

# The High Price of Full Disclosure: Informed Consent and Cost Containment in Health Care

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## I. INTRODUCTION

WITH INCREASING ECONOMIC CONSTRAINTS in Canadian health care, physicians will be faced with numerous pressures that may redefine and expand their legal and ethical duties. This article will examine an aspect of one of the most fundamental of these duties.<sup>1</sup> Specifically, we will examine the extent to which a physician is or should be required to inform a patient about cost containment policies that could affect the treatment available to that patient.

We begin by examining the relevant legal concepts — informed consent and fiduciary duty — and then discuss the ethical aspects of this issue. We will conclude with a discussion of the benefits and problems associated with requiring full disclosure to patients of cost containment policies.

## II. LEGAL BACKGROUND

DOES THE LEGAL DOCTRINE of informed consent and the physician's fiduciary duty require that patients be told about relevant cost containment policies?

### A. Informed Consent

The doctrine of informed consent, or full disclosure, is based on the premise that patients should have control over decisions concerning their health care and therefore they should be provided with all medically relevant information.<sup>2</sup> This is a legal manifestation of the

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<sup>1</sup> Portions of this article are from T.A. Caulfield, *The Last Straw: The Impact of Cost Containment in Health Care on Medical Malpractice Law* (LL.M. Thesis, Dalhousie University, 1993).

<sup>2</sup> See E.H. Morreim, "Cost Containment and the Standard of Medical Care" (1987) 75 Cal. L. Rev. 1719 at 1736; N. Jecker, "Futility and Rationing" (1990) 92 American Journal of Medicine 189 at 191; and R. Veatch, "Allocating Health Resources Ethically: New Roles for Administrators and Clinicians" (1992) 1 Frontiers of Health Services

broader ethical concept of patient autonomy, which will be addressed later in this article.<sup>3</sup>

The Supreme Court of Canada decision in *Reibl v. Hughes*<sup>4</sup> sets the legal standard for informed consent in the context of health care. In *Reibl*, the plaintiff suffered a massive stroke after surgery. It was found that he had not been told of the possible risk of a stroke as a result of surgery, and the Court held that the physician had been negligent for failing to disclose "attendant risks."<sup>5</sup> In determining whether there had been sufficient disclosure, the Supreme Court of Canada held, *inter alia*, that the appropriate standard was whether the risks in question are such that a reasonable person in the patient's position would be likely to attach significance to them in deciding whether or not to undergo the proposed therapy.<sup>6</sup> This represented significant development in malpractice law, breaking from the more paternalistic and traditional test of what a "reasonable physician would decide to disclose."<sup>7</sup>

In addition, the case established a causation rule that has proven to be a substantial barrier for malpractice claimants. In order to be successful, the patient must show not only that there was a failure to disclose information and that the patient was injured, but also that a "reasonable person in the patient's position would have declined treatment if the information had been disclosed."<sup>8</sup>

A number of other aspects of informed consent are relevant to this issue. The first is the requirement that the physician inform a patient of alternative treatments<sup>9</sup> and give the patient the opportunity to

Management 3 at 12.

<sup>3</sup> See for example T. Beauchamp and J. Childress, *Principles of Biomedical Ethics*, 3rd ed. (New York: Oxford University Press, 1989) at 67-119; and E. Picard, *Legal Liability of Doctors and Hospitals in Canada*, 2d ed. (Toronto: Carswell, 1984) at 113, where she stated, in reference to informed consent: "There is a new emphasis on the granting and informing, through the courts, of individual rights."

<sup>4</sup> [1980] 2 S.C.R. 880 [hereinafter *Reibl*]. See also G. Robertson, "Informed Consent Ten Years Later" (1991) 70 Can. Bar Rev. 423 at 424.

<sup>5</sup> *Reibl*, *ibid.* at 898 and 925.

<sup>6</sup> *Ibid.* at 899. See also *Ciarlariello*, *infra* note 11 and accompanying text.

<sup>7</sup> Robertson, *supra* note 4 at 425.

<sup>8</sup> *Ibid.* at 426.

<sup>9</sup> This is particularly true with respect to elective procedures. See Picard, *supra* note 3 at 93. See for example *Zimmer v. Ringrose* (1981), 16 C.C.L.T. 51 at 60 (Alta C.A.), where it was held that other sterilization options should be reviewed so that the risks

choose among the different treatment approaches.<sup>10</sup> Second, a physician must disclose anything that the physician knows, or ought to know, would be relevant to the patient's decision regarding the treatment.<sup>11</sup> Does the law of informed consent require a physician to disclose cost containment policies or programs that might affect the treatment available to a patient? A major component of obtaining informed consent is that the patient must be informed of material risks. Generally, courts have set a very low threshold for characterizing a risk as "material."<sup>12</sup> For example, a 1:100,000 risk of a fatal reaction to a contrast medium has been held to be a material risk.<sup>13</sup> Arguably, then, a cost containment policy must be disclosed where it

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can be compared. See also Canada, Royal Commission on New Reproductive Technologies, *Proceed with Care*, vol. 1 (Final Report) by P. Baird et al. (Ottawa: Minister of Government Services, 1993) see pp. 93-97, where the concept of "informed choice" is emphasized; and the *Consent to Treatment Act*, S.O. 1992, c.31, s. 5(2)(a), which reads as follows:

A consent is informed if, before giving it, the person received the information about the treatment, *alternative courses of action*, the material effects, risks and side effects in each case and the consequences of not having the treatment that a reasonable person in the same circumstances would require in order to make a decision... [emphasis added].

See also *Haughian v. Paine* (1987), 40 C.C.L.T. 13 at 35 (Sask. C.A.) which involved a patient who consented to surgery without having been informed of the alternative of "conservative management." The court held that "[i]n the absence of such information having been given to the [patient]... he was not in a position to give informed consent."

<sup>10</sup> See *Gorback v. Ting*, [1974] 5 W.W.R. 606 at 610 (Man Q.B.); *Kangas v. Parker*, *infra* note 33 and accompanying text; *Leadbetter v. Brand* (1980), 37 N.S.R.(2d) 581 at 601-602 (S.C.T.D.); and Picard, *supra* note 3 at 169.

<sup>11</sup> See *Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119 at 133 [hereinafter *Ciarlariello*], where the court notes that "[t]he test now focuses on what the patient would want to know." See also *Mitchell v. McDonald* (1987), 40 C.C.L.T. 266 at 286-289 (Alta. Q.B.) [hereinafter *Mitchell*], for a succinct judicial review of the informed consent law where Matheson J. noted, at 288, as follows: "The duty of disclosure also embraces what a surgeon knows or should know that the patient deems relevant to the patient's decision whether or not to undergo the operation." See also M.B. Kapp, "Health Care Delivery and the Elderly: Teaching Old Patients New Tricks" (1987) 17 *Cumberland L. Rev.* 437 at 454.

<sup>12</sup> Robertson, *supra* note 4 at 429. It should be noted that even a risk which is only a "mere possibility" should be disclosed if the "occurrence may result in serious consequences, such as paralysis or even death." *Mitchell*, *ibid.* at 288.

<sup>13</sup> See *Meyer Estate v. Rogers* (1991), 78 D.L.R. (4th) 307 (Ont. Gen. Div.) [hereinafter *Meyer Estate*].

might add to the material risks of a given treatment program; for instance, the use of less expensive drugs with more side effects or having to be placed on a waiting list for a surgical procedure.

The requirement that patients be informed of alternative treatments might mean that a patient must be told of *all* alternative treatments, even those that are not available because of cost containment measures. At present, there is no economic qualification for this aspect of the informed consent obligation and therefore it cannot be assumed that a court would accept economic constraint as an excuse for non-disclosure.

It should be noted, as an aside, that physicians are not required either to inform patients about, or perform, treatments that are medically futile; that is, treatments that will not produce the desired physiological effect.<sup>14</sup> The effectiveness of many medical procedures currently being used has not been scientifically tested<sup>15</sup> and, as a result, certain treatments may be discarded as it is not recognized that they are medically beneficial. In that case, these procedures would no longer be offered as viable alternatives, and there would be no obligation on the physician to inform the patient about the treat-

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<sup>14</sup> What is defined as "futile" is in itself a controversial topic since it is a concept which can easily be clouded by value judgments and professional paternalism. For a brief discussion see G. Griener "The Physician's Authority to Withhold Futile Treatment" (Paper presented at the Canadian Bioethics 5th Annual Conference, November 20, 1993). See also S. Miles, "Medical Futility" (1992) 20 *Law, Medicine and Health Care* 310-315, where the author outlines four "clinical usages of futility:"

- (i) "therapies that are *physiologically implausible*;"
- (ii) "therapies with important physiologic effects which medical judgment concludes are *non-beneficial* to the patient as a person;"
- (iii) "therapies which are *very unlikely* to produce a desired physiologic effect;" and
- (iv) "*non-validated* (but plausible) therapies for which there is no clinical experience to prove the (usually low) probability of benefit."

Without entering the debate as to the appropriate definition of futile treatment, we are proceeding on the assumption that at least some treatments are "physiologically implausible," and it is in this, narrowest, sense that we are using the concept of futility.

<sup>15</sup> See for example R. Rachlis & C. Kushner, *Second Opinion: What's Wrong with Canada's Health Care System and How to Fix It* (Toronto: Harper and Collins, 1989) at 47-69; and J. Wennberg, "Outcome Research, Cost Containment and the Fear of Health Care Rationing" (1990) 323 *New England Journal of Medicine* 1202. See also Royal Commission on Reproductive Technologies, *supra* note 9 at 70, where the authors report: "The evidence before the Commission suggests that a significant proportion of medical care is ineffective, inefficient and unevaluated."

ment.<sup>16</sup> A physician might wish to explain to patients why a particular treatment is no longer in use, but the failure to do so would not affect the legal validity of the consent.

Finally, the fact that a treatment is rationed might well be something that a physician "ought to know" would be relevant to a patient's decision, and something that a "reasonable person in the patient's position would want to know about;"<sup>17</sup> particularly if there is a possibility of the patient obtaining the rationed treatment through alternative means.<sup>18</sup> In fact, in a Canadian case which is presently being litigated, involving the death of a patient on a waiting list for cardiac surgery, it is alleged that the physicians were negligent in "[f]ailing to advise the Deceased to seek alternat[ive] treatment within British Columbia or in another jurisdiction or jurisdictions."<sup>19</sup>

Until this case, or a similar one, is decided in the courts, it will remain uncertain whether physicians have a legal obligation to disclose relevant cost containment policies to patients as part of obtaining an informed consent for treatment. However, Canadian and American jurisprudence on informed consent is leaning towards full disclosure in all circumstances.<sup>20</sup> As a result, it seems unlikely that

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<sup>16</sup> Strictly speaking a decision that a given treatment is no longer medically beneficial is not really a "cost containment" policy. However, these decisions may be the outcome of pressure to practice more economically. Therefore, they may be considered a "result" of cost containment pressure.

<sup>17</sup> Robertson, *supra* note 4 at 429; and Ciarlariello, *supra* note 11 at 133.

<sup>18</sup> Expecting physicians to consider patients' economic circumstances is not a new concept. In *Reibl*, *supra* note 4 at 899, the court noted that the plaintiff's anticipation of full pension benefits is a "special consideration" that should be factored into the informed consent duty. Similarly, a patient's ability to purchase alternative treatments may be considered a "special circumstance." See also *Chew v. Meyer* 527 A. 2d. 828 (Md. Ct. App. 1987); and E.H. Morreim, "Whodunit? Causal Responsibility of Utilization Review for Physicians' Decisions, Patients' Outcomes" (1992) 20 *Law, Medicine and Health Care* 40 at 51.

<sup>19</sup> *Sallis v. Vancouver General Hospital*, (No. C907316, Vancouver Registry), personal communication with plaintiff's counsel, David Bellamy, December, 1992 and November, 1993. See also F. Rozovsky, "The Legal Case Against Rationing Necessary Health Care: Ethical and Policy Implications" (1992) (presented at the "Struggle to Decide" Symposium, Cape Breton, Nova Scotia, September 1992) at 3.

<sup>20</sup> See for example *Meyer Estate v. Rogers*, *supra* note 13 at 316, where the court made it clear that the concept of "therapeutic privilege" does not exist in Canada since it may be incorrectly used to override the physician's obligation to disclose. It is also interesting to note that some have argued that the doctrine of informed consent includes the obligation to disclose any medical errors or omissions that occurred during treatment, see Robertson, *supra* note 4 at 436-37. This is another example of the expanding nature

the present emphasis on cost containment will be allowed to erode this emerging "patient right" to any significant degree. This is particularly true given the fact that there is a heightened duty of disclosure for elective procedures<sup>21</sup> and these procedures will undoubtedly be the first targets of cost containment programs and policies.

The State of Oregon serves as an example of a jurisdiction that has had to deal with an aggressive cost containment policy.<sup>22</sup> In Oregon, a patient may not be entitled to coverage for a beneficial medical treatment, at public expense, if it is not on the government's priority list. The Oregon legislation addresses the informed consent issue which arises from this situation by requiring physicians to inform patients of:

...any service, treatment or test that is medically necessary but not covered under the contract if an ordinarily careful practitioner in the same or similar community would do so under the same or similar circumstances.<sup>23</sup>

In other words, in order to meet the legal standard of care, a physician in Oregon must inform a patient of any treatment that would normally be undertaken but is being withheld because of the State's rationing policy. We submit that a Canadian court would probably require similar disclosure.

However, as mentioned above, even if the law on informed consent were interpreted so as to require physicians to inform patients about cost containment measures, failure to disclose would not automatically mean that a physician would be found liable.<sup>24</sup> In any particular case, a court might conclude that the patient would have consented to

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of the informed consent obligation. See also *Truman v. Thomas*, 611 P.D. 902, where the court held that a physician must disclose all risks of foregoing a diagnostic procedure. See also F. Miller, "Denial of Health Care and Informed Consent in English and American Law" (1992) 18 *American Journal of Law and Medicine* 37 at 74.

<sup>21</sup> See for example *LaFleur v. Cornelis* (1979), 28 N.B.R. 569 at 576 (Q.B.), where the court noted that "when the treatment is elective a very high standard of disclosure is required"; and *White v. Turner* (1981), 15 C.C.L.T. 81 at 103 (Ont. H.C.), aff'd (1982), 20 C.C.L.T. xxii (Ont. C.A.).

<sup>22</sup> See generally R. Nelson and T. Drought, "Justice and the Moral Acceptability of Rationing Medical Care: The Oregon Experiment" 17 *The Journal of Medicine and Philosophy* 87; and M. Garland, "Justice, Politics, and Community: Expanding Access and Rationing Health Services in Oregon" (1992) 20 *Law, Medicine and Health Care* 67.

<sup>23</sup> Oregon Rev. Stat. 414.745(5) (1991), in Miller, *supra* note 20 at 70. See also Nelson and Drought, *ibid.* at 106.

<sup>24</sup> Robertson, *supra* note 4 at 433-434.

the treatment which he or she actually received, even if the relevant information had been disclosed, in which case the patient's claim of negligence would fail.<sup>25</sup> In a cost containment case, the court might be more sympathetic to a patient's claim if it could be established that the patient had the resources (economic or otherwise) to obtain the rationed care from an alternative source. It would then be easier to argue that the patient would not have consented to the available, non-rationed treatment.

### B. Fiduciary Duty

Where the existence of a cost containment policy places a physician in an economic conflict of interest, the physician may have a fiduciary duty to inform patients of this conflict.<sup>26</sup>

In the Canadian case of *Henderson* the court stated as follows:

The medical practitioner, like the lawyer or other professional advisor, is bound, then, to see to it that in no circumstance will he allow his professional duty to come into conflict with his personal interests... if the medical advisor has a pecuniary interest - and a fee-splitting arrangement is such an interest - he must disclose it...<sup>27</sup>

In the American decision of *Moore*<sup>28</sup> a physician took cells from a surgical specimen to use in a research project, for his own monetary gain, which had no bearing on the patient's treatment or well-being. The court in *Moore* came to a similar conclusion as did the court in *Henderson*: a physician must disclose all material information about the medical treatment and any professional and economic conflicts.

[W]e hold that a physician who is seeking a patient's consent for a medical procedure must, in order to satisfy his fiduciary duty and to obtain the patient's informed consent,

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<sup>25</sup> See for example *Diack v. Bardsley* (1983), 46 B.C.L.R. 240 (S.C.), aff'd (1984), 46 B.C.L.R. xlv (C.A.); and *Meyer Estate v. Rogers*, supra note 13 at 316-319.

<sup>26</sup> See *McInerney v. MacDonald*, [1992] 2 S.C.R. 138 [hereinafter *McInerney*]; and *Norberg v. Wynrib*, [1992] 2 S.C.R. 226, which are two recent Supreme Court decisions which have re-emphasized the fiduciary nature of the physician/patient relationship.

<sup>27</sup> *Henderson v. Johnston*, (1956), 5 D.L.R.(2d) 524 at 533-34 (Ont. H.C.J.), aff'd (1958), 11 D.L.R. (2d) 19 (C.A.), aff'd (1959), 19 D.L.R. (2d) 201 (S.C.C.). See generally *McInerney*, *ibid.* at 148-49.

<sup>28</sup> *Moore v. Regents of the University of California*, 249 Cal. Rptr. 494, (1988) rev'd, 271 Cal. Rptr. 146 (2 Dist. 1988), rev'd 271 Cal. Rptr. 146 (1990). It should be noted that Canadian courts appear quite willing to adopt American jurisprudence in the area of informed consent. This was evidenced in *Reibl*, supra note 4 at 890 and 896, where the court considered the American decisions such as *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125 (1914); and *Canterbury v. Spence*, 464 F. 2d. 772 (1972).

disclose personal interests unrelated to the patient's health, whether research or economic, that may affect his medical judgment.<sup>29</sup>

Although the economic conflict in a cost containment situation may be less obvious than in *Henderson* or *Moore*, it has been argued that the reasoning in these decisions could still apply.<sup>30</sup> For example, a physician who was pressured by a hospital utilization review committee to forgo, delay or alter a given treatment, would be in a conflict of interest if the physician felt that the treatment was in the best interest of the patient.<sup>31</sup> Failure to comply with the review committee's recommendations might harm the physician's reputation within the hospital and thereby jeopardize his or her hospital privileges.<sup>32</sup> In such a situation, a court might find that the physician had a fiduciary duty to inform the patient of the conflict, which would, in effect, mean that the physician had a duty to inform the patient of the cost containment policy itself.<sup>33</sup>

### III. POLICY AND ETHICAL IMPLICATIONS

THUS FAR, WE HAVE examined whether Canadian law requires a physician to inform patients of cost containment policies. A discussion

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<sup>29</sup> *Moore, ibid.* at 152. See also Miller, *supra* note 20 at 64–65. It should be noted that one could argue that the fee-for-service system of compensation is itself an economic conflict.

<sup>30</sup> See for example Miller, *supra* note 20 at 65.

<sup>31</sup> See J. Brooke, "Ruling on Files Leaves MDs Open to Lawsuits" (1993) 29 *The Medical Post* 58 at 58, where it is reported that Dr. Bernard Dickens suggests that treating a patient when he/she was in a conflict of interest is an unethical act that "could land a doctor in court for breach of fiduciary duty."

<sup>32</sup> See also Canadian Council on Health Facilities Accreditation, *Perspectives On Implementing Utilization Management Initiatives in Canadian Health Care Facilities* (1992), for a general discussion of utilization review in Canada. One can only speculate regarding the probable sanctions for non-compliance with hospital policy; however, the granting of hospital privileges is the most obvious power that a hospital has over a physician.

<sup>33</sup> See also *Kangas v. Parker*, [1976] 5 W.W.R. 25 (Sask. Q.B.), *aff'd* [1978] 5 W.W.R. 667 (C.A.), where the court held that a physician should not let treatment decisions be affected by financial gain. See also Morreim, *supra* note 18 at 42, where the author argues that "physicians have a duty, as the patient's fiduciary, to ensure that the patient receives care of a certain standard;" and Kapp, *supra* note 11 at 454, where he argues that there is a "fiduciary duty to communicate."



of whether the law *should* place this duty on physicians involves a consideration of the ethical principles of autonomy and justice.

### A. Autonomy

Respect for an individual's autonomy is an integral aspect of the ethics of health care. While no one is completely autonomous, the "goal, realistically, is ... that ... consequential decisions be substantially autonomous."<sup>34</sup> In order for a choice to be autonomous, it must be made "(1) intentionally, (2) with understanding, and (3) without controlling influences that determine the action."<sup>35</sup>

It is the need for "understanding" which is relevant here, and which relates to the concept of informed consent. It can be argued that, without full information on cost containment policies, a patient would not be able to make an autonomous choice as to whether to accept the available treatment<sup>36</sup> or to try to gain access to another, rationed treatment. While attempting to obtain the rationed treatment in another jurisdiction using personal economic resources may be the most obvious example of an alternative course of action, there are other possibilities. These could include situations where a person has access to treatment through supplementary medical benefits provided by an employer, where a community raises money for a person to travel to wherever the needed treatment is available, or where an individual or advocacy group attempts to convince the health care provider that the individual does not fall within the parameters of the rationing scheme.

Furthermore, providing information on cost containment policies may empower patients, individually or in groups, to pressure the government or hospital to change the policy.

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<sup>34</sup> Beauchamp & Childress, *supra* note 3 at 69.

<sup>35</sup> *Ibid.*

<sup>36</sup> See for example W. Feldman, "To Test or Not to Test: A Medicolegal Problem" (April, 1986) *Legal Aspects of Medical Practice* 6 at 7; Kapp, *supra* note 11 at 454; R. Lee and F. Miller, "The Doctor's Changing Role in Allocating United States and British Medical Services" (1990) 18 *Law, Medicine and Health Care* 69 at 73; and Morreim, *supra* note 2 at 1736-37. See also M. Connors, "In the Absence of Candour, Benevolent Paternalism Hurts Everyone" (1993) 3 *Wellness MD* 26 at 26, for a brief discussion on whether it is ever appropriate to withhold information from a patient; and Linton, "Will Health Care Need to be Rationed?" (January, 1992) *Ontario Medical Review* 5 at 8, where he argues that there is a "question of how a patient could give informed consent to a proposed course of action if cost considerations are involved but concealed."

If patients are unaware of treatment options because doctors fail to reveal them, patients are deprived of the ability to judge the importance of those options by their own value systems. They are accordingly disqualified both from exercising choice about whether to purchase uncovered medical services from personal funds, and from trying to convince insurers and the government to change reimbursement or capital investment policy.<sup>37</sup>

This concept of "patient empowerment" is consistent with the increased public participation embraced in recent provincial reports on the health care system.<sup>38</sup>

It might be argued that if a medical resource is truly beyond the patient's means, then disclosure is not required, since mere "theoretical availability" does not enhance patient choice.<sup>39</sup> A similar argument would be that a physician need not inform a patient that a rationed treatment would be more readily available in another jurisdiction unless the physician "knew, or ought to know" that the patient is able to seek treatment in that jurisdiction.<sup>40</sup> However, as one commentator has noted:

Some patients may have their own resources for obtaining medical care about which their doctors are unaware. Others may choose to invest their energies in trying to change rationing policies that affect them detrimentally, rather than passively accepting denial of care as their lot. In any event, many patients may have personal business or professional priorities and commitments that would change in the light of full, truthful information about their medical conditions and treatment options. To deny patients such information is to compromise the exercise of personal autonomy, the *raison d'être* of the informed consent doctrine.<sup>41</sup>

Some physicians may fear that an open discussion of all treatment options will lead patients either to request treatment that simply

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<sup>37</sup> Lee & Miller, *ibid.* at 73.

<sup>38</sup> For example: Nova Scotia Provincial Health Council, *Nova Scotia Health Goals* (August, 1992); Premier's Commission on the Future Health Care of Albertans, *The Rainbow Report; Our Vision for Health* (Final Report) (Edmonton: The Commission, December, 1989); *The Government of Alberta's Response to the Premier's Commission on the Future Health Care for Albertans* (Edmonton: Alberta Health, November, 1991); and *Working Together to Achieve Better Health for All: Southwestern Ontario Comprehensive Health System Planning Commission* (December, 1991).

<sup>39</sup> D. Roy, B. Dickens, & M. McGregor, "The Choice of Contrast Media: Medical, Ethical and Legal Considerations" (1992) 147 CMAJ 1321 at 1323.

<sup>40</sup> *Ibid.*

<sup>41</sup> Miller, *supra* note 20 at 71. See also E.H. Morreim, "Stratified Scarcity: Redefining the Standard of Care" (1989) 17 Law, Medicine and Health Care 356 at 360-361.

cannot be provided because of cost containment measures or to request unnecessary treatments. Certainly, increased public attention on the miraculous achievements of modern medicine has created a more demanding and expectant patient population.<sup>42</sup> These pressures may, and do, influence physicians' treatment decisions.<sup>43</sup>

However, as noted earlier, there would not seem to be any reason why physicians should be required to tell patients about unnecessary or futile treatments, since presumably being offered a chance to choose a treatment that will be of no benefit will hardly increase a patient's autonomy. Similarly, if patients, of their own accord, request futile treatments, there is no ethical obligation on the physician to provide the treatment and, in fact, as will be discussed below, there are ethical reasons why a physician should not provide unnecessary treatments. Although the principle of autonomy recognizes the right of individuals to decide what is or is not to be done to their bodies, it does not grant them an automatic right of access to all medical treatment simply because they desire such treatment.

Autonomy is a liberty generating principle. It grants liberty rights, the right to decline or withdraw. It does not grant a right to access. Surely persons should not have a right of access at public or insurers' expense to treatments they desire that are not deemed beneficial by peer review or by a consensus of subscribers to the insurance plan.<sup>44</sup>

While there is clearly a difference between rationing and denying requests for futile treatments,<sup>45</sup> many of the same arguments apply.

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<sup>42</sup> See P. Meagher, "Our Health-Care System Takes a Heavy Toll on MDs" (1993) 5 *Family Practitioner* 15 at 15; and R. Blendon, et al., "Physicians' Perceptions on Caring for Patients in the United States, Canada, and West Germany" (1993) 328 *New England Journal of Medicine* 1011 at 1013.

<sup>43</sup> See S. Salloum & E. Franssen, "Laboratory Investigations in General Practice" (1993) 39 *Canadian Family Physician* 1055 at 1058-59, where it was noted that physicians' use of laboratory tests is influenced by patients' expectations. Generally, see also G. Langley, et al., "Effect of Non-Medical Factors on Family Physicians' Decisions about Referral for Consultation" (1992) 147 *CMAJ* 659; and J. Williams and E. Beresford, "Physicians, Ethics and the Allocation of Health Care Resources" (1991) 24 *Annals RCPSC* 305.

<sup>44</sup> Veatch, *supra* note 2 at 12.

<sup>45</sup> Jecker, *supra* note 2 at 194, identifies a number of significant differences between rationing and futility: first, "[w]hereas rationing indicates a priority between scarce resources, futility implies that a particular medical intervention produces a low likelihood or quality of effect;" second, the "criteria for rationing are far broader in scope than are the criteria for defining futility;" third, while "ethical rationing must meet standards articulated in theories of distributive justice," a determination that treatment

Advocating that physicians have an ethical duty to inform patients of cost containment measures that will affect their health care does not mean that physicians then have a duty to “bend the rules” for individual patients and provide care that the hospital or government has determined will not be made available. The point of full disclosure is to allow patients to consider whether there may be other ways of obtaining access (for instance, in another jurisdiction) or whether it is worthwhile pressuring decision-makers to change the policy in question.

Further, if given the choice, many patients may actually request *less* rather than more treatment. By fully disclosing all the benefits and risks of a proposed treatment, together with information about the alternative treatments, many patients may choose less aggressive, and less costly, treatment.<sup>46</sup> Thus, informed consent may actually help to control costs in health care.

## B. Justice

It seems clear that providing patients with information on cost containment policies affecting their health care would increase the possibility of more autonomous choices, regardless of whether a particular patient is in a position to, or chooses to, act on the information provided. However, this does not lead automatically to the conclusion that physicians should have to disclose information on cost containment measures. Respect for autonomy, while important, is not an absolute rule in most ethical philosophies, and can in certain situations be overridden by other principles,<sup>47</sup> including the principle

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is futile is not based on ethical theory but on a broad consensus of medical opinion “about such things as medical indications and community values and goals;” and finally, “the circumstances of rationing always presuppose scarcity. By contrast, it is possible to argue for denying futile treatment even where a resource is abundant or cheap.”

<sup>46</sup> Royal Commission on Reproductive Technologies, *supra* note 9 at 94–95. See also P. Singer & F. Lowy, “Rationing, Patient Preferences, and Cost of Care at the End of Life” (1992) 152 *Archives of Internal Medicine* 478 at 479, where the authors argue that following patient preferences will reduce the cost of health care since patients will often choose the cheaper, non-aggressive, forms of treatment. This is particularly true near the end of life.

<sup>47</sup> Beauchamp & Childress, *supra* note 3, identify four ethical principles: autonomy, beneficence, maleficence, and justice, and then propose a “composite theory” in which each principle is “*prima facie* binding,” but can be overridden by another of the four principles. According to the authors, at 51, “[a] composite theory permits each basic principle to have weight without assigning a priority weighting or ranking. Which principle overrides in a case of conflict will depend on a particular context, which always

of justice. In the context of health care decisions, the principle of justice relates to "the question of who will receive what share of society's resources, if any."<sup>48</sup>

Obviously, cost containment measures represent an effort by decision makers to allocate limited health care resources among individual members of society. Therefore, it could be argued that if a rationing policy has been accepted and justified at the "macro" or "meso" levels (i.e. a government or hospital decision), then the ethical principle of justice would allow that policy to outweigh autonomous choices made by individual patients for treatment that is not available because of the rationing. From this perspective, informing patients of the policy so as to enable them to mount a challenge could undermine policies of limited access, requiring cost containment policies to be re-analyzed, and perhaps altered, every time informed consent was sought from a patient whose health care might be affected by efforts at cost containment. Arguably, this approach would allow the principle of autonomy to override that of justice, which does not seem appropriate in the context of societal decisions regarding the allocation of health care resources.

A fundamental weakness in this argument is the assumption that the allocation of resources will always be done justly, unless we accept that all government decisions are, by their very nature, just. It may be that individual patients affected by a cost containment policy had little or no say in establishing the policy, and that their interests were not fairly represented at the time the decision was made. The informed consent process may be the only opportunity for patients to become aware of certain rationing policies and to obtain the information necessary to participate in the decision-making process.<sup>49</sup> Enabling patients to pressure governments and hospitals to re-evaluate policy choices might provide a useful ongoing scrutiny and increase the chance of new voices being heard in the debate on rationing health care.

Thus, the ethical principles of autonomy and justice are not necessarily in conflict. In fact, enhancing patient autonomy by providing information on cost containment policies may, in some situations, allow such policies to be formulated more justly. It is true

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has unique features."

<sup>48</sup> *Ibid.* at 257.

<sup>49</sup> See R. Lee, "Legal Control of Health Care Allocation" (1986) in *Medicine, Ethics and Law* (Great Britain: Association for Legal and Social Philosophy, 1986).

that autonomy and justice may collide if a patient wishes to challenge a cost containment policy that is, in fact, a just response to the realities of limited resources. However, that does not mean that patients should be kept in the dark as to the policy in question; instead, it would mean that in such a situation the patient's challenge to the cost containment decision would fail, as the principle of justice would, appropriately, outweigh that of autonomy.

The concept of justice also reinforces the argument made earlier that there is no obligation on physicians to provide futile treatment. While futility and rationing are two separate concepts, and there would be no requirement to provide futile care even if health care resources were limitless, it seems that where resources are scarce it would be unjust, and therefore unethical, to waste these resources on a patient when there is no medical justification for the desired treatment.<sup>50</sup> The concept of patient choice does not mean that a physician must accede to a patient's unreasonable request.

#### IV. OTHER BENEFITS AND PROBLEMS

THUS FAR, WE HAVE advanced a number of legal and ethical arguments for requiring physicians to inform patients of cost containment policies that might affect their treatment. These arguments are that such disclosure would form a logical part of the doctrine of informed consent; that in some situations a conflict of interest may exist which would place a fiduciary duty of disclosure on the physician; that such disclosure would enhance patient autonomy; and that, although the need to allocate society's resources fairly may override individual autonomy where just cost containment policies are in place, the principle of justice is not undermined simply by informing patients of those policies.

In addition, there are two other arguments that could be advanced in support of requiring disclosure. First, patients' knowledge that they will be given all the relevant information might maintain patient trust in physicians and in the health care system.<sup>51</sup> Second, a requirement of disclosure would oblige physicians to explain the most beneficial treatment, regardless of economic constraints, thus helping to ensure

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<sup>50</sup> Jecker, *supra* note 2 at 192.

<sup>51</sup> Morreim, *supra* note 2 at 1736; Stilling, "Who's In Charge: The Doctor or the Dollar? Assessing the Relative Liability of Third Party Payors and Doctors After *Wickline* and *Wilson*" (1992) 18 J. of Contemp. L. 285 at 303-304; Miller, *supra* note 2 at 70-71.

that the medical decision-making process remains intact and uncompromised.

However, a number of arguments may also be made against the full disclosure to patients of cost containment policies that may affect their health care. Although some patients might be reassured by the fact that no relevant information will be kept from them, in many cases informing a patient that a medically beneficial treatment is to be withheld, or is not immediately available, may leave the patient angry and disillusioned with the physician and the health care system as a whole. This is particularly true since physicians are not passive agents in the allocation process.

In certain instances, the principle could require the physician — unavoidably a pivotal agent of allocation decisions — to inform the patient that the physician himself is withholding some desirable intervention because of cost or of other patients' greater need. Where the patient lacks the money or political influence to secure the preferred care, it will hardly enhance her autonomy or her trust simply to tell her that her care is inferior.<sup>52</sup>

However, although a patient may be angry on discovering that the best treatment is not available or that there may be a long wait for that treatment, we speculate that most people would rather have that information than be kept in ignorance. The suggestion that it would be better for patients not to know would seem to be based either on the paternalistic assumption that patients must not be exposed to unpleasant realities or on an attempt to shield the medical profession from patients' anger regarding rationing. Neither of these grounds would justify the non-disclosure of information regarding cost containment policies and programs. Furthermore, although disclosure may initially have a negative impact on the physician/patient relationship, in the long term it may sensitize patients as to how "macro" decisions made by others affect physicians' decision-making.<sup>53</sup> This could have the result of allowing patients to view their physicians as partners in the struggle to obtain medical resources.

Another difficulty with full disclosure is that physicians may find it very difficult to say "no" to patients who request that the physician make an exception for them.<sup>54</sup> Undoubtedly, some physicians would

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<sup>52</sup> Morreim, *supra* note 2 at 1737.

<sup>53</sup> Miller, *supra* note 20 at 71.

<sup>54</sup> *Ibid.*

succumb to the plea, thereby undermining the cost containment program.<sup>55</sup>

The difficulty some physicians may have in refusing patients' requests may also cause physicians to avoid full disclosure (i.e. if the patients do not know about the treatment options, they can't ask for them).

Changes in the health care system may implicitly influence physicians to withhold material information about the patient's diagnosis, prognosis, and the risks and benefits of potential alternatives, thereby infringing on the patient's decision-making autonomy.<sup>56</sup>

This would not only be unethical, but if the law on informed consent is interpreted as requiring disclosure of cost containment policies, then taking the easy way out on the issue of disclosure could also lead to increased liability exposure.

Furthermore, the fact that physicians find it difficult to comply with a duty of disclosure is not a sufficient reason for keeping relevant information from patients. Although, arguably, patients could inform themselves about cost containment measures, the informed consent process might realistically be the only time patients would learn the details of rationing policies that could affect their health care. Therefore, as cost containment programs become more aggressive, physicians will have to "come to grips" with their increasingly difficult and crucial role as society's "front line" allocators of medical resources.

## V. CONCLUSION

WHILE IT IS NOT an easy role to ask physicians to play, there are strong ethical arguments for suggesting that physicians have a duty to inform their patients of cost containment measures that will affect patients' health care. Moreover, although there is not yet any case law specifically on point, it is quite possible that courts will interpret the doctrine of informed consent as including a requirement for such disclosure. It is interesting to note the continued importance which Canadian courts have placed on the principle of patient autonomy.<sup>57</sup>

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<sup>55</sup> Williams & Beresford, *supra* note 43.

<sup>56</sup> Kapp, *supra* note 11 at 454.

<sup>57</sup> For example: *Fleming v. Reid* (1991), 4 O.R. (3d) 74 (C.A.); *Malette v. Shulman* (1990), 72 O.R. (2d) 417 (C.A); *Ciarlariello*, *supra* note 11. In these cases the court is placing autonomy over a paternalistic "doctor knows best" approach. Rationing does not involve



True, telling patients that their treatment is being affected by rationing may well make them angry and may, at least initially, place a strain on the patient/physician relationship; however, these unfortunate consequences do not outweigh the arguments in favour of providing patients with the relevant information.

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tension between autonomy and beneficence. Instead, the fear is that full autonomy (i.e. full disclosure) might undermine decisions taken in the interests of societal justice. However, as we have argued above, disclosure itself does not create conflict between autonomy and justice; that would occur only if justly-established cost containment policies were set aside inappropriately because of individual patient demands.