

SHOULD PATIENT RESPONSIBILITY FOR COSTS CHANGE THE DOCTOR-PATIENT RELATIONSHIP?

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INTRODUCTION

Co-pays, deductibles, coinsurance, and reference prices all now expose patients to increasingly larger shares of the costs of health care.¹ In 2015, employees will pay fifty-five percent more for employer-sponsored health insurance premiums and out-of-pocket medical expenses than they did in 2010.² Federal policies are pushing employers and individuals toward plans with even greater cost sharing.³ How might such patient exposure to costs change the doctor-patient relationship?

Extant research on cost sharing has primarily focused on its impact on patients, their health care spending, and their health outcomes. A very brief review helps to situate the distinct question explored here.

Cost sharing gives patients an incentive to weigh the benefits of potential health care against the portion of the costs to which they

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1. See, e.g., GARY CLAXTON ET AL., KAISER FAMILY FOUND., EMPLOYER HEALTH BENEFITS: 2012 ANNUAL SURVEY 148–55 (2012) <http://kaiserfamilyfoundation.files.wordpress.com/2013/03/8345-employer-health-benefits-annual-survey-full-report-0912.pdf> (showing the prevalence of cost sharing).

2. *Aon Hewitt Analysis Shows Upward Trend in U.S. Health Care Cost Increases*, PR NEWSWIRE (Nov. 13, 2014), <http://www.prnewswire.com/news-releases/aon-hewitt-analysis-shows-upward-trend-in-us-health-care-cost-increases-282548451.html> (“[High deductible health plans] are the second most popular plan choice offered by companies, surpassing [health maintenance organizations]. Fifteen percent of companies offer a [high deductible health plan] as the only health plan option today, and another forty-two percent are considering doing so in the next three-to-five years.”).

3. See Julie Appleby, *Expect to Pay More for Your Employer-Sponsored Health Care Next Year*, KAISER HEALTH NEWS (Dec. 20, 2013), <http://www.kaiserhealthnews.org/stories/2013/december/20/expect-to-pay-more-for-employer-health-care.aspx> (finding that 2014 will likely bring higher deductibles and co-payments).

are exposed.⁴ As a mechanism for allocating scarce health care resources, in the ideal conception, cost sharing promotes patient autonomy and personalization of medicine to individual needs and preferences as it empowers patients to make cost-benefit trade-offs themselves.⁵

The empirical literature shows that cost sharing can be effective in reducing health care prices and consumption, and it can sometimes do so without harming health.⁶ Cost sharing may make our health spending more rational, as a proportion of our total spending, toward overall welfare. These features explain the popularity of cost sharing in health insurance designs.

There is a range of well-known problems, however. First, because cost sharing is simply the absence of insurance for the out-of-pocket costs, for some patients it creates a well-documented problem of “underinsurance,” where their coverage is too thin to protect the patients from risk and guarantee their access to care.⁷ Today, many Americans contribute ten percent, twenty percent, or even more of their entire income toward their health care.⁸ When cost-sharing mechanisms are poorly tailored, they can actually limit access to health care, worsen disparities, undermine health, and

4. Christopher T. Robertson, *Scaling Cost-Sharing to Wages: How Employers Can Reduce Health Spending and Provide Greater Economic Security*, 14 YALE J. HEALTH POL'Y L. & ETHICS 239, 239 (2014).

5. See Christopher Robertson, *The Split Benefit: The Painless Way to Put Skin Back in the Health Care Game*, 98 CORNELL L. REV. 921, 946 (2013) (discussing how cost-sharing mechanisms allow for increased personal choice in health care decisions); James C. Robinson & Kimberly MacPherson, *Payers Test Reference Pricing and Centers of Excellence to Steer Patients to Low-Price and High-Quality Providers*, 31 HEALTH AFF. 2028, 2028 (2012) (discussing reference pricing and centers-of-excellence contracting).

6. See JOSEPH P. NEWHOUSE, FREE FOR ALL? LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT 338 (1993) (observing that the RAND Health Insurance Experiment found that cost sharing reduced appropriate and inappropriate services, the use of antibiotics, hospitalizations, and preventive services); Alexander J. Ryu et al., *The Slowdown in Health Care Spending in 2009–11 Reflected Factors Other than the Weak Economy and Thus May Persist*, 32 HEALTH AFF. 835, 837–38 (2013) (“[A] change in benefit design that resulted in higher out-of-pocket expenses for enrollees partially accounted for slower [health care] spending growth.”).

7. Rashid Bashshur et al., *Defining Underinsurance: A Conceptual Framework for Policy and Empirical Analysis*, 50 MED. CARE REV. 199, 202 (1993) (“Underinsurance refers to one or more conditions: where (a) too few services are covered or the coverage is inadequate; (b) amounts of out-of-pocket expenditures, with or without regard to family income, are excessive; (c) insurance is perceived to be inadequate; or (d) some combination is present. Hence, underinsurance reflects a situation in which the consequences of having less than full coverage are so burdensome to the insured that they offset the desired benefits of limiting the scope of insurance.”).

8. See Robertson, *supra* note 4, at 249 fig.1.

cause financial instability.⁹ Cost-sharing obligations have been found to impose significant financial distress on individuals and families and are cited as a reason why some patients skip necessary medical care.¹⁰ The problem is likely to worsen, replacing the problem of “uninsurance” in America, as more people obtain coverage under the Affordable Care Act, but nonetheless remain exposed to thousands of dollars of health expenses in a given year.¹¹

Scholars have also asked whether it is fair that those who are unlucky to be the sickest among us should bear the largest costs.¹² Of course, outside the health context, individuals are exposed to bad luck and good luck ubiquitously. And it is an infamously difficult problem to untangle misfortune from responsibility in a complex, interdependent world. Thus, I suggest elsewhere that cost sharing may not be unjust if it is tailored in a way that the cost-sharing burdens are bearable to the individuals so exposed.¹³ But this is a thorny question.

In another vein, the behavioral sciences show how cost sharing forces patients to weigh incommensurable factors in a domain where they may have little capacity, potentially worsening their difficult

9. See, e.g., David U. Himmelstein et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. MED. 741, 741 (2009) (finding that 62.1% of all bankruptcies in 2007 were medically related); Melissa B. Jacoby et al., *Rethinking the Debates over Health Care Financing: Evidence from the Bankruptcy Courts*, 76 N.Y.U. L. REV. 375, 408–09 (2001) (indicating increased correlation between medical and financial distress); Christopher Tarver Robertson et al., *Get Sick, Get Out: The Medical Causes of Home Mortgage Foreclosures*, 18 HEALTH MATRIX 65, 66 (2008) (finding that half of all home foreclosures in four states had medical causes); Robertson, *supra* note 4, at 250 (discussing the expansive literature on the relationship between medical problems and financial distress).

10. See ROBIN A. COHEN ET AL., FINANCIAL BURDEN OF MEDICAL CARE: EARLY RELEASE OF ESTIMATES FROM THE NATIONAL HEALTH INTERVIEW SURVEY, JANUARY–JUNE 2011 (2012), available at http://www.cdc.gov/nchs/data/nhis/health_insurance/financial_burden_of_medical_care_032012.pdf (noting that a 2011 study by the U.S. Centers for Disease Control found that nearly one-third of U.S. citizens lived in families who were experiencing financial burdens due to health care, in part due to cost-sharing obligations); John D. Piette et al., *Cost-Related Medication Underuse Among Chronically Ill Adults: The Treatments People Forgo, How Often, and Who Is at Risk*, 94 AM. J. PUB. HEALTH 1782, 1782–86 (2004) (“Many chronically ill patients take less of their medication than has been prescribed, owing to cost concerns . . .”).

11. Robertson, *supra* note 4, at 242–43; Cathy Schoen et al., *How Many are Underinsured? Trends Among Adults, 2003 and 2007*, 27 HEALTH AFF. w298, w300 (2008) (finding that in 2007 forty-two percent of U.S. adults were underinsured or uninsured).

12. Robertson, *supra* note 4, at 262 (discussing the theory of “luck egalitarianism”); see also Mary Crossley, *Discrimination Against the Unhealthy in Health Insurance*, 54 KAN. L. REV. 73, 73 (2005).

13. Robertson, *supra* note 4, at 263.

decisions and sowing regret.¹⁴ Still, it is an open normative question whether this disadvantage makes cost sharing worse than alternative forms of rationing.

The foregoing problems have been well studied. Scholars have paid much less attention to the question of how patient exposure to health care costs may impact physicians and their relationships with their patients.¹⁵ This Essay is given on the occasion of a symposium motivated by two recent books by David Schenck, Larry Churchill, and Joseph Fanning that highlight the relational aspects of health care ethics.¹⁶ Accordingly, this Essay explores the impact of cost sharing on the doctor-patient relationship, specifically whether the patient's exposure to cost should be understood as an essential or tangential part of that relationship. And, if essential, whether that insight should change the ways that doctors establish their relationships with patients, the ways they communicate with patients, and ultimately the substance of their treatment recommendations for patients.

I. FORMATION OF THE RELATIONSHIP

Mark Hall has described a “power of healing” as “the dimension of doctoring that enables physicians to confer relief through spiritual or emotional means akin to those used by parents or priests.”¹⁷ Consistent with this idea, Schenck and Churchill write about the “ritual” of forming a treatment relationship, the “rite of passage” as a patient moves into that relationship, and the relationship itself as an “ancient and archetypal journey” where the physician serves as

14. See, e.g., ELISE GOULD, INCREASED HEALTH CARE COST SHARING WORKS AS INTENDED: IT BURDENS PATIENTS WHO NEED CARE THE MOST (2013), available at <http://s1.epi.org/files/2013/increased-health-care-cost-sharing-works.pdf>; Christopher T. Robertson & David V. Yokum, *The Burden of Deciding for Yourself: The Disutility Caused by Out-of-Pocket Healthcare Spending*, 11 IND. HEALTH L. REV. 609, 609 (2014); Robertson, *supra* note 4, at 251–52 (highlighting how “disparity between costs and ability to pay also distorts healthcare consumption decisions” and noting that too little insurance reduces spending on high-value care and too much insurance can stimulate spending).

15. See David Mechanic, *The Functions and Limitations of Trust in the Provision of Medical Care*, 23 J. HEALTH POL. POL'Y & L. 661, 667–68 (1998) (discussing how the changing organizational arrangements, however, may be eroding patients' trust that doctors are motivated to serve patients' needs rather than economic concerns).

16. LARRY R. CHURCHILL, JOSEPH B. FANNING & DAVID SCHENCK, WHAT PATIENTS TEACH: THE EVERYDAY ETHICS OF HEALTH CARE 1 (2013) (focusing on the healing powers of building relationships and seeking help); DAVID SCHENCK & LARRY CHURCHILL, HEALERS: EXTRAORDINARY CLINICIANS AT WORK 42 (2012) (“The underlying dynamic, which the practitioner is constantly intentional about, is trust-building.”).

17. MARK HALL, MAKING MEDICAL SPENDING DECISIONS (1997), reprinted in MARK HALL ET AL., HEALTH CARE LAW & ETHICS 20, 21 (8th ed. 2013).

the “guide” and “companion.”¹⁸ The authors advise that the treatment relationship can get off to a good start through the physical touching of physician and patient—even if just a handshake.¹⁹

During the managed care wave, many scholars and courts worried, and some evidence suggested, that such financial oversight of physicians could undermine trust and the doctor-patient relationship.²⁰ One concern with managed care, and with more recent initiatives like “accountable care,” is that the physicians have incentives to deliver less care or cheaper care.²¹ Such incentives might be contrary to the interests of individual patients and thus undermine patients’ trust in their physicians. Cost sharing is the opposite model for cost control, one that imposes incentives for thrift *on the patient* rather than the provider.²² Still, cost-sharing burdens may reshape the formation of the relationship in a different way, perhaps changing the meaning of the relationship for the patient and the physician. If so, cost sharing may undermine the physician’s power to heal.

How might such a problematic dynamic arise? Before the ritual of healing can begin, patients must choose their health care providers. We know from the behavioral science literature that human decisions are often driven by the decision maker’s governing conceptual frameworks and initial impressions, which provide a way of making sense of all the subsequent information.²³ Cost sharing is likely to import two relevant frames on the way the patient perceives her physician.

First, if cost sharing succeeds in driving patients toward lower-cost providers or lower-cost treatments, those chosen providers and treatments will be perceived as “lower-cost.” The behavioral literature shows that consumers infer quality from price, such that

18. SCHENCK & CHURCHILL, *supra* note 16, at 26–36.

19. *Id.* at 31.

20. *See, e.g.*, Neade v. Portes, 739 N.E.2d 496, 504 (Ill. 2000) (“Physicians must assure disclosure of any financial inducements that may tend to limit the diagnostic and therapeutic alternatives that are offered to patients or that may tend to limit patients’ overall access to care. Physicians must satisfy this obligation by assuring that the managed care plan makes adequate disclosure to patients enrolled in the plan.” (quoting the Am. Med. Ass’n Council on Ethical and Judicial Affairs, Current Op. 8.132 (1995–2000)); Mechanic, *supra* note 15, at 661.

21. Mechanic, *supra* note 15, at 666–69.

22. John Goodman, *Cost Sharing: The Good, the Bad, and the Ugly*, HEALTH AFF. BLOG (May 25, 2010, 4:11 PM), <http://healthaffairs.org/blog/2010/05/25/cost-sharing-the-good-the-bad-and-the-ugly/> (“All too often, cost-sharing arrangements are a façade—masking an underlying effort to shift costs from the healthy to the sick.”).

23. *See generally* Dan M. Kahan, *Laws of Cognition and the Cognition of Law*, 135 COGNITION 56 (2015) (discussing how prior beliefs and impressions influence decision making).

higher-priced products and services are perceived to be of higher quality.²⁴ Moreover, the biomedical literature shows that healing works, in part, through a mind-body connection, mediated by the patient's own expectations. In blinded, randomized experiments, patients who believe that they have a higher likelihood of receiving the treatment (versus control) show greater efficacy.²⁵ Although this phenomenon has not been studied directly, it is likely that a perception that providers are less expensive may lead to a perception that they are less effective healers and that perception may in fact generate worse treatment outcomes for their patients. Cost sharing may in this way undermine the healing ritual of the doctor-patient relationship in contexts where the price is salient, where patients are exposed to marginal differences in price, and where providers compete along this dimension.

Second, cost sharing may change the patient's perception of his or her own relationship with his or her physician if it frames the relationship as between a consumer and a seller in a market.²⁶ Framing around costs makes the doctor-patient relationship transactional, an explicit quid pro quo exchange.²⁷ Some scholars suggest that this frame creates a profound reorientation.²⁸ Unlike "the client [who] comes to the professional for advice and accepts the professional's opinion[,] the consumer, in contrast, listens to the thoughts of the provider, or of several providers, but ultimately makes his or her own decisions."²⁹ More pointedly, the consumerist relationship can be overtly adversarial, one of rational distrust, as "consumer-oriented patients are motivated to approach any doctor-patient relationship warily."³⁰ In short, this is the model of the used car sale, where "consumers distrust sellers' motives, and they expect

24. Kyle Bagwell & Michael H. Riordan, *High and Declining Prices Signal Product Quality*, 81 AM. ECON. REV. 224, 224 (1991).

25. Anup Malani & Daniel Houser, *Expectations Mediate Objective Physiological Placebo Effects*, in NEUROECONOMICS 311, 315 (Advances in Health Economics and Health Services Research, Vol. 20, 2008); Anup Malani, *Identifying Placebo Effects with Data from Clinical Trials*, 114 J. POL. ECON. 236, 249 (2006).

26. See James F. Childress & Mark Siegler, *Metaphors and Models of Doctor-Patient Relationships: Their Implications for Autonomy*, 5 THEORETICAL MED. 17, 19, 23 (1984) (describing a "rational contractors" model and a "negotiation" model of the doctor-patient relationship).

27. *Id.* at 19.

28. Analee E. Beisecker & Thomas D. Beisecker, *Using Metaphors to Characterize Doctor-Patient Relationships: Paternalism Versus Consumerism*, 5 HEALTH COMM. 41, 50 (1993).

29. *Id.* at 49 (citing Leo G. Reeder, *The Patient-Client as a Consumer: Some Observations on the Changing Professional-Client Relationship*, 13 J. HEALTH & SOC. BEHAV. 406, 407 (1972)).

30. *Id.* at 52 (discussing HAROLD J. CORNACCHIA & STEPHEN BARRETT, CONSUMER HEALTH: A GUIDE TO INTELLIGENT DECISIONS (2d ed. 1980)).

this distrust to be reciprocated.”³¹ This consumerist, caveat emptor frame, which is reinforced by—if not altogether created by—cost sharing, is in stark contrast to some of the themes developed by Churchill, Fanning, and Schenck’s relationship-centered health care. In their conception, physicians are counseled to “invest in trust” as an essential ingredient in the relationship, and patients identify “caring, empathy, and compassion” as the most important clinician traits.³²

Future work should explore whether cost sharing does in fact undermine the healing relationship in a way that may actually worsen health outcomes. But given that cost sharing has advantages as a rationing mechanism and given that it seems well-established in the American health care system, further research should also explore whether there are ways to have our cake and eat it too. Can cost sharing perform its behavioral function of reducing wasteful consumption and driving competition on price but then recede into the background of the treatment relationship so that healing can proceed? These are interesting practical and empirical questions for future study.

II. INFORMED CONSENT

Patient exposure to costs can also impact the validity of informed consent and the process of securing that consent. It is clear that patients have a right to information about how much they will have to pay for their own health care if they ask for it.³³ Some patients will not be aggressive in seeking cost-sharing information or using that information to actively shop around, however. Is there nonetheless a responsibility for a physician to discuss costs prior to commencing treatment?

31. *Id.*

32. CHURCHILL, FANNING & SCHENCK, *supra* note 16, at 33–34 tbl.2.1; SCHENCK & CHURCHILL, *supra* note 16, at 23–24 tbl.1.2.

33. According to the National Health Council, a coalition of patient advocacy organizations:

ALL PATIENTS HAVE THE RIGHT TO COMPLETE AND EASILY UNDERSTOOD INFORMATION ABOUT THE COSTS OF THEIR COVERAGE AND CARE. This information should include the premium costs for their benefits package, the amount of any patient out-of-pocket cost obligations (e.g., deductibles, copayments, and additional premiums), and any catastrophic cost limits. *Upon request*, patients should be informed of the costs of services they’ve been rendered and treatment options proposed.

Principles of Patients Rights’ and Responsibilities, NAT’L HEALTH COUNCIL, <http://www.nationalhealthcouncil.org/resources/nhc-publications/principles-patients-rights-and-responsibilities> (last visited May 2, 2015) (emphasis added); see also G. Caleb Alexander et al., *Barriers to Patient-Physician Communication About Out-of-Pocket Costs*, 19 J. GEN. INTERNAL MED. 856, 859 (2004) (encouraging patients to bring up cost-related conversations rather than having the physician initiate these conversations).

At a polar extreme, there are infamous cases of “drive-by doctoring.”³⁴ In one publicized case, a patient had carefully chosen an in-network hospital and explicitly discussed costs with his surgeon, but then once he was anesthetized a second surgeon appeared to assist in the procedure.³⁵ The patient then received a six-figure bill from this stranger, on top of the negotiated rates charged by the hospital and primary surgeon.³⁶ In this fact-pattern, there are obvious issues of contract law with regard to whether the patient has a duty to pay these rates. These include fundamental questions of formation (whether there is a contract or quasi-contract at all) and, if so, whether the price charged is reasonable, given that the contract or quasi-contract failed to specify a price (making it an “open-price” contract).³⁷

High prices also raise questions about the rules of professionalism for physicians.³⁸ In the regulation of lawyers, similar provisions have teeth; they are routinely used by courts to reduce the amount of fees charged by attorneys and as a basis for attorney discipline.³⁹ For physicians, however, it is not clear that such rules are ever actually applied.⁴⁰

The attorney rule for professional conduct with regard to charges specifically requires disclosure of any fees to be charged.⁴¹ For physicians, the question of disclosure is inexplicably left open.⁴²

34. Elisabeth Rosenthal, *After Surgery, \$117,000 Bill for Doctor He Didn't Know*, N.Y. TIMES, Sept. 21, 2014, at A1; Carrie Feibel, *Surprise Medical Bills: ER Is in Network, but Doctor Isn't*, NPR (Nov. 11, 2014, 4:55 PM), <http://www.npr.org/blogs/health/2014/11/11/363059517/surprise-medical-bills-er-is-in-network-but-doctor-isnt?sc=17&f=1001>.

35. Rosenthal, *supra* note 34.

36. *Id.*

37. See Nicholas Bagley, *Is Drive-By Doctoring Legal?*, INCIDENTAL ECONOMIST (Sept. 23, 2014, 11:58 AM), <http://theincidentaleconomist.com/wordpress/is-drive-by-doctoring-legal/>.

38. AM. MED. ASS'N CODE OF MED. ETHICS, Op. 6.05 (1994), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion605.page?> (“A physician should not charge or collect an illegal or excessive fee. . . . A fee is excessive when after a review of the facts a person knowledgeable as to current charges made by physicians would be left with a definite and firm conviction that the fee is in excess of a reasonable fee.”).

39. MODEL RULES OF PROF'L CONDUCT r. 1.5(a) (1983); see *In re Goldstein*, 430 F.3d 106, 107, 112 (2d Cir. 2005) (reducing an attorney's unreasonable fees); *Kentucky Bar Ass'n v. Fish*, 2 S.W.3d 786, 787 (Ky. 1999) (disciplining an attorney for charging an unreasonable fee by publicly reprimanding the attorney).

40. See Nadia N. Sawicki, *Character, Competence, and the Principles of Medical Discipline*, 13 J. HEALTH CARE L. & POL'Y 285, 286–87 (2010).

41. MODEL RULES OF PROF'L CONDUCT r. 1.5(b).

42. For a history of physician-patient disclosures, see JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 1, 3, 26 (1984), which traces “a history of silence,” i.e., physician unwillingness from the time of Hippocrates to the present, to disclose to patients information about the treatment the physician

Thus, lacking any specific regulation from the professional rules, patients are left to the more general doctrine of informed consent. If costs are not disclosed to patients but are material to the patient's decision, and the physician proceeds to provide health care, he or she may thereby commit malpractice, battery, or even fraud.⁴³

Some scholars have suggested that the historic movement toward a patient-driven model of informed consent was in part driven by national cost concerns.⁴⁴ However, subsequent analyses of informed consent have rarely turned on cost concerns.⁴⁵ The law of informed consent has primarily focused on the risks of treatment, and provides that, in determining whether and how much he should disclose, the physician must consider the probable impact of disclosure on the patient—taking into account the physician's peculiar knowledge of the patient's psychological, emotional, and physical condition—and must evaluate the magnitude of the risk, the frequency of its occurrence, and the viability of alternative therapeutic measures.⁴⁶

Of course, patients can always ask about costs or anything else and decline treatment if they do not get satisfying answers. However, the courts have imposed the informed-consent duty affirmatively, obligating the physician to provide certain information, even if patients do not affirmatively demand it.⁴⁷ The

was about to administer and asserts that physicians “shape the disclosure process so that patients will comply with their recommendations.” *See also* Cathy J. Jones, *Autonomy and Informed Consent in Medical Decisionmaking: Toward a New Self-Fulfilling Prophecy*, 47 WASH. & LEE L. REV. 379, 402–03, 408 (1990) (asserting that information is “slanted” to assure that the patient accepts the alternative favored by the doctor and that patient decisions are “virtually foreordained” by the way doctors phrase information).

43. *See, e.g.,* Mohr v. Williams, 104 N.W. 12, 16 (Minn. 1905) (“[A]ny unlawful or unauthorized touching of the person of another, except it be in the spirit of pleasantry, constitutes an assault and battery.”), *overruled on other grounds by* Genzel v. Halvorson, 80 N.W.2d 854 (Minn. 1957); *see also* Grant H. Morris, *Dissing Disclosure: Just What the Doctor Ordered*, 44 ARIZ. L. REV. 313, 320 (2002) (arguing that failure to obtain informed consent is offensive contact and imposes intentional tort liability for battery, regardless of an absence of hostile intent or motive).

44. Cathy Charles et al., *Decision-Making in the Physician-Patient Encounter: Revisiting the Shared Treatment Decision-Making Model*, 49 SOC. SCI. & MED. 651, 653 (1999) (“The joining together of cost and quality concerns resulted in recommendations to make physicians more explicitly accountable to patients, the public, and in the case of the United States, to third party payers.”).

45. Amir Halevy, *Medical Futility, Patient Autonomy, and Professional Integrity: Finding the Appropriate Balance*, 18 HEALTH MATRIX 261, 265–66 (2008).

46. *See, e.g.,* Patrick v. Sedwick, 391 P.2d 453, 458 (Alaska 1964) (“[D]octors frequently tailor the extent of their preoperative warnings to the particular patient to avoid the unnecessary anxiety and apprehension which such appraisal might arouse in the mind of the patient.”).

47. *Canterbury v. Spence*, 464 F.2d 772, 785 (D.C. Cir. 1972).

burden of securing consent before touching is on the physician, and the doctrine requires *informed* consent.

Some may counter that only “medical” or “health-related” risks and benefits are material to the treatment choice (and thus must be affirmatively disclosed), and some case law supports such a narrow reading.⁴⁸ The American Medical Association (“AMA”) rule is couched in such terms: “Withholding *medical* information from patients without their knowledge or consent is ethically unacceptable.”⁴⁹ Of course, it is fair to ask whether the costs of medicine are, or are not, medical information. Thus, even under a narrow definition, costs may be included.

Some courts are moreover embracing a broader, functional notion of materiality.⁵⁰ In *Canterbury v. Spence*,⁵¹ the court defined “material risks” as those risks a reasonable person in the patient’s position would be likely to consider significant.⁵² Physicians have been required to disclose personal or economic interests that may influence their judgment,⁵³ all diagnostic tests that may rule out a possible condition,⁵⁴ potential risks associated with not seeking

48. See, e.g., *Arato v. Avedon*, 858 P.2d 598, 599–600 (Cal. 1993) (“We hold . . . that the Court of Appeal erred in suggesting, as it appeared to do, that under the doctrine of informed consent, a physician is under a duty to disclose information material to the patient’s *nonmedical* interests.”).

49. AM. MED. ASS’N CODE OF MED. ETHICS, Op. 8.082 (2006), *available at* <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion8082.page> (emphasis added).

50. Even though the court in *Arato* held that the doctrine of informed consent does not include a duty to disclose information related to a patient’s nonmedical interests, *Arato*, 858 P.2d at 599–600, the court later held:

[T]he better rule is to instruct the jury that a physician is under a legal duty to disclose to the patient all material information—that is, “information which the physician knows or should know would be regarded as significant by a reasonable person in the patient’s position when deciding to accept or reject a recommended medical procedure”—needed to make an informed decision regarding a proposed treatment.

Id. at 607 (citing CAL. JURY INSTRUCTIONS: CIVIL (BAJI) No. 6.11 (5th ed. 1969)).

51. 464 F.2d 772 (D.C. Cir. 1972).

52. *Id.* at 781, 787 (identifying key pieces of information that a physician must disclose: (1) the condition being treated; (2) the nature and character of the proposed treatment or surgical procedure; (3) the anticipated results; (4) the recognized possible alternative forms of treatment; and (5) the recognized serious possible risks, complications, and anticipated benefits involved in the treatment or surgical procedure, as well as the recognized possible alternative forms of treatment, including nontreatment); see *Adler ex rel Johnson v. Kokemoor*, 545 N.W.2d 495, 498 (Wis. 1996) (holding that patients may not make informed decisions about their treatment unless the physician discloses viable alternatives to and risks of the treatment proposed).

53. *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479, 483 (Cal. 1990).

54. *Jandre v. Physicians Ins. Co. of Wis.*, 792 N.W.2d 558, 560 (Wis. Ct. App. 2010).

treatment,⁵⁵ and any information that a reasonable person in the patient's position would find important,⁵⁶ including any particular benefits or risks that may be significant to the particular patient.⁵⁷

On this broader notion of "materiality," are costs a material factor in the informed consent process? Based on prior work with coauthors, I argue that a causal notion of materiality is helpful: information is material if it is likely to change the decision of a substantial number of patients.⁵⁸ In an experimental investigation of this question where we manipulated the presence or absence of the information in question, we found that the physician's financial relationships may be material in this sense.⁵⁹ Although the finding that such financial considerations are material is suggestive for present purposes, future research should target the question of costs-of-care in particular.

One might counter this analysis on the basis of custom. Traditionally, courts held that a physician's duty to disclose information to the patient was based on what the majority of physicians in a particular community would customarily disclose to their patients.⁶⁰ Courts have recognized that a community-based standard is problematic because there are perverse incentives for physicians to avoid disclosure, which can systematically depress the community standards.⁶¹ For that reason, a custom-based approach is inappropriate here.

55. *Truman v. Thomas*, 611 P.2d 902, 908 (Cal. 1980).

56. *Nixdorf v. Hicken*, 612 P.2d 348, 354 (Utah 1980).

57. Bryan Murray, *Informed Consent: What Must a Physician Disclose to a Patient?*, 14 AM. MED. ASS'N J. ETHICS 563, 565 (2012), available at <http://journalofethics.ama-assn.org/2012/07/pdf/hlaw1-1207.pdf> ("For example, any risk of injury to a patient's hand is especially important to a concert violinist or professional baseball pitcher. In the briefest terms, a physician is required to provide general information about a proposed diagnosis or treatment and more personalized information about how the treatment might reasonably affect the particular patient.").

58. Roy Spece et al., *An Empirical Method for Materiality: Would Conflict of Interest Disclosures Change Patient Decisions?*, 40 AM. J.L. & MED. 234, 271 (2014) (arguing that material information is that which would change the decisions of a substantial number of patients). Similarly, in the legal context, see *In re Conduct of Bennett*, 14 P.3d 66, 70 (Or. 2000) (quoting *In re Conduct of Gustafson*, 968 P.2d 367, 375 (Or. 1998)), which states that for a lawyer's nondisclosure, "[a] material misrepresentation involves information that, if the decision-maker had known of it, 'would or could have influenced the decision-making process significantly.'"

59. Spece et al., *supra* note 58.

60. See *Di Filippo v. Preston*, 173 A.2d 333, 336 (Del. 1961).

61. See *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479, 485 (Cal. 1990) (holding that a research physician has a duty under the doctrine of informed consent to disclose financial compensation to his patient); *Carr v. Strode*, 904 P.2d 489, 499–500 (Haw. 1995) (adopting a patient-oriented standard of a physician's duty to disclose risk that is based on what a reasonable person

If a physician must affirmatively engage in such cost conversations, this policy will impose on the physician's time, which is a distinct disadvantage of such a policy. Furthermore, there will be instances in which the cost information causes patients to decline care that the physician believes to be in the best interest of the patient.⁶² Other barriers to discussing treatment costs may include patient discomfort in discussing costs and concerns that discussing cost would impact the quality of care.⁶³ Apparently sensing these burdens, some ten percent of patients and twenty percent of physicians in one study reported that they did not bring up costs when they wanted to on at least one occasion.⁶⁴

Nonetheless, informed consent doctrine is motivated, at least in part, by non-consequentialist concerns.⁶⁵ Autonomy may be costly.⁶⁶ Arguably, then, costs are a fact that patients have a right to know, regardless if its consequences for their welfare.

These questions are complicated when the costs are beyond the range that is reasonably expected and when the cost information is unavailable to either or both parties.⁶⁷ Cost information may be unavailable because either it is not yet known what procedures will be utilized or because the procedures are known but the pricing data is unknown.⁶⁸ Several states have passed laws to promote greater price transparency.⁶⁹ But until that transparency is achieved,

needs to hear in order to make an informed decision regarding proposed medical treatment).

62. See Alexander et al., *supra* note 33, at 856.

63. *Id.*

64. *Id.*; see also Alan Meisel & Loren H. Roth, *Toward an Informed Discussion of Informed Consent: A Review and Critique of the Empirical Studies*, 25 ARIZ. L. REV. 265, 334 (1983) (finding that informed consent as envisioned by the courts is a relatively rare phenomenon in the clinical setting).

65. Spece et al., *supra* note 58.

66. PETER A. UBEL, CRITICAL DECISIONS 137, 154, 156 (2012) (arguing that rational decision making in the medical context is difficult to attain, even for those who are well-informed, because of the emotions involved); Alexander et al., *supra* note 33, at 856 (stating that there are barriers to discussing costs for physicians, including "insufficient time . . . and a belief that they [do] not have a solution to offer").

67. See Alexander et al., *supra* note 33, at 858 (discussing the difficulty that physicians have in determining patient costs); see also Peter A. Ubel et al., *Full Disclosure—Out-of-Pocket Costs as Side Effects*, 369 NEW ENG. J. MED. 1484, 1484 (2013) ("The current reality is that it is very difficult, and often impossible, for the clinician to know the actual out-of-pocket costs for each patient, since costs vary by intervention, insurer, location of care, choice of pharmacy or radiology service, and so on . . .").

68. See Alexander et al., *supra* note 33, at 858.

69. See, e.g., An Act to Promote Cost Containment, Transparency and Efficiency in the Delivery of Quality Health Care, ch. 305, 2008 Mass. Acts 1322 (codified as amended in scattered sections of Massachusetts General Laws); Development of a Comprehensive Health Care Information System, N.H. REV. STAT. ANN. § 420-G:11-a (LexisNexis 2011); N.H. COMPREHENSIVE HEALTH CARE INFO. SYS., <https://nhchis.com/NH/> (last visited Apr. 15, 2015); *Transparency*

patients and physicians will have to make do. Compared to the patient, the physician will often be in a better position to secure this information or at least provide reasoned estimates. A failure to do so may be tantamount to willful ignorance.

The foregoing analyses suggest that patient responsibility for health care costs may well change the doctor-patient relationship by creating a duty for the physician to discuss such costs. This conclusion thus underlines the prior section, showing how cost considerations, once made so salient, may change the patient's conception of, and relationship with, her physician.

III. TREATMENT DECISIONS

Patient responsibility for health care costs can, and arguably should, also change the physician's substantive treatment recommendations for her patients. For this discussion, it is important to distinguish the policy question of whether patients should be required to pay costs out-of-pocket from the subsequent ethical and legal questions of whether physicians should allow the given fact of patient cost burdens to impact their treatment decisions once that policy decision has been resolved. We are interested in the latter question.

As a case study, consider that cataracts affect about one in six Americans over the age of forty and cause partial or complete blindness.⁷⁰ The typical treatment, phacoemulsification cataract surgery ("PCS"), costs about \$3500 per eye, and for patients with large cost-sharing exposures, that cost may make PCS unaffordable.⁷¹ Another procedure—manual small incision cataract surgery ("MSICS")—has revolutionized the access to cataract treatment in the developing world.⁷² In India, MSICS is a five-minute inpatient hospital procedure performed for fifteen dollars that offers excellent outcomes comparable to PCS in the United States.⁷³

and Disclosure of Health Costs and Provider Payments: State Actions, NAT'L CONF. OF STATE LEGISLATURES, <http://www.ncsl.org/research/health/transparency-and-disclosure-health-costs.aspx> (last updated Jan. 2015).

70. *Common Eye Disorders*, CENTERS FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/visionhealth/basic_information/eye_disorders.htm (last updated Apr. 23, 2013).

71. *Average Cost of Cataract Surgery & Prices Explained*, STEPHENSON EYE ASSOCS., <https://www.qualsight.com/ataract/average-cost-of-cataract-surgery> (last visited Apr. 15, 2015).

72. Rengaraj Venkatesh et al., *Phacoemulsification Versus Manual Small-Incision Cataract Surgery for White Cataract*, 36 J. CATARACT & REFRACTIVE SURGERY 1849, 1849 (2010).

73. David F. Chang, *A 5-Minute, \$15 Cure for Blindness: Tackling Cataract Blindness in the Developing World*, CATARACT & REFRACTIVE SURGERY TODAY (2006), available at http://crstodayeurope.com/2006/01/0106_10.php.

The safety and efficacy of the MSICS procedure is now well understood.⁷⁴ Those receiving MSICS may have somewhat longer postoperative discomfort and increased likelihood of periorbital ecchymosis (commonly known as “black eye,” which is a harmless and temporary condition).⁷⁵ Compared to PCS, MSICS patients have a larger incision, with greater risk of surgically induced astigmatism,⁷⁶ but that only requires eyeglasses after surgery. Aside from these considerations, the primary risks and benefits of MSICS and PCS are similar, although the latter is dramatically more expensive.

Suppose that MSICS could be introduced into the United States market as a \$500 treatment for cataracts. Should an American physician ever prescribe it? For patients who simply cannot afford the cost-sharing burden associated with PCS, the tangible choice is between MSICS or continuing blindness (partial or complete). The only reason a physician would recommend MSICS is to reduce the cost burden on his or her patients. This case can thus be a test for the ethical and legal analysis of the appropriate role of costs in shaping the physician’s substantive treatment recommendations.

One of the primary teachings of Churchill, Fanning, and Schenck is that an essential function of the doctor-patient relationship is to allow physicians to effectively learn about their patients’ particular needs and values, respecting their particularities, even if those needs do not perfectly align with a physician’s own beliefs.⁷⁷

This analysis can be made just as well by invoking the core ethical principles of beneficence and nonmaleficence.⁷⁸ A physician should select the treatment that delivers the greatest net benefits to her patient in consideration of relevant harms (risks). For a given intervention, the trade-offs on each dimension will be advantageous for some patients but not for others.

Even from a technical point of view (e.g., adjusting the dose of a drug to a particular patient), one of the primary jobs of a physician is to solve a heterogeneity problem. We call upon physicians to exercise their expertise in matching treatments to patients, who vary according to their diagnoses, physiology, prognoses, tolerances, and personal preferences. If not for this heterogeneity—if, instead, one size fit all—there would be little or no need for physicians

74. Venkatesh et al., *supra* note 72, at 1854.

75. Jia-yu Zhang et al., *Phacoemulsification Versus Manual Small-Incision Cataract Surgery for Age-Related Cataract: Meta-Analysis of Randomized Controlled Trials*, 41 CLINICAL & EXPERIMENTAL OPHTHALMOLOGY 383, 385 (2013).

76. Venkatesh et al., *supra* note 72, at 1853.

77. See CHURCHILL, FANNING & SCHENCK, *supra* note 16, at 61–63.

78. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 12 (5th ed. 2001).

(except for those whose skill consists of manipulation, such as surgeons).

I suggest that patient heterogeneity with regard to exposure to costs (i.e., based on the breadth of a patient's particular insurance coverage) and the patient's ability to bear those costs (i.e., based on income and wealth availability) is another important dimension of the physician's role as customizer. An appropriate treatment for a wealthy, well-insured person may be inappropriate for a poor, underinsured person, and vice versa. The physician must exercise particularized judgment, "holding the best interests of the patient as paramount."⁷⁹

Beyond the ethical analysis, there are also legal questions. For the law, a physician is held generally to a "reasonable physician" standard of care.⁸⁰ One can imagine a medical malpractice case alleging that the physician selected a procedure that was inappropriate for the patient due to cost. The case would be exacerbated if there were a failure to discuss costs (as above).

The legal case against a physician who prescribes an expensive treatment that is inappropriate for his patient on that dimension, would be strengthened if it could be shown that the physician may have had ulterior, conflicting interests in the transaction. The treatment relationship has been routinely characterized as "fiduciary" in character.⁸¹ Yet we also have a long tradition of tolerating self-dealing by physicians.⁸² Self-dealing by a fiduciary is intolerable in other settings.⁸³ Patient responsibility for health care costs may begin to resolve this incongruity as it sharpens the analysis. Where the patient's interests are also financial and contrary to the physician's financial interests, it becomes more difficult to ignore the conflicting interests as a matter of law and policy.

Against this argument that physicians should pay attention to cost and the patient's ability to bear it when making substantive

79. AM. MED. ASS'N CODE OF MED. ETHICS, Op. 10.015 (2001), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion10015.page?>.

80. See 1 STEVEN E. PEGALIS, AMERICAN LAW OF MEDICAL MALPRACTICE § 3:3 (3d ed. 2014) (however a "reasonable physician" is often determined on a case by case basis from the expert testimony of a similarly situated physician).

81. See *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479, 483 (Cal. 1990).

82. A.S. Kesselheim et al., *Distributions of Industry Payments to Massachusetts Physicians*, 368 NEW ENG. J. MED. 2049, 2049 (2013); Christopher Robertson et al., *Effect of Financial Relationships on the Behavior of Healthcare Professionals: A Review of the Evidence*, 40 J.L. MED. & ETHICS, 452, 462 (2012).

83. See, e.g., OFFICE OF THE COMPTROLLER OF THE CURRENCY, *Asset Management: Conflicts of Interests*, in COMPTROLLER'S HANDBOOK 5 (2015), available at <http://www.occ.gov/publications/publications-by-type/comptrollers-handbook/conflictinterest.pdf>; John F. Mariani et al., *Understanding Fiduciary Duty*, 84 FLA. BAR J. 20, 20–21 (2010).

treatment recommendations, some have argued that physicians should instead be focused on promoting health alone.⁸⁴ This point is closely related to the health essentialism that has infected some of the informed consent doctrine.⁸⁵ Echoing this argument, some patients, especially poorer ones, have worried that cost concerns may distract clinicians from delivering the best health care.⁸⁶

Yet, even for health essentialists, it must be remembered that cost exposures can hinder health. The evidence is mounting that cost pressures can undermine patients' adherence to medical interventions, can create stress and more severe mental health problems, and can worsen other social determinants of health.⁸⁷ For example, health care costs can worsen housing quality through a medically-caused foreclosure.⁸⁸ In this sense, as some scholars have recently said, costs are a side effect or a risk of treatment.⁸⁹ Physicians must consider how a costly course of treatment may impact their patient's health, especially in situations where the costly treatment is unproven to deliver marginal benefits over the less-expensive standard of care.⁹⁰

The foregoing analysis presumes that physicians should attend only to health, ignoring all the other bona fide interests of their patients. Alternatively, the physician can be conceived as the agent of the patient, a principal who has a broader set of interests (ends),

84. Neel T. Shah, *A Role for Physicians: An Observation on Cost Containment*, 44 AM. J. PREVENTIVE MED. S19, S19 (2013).

85. See, e.g., *Arato v. Avedon*, 858 P.2d 598, 599–600 (Cal. 1993); *supra* text accompanying note 48.

86. See Roseanna Sommers et al., *Focus Groups Highlight That Many Patients Object to Clinicians' Focusing on Costs*, 32 HEALTH AFF. 338, 341 (2012) (reporting that low-income patients are especially worried about the relationship between costs and their level of care).

87. See, e.g., Scott Ramsey et al., *Washington State Cancer Patients Found to Be at a Greater Risk for Bankruptcy than People Without a Cancer Diagnosis*, 32 HEALTH AFF. 1143, 1148 (2013) (finding that people with cancer diagnoses were approximately two and one-half times more likely to file for bankruptcy than their age-matched peers); S. Yousuf Zafar et al., *The Financial Toxicity of Cancer Treatment: A Pilot Study Assessing Out-of-Pocket Expenses and the Insured Cancer Patient's Experience*, 18 ONCOLOGIST 381, 382 (2013) (discussing how cancer treatments can cause even the insured to need nonprofit or government assistance).

88. *Medical Reasons Behind Foreclosure of Houses That Are Homes*, FORECLOSURE REPOS, <http://www.foreclosurerepos.com/blog/foreclosure-house/medical-reasons-behind-foreclosure/> (last visited Apr. 15, 2015).

89. Ubel et al., *supra* note 67 (arguing that physicians should discuss out-of-pocket costs with their patients and contending that “[b]ecause treatments can be ‘financially toxic,’ imposing out-of-pocket costs that may impair patients’ well-being, . . . physicians need to disclose the financial consequences of treatment alternatives just as they inform patients about treatments’ side effects.”).

90. See Robertson, *supra* note 5, at 928–29 (discussing unproven expensive treatments, such as off-label use of Avastin and prophylactic use of heart stents).

for which healthcare is mere means. Holding all else equal, a patient may well have an interest in cost that counsels towards less expensive treatment (or no treatment at all), and it would be inappropriate for physicians to ignore that interest. This principle has been recognized in specific domains. For example, an NIH consensus document has explained that “outcome domains related to end of life include physical or psychological symptoms, social relationships, spiritual or philosophical beliefs, hopes, expectations and meaning, satisfaction, *economic considerations*, and caregiver and family experiences.”⁹¹ Thus, even if costs did not impact health, physicians may have a duty to consider them as a bona fide patient interest when rendering treatment recommendations or making outright treatment decisions.

Another objection to this thesis arises from equality. It may seem unfair for physicians to recommend one treatment for a wealthy person but another treatment for a poor person. Such a concern would arise from a fundamental human right to health or from conceptions of health care justice.⁹² Yet, such arguments are best addressed to systemic reforms, not to analysis of the doctor-patient relationship or the choice of treatments therein. Physicians may have a duty to lobby Congress for better health care coverage, but within the clinic in the meantime, the physician must take for granted that some patients will come with greater wealth and better insurance than others.

Admittedly, considerations of cost will require awkward conversations, such as “I usually do *x*, but since your insurance imposes such a large out-of-pocket exposure, *y* may be a better choice for you.” This is precisely the sort of conversation that “consumer directed health care” seeks to encourage. If it seems absurd, then that counsels against trying to empower patients as cost-conscious consumers, and thereby as rationers in our healthcare system.

91. NAT'L INSTS. OF HEALTH, NIH CONSENSUS AND STATE-OF-THE-SCIENCE STATEMENTS ON IMPROVING END OF LIFE CARE 11 (2004) (emphasis added), available at <http://consensus.nih.gov/2004/2004EndOfLifeCareSOS024PDF.pdf>. See generally JOSEPH J. FINS, A PALLIATIVE ETHIC OF CARE: CLINICAL WISDOM AT LIFE'S END (2006) (discussing the essential elements of ethical and palliative care with emphasis on how to choose an approach for an individual patient and family).

92. WORLD HEALTH ORG., *Constitution of the World Health Organization*, in BASIC DOCUMENTS 1, 1 (2014), available at <http://apps.who.int/gb/bd/PDF/bd48/basic-documents-48th-edition-en.pdf> (“The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being”); William W. Fisher & Talha Syed, *Global Justice in Healthcare: Developing Drugs for the Developing World*, 40 U.C. DAVIS L. REV. 581, 641 (2007). See generally NORMAN DANIELS, JUST HEALTH: MEETING HEALTH NEEDS FAIRLY 354–55 (2008) (discussing the need for justice and fairness in the distribution of health care).

In the cataracts example, a particular physician may well offer both PCS and MSICS, providing the former to some patients and the latter to others. The appropriateness of the care must be tailored to the individual patient and must be considered against the practical alternative. For patients unable to pay for PCS, the practical alternative to MSICS is continuing blindness. That is the world that our contemporary healthcare policy has created for them. In that real world, MSICS may be the best available health care.

An alternative approach would be for some physicians to specialize in high-cost care while others specialize in low-cost care and then use marketing, geography, and referrals to steer patients towards the appropriate sort of physician for them. To some degree, this market differentiation may be already happening. However, the difficulty of this approach is that patients will sometimes need good advice about which health care provider is best for them. The costs of switching physicians to simply get a different treatment may be onerous.

In sum, these considerations suggest that the patient's ability to pay for procedures, drugs, and medical devices should be a part of the reasonable physician's medical evaluation. Such a consideration will allow the physician to choose an appropriate therapy for the patient and thereby comply with the legal standard of care. Failure to do so may actually hinder patients' short- and long-term health or harm patients' welfare more generally.

CONCLUSION

With the rise of cost sharing likely to continue, the patient's financial obligations will play an increasingly important role in the physician-patient relationship. As physicians respond to these changes, I argue that they should see the cost of care as an essential part of their relationship with patients. These costs not only impact the formation of the physician-patient relationship, but also require changes in the way that physicians and patients communicate with one another. Ultimately, patient responsibility for costs may shape the standard of care itself. These observations take for granted much deeper questions of health policy and in some ways make the implications of these policies more apparent.