* 42-43 (1993).

51. Relying on legal oversight begs the question. Legal oversight can take many forms. The most recent is a limit on the percentage of a physician's income that can be at risk coupled with certain disclosure and reinsurance requirements. 42 C.F.R. § 417.479 (1997). For a discussion of approaches taken by the various states, see Allison Overbay & Mark A. Hall, *Insurance Regulation of Providers that Bear Risk*, 22 AM. J.L. & MED. 361 (1996). Another approach might be to require actuarial soundness of all reimbursement arrangements that shift or share risk with physicians and managed care organizations.

common.⁵² I am somewhat less confident than Professor Hall about the ability of financial incentives to produce rationing decisions that serve societal interests in overall health care spending, rather than merely the physician's or managed care organization's own economic well-being. The lack of empirical work in this area, however, hampers any meaningful analysis.⁵³ While this lack of certainty does not dictate a ban on the use of financial incentives, it does suggest a need for effective controls.

Some of the oversight mechanisms suggested by Professor Hall are flawed in their ability to restrict abuse that might result from financial incentives. When patients are not fully informed that their physicians are withholding some beneficial care, as is suggested by this analysis, the availability of grievance procedures to dispute decisions to withhold care is of little practical value.⁵⁴ If, for example, the patient is unaware that but for the source of payment, his attending physician would have referred him to a specialist, he cannot effectively appeal that decision through a grievance procedure.⁵⁵ Similarly, the physician's traditional duty of beneficence as a means of oversight will be compromised by including an economic element in the balance, as is envisioned by Professor Hall's analysis.⁵⁶ Relying on a duty that arises from the absolute quality to guard against

52. See, e.g., N.J. STAT. ANN. § 26:2S-5(a)(2) (1997) (effective Feb. 4, 1998) (requiring managed care plans to disclose information about financial incentives between participating physicians under contract with the plan); VT. STAT. ANN. tit. 18, § 9414(a)(2)(C) (1997) (requiring managed care organizations to disclose financial inducements offered to any health care provider or facility to reduce or limit health care services). In the marketing materials I reviewed when writing this book review, however, only one of five mentioned the means of physician reimbursement. See, e.g., *infra* notes 82-85.

53. See Henry Greeley, *Direct Financial Incentives in Managed Care: Unanswered Questions*, 6 HEALTH MATRIX 53 (1996).

54. Professor Hall states "it is clear that no existing source of law . . . requires the disclosure of the numerous HMO physician incentive payment plans. . . ." P. 196. Since the publication of this book, a U.S. court of appeals has ruled that ERISA fiduciaries must disclose financial incentives to withhold care. See *Shea v. Esenstein*, 107 F.3d 625 (8th Cir. 1997). See also The White House Office of Communications, Fact Sheet on Federal Health Plans (Feb. 26, 1998), 1998 WL 80261 (White House) (reporting that the President will issue a directive aimed at ensuring that federal health plans come into compliance with the Consumer Bill of Rights which requires, among other things, disclosure of financial incentives). But see *Weiss v. CIGNA Healthcare Inc.*, 972 F. Supp. 748 (S.D.N.Y. 1997) (finding that HMO did not breach its fiduciary duty for failing to disclosed financial incentives to lower rates of hospitalization and referrals to specialists).

55. In testimony before a Senate Labor and Human Resources Committee convened to consider the need for legislative initiatives to address the quality and accountability of managed care organizations, Karen Ignagni, President and CEO of the American Association of Health Plans, cites to these mandated internal appeals processes to argue against additional federal oversight. *Statement on Health Plan Quality, May 20, 1997*, (visited April 13, 1998) <<http://www.aahp.org/services/government&advocacy/policy/testimony/qualityk.htm>>.

56. The duty of beneficence, which required that a physician subordinate his interests to the medical needs of the patient, in its traditional formulation would have prohibited a physician from acting on the economic incentive to do more — in managed care terms to "overutilize" — to enhance the physician's financial well-being.

an economic incentive that is premised upon a significant modification of that ethic seems disingenuous. A physician can serve her own, as well as her patient's economic interests, by aggressively withholding medical care. But aggressive withholding of care might not be in the patient's medical interest.

A recent case illustrates these points quite poignantly.⁵⁷ Patrick Shea, a forty-year-old man with a family history of heart disease, was experiencing severe chest pains and shortness of breath. He was enrolled in a health maintenance organization. Accordingly, he asked his primary care physician for a referral to a cardiologist. His physician declined, assuring Mr. Shea that he was too young and did not have enough symptoms to justify a visit to a cardiologist. He was wrong. Several months later, Mr. Shea died of heart failure. The HMO in which Mr. Shea was enrolled used physician financial incentives to minimize specialist referrals. Mr. Shea was not advised of that fact, nor was he advised whether his physician's clinical decision was affected by his enrollment in an HMO. None of us can say whether those simple disclosures would have caused Mr. Shea to seek out additional care at his own expense or appeal the decision not to refer him to a cardiologist, or whether either of those actions would have saved his life. Mrs. Shea alleged that disclosure of the financial incentive would have been enough to cause Mr. Shea to visit a specialist.⁵⁸ The court agreed that Mr. Shea should have had the information necessary for him to make that choice.⁵⁹

Meaningful patient disclosures are important, therefore, not only to obtain consent to a physician's conflict of interest, but also to give meaning to the mechanisms available to oversee the physician's rationing of care under the influence of personal financial incentives.

II. INFORMING CONSUMERS

In Chapter Six, Professor Hall considers the questions to what extent and at what point resource allocation mechanisms must be disclosed to the patient. Without purporting to resolve the specifics of the disclosure, he concludes that global disclosure of resource allocation mechanisms should be made by the managed care organization to the consumer at the time of enrollment (pp. 194-98). Physicians should reinforce this global disclosure at the time of the first visit with the patient by reiterating the nature of managed care

57. See *Shea v. Esenstein*, 107 F.3d 625 (8th Cir. 1997).

58. See *Shea*, 107 F.3d at 627. Of course, this case might simply involve defendant's medical error unrelated to cost considerations, or plaintiff's ex post analysis of events that might have been.

59. See *Shea*, 107 F.3d at 629.

and the physician's role in keeping costs down.⁶⁰ These suggestions are sound. But are they enough?

The more difficult question is whether and when the physician must disclose the role of cost in her bedside treatment decisions. To analyze this issue, Professor Hall focuses on the law of informed consent.⁶¹ He concludes that expansion of the law of informed consent to require disclosure of the role of cost in a given clinical encounter has not yet occurred. Such an expansion, he maintains, would be unwise. I find his reasons for this conclusion unpersuasive.⁶²

First, Professor Hall maintains that bedside disclosure is impractical, because physicians might not overtly engage in a cost-benefit analysis in making clinical decisions. The physician is unable to disclose his thought process to the patient because it is unconscious (p. 205). That physicians must sometimes be unaware of the role of cost in a clinical decision, however, is no reason to relieve them of a duty to disclose when a decision is knowingly affected by the cost of care and the source of payment. Since Professor Hall proposes in this book that a physician's authority to ration is based on the patient's enrollment in a restrictive insurance plan, a physician would have to engage in some conscious thought. A physician must first determine whether this patient is one to whom the duty of beneficence has been modified and from whom he has authorization to ration through insurance selection. A but-for formulation of the duty to inform would satisfy this concern. If the physician's clinical decision would have been different but for the source or method of payment for the patient's care, then the role of cost should be disclosed. Disclosure would give the patient the opportunity to proceed with the care as recommended, to disagree and consider a

60. The term "first visit" might be misleading. The patient-physician relationship might have predated the patient's enrollment in an HMO. One of the primary factors in a consumer's selection of a plan is that the consumer's physician is under contract to the plan. Physicians will be required to discuss these issues at the first visit after the patient enrolls in a restrictive insurance plan. For a discussion of factors influencing consumer selection of a managed care plan, see Deborah A. Gibbs et al., *Consumer Perspectives on Information Needs for Health Plan Choice*, HEALTH CARE FINANCING REVIEW, Fall 1996, at 55; David Mechanic, *Commentary: Consumer Choice Among Health Insurance Options*, HEALTH AFF., Spring 1989, at 138.

61. The law of informed consent, which arose from the law of battery, was concerned with medical risks. P. 200. As the law of informed consent has evolved, the nature and scope of required disclosure has expanded, and could now be interpreted to include decisions not to treat. Pp. 202-04 and cases cited therein.

62. In my view, physicians should be legally required to engage in meaningful discussions with their patients when but for the cost of care, their clinical decisions would have been different. Whether this disclosure is accomplished through an extension of the legal doctrine of informed consent or of standard fiduciary principles is less significant to me. I would not, however, rely completely on aspirational pronouncements for fear that physicians would too often fall short of achieving that aspiration. Cf. Hall & Berenson, *supra* note 16.

grievance procedure through her managed care organization, or to pay for additional care from personal resources.

Second, Professor Hall states that disclosure of the role of cost in a clinical decision could harm the patient-physician relationship by undermining the patient's trust in the physician's commitment to the patient's medical welfare (pp. 205-06). Patient trust in the physician is associated with a healing effect. If trust is lost, some psychological element of healing is also lost (pp. 39-40). I agree that frequent disclosures that a physician's clinical decisions are cost driven could undermine patient trust. But, if trust is lost, it is lost because the physician has and regularly exercises the right to ration the patient's care. Encouraging misplaced reliance on the physician by withholding disclosure of truthful information would seem paternalistic at best and hazardous at worst.⁶³

The risk of paternalism is apparent in Professor Hall's argument that physicians should not have to disclose the role of cost in a particular clinical decision because patients might prefer not to know about the "unalterable reality of limited resources . . . at a time when patients may be emotionally vulnerable and in need of reassurance due to the extreme anxiety of serious illness" (p. 205). I have two problems with this reasoning. First, if the patient is seriously ill and the care to be withheld is potentially lifesaving or life-prolonging, the situation is one of high-stakes, high-drama. The earlier analysis seemed to conclude that such care is not marginally beneficial and should not be subject to physician rationing without patient involvement (pp. 117-18). Second, assuming that additional resources are not available begs the question. Scarcity of resources for marginally beneficial care is usually only relative, not absolute. The unavailability of a donor liver is a typical example of absolute scarcity. Resource scarcity in a market-based system is not necessarily unalterable when sources other than insurance coverage might be available to the fully informed patient. That some patients cannot afford to purchase additional care is not a reason to withhold information about care options from all patients. If a patient does not want to know that if she were a rich woman her physician would make different clinical decisions, she can say so directly. We need not rely on the fiction of insurance selection to assume that HMO enrollees do not desire this information.

Finally, Professor Hall reasons that disclosures about the withholding of care would give rise to contract disputes over the terms of the insurance coverage (p. 206). Insurance plans generally re-

63. I also find unpersuasive the argument that withholding information from patients is justified to avoid disputes between patient and physician about the physician's cost-based clinical decision. That patients might make their physicians uncomfortable by disagreeing with their clinical decisions is too convenient an excuse to avoid difficult discussions.

quire payment for medically necessary services. Professor Hall maintains that medical necessity is interpreted in practice as covering any treatment that is "potentially of any medical benefit" (p. 206). His statement is accurate with respect to the relatively small percentage of cases that are litigated, most, if not all of which fall into the "high-stakes, high-drama" category and would be discussed with the patient even under Professor Hall's analysis. Standard definitions of medical necessity in managed care plans are more restrictive.⁶⁴ If the source of the medical-spending dilemma is that the legal system is failing to enforce the terms of restrictive insurance contracts, that problem should be addressed directly through the legal system, not indirectly through restricting information about a consumer's contractual rights.⁶⁵ In our market-based system of health care, consumers are entitled to the benefit of their bargains with health maintenance organizations.⁶⁶

Unlike Professor Hall, I have a fundamental reluctance to forego disclosure of information to consumers for three reasons. First, a market-based reason: efficient markets rely on the value-based purchasing decisions of informed consumers. In a market-based system, therefore, all relevant, available information should be shared if we are to rely on the collective purchasing decisions of consumers in the marketplace to yield the most efficient use of resources, or in this case, the best mix of medical spending decisionmakers. Second, an ethics-based reason: patients have come to rely on physicians' oft-stated ethical obligation to put the patient's interest ahead of all other interests. A shift in that patient-directed ethic should be clearly signaled to prevent misplaced reliance and to alert patients to physicians' new roles. Third, a law-related reason: recent legislative actions rely on mandated consumer disclosures as a means to facilitate market oversight of managed care. A

64. See, e.g., PRIMARY CARE PHYSICIAN AGREEMENT § 12, Definition 12.7 (Aetna U.S. Healthcare 1996) (on file with the author), providing that "Medically Necessary Services shall mean . . . health care services that are appropriate and consistent with the diagnosis . . . and which are likely to result in demonstrable medical benefit, and which are the least costly of alternative supplies or levels of service which can be safely and effectively provided. . . ."

65. Any prudential concern with enforcement of medical necessity provisions in managed care contracts loses importance as managed care organizations delegate utilization management responsibility to physicians who are reimbursed on a capitated basis. See Peter D. Jacobson et al., *Defining and Implementing Medical Necessity in Washington State and Oregon*, 34 INQUIRY 143 (1997).

66. Ironically, the managed care industry itself rejects the suggestion that physicians should withhold information from patients. The 1998 accreditation standards adopted by the National Committee on Quality Assurance require that managed care organizations have a written policy stating that "[M]embers have a right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage," as well as the right "to participate with practitioners in decision making regarding their healthcare." See STANDARDS FOR THE ACCREDITATION OF MANAGED CARE ORGANIZATIONS, Standards for Members' Rights and Responsibilities 189, Standard Rules 1.3 & 1.4 (National Committee on Quality Assurance 1998).

proposal that may result in the intentional withholding of information from HMO enrollees could thwart those efforts and have the unintended consequence of more intrusive, expensive, and burdensome means of regulating managed care organizations.

A. Insurance Selection as Informed Consent

In response to these difficulties with providing bedside information about and obtaining patient consent to cost-conscious medical decisions, Professor Hall returns to the centrality of insurance selection to formulate a theory of economic informed consent.⁶⁷ Before I explain why I doubt selection of an HMO can be a viable substitute for information and consent, I wish to note some prudential problems with the operation of a theory of economic informed consent. First, I am troubled by the suggestion that information will be provided only in response to specific questions from a patient. This aspect of the theory favors sophisticated consumers who will know enough to ask the right questions to obtain information and further disadvantages the neediest individuals.⁶⁸ To the extent that physicians might act on unconscious biases in favor of educated, affluent patients, this theory exacerbates the problem.⁶⁹ To the extent that the theory applies only to HMO enrollees, a subject to which I turn next, it also makes HMO enrollees bear the brunt of societal efforts to curb medical spending not solely through their insurance purchase but also by restricting information that would permit them to make future choices.⁷⁰

67. P. 209. Under this theory, when a consumer decides to enroll in a health maintenance organization, the consumer knowingly elects a style of medicine that rations "marginally beneficial care" either through the payer's centralized rules or the physician's bedside discretion. P. 210. This selection of a health care benefit design constitutes either advance consent to, or waiver of the right of informed consent to, withholding items of treatment or diagnostic services based on their costs, if the patient is informed of the rationing rules and incentives at the time of enrollment. P. 211. Detailed disclosures about the role of cost in a clinical decision at the time of treatment would be required only in response to specific questions by the patient. This principle of nondisclosure would not apply to "high-stakes" or "value-laden" treatments. P. 226. Examples of high-stakes decisions include terminating life support and life-saving surgery. Value-laden treatments are those of particular importance to a given patient, for example treatment to avoid slight physical impairments to athletes or performing artists. P. 226. Professor Hall leaves the precise details for later work.

68. As consumers become aware of the "if you don't ask, I won't tell" approach to the role of cost in clinical decisions, even less sophisticated consumers will begin to ask, curing both the problem I raise here as well as tending over time to eliminate the utility of the theory of economic informed consent.

69. Professor Hall rejects the potential for abuse of the authority to ration as an argument in favor of the absolute quality ethic. Pp. 119-22. I raise the potential for abuse here only to suggest that in fashioning a system for physician rationing, factors that might exacerbate the opportunity for abusive decisionmaking should be avoided.

70. To the extent this proposal permits discrimination based on source of payment, physicians complying with it would be violating standard provisions in some managed care contracts that prohibit physician discrimination against their enrollees on the basis of source of payment. See, e.g., PRIMARY CARE PHYSICIAN AGREEMENT (Aetna), *supra* note 64 ("Pro-

Second, Professor Hall does not explicitly address whether the theory of economic informed consent can be applied to managed care benefit designs other than HMOs. If the theory applies only to HMO enrollees, it will apply to fewer patients over time as less restrictive managed care benefit designs enter the marketplace and displace HMOs. Consider, for example, the fastest growing benefit design, the point-of-service plan. This benefit design permits the enrollee to decide at each clinical encounter whether to comply with the more restrictive HMO-like rules in exchange for an enhanced financial benefit or to avoid these restrictions by accepting a lower coverage level. Even if I were to accept Professor Hall's view that insurance selection is more than a present-day consumption decision, I would view selection of a benefit design in which a consumer retains the right to trade-off levels of coverage for self-directed care at each clinical encounter as an affirmative declaration that that consumer does not waive the right to decide about individual items of treatment. Selection of a point-of-service plan may therefore be viewed as a rejection of the "bundled consent to a diminished standard of care" (p. 212) on which Hall's theory of economic informed consent is based. In addition to these concerns, for reasons discussed below I have significant doubts that a physician can properly interpret a patient's selection of an HMO as a proxy for the patient's consent to the physician's withholding of marginally beneficial care.

Professor Hall offers informed choice of an insurance plan as a means to reach "an attractive solution to virtually any question of medical ethics" that involves "the delivery or refusal of services potentially paid for by insurance" (p. 248). In the final chapter of this book, he considers a variety of moral and political perspectives, from classic individual liberalism through communitarianism, to determine whether the shortcomings in the marketplace for insurance undermine the use of insurance selection to resolve medical ethical issues. His cogent analysis throughout this work has caused me to take his suggestions about insurance selection more seriously than I would have thought possible. In the end, however, we have a philosophical disagreement about the conclusions that can be reached based on source of payment. I also have pragmatic concerns about a suggestion that physicians do not have an obligation to provide information to HMO patients about cost-conscious decisions. I am

vider shall not differentiate or discriminate in the treatment, or in the access to treatment, of Members on the basis of . . . source of payment for services, . . . status as Members, . . ."); Medical Service Agreement with a Primary Care Group (Blue Cross Network - Southeast Michigan 1996) (on file with the author) ("Physician agrees . . . [t]o provide Covered Services to Members in the same manner and equal in quality and promptness as services are provided to the Physicians' [sic] other patients.").

simply unpersuaded that one can, or should, reason from source of payment to a whole schema of preferences.

B. *The Market for Health Insurance*

Professor Hall and I agree that the market for health insurance is imperfect, although we might differ on the weight and impact of those market failings on placing broad reliance on purchasing decisions. The theory of economic informed consent requires more disclosures at the time of enrollment than presently occur and, therefore, depends upon a correction of some of the market failures I discuss. My first, but not only, objection to relying on insurance selection as a proxy for specific information and consent arises from these imperfections in choice and information.

In choosing an HMO, does a consumer signal a choice for less than optimal medical benefit, thereby authorizing her physician to engage in bedside rationing? As an initial matter, even classifying the selection of a health benefit design as a choice be may misleading. Many working Americans do not have a selection of employer-provided health benefit plan designs from which to choose.⁷¹ Professor Hall acknowledges this lack of choice (p. 252). “[A]cknowledging that any restriction in choice entails a moral compromise of the ethical ideal,” Hall asks, “is there a point at which choice is so constrained that liberalism attaches absolutely *no* moral force to a subscriber’s enrollment decision?” (p. 250).

My question is somewhat different. It is not whether a patient can be held to the consequences of a choice without options, but rather what does insurance selection tell us about the consumer’s choices. Under Professor Hall’s theory, insurance selection is the means by which a patient moderates a physician’s duty of beneficence and authorizes and consents to the effects of physician rationing. I ask, therefore, whether a physician, acting under the twin burdens of physician beneficence and respect for patient autonomy, can reach a conclusion about patient values and preferences based on the source of payment for the patient’s care. My answer is that insurance selection is scant evidence from which to reach any conclusions.

Consider an example. Assume that the only benefit design available to a forty-five-year-old woman through her employer does not cover annual mammograms for women between the ages of

71. See Karen Davis & Cathy Schoen, *Managed Care, Choice, and Patient Satisfaction*, THE COMMONWEALTH FUND (Aug. 1997) <http://www.cmf.org/health_care/satis.html> (showing percentages of Americans with choice of health plans).

forty and fifty.⁷² Assume that this woman's physician regularly discusses the benefits and detriments of annual mammograms with her and that he regularly prescribes annual mammograms for his forty-something year-old patients. Following Professor Hall's proposal and viewing this example from the physician's point of view, when the patient is an HMO enrollee, the physician must first determine whether a mammogram for patients in this age group is "marginally beneficial care."⁷³ If the physician concludes that such care would be marginally beneficial, under Professor Hall's theory he is authorized to withhold this diagnostic test on the basis of its cost without engaging in his customary discussion with his patient.⁷⁴

Consider now the HMO enrollee's point of view. A mammogram is a diagnostic test that many women can afford for a disease that many women greatly fear. The HMO enrollee is bound by the terms of her coverage. She has — and should have — no legal or moral claim to payment from the HMO regardless whether she had a choice of plans. She might, however, reasonably elect to pay out-of-pocket for a mammogram. She cannot make this decision, however, if she is not informed of the cost basis for the physician's clinical decision. An educated woman might ask. A less sophisticated, or more trusting, woman might simply conclude that the doctor knows best. All my hypothetical HMO enrollee has done is make a rational decision to accept the health care coverage that is available from her employer, with its limitations, rather than to decline employer-sponsored coverage altogether. This decision might not involve any legally or morally cognizable coercion or duress.⁷⁵ But it is a weak basis on which to conclude that she has made an autonomous decision to forego both medical care that her physician unilaterally concludes is marginally beneficial and the opportunity to receive information about or have input into that decision.

The benefit design as proxy for patient participation in decision-making can be problematic, however, even when an employee has a

72. The woman might not be aware of this coverage limitation, as it is likely to fall into the amorphous category of "not medically necessary" based on the conflicting medical data, rather than to be listed in the policy as a specific exclusion from coverage.

73. A mammogram arguably falls within the broad parameters defining marginally beneficial care. It is an "extra diagnostic test" intended to supplement a physician's confidence based on a manual breast examination. In addition, medical data are inconclusive on the number of lives saved as a result of mammograms for women under fifty years of age.

74. Professor Hall's proposal presumes that marginally beneficial care will be withheld only in circumstances when the withholding of that care would not constitute medical negligence. P. 118. For purposes of this discussion, therefore, I do not reach the question whether a physician would be shielded from malpractice liability for withholding care by disclosing that he was making a cost-based decision to deny care. For a discussion of the effect of resource limits on medical negligence standards, see E. Haavi Morreim, *Medicine Meets Resource Limits: Restructuring the Legal Standard of Care*, 59 U. PITT. L. REV. 1 (1997).

75. Cf. pp. 250-51.

choice of benefit designs. An employee obtaining health coverage through an employer health benefit plan makes the choice for herself and for all her covered dependents. The unemployed spouse or the college-student child has no choice and may have little or no information about the employee's choice.⁷⁶ The employee's choice, therefore, directly and tangibly affects the rights of each dependent under a theory of economic informed consent.⁷⁷ Since a physician rarely knows whether a patient herself selected the insurance vehicle or whether the selection was made without her express input, the physician should be reluctant to assume that he has patient authorization for bedside rationing based solely on the source of payment for a patient's care.⁷⁸

Lack of choice is not the only imperfection in the market for health insurance. The information that is available to consumers about their choices is also relevant to drawing conclusions about their intent when they select an HMO. In the current market for health insurance, consumers are frequently uninformed about or misunderstand the nature of their options.⁷⁹ If selection of a health maintenance organization is intended to express a preference for "less than optimal" medical benefit, consumers also may be affirmatively misinformed about the nature of their purchase.⁸⁰ A brief examination of the materials that are prepared by HMOs both to promote and to describe their plans and that are provided to potential HMO enrollees by their corporate employers proves this point.⁸¹

76. For example, the managed care industry rarely discloses that employees' dependents are not even given an opportunity to consent to the release of their own medical information. A consent to release medical information is usually signed by the employee as part of the enrollment process. The consent is treated as effective for all those covered through the employee.

77. Cf. p. 249 ("On the surface, this liberal solution to virtually any question of medical ethics [by reference to the type of insurance individuals choose] fails only in specialized areas such as pregnancy, pediatrics, and contagious disease where one's enrollment and spending decisions directly and tangibly affect the rights and interests of others.").

78. While an argument can be made that the dependent has appointed the employee to act as her agent, a not unreasonable appointment given the nature of the relationship, I find reliance on agency in this circumstance unnecessary. The dependent will be bound to the terms of the insurance coverage selected by the employee. Here, I am suggesting only that a physician need not rely on the double fiction that the patient selected the insurance vehicle and that the insurance vehicle indicates ipso facto that the patient consents to the physician's rationing decisions, when he can simply ask the patient about her preferences.

79. I agree with Professor Hall that subjective understanding cannot be the standard due to individual limitations on ability to comprehend. Pp. 218-21. I would find that a managed care organization fulfilled its obligation, if judged on an objective standard, it conveyed information reasonably calculated to inform enrollees and potential enrollees about the nature of their purchase.

80. Professor Hall also acknowledges this problem. Pp. 196-97.

81. I received these materials from the University of North Carolina at Chapel Hill when I was selecting my own health coverage.

"At [HMO], our top priority is your health [HMO] also offers health and wellness programs that focus on *your* health."⁸²

"We are committed to offering members top-quality medical care and services [Y]ou and *your* doctor — not an insurance company — decide[] what medical care is best for you."⁸³

HMO promises enrollees "[a]n ongoing relationship with a personal physician who coordinates your care and knows your medical history, current medication, and personal preferences. . . . If you need to see a specialist, your personal physician will give you a referral."⁸⁴

Even the names under which health maintenance organizations conduct business undercut an assertion that less than optimal medical benefits are offered.⁸⁵

A knowledgeable consumer of health care services searches in vain in the promotional materials for any statements conveying to the unsuspecting that the coverage or the medical care will be less than optimal. Asking consumers to indicate this choice by selecting an HMO asks them to purchase a product that HMOs are not, or have not admitted to, selling.

I would have difficulty accepting an economic theory of informed consent even if the market imperfections that I have discussed so far were corrected. In my view, the selection of insurance coverage is simply that: a choice of those risks that the insured wishes to transfer to the insurer through the payment of a premium. The role of an insurance market is not to resolve physicians' ethical dilemmas, but to enable risk-averse people to eliminate the financial effects of risks that they have to face.⁸⁶

An individual who elects not to insure against a risk should not be able to look to the insurer for indemnification when the risk presents itself.⁸⁷ Although the economic decision whether to

82. Prudential Health Care materials given to potential enrollees (Sept. 1996) (on file with author) (emphasis in original).

83. Kaiser Health Plan marketing materials given to potential enrollees (1996) (on file with the author) (emphasis in original).

84. Blue Cross/Blue Shield of North Carolina marketing materials given to potential enrollees (undated) (on file with the author) (emphasis omitted).

85. See, e.g., "Optimum Choice of the Carolinas, Inc."

86. See MICHAEL L. KATZ & HARVEY S. ROSEN, *MICROECONOMICS* 190 (2d ed. 1994).

87. Professor Hall relies on this *ex ante* versus *ex post* perspective to point out the shortcomings of the judicial system in resolving coverage disputes. P. 70. A review of the case law involving disputes about scope of health care coverage leaves the reader wondering what more an insurer could do to make clear its intention to exclude coverage for a medical procedure. See, e.g., *Bailey v. Blue Cross & Blue Shield of Virginia*, 67 F.3d 53, 55 (4th Cir. 1995) (contract disclaiming coverage of "[a]utologous bone marrow transplants or other forms of stem cell rescue (with high dose chemotherapy and/or radiation) . . . [as] determined by the Company in its sole discretion" ambiguous with respect to coverage for high dose chemotherapy for stage IV breast cancer). Such disputes, however, will generally be unaffected by this proposal, since the disputed medical treatment is invariably a "high-stakes, high-drama" treatment of last resort. See *supra* text accompanying notes 38-47. Even when this proposal

purchase insurance, therefore, is of critical financial significance in the event a risk materializes or a loss occurs, it is not a reliable indicator of a consumer's response when confronting the eventuality. A car owner might elect not to insure an automobile against theft and still elect to buy a new car if the uninsured car is stolen.⁸⁸ Similarly, a health care consumer might decide not to insure against a perceived remote risk of organ failure, but when faced with that eventuality, the consumer-cum-patient might elect to finance (or attempt to finance) an organ transplant through means other than her insurance carrier.

In the less dramatic realm, a consumer might enroll in an HMO that has adopted clinical protocols that require a patient to undergo a barium enema before, or in lieu of, a colonoscopy.⁸⁹ When such diagnostic testing is actually required, that same consumer might prefer to pay out-of-pocket for the more comprehensive and less uncomfortable colonoscopy, valuing a better diagnostic tool against a potentially fatal disease more than other potential uses for the patient's discretionary funds.⁹⁰ But she cannot make this autonomous election, even from her own funds, if her physician relies on her source of payment to justify failing to inform her that, but for her enrollment in an HMO, he would have recommended the more costly, but more accurate, diagnostic tool. Even assuming that a consumer is informed of and consents generally to an HMO's overall philosophy of cost-conscious clinical decisionmaking, a consumer should not be expected to agree with each specific coverage decision.

Professor Hall maintains that "the precommitment [to physician rationing] entailed in HMO enrollment is properly viewed as protection against an anticipated period of irrational influence caused by the distorting incentives of insurance" (p. 153). In my view, the

would apply, however, and the medical spending dilemma results from an insured's demand exceeding insurer coverage, I would prefer a solution that looks to the insurance industry and the relationship between insurer and insured to one that resolves the dilemma by keeping patients uninformed about their medical options.

88. For reasons I cannot explain, my anecdotal experience suggests that health law teachers and health law students are inordinately fond of automobile analogies. See, e.g., HAVIGHURST, *supra* note 23, at 104 (health care coverage and Cadillac); Susan D. Goold, *Allocating Health Care: Cost-Utility Analysis, Informed Democratic Decision Making, or the Veil of Ignorance?*, 21 J. HEALTH POL. POLY. & L. 69, 72 (contrasting health care services and Mercedes-Benz automobiles); David Orentlicher, *Destructuring Disability: Rationing of Health Care and Unfair Discrimination Against the Sick*, 31 HARV. C.R.-C.L. L. REV. 49, 49 n.7 (1996) (rationing health care contrasted with unaffordability of cars).

89. A colonoscopy detects a higher percentage of masses than does a barium enema. A barium enema is cheaper. See Michael J. Malinowski, *Capitation, Advances in Medical Technology, and the Advent of a New Era in Medical Ethics*, 22 AM. J.L. & MED. 331, 346, n.108 (1996). That the consumer made such an election knowingly is unlikely. Guidelines used to make medical necessity determinations are generally considered proprietary information and are not widely revealed.

90. This example is not hypothetical.

"distorting incentives of insurance" can be minimized by enforcing the terms of limited insurance: an HMO need not pay for all the care that might be demanded. Having to bear the cost of a decision to purchase more care than is covered by the HMO will protect against "irrational influence[s]." Restricting treatment choices through silent physician rationing is too drastic a remedy.

I am not proposing that a physician may never consider cost in making clinical decisions at the bedside. I agree with Professor Hall that the absolute quality ethic is not sustainable and that physicians cannot and should not ignore the cost of their clinical decisions. Because I do not believe that a patient's economic decision about insurance does or should dictate a physician's ethical obligations to a patient, I would extend the theory to suggest that if the absolute quality ethic is abandoned, the ethic that replaces it should apply to all patients, not merely HMO enrollees. I am also not suggesting that the law impose on a physician an obligation to disclose to a patient the physician's unconscious or automatic cost-benefit analysis in making clinical decisions. My proposal is a more modest one. If a physician makes a clinical decision that is significantly influenced by the source of payment or by the physician's own financial interest, she should discuss the basis of that clinical decision with the patient. To return to my examples, if a physician regularly orders annual mammograms for women in their forties, she should disclose to HMO enrollees that if their insurance were more extensive, she would be inclined to order a mammography. If a physician would order a colonoscopy except for an HMO's payment policies, she should disclose that choice to her patient. Nothing prevents the payer from making the medical spending decision about the treatment for which it will remit payment. But the patient should have some input into the treatment decision even if that requires that she pay for the care out-of-pocket. That individuals with fewer financial resources will not always have the option to pay and, therefore, will receive less treatment than more affluent patients is regrettable but inevitable in a market-based system.

C. *A Return to a Professional Dominance Model?*

Coupling bedside rationing with the theory of economic informed consent foretells a return to a physician dominance model of medical decisionmaking, a model that has been rejected by scholars, policymakers, and physicians for nearly thirty years.⁹¹ This modern version of the physician dominance model is more objec-

91. See THOMAS A. MAPPEL & JANE S. ZEMBATY, *BIOMEDICAL ETHICS* 44-45 (1981) (discussing the criticism of medical paternalism that arose as the lay attitudes toward healthcare professionals shifted to a greater emphasis on the right of patients to act as "autonomous decision makers").

tionable than its historical counterpart, due to the elimination of the traditional formulation of physician beneficence.

Under a paternalistic model of medical care delivery, the physician acted as the patient's guardian, exercising medical judgment to determine and implement what was in the physician's view best for the patient.⁹² Since medical well-being was the physician's goal, he was content to ignore the patient's autonomy, when, in the physician's view, the two came into conflict. A physician imparted to the patient only such information that he deemed necessary to persuade the patient to comply with the physician's determinations. The patient's autonomy, such as it was, was limited to patient assent to the physician's decisions, expressed generally through simple, and silent, acquiescence. The physician-dominance model assumed that the physician could determine the patient's interests without patient input, and that the patient impliedly consented to the physician's decisions by seeking the physician's assistance.

In ensuing decades, bioethicists rejected this view and came to focus on the centrality of patient autonomy as a counterbalance to physician dominance in the patient-physician relationship.⁹³ The pretense that a patient agreed to every decision made by the physician she freely selected was abandoned. In my view, Professor Hall's argument that a patient consents to each of her physician's cost conscious decisions merely by enrolling in a health maintenance organization is a thinly disguised, slightly updated version of the long-rejected premise that a patient impliedly consents to a physician's subsequent clinical decisions merely by seeking the physician's assistance.

The consent that can be implied through an informed enrollment process then is not consent to later clinical decisions, but rather, consent to confront a physician's potential conflict of interest in a managed care setting.⁹⁴ Global disclosures by an HMO to potential enrollees provide information, or a warning, that HMO physicians have obligations in addition to those to their patients and that incentives have been provided to those physicians to fulfill the other obligations. The enrollee's consent, expressed through an informed enrollment process, therefore, is an expression of a willingness to proceed with the relationship in the face of the conflict. But consenting to the existence of a conflict of interest is not the legal,

92. See Ezekiel J. Emanuel & Linda J. Emanuel, *Four Models of the Physician-Patient Relationship*, 267 JAMA 2221 (1992).

93. The cornerstone of patient autonomy is the right to control bodily integrity through the informed consent process. See *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972).

94. See Martin Gunderson, *Eliminating Conflicts of Interest in Managed Care Organizations Through Disclosure and Consent*, 25 J.L. MED. & ETHICS 192 (1997).

moral, or ethical equivalent to acceptance of all effects of that conflict.

Conflicts between patients and physicians existed long before managed care.⁹⁵ And I agree with Professor Hall that elimination of all conflicts between physician and patient is neither practical nor legally required (pp. 174-75). But knowledge that a conflict exists is not the same as consent to the results of that conflict.⁹⁶ Patients have never been deemed to consent, or to waive the right to consent, to overutilization of medical services merely because they were aware of the financial incentives to overtreat that exist in fee-for-service medicine. Simple disclosure that an ophthalmologist owns an interest in an ambulatory care center where radial keratotomy is performed is not enough to excuse a physician's discussion of a patient's treatment options when the physician recommends keratotomy at that facility. Whether under fee-for-service medicine, where a physician may benefit financially by having a patient elect radial keratotomy, or under managed care, where an physician may benefit financially from withholding that treatment option, a patient whose vision is failing has a reasonable expectation that her physician will discuss all options with her. A simple disclosure of the financial conflict of interest is not enough to inform the patient about those options.

D. *Disclosures as a Means of Oversight*

A proposal that is likely to result in the withholding of available relevant information from health care consumers is inconsistent with recent legislative and regulatory trends and could have unintended, and untoward, consequences for the managed care industry.⁹⁷ Managed care is the marketplace response to demand for health care reform. While the health policy debate rages about whether managed care should be subject solely to market forces or also to legislative oversight, state legislatures, the President, and Congress have been busily calling for more disclosure by managed

95. For a discussion of conflicts in fee-for-service medicine, see generally RODWIN, *supra* note 49. See also Susan J. Goldberg, *A Cure for What Ails? Why Medical Advocate Is Not the Answer to Problems in the Doctor-Patient Relationship*, 1 SPG WIDENER L. SYMP. J. 325, 325-28 (1996).

96. See Kate T. Christensen, *Commentary: A Physician's Perspective on Conflicts of Interest*, 25 J.L. MED. & ETHICS 199 (1997).

97. For a sampling of articles addressing issues related to market oversight versus regulation, see Jeffrey Boyd & Lauren Kelley, *Health Law 2000: Regulation, Litigation, or Strangulation*, HEALTH AFF. Fall 1996, at 31; Timothy S. Jost, *Oversight of the Quality of Medical Care: Regulation, Management, or the Market*, 37 ARIZ. L. REV. 825 (1995); Wendy E. Parmet, *Regulation and Federalism: Legal Impediments to State Health Care Reform*, 19 AM. J.L. & MED. 121 (1993); Stanley S. Wallack et al., *Redefining Rate Regulation in a Competitive Environment*, 21 J. HEALTH POL. POLY. & L. 489 (1996).

care organizations to consumers.⁹⁸ Without information, they reason, consumers have no power. Powerless consumers can lead to an overreaching and unresponsive managed care industry.

From the perspective of the managed care industry, if managed care is going to be subject to legislative and regulatory oversight, as seems inevitable in the current climate, mandating disclosures offers two significant benefits. First, disclosures are inexpensive, at least when compared with other legislative options.⁹⁹ This is particularly true when, as here, the information that is to be disclosed is readily available.¹⁰⁰ Second, mandating disclosures intrudes less into managed care operations than many other regulatory options. For example, at least twenty states and the federal government have enacted maternity lengths-of-stay bills that generally require payers to offer forty-eight hours of coverage for uncomplicated vaginal births and ninety-six hours for cesarean sections.¹⁰¹ At least nineteen states have enacted so-called direct access statutes that enable patients to avoid typical managed care restrictions that require patients to obtain a referral from a primary care physician to access a specialist.¹⁰² We need not decide the wisdom, or lack thereof, of these enactments to conclude that they increase costs to consumers and that they interfere with the operations of managed care organizations.

In contrast, at least seventeen states have enacted laws or promulgated regulations that require disclosure of various types of information to managed care enrollees.¹⁰³ The information ranges from explanations of the procedures used to obtain a referral to a specialist, to drug formularies and policies on covering experimental and investigational procedures. Disclosure enhances consumer choice and supports market-based health care. Disclosures about the role of cost in clinical decisions similarly provide meaningful information about the actual trade-offs between medical care and cost. Assuming consumers have a choice to make, they can then

98. See, e.g., *Consumer Bill of Rights and Responsibilities, Chapter One: Information Disclosure*, <<http://www.hcqualitycommission.gov>>; CAL. HEALTH AND SAFETY CODE §§ 1363(a)(1)-(14), 1363.5(a) (West 1998); FLA. STAT. ANN. § 641.31(4)-(5) (West 1996); GA. CODE ANN. § 32-20A-5(1)(A)(i)-(iii) & (B) (1998); IDAHO CODE § 41-3914 (1991); MASS. GEN. LAWS ANN. ch. 176G, § 7 (West 1998); MO. REV. STAT. § 354.442 (West 1997).

99. See Walter A. Zelman, *Consumer Protection in Managed Care: Finding the Balance*, HEALTH AFF. Jan.-Feb. 1997, at 158.

100. Since I propose only that physicians disclose the actual role of cost in their clinical decisions, neither a managed care organization nor a physician will be required to obtain, create, or compile information that is not readily available.

101. See, e.g., statutes cited *supra* note 28.

102. See, e.g., COLO. REV. STAT. ANN. § 10-16-107(5)(a) (West 1998); GA. CODE ANN. § 33-24-56 & 33-24-59 (West 1998); 215 ILL. COMP. STAT. 5/356r(b) (West 1998); LA. REV. STAT. ANN. § 215.17 (West 1998); N.Y. PUB. HEALTH LAW § 4406-b (McKinney 1997); N.C. GEN. STAT. § 58-51-38 (1997); TEX. INS. CODE ANN. art. 21.53D (West 1997).

103. See, e.g., statutes cited *supra* note 97.

decide whether they want to pay for a richer benefit package or whether they would prefer to accept the limitations inherent in less costly coverage.

Managed care organizations have already suffered a popular backlash from an allegation that they were interfering with physician communications with patients. Managed care contracts with physicians were said to include gag clauses that restricted the physician's ability to disclose treatment options to patients. A General Accounting Office (GAO) report revealed that there were no gag clauses that prohibited physicians from discussing medical options with their patients in any of the HMO contracts it examined.¹⁰⁴ The report did find the standard commercial terms prohibiting disclosures of proprietary information and imposing antidisparagement and nonsolicitation obligations, none of which are aimed at discussions of medical treatment options. Despite the lack of evidence that gag clauses existed, the controversy resulted in a public outcry and a wave of state and federal legislation.¹⁰⁵ Although Professor Hall takes great pains to state in this book that he is not advocating, and does not support, gag clauses in physician contracts, a proposal that could restrict, or could be read as a justification for restricting, disclosures of medical information to managed care patients is almost certain to result in more, and more intrusive, regulation.

Disclosure of rationing decisions at the bedside will serve both to avoid intrusive regulation and to moderate patients' expectations and demands. Physician rationing that is invisible to the patient will not accomplish patient or societal acceptance of a role for physicians that no longer includes an absolute quality ethic. Hidden cost-consciousness at the bedside continues the myth that patients, their physicians, and society need not make hard choices. Neither enrollees in managed care organizations nor those organizations are well served by the failure of physicians to discuss the effect of cost on their clinical decisions.

III. CONCLUSION

I agree with Professor Hall that the absolute quality ethic is not the right prescription for American medicine. Having disagreed with his theory of economic informed consent, I offer the following. First, patients must know in advance that their physicians have the

104. See General Accounting Office, *Managed Care: Explicit Gag Clauses Not Found in HMO Contracts, But Physician Concerns Remain*, GAO/HEHS-97-175 (Aug. 29, 1997).

105. For a comprehensive discussion of gag clause legislation, see *The Text of State HMO Consumer Protection Provision* (visited April 14, 1998) <<http://www.familiesusa.org/hmostat2.html#protections>>. See also David A. Hyman, *Consumer Protection and Managed Care: With Friends Like These . . .*, 43 VILL. L. REV. 409 (1998).

discretion to withhold care for economic reasons. This conclusion is consistent with and flows from Professor Hall's analysis and can be satisfied by properly formulated global disclosures at the time of enrollment as he suggests (p. 143). Second, patient and physician at the initiation of their relationship should engage in a substantive discussion about a physician's values concerning the proper balance between a patient's medical needs and the larger societal goals to contain health care costs and ensure affordable health insurance. This discussion is relevant to inform a patient's selection of a caregiver and to enable a patient to find a physician whose values most closely approximate her own. Here, too, Professor Hall and I concur. Third, when a physician is making a decision to withhold care that, but for the patient's enrollment in a health maintenance organization she would recommend, the patient should be informed. In my view, global disclosures are necessary, but they are not sufficient. Disclosing to patients sufficient information to permit them to participate meaningfully in the immediate treatment decision fulfills the physician's fiduciary duty, respects patient autonomy, and maintains physician trustworthiness.

Although I was not fully convinced by Professor Hall's analysis, and I was left with some significant questions at the book's end, this is a compelling work. Professor Hall has opened the way for a meaningful dialogue on the uses and limitations of physician bedside rationing, ably laying the groundwork for further thought. This book will surely spawn many "creative ideas" (p. 262). I commend it to you.