1993

Autonomy and Privacy: Protecting Patients from their Physicians

Mary Anne Bobinski
Allard School of Law at the University of British Columbia, bobinski@allard.ubc.ca

Follow this and additional works at: http://commons.allard.ubc.ca/fac_pubs
Part of the Health Law and Policy Commons

Citation Details

This Article is brought to you for free and open access by the Faculty Scholarship at Allard Research Commons. It has been accepted for inclusion in Faculty Publications by an authorized administrator of Allard Research Commons.
ARTICLES

AUTONOMY AND PRIVACY: PROTECTING PATIENTS FROM THEIR PHYSICIANS

Mary Anne Bobinski*

TABLE OF CONTENTS

I. Introduction .................................................. 292
II. Provider-Associated Risk in the Physician-Patient Relationship .................................................. 294
   A. Provider Characteristics ..................................... 295
   B. Economic Conflicts of Interest .............................. 301
      1. Incentives to Promote the Purchase of Health Services ................................................. 302
      2. Incentives to Deny Treatment or Referral .............................................................. 305
III. Patient Risk and the Duty to Refrain ..................... 309
   A. Malpractice Law and Risk to Patients .................... 310
      1. Personal Characteristics .................................. 312
      2. Economic Incentives ...................................... 315
   B. Legislative Prohibitions: Fencing the Fox .............. 319
      1. Personal Characteristics .................................. 321
      2. Economic Incentives ...................................... 323

* Assistant Professor, University of Houston Law Center. J.D., SUNY/Buffalo (1987), LL.M., Harvard Law School (1989). Thanks are due to Seth Chandler, David Dow, Mark Hall, Laura Oren, Phil Peters, Irene Rosenberg, Mark Rothstein, and Bill Winslade for their comments and criticisms. A number of research assistants and library personnel assisted with the laborious task of gathering and cite checking references, including Harriet Richman, Sharon Kahn, Robert Moosy, Leanne Reid, Rafe Taylor and Rob Wilson. Support for this research was provided by the University of Houston Health Law & Policy Institute and the University of Houston Law Foundation. Thanks also to Mark Hall for inviting me to present some of these ideas at the Law, Medicine and Health Care Section Session of the Association of American Law Schools Annual Meeting in January of 1992.
I. INTRODUCTION

Whom do physicians serve first: themselves, their patients, insurers, or society-at-large? This article constitutes the first scholarly exploration of the legal system's sometimes conflicting attempts to resolve this issue in the context of provider-associated risk.\(^1\) Courts and commentators are reflexively reacting to physician risks by uprooting and transplanting regulatory concepts from other areas, often without considering either the legal basis or the likely consequences for patients, physicians and society. In fact, these risks require a novel, and to some extent counterintuitive, judicial and legislative response.

Our health care system is undeniably complex: full of hope and despair, sickness and health, greed and altruism, service and sales. We live in a time when competing visions of this system vie for our allegiance, somewhat like the gestalt pictures in which we blink and suddenly see a different view. One paradigmatic vision is of our good fortune to live in the country with 'the most advanced medical system in the world,' in which knowledge, technology and selfless service join to create miracles. The other view, considerably less appealing, is of a health care marketplace in which those fortunate enough to be insured have little power and even less knowledge with which to protect them-

---

1. This article analyzes the regulation of physician-associated risks, although other terms, such as "provider" or "doctor," are occasionally used for linguistic variation. This Article's mode of analysis is transferable to other types of risks in society, but the specific regulatory framework will vary depending on the nature of the individual or institution that is creating the risk.
selves from poor quality care and mercantile providers. Our view of the doctor-patient relationship is similarly fractured. As patients, we place hope and trust in our physicians. As health care consumers, we are suspicious of where we fall on our physician's list of priorities.

There is a new perception that patients can be injured by physician self-interest. In the past, both patients and courts have focused attention on the benefits and risks of a particular treatment rather than on the characteristics of particular providers. Provider-associated risks are just becoming salient within this system, and both courts and legislatures are muddling through by failing to examine the questions raised by the special nature of these risks. How should we respond to physicians who pose some risk to their patients because of alcohol or drug use, poor success rates, or HIV infection? What legal effect should be given to a physician’s economic incentive to recommend a procedure or to deny access to a treatment? A physician’s personal characteristics or economic relationships with others might ultimately cause patient injury; physicians seeking to provide care for patients therefore inevitably must confront conflicting interests.

Part II of this article describes two major types of physician-associated risks: those arising out of the provider's economic arrangements with others, and those arising out of some other personal characteristic of the physician. A review of recent research indicates that physicians can present identifiable risks to their patients that are distinguishable from the risks that patients ordinarily face from illnesses or treatments. The remainder of the article considers the appropriate type and scope of governmental intervention to deal with provider-associated risk.

There are two possible types of governmental market interventions designed to combat these problems: prohibitions and disclosure obligations. Part III of the article considers the use of prospective or retrospective prohibition, accomplished either through regulation or malpractice litigation. Licensure laws, for example, ensure minimal levels of competence while malpractice provides compensation and deterrence for poor quality care. This article concludes that these historically-favored mechanisms for dealing with provider risk may provide largely illusory protection because of gaps in the regulation of certain types and degrees of provider-associated risks.

Disclosure obligations are the major alternative to transaction

---

2. See infra Part II.
3. See infra Part III.
bars, and are considered in Part IV. In recent years, both courts and commentators have argued for the empowerment of patients through the required transfer of information from physician to patient. Under disclosure regimes, physicians are permitted to perform acts that might pose some risk to their patients, but are required to disclose risk-related information to patients under common law or statutory rules. These disclosure duties infringe on a provider's privacy rights. Yet, courts are increasingly relying on such disclosures as a method of protecting patients. The gaps and inconsistencies in the doctrinal support for disclosure obligations are analyzed in this section.

In Part V, this article analyzes the application of prohibitions and disclosure obligations to provider-associated risks. It concludes that risks arising from providers' personal characteristics should be regulated through improved prohibitory regulation rather than through the imposition of additional disclosure obligations. This counterintuitive argument is based on the greater protections to both physician privacy interests and patient health provided by prohibitions. Risks associated with providers' economic interests, however, require a different response. Current social policies incorporate the use of economic incentives to direct and control the use of health care resources, and prohibiting some types of economic incentives would conflict with these policies. As pressure to contain costs moves our physicians and patients into an even more conflicted relationship, disclosure of a provider's economic relationships would provide important benefits to patients.

II. PROVIDER-ASSOCIATED RISK IN THE PHYSICIAN-PATIENT RELATIONSHIP

Consumers of health care services confront different types of risks. That most commonly recognized is the risk to physical and mental integrity that accompanies illness and its treatment. There is, however, another important type of risk: that associated with the nature of the physician rather than the nature of the illness. The identity, qualifications, and other characteristics of the physician providing treatment can have important implications for the patient seeking good or better health. There are two types of provider-associated risk. The first type arises from the characteristics of the provider herself. The second, related, type of physician-associated risk arises from the nature of the

4. See infra Part IV.
5. See infra Part V.
physician's economic relationships with other entities. The appropriate legal treatment of these risks will depend at least in part on their prevalence and magnitude. There may also be important differences in the social benefits associated with different physician risks and an understanding of these issues is a necessary precondition to any legal analysis.

A. PROVIDER CHARACTERISTICS

A seemingly infinite number of provider characteristics combine to determine the physician's ability to deliver appropriate care to a particular patient at any given moment. The provider's training, education, and experience are clearly relevant. Nevertheless, more intangible factors also affect the care delivered; these may range from the provider's moral beliefs to the amount of sleep she has recently enjoyed. Many personal characteristics are not associated with negative outcomes for patients. Further, some physician characteristics that consistently might be associated with negative patient outcomes or with increased risks to patients do not provide any corresponding benefit to those patients. In these cases, a patient could avoid the particular risk presented by the provider by simply choosing a different caregiver.

This article will analyze three different examples of risky personal characteristics: a physician might have a relatively poor success rate with a particular procedure; she might have a history of addiction to drugs or alcohol; or she might suffer from some contagious condition. In each of these cases, a characteristic of the provider arguably creates an identifiable risk of harm to the patient. These examples are illustrative but not exhaustive; one of the most difficult analytic problems in this area is identifying which risks should be regulated.

6. A provider's sexual orientation, for example, is a personal characteristic that has not been empirically correlated with either good or poor care. Some personal characteristics, such as gender, might affect patient satisfaction with treatment in individual cases. See, e.g., Carol S. Weissman & Martha Ann Teitelbaum, Physician Gender and the Physician-Patient Relationship: Recent Evidence and Relevant Questions, 20 Soc. Sci. Med. 1119, 1123 (1985).

7. It could be argued, however, that net risks to the patient would remain the same even if another provider is selected. If a patient chooses to avoid the risk of hepatitis transmission during a procedure by rejecting the care of an infected physician, for example, she might merely confront different risks associated with her newly chosen provider. Acceptance of this position implies that, on average, the risks presented by all providers are roughly equal. It also carries with it the suggestion that patients are not entitled to weigh risks differently, choosing to confront the risks presented by an inexperienced surgeon, for example, over those presented by a surgeon with hepatitis B infection.

8. The use of specific examples in this article should not obscure an extremely important
Providers do not all have the same level of success with diagnostic procedures and treatments. Statistical success could be related to a number of provider characteristics, including experience,\(^9\) education,\(^10\) manual dexterity, reactions to stress, and so forth.\(^11\) One could imagine

problem in the analysis of provider-associated risk: the difficulty in determining the degree of risk associated with a particular characteristic and in determining the level of risk at which some legal intervention is appropriate. A provider’s ability to render care is a product of an infinite number of characteristics; it is not easy to determine which risks could or should be regulated. This problem will be considered in more detail in Part V, infra text accompanying notes 342-60.

9. Studies regularly indicate that success rates for heart transplants are better at institutions where more transplants have been performed. See, e.g., Glenn L. Laffel et al., *The Relation Between Experience and Outcome in Heart Transplantation*, 327 NEW ENG. J. MED. 1220, 1224 (1992) (experience of heart transplantation center and of center cardiologists is related to success rate; experience of surgeons not related to outcome). But see Roger W. Evans, *The Relation Between Experience and Outcome in Heart Transplantation*, 328 NEW ENG. J. MED. 514, 514 (1993) (Evans’ own study on same subject found that “experience, however it was measured, had both a statistically insignificant and a clinically unimportant effect on the survival of heart-transplant recipients”). The current regulatory scheme for transplant centers emphasizes the acquisition of experience. *See Laffel et al., supra,* at 1220 (“Medicare’s reimbursement policy for heart-transplantation procedures requires that a center perform 36 transplantations before it can be certified.”).

A number of research studies have confirmed the relationship between provider experience and patient outcomes, although much of the data focuses on hospitals rather than physicians. *See, e.g.,* Edward L. Hannan et al., *Coronary Artery Bypass Surgery: The Relationship Between In-Hospital Mortality Rate and Surgical Volume After Controlling for Clinical Risk Factors*, 29 MED. CARE 1094, 1098, 1103-04 (1991) (both hospital and surgeon experience correlated to better patient outcomes; higher volume may be a result rather than the cause of success); Valerie E. Stone et al., *The Relation Between Hospital Experience and Mortality for Patients with AIDS*, 268 JAMA 2655, 2659 (1992) (lower mortality rate and shorter stays in hospitals with experience; better patient outcomes are related to “greater institutional familiarity”); *see also* Harold S. Luft et al., *The Volume-Outcome Relationship: Practice-Makes-Perfect or Selective-Referral Patterns?*, 22 HEALTH SERVICES RES. 157, 179 (1987) (researchers investigate alternative explanation for relationship between experience and success in which successful providers get more referrals and therefore more experience, and conclude that both explanations are supported by evidence). But see Eugene C. Rich et al., *The Relationship of House Staff Experience to the Cost and Quality of Inpatient Care*, 263 JAMA 953, 955 (1990) (no relationship between house staff experience and hospital mortality for patients); Elliott J. Sussman et al., *Surgical Outcome for Resident and Attending Surgeons*, 144 AM. J. SURGERY 250, 251 (1982) (no significant differences in post-operative stay or complications between residents and attending physicians performing appendectomies).

10. *See, e.g.,* Paul G. Ramsey et al., *Predictive Validity of Certification by the American Board of Internal Medicine*, 110 ANNALS INTERNAL MED. 719, 724 (1989) (study indicates that Board certification is correlated with higher ratings of clinical skills).

11. There is a subtle problem lurking here in that this article suggests that patient outcomes can be related to something that the physician does. This seems both intuitively correct and problematic. A physician’s actions or inactions can have an effect on patient health outcomes. Yet it should also be noted that the patient herself can affect these outcomes: some patients may be so ill that even very good physicians could not save them, and other patients may thwart the best care regimens through their inability to follow medical treatments.

The relationship between health care and health outcomes is a burgeoning area of research
a bell curve representing individual physician performance of a particular procedure: sometimes the physician will perform better or worse than her own mean level of performance. This individual bell curve theoretically then could be compared to the aggregate performance of physicians as a group for a particular procedure. A particular physician's average performance level could be significantly above or below that of physicians as a group. These theoretical musings about physician success rates have practical significance because of the recent movement toward the collection of provider-specific information. 

It is clear that the malpractice system will punish a significant departure from minimally competent provision of care for a particular patient. But what should be the effect of a physician's overall lower mean, in comparison to other physicians? A state medical board or hospital credentialing committee may eventually take action against a physician who consistently falls seriously below the average level of performance. But should the surgeon have a duty to disclose her success rate sua sponte? Required disclosure could permit an individual...
patient to reduce the risk of harm from surgery by rejecting care from an atypically unsuccessful surgeon.¹⁷

Regular television viewers may have gained the impression that drug and alcohol abuse are problems of the economic underclass. Yet studies indicate that a small but significant proportion of physicians use self-prescribed (and potentially addictive) opiates and benzodiazepines.¹⁸ Further, physician usage of alcohol, cocaine, and marijuana is at best only slightly lower that the rate of usage in the general population.¹⁹ This finding is generally explained by several factors, including the high levels of stress associated with the practice of medicine and the ready availability of controlled substances.²⁰

The abuse of drugs and alcohol is in turn associated with higher risks of work-related performance deficits.²¹ Physicians with substance

¹⁷. To the individual patient, obtaining information about success rates appears to permit the reduction of risk. Nevertheless, this risk reduction might very well be illusory if the focus of analysis is changed. In some cases, permitting an individual patient to reduce her personal risk by rejecting care by a particular physician may lead to increased overall risks for patients in general. This can clearly be seen in the case of the experienced surgeon: if all patients reject inexperienced surgeons then they will never become experienced and all patients will suffer. Cf. Norman Daniels, HIV-Infected Health Care Professionals: Public Threat or Public Sacrifice?, 70 MILBANK Q. 3, 32-37 (1992) (arguing that physicians’ failure to disclose HIV status maximizes social utility through a similar analysis). But see Williams & Fost, supra note 16, at 226-27 (discussing but rejecting argument that disclosing lack of experience could prevent providers from gaining experience). This problem could be addressed through differential pricing: an inexperienced or less successful surgeon could set lower fees to induce patients to accept these risks.

¹⁸. See, e.g., Patrick H. Hughes et al., Prevalence of Substance Use Among US Physicians, 267 JAMA 2333, 2336 (1992) [hereinafter Hughes I] (survey indicates that “physicians were more likely to use alcohol and prescription substances, such as benzodiazepines and prescription opiates, than their age and gender peers in the general population”); Patrick H. Hughes et al., Resident Physician Substance Use in the United States, 265 JAMA 2069, 2070 (1991) [hereinafter Hughes II] (reporting similar pattern of use for residents); William E. McAuliffe et al., Psychoactive Drug Use Among Practicing Physicians and Medical Students, 315 NEW ENG. J. MED. 805, 805 (1986) (25 percent of physicians responding to a survey reported that they “had treated themselves with a psychoactive drug” in the previous year; “10 percent had used one recreationally”).

¹⁹. See, e.g., sources cited supra note 18; G. Douglas Talbott & Earl B. Benson, Impaired Physicians: The Dilemma of Identification, 68 ALCOHOL & DRUG PROBS. 56, 56 (1980) (estimating that about “one of eight physicians in Georgia has been, is, or will be afflicted with the disease of chemical dependency”); Cf. Joan M. Brewster, Prevalence of Alcohol and Other Drug Problems Among Physicians, 255 JAMA 1913, 1919 (1986) (arguing that careful review of existing data supports conclusion that physician substance abuse rates may be similar to those in the general population).

²⁰. See, e.g., Hughes I, supra note 18, at 2338.

²¹. See, e.g., Robert S. Walzer, Impaired Physicians: An Overview and Update of the Legal Issues, 11 J. LEGAL MED. 131, 131 (1990) (“Reliable analyses attribute three-fourths or more of physician impairment cases to substance abuse and addiction, either ‘primary’ or ‘secondary’ to other underlying psychopathology.”).
abuse problems may present several different sorts of risks to their patients. First, and most obviously, a physician's performance may be impaired. Second, a physician's abuse of drugs or alcohol might distort her judgment about the patient's need for services, particularly in light of the physician's need for a steady cash flow to support drug dependency. A physician with substance abuse problems might therefore perform more procedures or diagnostic tests because she gains an economic benefit.

A physician's substance abuse problems could lead to professional disciplinary or malpractice claims. Patients might want information about a physician's abuse of alcohol or drugs so they could avoid some risks by choosing another provider. Disclosure duties in this area present in clear relief the sharp conflicts between patients' informational claims and providers' confidentiality concerns.

Public attention has been focused on the risk of disease transmission from health care provider to patient ever since the tragic illness and death of Kimberly Bergalis, who is believed to have contracted HIV infection from her dentist. Several different types of transmissible conditions could pose risks for patients, including hepatitis, tuberculosis.

---

22. Id.
24. See infra text accompanying notes 107-114.
25. See infra text accompanying notes 68-77.
26. See infra text accompanying notes 137-70. There are also the practical problems associated with determining whether disclosure should be limited to current use of drugs/alcohol or whether even recovering addicts need disclose past use.
28. See, e.g., Centers for Disease Control, U.S. Dep't of Health & Human Servs., Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures, 40 Morbidity & Mortality Wkly. Rep., July 12, 1991 (Recommendations & Reports), at 1, 2-3 (summarizing studies of HBV transmission by health care workers during invasive procedures, noting that use of universal precautions did not eliminate risk of transmission); P.J. Grob et al., Cluster of Hepatitis B Transmitted by a Physician, 2 Lancet 1218 (1981) (discussing cluster of transmission cases found in patients of general practitioner with hepatitis); Hepatitis B Transmission Between Dental or Medical Workers and Patients, 95 Annals Internal Med. 229 (1981) (summarizing studies and assessing risks to patients).
culosis,\textsuperscript{29} and, in limited circumstances, HIV.\textsuperscript{30} There is no definitive data estimating the percentage of physicians affected by these conditions, although the likelihood of infection varies depending on the nature of the physician's specialty and her practice location.\textsuperscript{31} These diseases can be seen on a continuum, with tuberculosis being fairly easy to transmit in health care settings,\textsuperscript{32} hepatitis transmission being rela-

\textsuperscript{29}. See, e.g., K.P. Goldman, \textit{Tuberculosis in Hospital Doctors}, 69 \textit{Tubercle} 237, 238 (1988) (discussing cases in which undiagnosed TB in health care worker led to infection of patients). TB can be transmitted from a person with an active pulmonary infection through airborne routes. \textsc{Merck Manual} 113 (Robert Berkow et al. eds., 15th ed. 1987).

\textsuperscript{30}. Compare Ban Mishu & William Shaffner, \textit{HIV-Infected Surgeons and Dentists: Looking Back and Looking Forward}, 269 \textit{JAMA} 1843 (1993) (summarizing research data on lack of HIV transmission by health care workers, and suggesting that HIV could be transmitted in clusters by particular health care workers for reasons not understood) with Audrey Smith Rogers et al., \textit{Investigation of Potential HIV Transmission to the Patients of an HIV-Infected Surgeon}, 269 \textit{JAMA} 1795, 1795 (1993) (survey of patients of HIV-infected surgeon finds no HIV transmission in “369 person-hours of surgical exposure, indicating that HIV transmission to patients is unlikely to occur more frequently than once per 1000 person-hours of surgical exposure”).

\textsuperscript{31}. Historically, the prevalence of HBV among health care workers was between 10% and 30%, with the higher rates found among persons who performed invasive procedures and/or who worked in emergency rooms. Kenneth V. Iserson & Elizabeth A. Criss, \textit{Hepatitis B Prevalence in Emergency Physicians}, 14 \textit{Annals Emergency Med.} 119, 119 (1985); see also Alexander E. Denes et al., \textit{Hepatitis B Infection in Physicians}, 239 \textit{JAMA} 210, 210-11 (1978) (seroprevalence rate varies by specialty and location of practice). Health care institutions are now required to provide HBV vaccinations to workers at risk for occupationally-acquired HBV, 29 C.F.R. § 1910.1030(f) (1992); the rate of infection therefore should be diminished in the future.

Physicians are also disproportionately infected by TB. Elizabeth Barrett-Connor, \textit{The Epidemiology of Tuberculosis in Physicians}, 241 \textit{JAMA} 33 (1979) (survey of TB exposure and development rates; data gathered before recent decade of increase in TB rates); P. Jan Geiseler et al., \textit{Tuberculosis in Physicians: A Continuing Problem}, 133 \textit{Am. Rev. Respiratory Disease} 773, 774-75 (1986) (physicians at higher risk for TB than general population); Goldman, supra note 29, at 237 (discussing risk of TB infection for physicians).

In contrast with HBV and TB, the prevalence of HIV infection among physicians is similar to the pattern of HIV infection found in the general population. Bobinski, supra note 27, at 238. As of December 1992, between approximately 60 and 100 health care workers were reported definitely or possibly to have acquired HIV infection in the course of providing treatment to HIV-infected patients. See Centers for Disease Control, U.S. Dept of Health and Human Services, \textit{Table 15, HIV/AIDS Surveillance}, Feb. 1993, at 18.

\textsuperscript{32}. Tuberculosis is carried by airborne bacterial particles which can be created by coughing or spitting. \textsc{Merck Manual}, supra note 29, at 113; Centers for Disease Control, U.S. Dept of Health and Human Servs., \textit{National Action Plan to Combat Multidrug-Resistant Tuberculosis, 41 Morbidity and Mortality Wkly. Rep.}, June 19, 1992 (Recommendations & Reports), at 5, 29-30 (discussing infection control techniques to reduce transmission in health care and other institutional settings); see Richard A. Goodman & Steven L. Solomon, \textit{Transmission of Infectious Diseases in Outpatient Health Care Settings}, 265 \textit{JAMA} 2377 (1991) (discussing transmission of a variety of conditions, including TB, in outpatient settings).
tively rare,\textsuperscript{33} and HIV transmission being the least likely.\textsuperscript{34} Each of
these diseases can have significant health effects on patients.\textsuperscript{35}

The appropriate legal response to a provider's infection may vary
depending on the severity of disease and the risk of transmission to
others. Some conditions, such as tuberculosis, might present a degree of
risk that could lead to practice prohibitions. Less transmissible dis-
eases, such as HBV or HIV, are more problematic. Possible responses
range from practice prohibitions, to disclosure, to no legal action at all.

\textbf{B. Economic Conflicts of Interest}

It should come as no surprise that physicians have an economic

\begin{itemize}
  \item \textsuperscript{33} Hepatitis is communicated through contact with blood or other body fluids. \textsc{Merck Manual}, \textit{supra} note 29, at 860-61 (hepatitis B transmission routes); see Centers for Disease Control, U.S. Dept' of Health & Human Servs., \textit{supra} note 28, at 2-3 (summarizing risk of HBV transmission in health care setting). The "[r]isk of contracting fatal hepatitis B virus infection from an HBeAg-positive surgeon during [an] invasive procedure" was estimated to be "1 in 76000 to 1 in 1.4 million persons undergoing invasive procedure[s]." Bernard Lo & Robert Steinbrook, \textit{Health Care Workers Infected With the Human Immunodeficiency Virus}, 267 JAMA 1100, 1101 (1992) (table) (emphasis added; the rate of contracting non-fatal HBV infection would of course be significantly higher since about 10% of HBV infections result in death).
  \item \textsuperscript{34} Cf. Harry Hollander, \textit{Transmission of HIV in Body Fluids, in The AIDS Knowledge Base} 1.2.1, at 1, 2 (P.T. Cohen et al. eds., 1990) (fluids in which HIV has been isolated). Physicians can expose their patients to infectious blood or body fluids during the course of performing invasive procedures. Hepatitis is more readily transmitted in this fashion than HIV. See Centers for Disease Control, U.S. Dept' of Health & Human Servs., \textit{supra} note 28, at 3-5 (risk of HIV transmission is less than risk of HBV transmission in health care settings). The Centers for Disease Control has estimated that the risk of HIV transmission from an infected surgeon to a patient is "1 in 42,000 to 1 in 420,000 persons undergoing invasive procedure[s]." Lo & Steinbrook, \textit{supra} note 33, at 1101 (table).
  \item \textsuperscript{35} Infection with HIV can have a long latency period but is currently believed to be inevitably fatal. Dennis Osmond, \textit{Progression to AIDS in Persons Testing Seropositive for Antibody to HIV, in The AIDS Knowledge Base, supra} note 34, 1.1.6, at 1 ("[A] very high proportion of seropositive persons will ultimately develop disease.").

Hepatitis is a serious illness with a significant mortality rate from the infection itself and from associated increases in the risk of liver cancer. HBV most often results in an acute infection which resolves within a month or two, although mortality rates of 10\% are possible. \textsc{Merck Manual}, \textit{supra} note 29, at 862. HBV is also a cause of chronic active hepatitis, which often leads to death within a few years. \textit{Id.} at 864-65.

Tuberculosis can also be quite debilitating with a long treatment period and significant mortal-
ity rates, particularly given recent increases in the prevalence of drug-resistant strains. Only about 10\% of otherwise healthy persons exposed to mycobacterium tuberculosis become ill within two years of exposure. \textit{Id.} at 113-14 (infection lies dormant in remaining 90\% of exposed persons; disease expression possible at any point in lifespan). Persons with active tuberculosis are generally treated in a multi-drug regimen for two years. \textit{Id.} at 116-17. There is a mortality rate of nearly 10\% associated with active infection. \textit{Id.} at 113. The mortality rate for TB infection is actually increasing because of the emergence of drug resistant strains. See, e.g., Dixie E. Snider, Jr. & William L. Roper, \textit{The New Tuberculosis}, 326 \textsc{New Eng. J. Med.} 703, 704 (1992).
\end{itemize}
interest in the services provided to patients; the difficulty lies in determining whether economic influences are to be feared or praised. As patients, we hope that economic interests do not intrude into the physician's exercise of professional judgment. As politicians and health market reformers, we believe, or at least hope, that economic incentives affect physician behavior: numerous governmental and private proposals to contain the escalating costs of health care attempt to influence physician behavior through economic pressure. The apparent conflict in our hopes can be resolved only if professional judgment is not adversely affected by economic factors: we want to ensure that patients receive good quality care of sufficient amount, duration, and scope regardless of the system of financial incentives imposed on physicians. Empirically, this utopian view is difficult to support. The data certainly supports the view that economic arrangements have an impact on the types of care delivered by physicians. It is more difficult to determine the impact of economics on quality. Two different systems of economic incentives might affect physician behavior: (1) incentives to provide treatment, and (2) incentives to withhold care.

1. Incentives to Promote the Purchase of Health Services

Physicians can have economic incentives to advise their patients to purchase health care services. The incentives created by fee-for-service medicine are familiar, as evidenced by cocktail party jokes about gall bladder surgeries funding Caribbean cruises. Historically, the physician's incentive to provide care may have been viewed sympathetically, because most people equated more health care with better health. Recent years, however, have seen more overt criticism of the rate of unnecessary medical treatment because such treatment carries both economic and physiological costs. The suspiciously high level of hysterectomies and caesarean deliveries, for example, results in millions

36. The risks created by a provider's economic interests are related to those created by her personal characteristics. Once revealed, a provider's personal characteristics can have economic implications.


38. See infra text accompanying notes 47-61.
of dollars of unnecessary medical costs, along with substantial morbidity and even, in some cases, mortality. Medical practice patterns vary when compared across geographic areas or between individual providers, and the variation in practice does not correlate with different or better outcomes for patients. This constitutes strong evidence that some significant, although unquantified, proportion of medical care is unnecessary.

39. Numerous studies have documented variations in the rate of caesarean section deliveries that seem unrelated to medical necessity. See, e.g., Robert K. DeMott & Herbert F. Sandmire, The Green Bay Cesarean Section Study: I. The Physician Factor as a Determinant of Cesarean Birth Rates, 162 AM. J. OBSTETRICS & GYNECOLOGY 1593 (1990). Demott and Sandmire imply that the optimal rate might be about 6-8%, id. at 1598, and argue that the risk of legal liability is a major cause in driving rate upward, id. at 1596; cf. Harry S. Jonas & Sharon L. Dooley, The Search for a Lower Cesarean Rate Goes On, 262 JAMA 1512, 1512 (1989) (national rate of about 25% of all deliveries, compared with historical rate of 5%; rate of increase in cesareans is slowing). Cesareans may cost $4-5,000 more than vaginal deliveries. Benjamin P. Sachs, Is the Rising Rate of Cesarean Sections a Result of More Defensive Medicine?, in 2 MEDICAL PROFESSIONAL LIABILITY AND THE DELIVERY OF OBSTETRICAL CARE 27, 36 (Victoria P. Rostow & Roger J. Bulger eds., 1989). Furthermore, women undergoing cesarean sections are more likely to face an extended recovery period after birth. See id. at 34.

A substantial, but uncertain, proportion of hysterectomies are also believed to be medically unnecessary. See, e.g., H. David Banta & Stephen B. Thacker, The Case for Reassessment of Health Care Technology: Once is Not Enough, 264 JAMA 235, 238 (1990) (hysterectomy rates have been declining; determining which hysterectomies are medically necessary is problematic); Richard C. Dicker et al., Hysterectomy Among Women of Reproductive Age: Trends in the United States, 1970-1978, 248 JAMA 323 (1982) (discussion of trends in hysterectomy rates over time and variations between geographic regions). Medically unnecessary hysterectomies also impose economic and health costs:

Hysterectomy has significant risks and the costs are high, estimated in 1983 at $3200 to $6200 in direct medical care expenses alone. For selected indications in women aged 30 to 60 years, gains can be expected from hysterectomy in both life expectancy and quality of life . . . . For others, the costs of elective hysterectomy seem to outweigh the benefits, with net losses in life expectancy and/or quality of life.

40. See, e.g., Benjamin A. Barnes et al., Report on Variation in Rates of Utilization of Surgical Services in the Commonwealth of Massachusetts, 254 JAMA 371 (1985) (finding large variations in the per capita surgery rate for various conditions across geographic areas within Massachusetts); DeMott & Sandmire, supra note 39, at 1594 (caesarean usage among individual physicians in study varied from approximately 6% to 20%); W. Pete Welch et al., Geographic Variation in Expenditures for Physicians' Services in the United States, 328 New Eng. J. Med. 621 (1993) (finding significant variation in provision of physicians' services among geographic areas).


42. In a provocative essay, Marcia Angell argues that billions of dollars of unnecessary medical care could and should be eliminated. Marcia Angell, Cost Containment and the Physi-
While the existence of unnecessary medical care is indisputable, the linkage between economic incentives and the provision of unnecessary care is more contested. Considerable evidence supports the conclusion that economic factors affect a physician's rate of referral to other health services. Many commentators argue, for example, that the threat of legal liability drives physicians to perform procedures and diagnostic tests that are not medically indicated. A significant percentage of physicians maintain ownership interests in other health care providers, such as diagnostic imaging centers, clinical laboratories, or durable medical equipment suppliers. The results of several large-

cian, 254 JAMA 1203 (1985). Angell describes three different types of unnecessary care and estimates the amount of money that could be saved by reducing known waste: "little-ticket items" like laboratory tests and chest x-rays could be reduced by $11.5 billion per year; $1.25 billion per year could be saved on "big-ticket items" like "coronary artery bypass grafting and carotid endarterectomy"; and the $8 billion per year "spent on the final admissions of patients known to be dying" could be greatly reduced by "[t]reating these patients much less aggressively." Id. at 1204; see also Edward B. Hirshfeld, Should Ethical and Legal Standards for Physicians be Changed to Accommodate New Models for Rationing Health Care?, 140 U. PA. L. REV. 1809, 1821 (1992) (20-30% of care unnecessary); Leape, supra note 41, at 374 (rate of unnecessary surgical procedures varies significantly by type; author concludes that "10% or more of surgical procedures are unnecessary").

There are, of course, substantial difficulties in determining which care is "necessary" and which is not. See Jan Blustein & Theodore R. Marmor, Cutting Waste by Making Rules: Promises, Pitfalls, and Realistic Prospects, 140 U. PA. L. REV. 1543, 1545-47 (1992) (discussing difficulties of defining "'wasteful'" medical practices); Mark A. Hall & Gerard F. Anderson, Health Insurers' Assessment of Medical Necessity, 140 U. PA. L. REV. 1637 (1992) (discussing judicial reaction to private attempts to define medical necessity); Leape, supra note 41, at 365-67 (defining unnecessary surgery).

43. See, e.g., DeMott & Sandmire, supra note 39, at 1596-98 (authors contend that risk of legal liability is a major cause in driving cesarean rate upward); Richard L. Kravitz et al., Malpractice Claims Data as a Quality Improvement Tool: I Epidemiology of Error in Four Specialties, 266 JAMA 2087, 2090 (1991) (malpractice claims arise from failure to perform cesarean sections far more frequently than from overperformance of the procedure). Of course, a physician who performs unnecessary procedures because of malpractice fears is in effect responding to his or her own personal economic interests rather than to the medical needs of the patient. A major cause of unnecessary health care, however, is likely to be medical ignorance rather than medical avarice. See Leape, supra note 41, at 374-78.

44. See, e.g., OFFICE OF INSPECTOR GEN., U.S. DEP'T OF HEALTH & HUMAN SERV., FINANCIAL ARRANGEMENTS BETWEEN PHYSICIANS AND HEALTH CARE BUSINESSES 11 (1989) [hereinafter INSPECTOR GENERAL'S REPORT] (reporting that "'[t]welve percent of physicians who bill Medicare have ownership or investment interests in entities to which they make patient referrals"); John K. Iglehart, Efforts to Address the Problem of Physician Self-Referral, 325 NEW ENG. J. MED. 1820, 1822 (1991) (almost all free-standing diagnostic-imaging centers in Florida were owned by physicians); Jean M. Mitchell & Elton Scott, New Evidence of the Prevalence and Scope of Physician Joint Ventures, 268 JAMA 80, 84 (1992) (approximately 40% of Florida physicians had ownership interests in other health care entities). Physicians may also enter into other arrangements with hospitals which have the effect of encouraging hospital admissions. See, e.g., Robert A. Musacchio et al., Hospital Ownership and the Practice of Medicine: Evidence
scale studies indicate that physicians with ownership interests in health-related entities recommend such services to patients at significantly higher rates than do other physicians and that these patients purchase such services more often. At a minimum, inappropriate physician referrals to diagnostic or other services create inflated prices for patients and insurers. Intrusive and unnecessary medical procedures can also cause physical injury.

2. Incentives to Deny Treatment or Referral

Rapidly rising health care costs have encouraged public and private attempts to reverse the incentives provided under traditional fee-for-service practice. Negative incentives—those which encourage physicians to deny certain kinds of treatment—are thus a recent development. A variety of mechanisms are or could be employed to this end, from the use of capitation payments or risk pools, to the adoption of

---

from the Physician’s Perspective, in For-Profit Enterprise in Health Care 385, 393-94 (Bradford H. Gray ed., 1986) (discussing physician payment arrangements with hospitals).


The effect varies depending on the type of health service. Medicare patients of physicians with an ownership interest in a clinical laboratory received far more clinical laboratory services than other patients. INSPECTOR GENERAL’S REPORT, supra note 44, at 18 (finding that such patients “received 45 percent more clinical laboratory services than all Medicare patients in general... [and] 34 percent more services from independent clinical laboratories than all Medicare patients in general”). The effect for patients of physicians with an ownership interest in physiological laboratories was not as large. Id. (such patients use 13% more services). Patients of physicians with ownership interests in durable medical equipment do not use more of such services. Id. at 21.


47. Under a capitated payment system, a physician receives a set fee for each patient enrolled in the physician’s practice. The physician does not receive additional payments for services rendered and thus has an incentive to provide enough services to retain the patient without providing unnecessary and uncompensated additional services. See Alan L. Hillman et al., Contractual Arrangements Between HMOs and Primary Care Physicians: Three-Tiered HMOs and Risk Pools, 30 Med. Care 136, 137 (1992).

48. Physicians are given an incentive to reduce the hospitalization and referral rates of their
global budget schemes under President Clinton's proposed health plan. Rarely, economic incentives constitute attempts to pursue non-economic policy objectives, such as reducing the number of abortions.

Increasingly, Americans are part of health care systems that attempt to reduce costs. Health maintenance organizations (HMOs) patients through the use of risk pool arrangements. In the typical arrangement, an HMO creates a pool of money from which hospitalization or specialist fees are drawn. Physicians may directly or indirectly contribute to the pool. Physicians receive some or all of the pool amounts remaining after a specified period of time, and sometimes might be liable for some portion of pool deficits. Thus, the physicians earn more money if they make fewer referrals or reduce the rate of hospitalization for their patients. See Hillman et al., supra note 47, at 137-39, 145-47; Alan L. Hillman et al., HMO Managers' Views On Financial Incentives and Quality, 10 HEALTH AFF. 207, 208 (1991). See generally Lawrence P. Casalino, Balancing Incentives: How Should Physicians Be Reimbursed?, 267 JAMA 403, 404 (1992) (discussing possible incentive payment arrangements designed to reduce unnecessary referrals); Alan L. Hillman, Financial Incentives for Physicians in HMOs: Is There a Conflict of Interest?, 317 NEW ENG. J. MED. 1743 (1987) (survey of incentive arrangements used by HMOs); Hillman et al., supra note 47, at 137-39, 145-47 (discussing mechanics of risk pool arrangements). The incentive effect on physician behavior is obviously greater when the risk pools are smaller because the gain or loss to risk pool participants will be more directly tied to individual conduct in smaller pools. See Hillman et al., supra note 47, at 143-44 (analyzing risk pool sizes for different types of HMOs); Hillman et al., supra, at 210-13 (discussing HMO manager perceptions of relationship between degree of risk and appropriate or inappropriate alterations of physician behavior).

49. Total health care expenditures are likely to be capped under President Clinton's proposed global budgets. Jacqueline Frank, Clinton Advisers Urge Strict Health Limits, REUTERS NEWS REPORTS, June 24, 1993, available in Nexis Library, Reuter File. To be effective, a global budget will have to be transformed into specific mechanisms for reducing costs, such as through increased use of capitation payments or through reductions in physician payments. See id.

50. Receipt of public funds can lead to demands to alter the content of care itself. The most recent and notorious example is the federal "gag rule" which prohibited abortion counselling by recipients of family planning funds. 42 C.F.R. § 59.7 (1992). The regulations were promulgated under the authority granted to HHS under the Public Health Service Act, 42 U.S.C. §§ 300a, 300a-6 (1988), and upheld by the Supreme Court in Rust v. Sullivan, 111 S. Ct. 1759 (1991). President Clinton has reversed the policy by executive order. Memorandum on the Title X "Gag Rule," 29 WEEKLY COMP. PRES. DOC. 87, 88 (Jan. 22, 1993). The demise of the gag rule does not completely resolve the larger problem of the use of funding to control the delivery of care. Although issued in the context of the abortion controversy, the Court's opinion in Rust v. Sullivan would theoretically support substantive regulation of the doctor-patient relationship in other contexts as well. Patients might be denied access to information and referrals because of their provider's financial relationship with government or private entities.

51. Over thirty-eight million Americans were enrolled in HMOs in 1991. John K. Iglehart, The American Health Care System: Managed Care, 327 NEW ENG. J. MED. 742, 744 (1992). Almost one quarter of employees with health insurance benefits were enrolled in HMOs in 1991. Milt Freudenheim, The Physicians' View When Managed Care Comes to Town, N.Y. TIMES, June 14, 1992, § 3 (Business), at 4 (chart).

Preferred provider organizations (PPOs) are yet another method for reducing the cost of health care. Under a PPO system, health care providers agree to reduced health care prices in return for access to a stream of patients provided by an insurer. Often, the PPO also includes various utilization controls. Deborah W. Garnick et al., Services and Charges by PPO Physicians
are the archetypical example of attempts to alter physician behavior by altering the mix of economic incentives. There are different types of HMOs, each employing slightly different cost reduction mechanisms. Results of research on the effects of incentive arrangements are equivocal. Studies indicate that some types of HMOs do reduce health care costs. They appear to do so by giving physicians an economic incentive to reduce their use of hospitalization and medical tests. These

---

for PPO and Indemnity Patients, 28 MED. CARE 894, 894-95 (1990). PPOs typically give physicians the same incentives as fee-for-service methods of payment because a physician can increase income by increasing services (unless the established price for a service is not adequate). See id. at 895. Perhaps for this reason, there is little research demonstrating that PPOs actually reduce health care costs. See id. at 895, 906. PPO physicians will be assumed to operate under the same incentives as fee-for-service physicians in this Article.

52. Staff HMOs directly employ physicians. STEVEN R. EASTAUGH, FINANCING HEALTH CARE: ECONOMIC EFFICIENCY AND EQUITY 152 (1987). The salaries of staff physicians may be adjusted, through bonuses or withholds, to reflect their adherence to HMO cost containment goals. Hillman et al., supra note 47, at 139-40.

Other HMOs operate through contractual arrangements with independent physicians or with groups of physicians. EASTAUGH, supra, at 152-53. See generally W.P. Welch, The New Structure of Individual Practice Associations, 12 J. HEALTH POL., POL'Y & L. 723 (1987) (discussing expanding use of incentives in HMOs implemented through individual practice associations). These HMOs often use capitated payments, in which physicians are paid a set amount per year in exchange for providing care for an enrolled patient. See supra note 47.

In addition, participating physicians may be given direct financial incentives to reduce the amount of authorized hospitalization or specialist referral. See supra note 48.

53. See Alexander M. Capron, Containing Health Care Costs: Ethical and Legal Implications of Changes in the Methods of Paying Physicians, 36 CASE W. RES. L. REV. 708, 727 (1986) (overall, HMOs are 10-40% less expensive than fee-for-service insurance); Iglehart, supra note 51, at 745-46 (1992) (group and staff model HMOs may do a better job of cost containment).

54. See, e.g., Capron, supra note 53, at 727 (hospitalization rates for some types of HMOs are up to 45% less than conventional fee-for-service practice styles); Sheldon Greenfield et al., Variations in Resource Utilization Among Medical Specialties and Systems of Care, 267 JAMA 1624, 1627 (1992) (fee-for-service physicians had a hospitalization rate over 40% greater than HMO physicians); Alan L. Hillman et al., How Do Financial Incentives Affect Physicians' Clinical Decisions and the Financial Performance of Health Maintenance Organizations, 321 New Eng. J. MED. 86, 88 (1989) (capitation and salaried HMO physicians had lower rates of patient hospitalization).

55. See, e.g., Carolyn M. Clancy & Bruce E. Hillner, Physicians as Gatekeepers: The Impact of Financial Incentives, 149 ARCHIVES INTERNAL MED. 917, 919 (1989) (physicians ordered fewer tests for HMO enrollees than for fee-for-service patients; tests eliminated tended to be the "discretionary" or "unnecessary" tests); Arnold M. Epstein et al., The Use of Ambulatory Testing in Prepaid and Fee-for-Service Group Practices, 314 NEW ENG. J. MED. 1089, 1089 (1986) (fee-for-service physicians ordered 50% more EKGs and 40% more chest radiographs compared to HMO physicians); Mark A. Hlatky et al., Diagnostic Test Use in Different Practice Settings: A Controlled Comparison, 143 ARCHIVES INTERNAL MED. 1886, 1888 (1983) (HMO physicians rated the need for coronary angiography lower than other community cardiologists); James P. Murray et al., Ambulatory Testing for Capitation and Fee-for-Service Patients in the Same Practice Setting: Relationship to Outcomes, 30 MED. CARE 252, 258-59 (1992) ("capitation patients of physicians . . . had fewer hypertension-related laboratory tests and consequently had
reduced utilization rates, however, are not enough to condemn negative economic incentives. If large amounts of medical care are simply unnecessary, needlessly exposing patients to walletectomies and to the risks of medical care, then HMO health care reductions should be applauded.\textsuperscript{56}

Research indicates that HMO physicians may produce the same or better health care outcomes for their patients as fee-for-service practitioners.\textsuperscript{57} If this is so, then physicians who participate in economic incentives designed to reduce the amount and cost of health care may not pose additional risks to their patients. Despite this research, however, reports of diminished quality of care in HMOs remain common.\textsuperscript{58} Anecdotal reports frequently note the need for HMO patients to be active consumers who push for access to treatments.\textsuperscript{59} In individual

\begin{itemize}
  \item lower charges per patient than patients with fee-for-service physicians\textsuperscript{6}).
  \item See supra text accompanying note 46.
  \item Studies indicate, for example, that HMO physicians do provide appropriate preventive care for their patients and that economic incentives may have limited impact on the frequency of medical testing and specialist referrals. See Clancy & Hillner, supra note 55, at 919-20 (physicians provided equivalent amounts of appropriate preventive care for HMO and fee-for-service enrollees); Mark A. Hall, Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment, 137 U. PA. L. REV. 431, 487 & n.201 (1988); Albert R. Martin et al., A Trial of Two Strategies to Modify the Test-Ordering Behavior of Medical Residents, 303 NEW ENG. J. MED. 1330, 1335 (1980) (minimal financial inducement had no effect on number of medical tests ordered by group of residents).
  \item The quality of care also seems to be appropriate. See, e.g., Timothy S. Carey et al., Prepaid Versus Traditional Medicaid Plans: Lack of Effect on Pregnancy Outcomes and Prenatal Care, 26 HEALTH SERVICES RES. 165, 176-79 (1991) (pregnancy outcomes for HMO and fee-for-service patients was similar); Howard P. Greenwald & Curtis J. Henke, HMO Membership, Treatment, and Mortality Risk among Prostatic Cancer Patients, 82 AM. J. PUB. HEALTH 1099, 1102 (1992) (finding differences in treatment methods and better survival times for HMO patients); Murray et al., supra note 55, at 258-59 (noting fewer tests ordered for capitation patients than fee-for-service patients in study and finding no difference in health outcomes after one year); Gerald Riley et al., Enrollee Health Status under Medicare Risk Contracts: An Analysis of Mortality Rates, 26 HEALTH SERVICES RES. 137, 153 (1991) (HMO Medicare patients had lower mortality rates than fee-for-service Medicare patients; difference in mortality rates could be due to selection bias or better patient care); I. Steven Udvarhelyi et al., Comparison of the Quality of Ambulatory Care for Fee-for-Service and Prepaid Patients, 115 ANNALS INTERNAL MED. 394, 398 (1991) (HMO care equal to or better than fee-for-service care).
  \item See id. One group of researchers has suggested that the apparently equivalent health outcomes found for HMO and fee-for-service patients might be related to the aggressiveness of HMO patients: "It is possible that the quality of care for HMO patients was . . . more a function of patients who have a greater interest in looking after their health and a greater propensity to use health care services choosing HMO coverage." Udvarhelyi et al., supra note 57, at 398.
\end{itemize}
cases, a physician’s disincentive to refer or hospitalize could clearly have a negative impact on patient health outcomes.

Global budget caps, as proposed by President Clinton, have the potential for increasing the economic conflicts between physicians and their patients.60 A cap on health care spending is likely to be implemented through the greater use of capitated payments or through reductions in physician fees.61 Capitated payments will lead to even more widespread incentives to reduce the amount of health care delivered to patients. Physicians faced with fee reductions may increase the total number of procedures performed in order to stabilize their income.

Available data suggests that incentives to deny care sometimes can be correlated with poor patient outcomes and needless expenses. The legal response to these risks must take into account not just the risk to patients, but also the social demand to reduce the cost of health care. This article considers whether and how these provider-associated risks should be recognized by the legal system: Will legislatures prohibit the infliction of the risk on patients through practice prohibitions? Will courts respond only to the fruition of the risk by permitting a traditional malpractice action? Or, will mandatory disclosure obligations be imposed to protect a patient’s right to decide whether or not to encounter a risk?

III. PATIENT RISK AND THE DUTY TO REFRAIN

States sometimes impose transaction bars, under which physicians are barred from exposing patients to certain kinds of risks. The prohibition can be imposed retrospectively or prospectively. Under retrospective transaction bars, the physician’s creation of risk is punished through the imposition of malpractice liability. Prospective prohibitions take the form of statutes prohibiting certain conduct by physicians. The most salient difference between these approaches lies in their treatment of patient injury. Malpractice actions require proof that the provider-associated risk actually injured the patient; prospective statutory prohibitions assume the existence of such injuries. This difference has important implications for both patient and provider.

A. Malpractice Law and Risk to Patients

A physician is liable for malpractice when her breach of the applicable standard of care causes a patient injury. Defining the standard of care and determining causation are the two most problematic elements of a malpractice action premised on provider-associated risks. Malpractice, which is often an unwieldy and inaccurate mechanism for protecting patients, is even more so here.

The growing majority of jurisdictions employ some variation of the national standard of care: a physician has a duty to employ the same reasonable diligence, skill, competence, and prudence as a minimally competent practitioner in the same general specialty, without regard to whether the care is delivered in an urban or rural setting. This standard of care is not monolithic; it does not penalize and therefore permits many variations in physician practice. Physicians are generally free from liability for injuries caused by the mere exercise of medical judgment, which might lead to differing treatments based on the same

62. See generally 2 TREATISE ON HEALTH CARE LAW § 12.04[3] (Michael G. MacDonald et al. eds., 1992) [hereinafter 2 TREATISE ON HEALTH CARE LAW]. Historically, the standard of care was tied to the community in which the physician practiced. Under the “locality” rule, a physician was not liable for malpractice so long as she reasonably employed the knowledge and skill of a minimally competent practitioner in her community. The locality rule is both substantive and evidentiary. See, e.g., Hall v. Hilbun, 466 So. 2d 856, 866 (Miss. 1985) (discussing substantive and evidentiary aspects of using local or national definitions of the standard of care in malpractice cases).

63. These doctrines are essentially protective of physicians. There are a few judicial decisions, however, which indicate a willingness to impose liability even where physicians conform to the prevailing community practice. See Lundahl v. Rockford Mem. Hosp, 235 N.E.2d 671, 674 (Ill. App. Ct. 1968) (customary practice itself might be negligent); Morgan v. Sheppard, 188 N.E.2d 808, 816-17 (Ohio Ct. App. 1963) (usual and customary methods generally employed cannot provide and establish these methods as safe in law when they are, in fact, negligent); Helling v. Carey, 519 P.2d 981, 983 (Wash. 1974) (much criticized decision recognizing that the profession as a whole may permit a negligent standard to develop, and holding that when this happens, “it is the duty of the court[] to say what is required”); Vassos v. Roussalis, 658 P.2d 1284, 1288 (Wyo. 1983) (standard of care is not what is “ordinarily”, “generally”, or “customarily” done, but rather what reasonably should have been done) (quoting Vassos v. Roussalis, 625 P.2d 768, 772 (Wyo. 1981)).

Some jurisdictions still cling to the locality rule’s protection of community practices, even when those practices may deviate significantly from those in other geographic areas. Jurisdictions employing a national standard of care often take into account local resources. In Hall v. Hilbun, for example, the court adopted a national standard of care while retaining a “resource-based caveat.” 466 So. 2d at 872-73. The process of defining the relevant community for malpractice purposes is a matter of geography, but practice styles in different geographic locations might be indirectly related to differing financial incentives, different levels of experience, or different ethical beliefs.
diagnosis, or to different use of diagnostic tests. In addition, courts often explicitly provide protection for what is termed “the respectable minority” position.

Defining the standard of care is extremely important for malpractice claims based on provider-associated risks. Patients might claim that physicians with some personal characteristics or economic incentives should refrain from providing treatment at all. In the alternative, plaintiffs could contend that a physician erred in providing a specific kind of care because of some personal characteristic or incentive. These causes of action appear similar, but the claimed breaches of the standard of care are quite different. In one, the patient must show that a minimally competent physician with some particular characteristic would not have provided care. In the other, the patient must prove that the minimally competent physician would not have provided the service in the manner it was delivered.

A mere breach of the standard of care is not, of course, sufficient to guarantee recovery. A patient must also show that her injuries were caused by the breach. This is another difficult task for patients who seek to bring malpractice actions based on provider-associated risks. Imagine that a physician with a drug addiction problem performs an operation, and the patient suffers some complications from the procedure. Imagine further, that there is widespread consensus that physicians with drug-related impairments should not perform surgery. The patient could not claim malpractice damages merely by noting that drug-impaired physicians should not perform surgery. The patient would have to prove that her complications were caused in some fashion by the physician’s drug dependence. The patient would be forced to prove that the physician’s actual provision of care was deficient in some

64. As the court noted in Hall, “[w]e must be vigilant that liability never be imposed upon a physician for the mere exercise of a bona fide medical judgment which turns out, with the benefit of 20-20 hindsight, (a) to have been mistaken, and (b) to be contrary to what a qualified medical expert witness in the exercise of his good medical judgment would have done.” Id. at 871; accord Ehlinger v. Sipes, 454 N.W.2d 754, 761 (Wis. 1990) (medicine is not exact science, no liability for unfavorable results alone).

65. 2 TREATISE ON HEALTH CARE LAW, supra note 62, § 12.04(3)(e). This protection is related to that provided for medical judgment generally, but is more specifically focused on a recognition of different types of practice styles or perspectives. Physicians might be protected from malpractice liability so long as they act in conformity with some minority position. Cf. Jones v. Chidester, 610 A.2d 964, 969 (Pa. 1992) (refining “two schools” analysis to require that minority position be held by significant number of practitioners).

66. 2 TREATISE ON HEALTH CARE LAW, supra note 62, § 12.06[1].
way. Evidence of the drug addiction would be useful in asserting the claim, but could not be sufficient.

1. Personal Characteristics

The most important aspect of litigation based on a provider's personal characteristics is likely to be the incentive for settlement created by the specter of negative publicity. Leaving aside this important reality and looking at the problem from a strictly legal standpoint, it may be difficult to tie the personal characteristics of a provider to liability because of the causation requirement. Under current legal doctrines, a plaintiff might assert that certain physicians have a duty not to engage in some types of care. Thus she might claim that physicians without adequate training or experience, those with drug or alcohol abuse

67. The plaintiff’s bargaining position may be especially improved where the physician’s negligence is related to some socially stigmatized characteristic, such as drug addiction or infection with a contagious disease. Defendants in these cases may be particularly anxious to settle, regardless of the legal merits of the plaintiff’s case.

This conclusion is supported by a review of reported malpractice cases, which reveals a sizeable group of cases dealing with provider inexperience but very few cases in which the plaintiffs’ claims are based on a provider’s use of alcohol or drugs. Search of LEXIS, Mega file (Mar. 20, 1993). Cf. Ross v. Patterson, 817 S.W.2d 418 (Ark. 1991) (no intentional infliction of emotional distress where obstetrician-gynecologist was admitted for drug and alcohol treatment one day before plaintiff gave birth to baby, who later died).

The tendency to settle cases may be reduced now that the Health Care Quality Improvement Act requires that malpractice settlements be reported to a centralized data bank, where they will be made available to hospitals considering whether to grant or continue a physician’s admitting privileges. 42 U.S.C. § 11131(a) (West 1988). Even relatively small payments are reportable under this provision. 45 C.F.R. § 60.7 (1992) (all malpractice payments must be reported regardless of amount).

68. [O]ne of the requirements which the law exacts of general practitioners of medicine is that if, in the exercise of the care and skill demanded by those requirements, such a practitioner discovers, or should know or discover, that the patient’s ailment is beyond his knowledge or technical skill, or ability or capacity to treat with a likelihood of reasonable success, he is under a duty to disclose the situation to his patient, or to advise him of the necessity of other or different treatment.

Lane ex rel. Lane v. Skyline Family Medical Ctr., 363 N.W.2d 318, 323 (Minn. Ct. App. 1985) (quoting Larsen v. Yelle, 246 N.W.2d 841, 845 (Minn. 1976)); accord Weinstock v. Ott, 444 N.E.2d 1227 (Ind. Ct. App. 1983) (plaintiff successfully brings cause of action based on defendant physician’s negligent failure to refer for diagnostic consultation). The general physician is then held to the standard of care that would have been exercised by the specialist to whom the referral should have been made. Id.; cf. Schmitz v. Blanchard Valley OB-Gyn, Inc., 580 N.E.2d 55 (Ohio Ct. App. 1989) (plaintiff unsuccessfully argues defendant negligently failed to consult cardiologist).
problems, or those who are infected with a transmissible condition, might have the duty to refrain from providing care.

Although these claims appear initially promising, the challenge lies in identifying when the duty to refrain begins. No clear norm of medical practice prohibits physicians from acquiring experience by performing procedures on patients. Mere inexperience or lack of prior success is not ordinarily sufficient to show a breach of the standard of care. Statutes, medical practice, and ethical commentaries, all support the continued practice of physicians with alcohol or drug problems, and of those with at least some transmissible diseases.

It is therefore difficult to prove a deviation from the required standard of care by merely pointing to some personal characteristic of the provider. Liability can more likely be shown by linking that personal characteristic to a specific action or inaction by the provider that breaches the standard of care, and thereby transforms the personal characteristic into an actionable error. An inexperienced physician, for example, might fail to identify correctly some condition. A provider with drug addiction problems might bungle a surgical procedure.

69. Continued practice of medicine while impaired by drug or alcohol use is unprofessional conduct under many state licensure codes and the American Medical Association Code of Ethics. See, e.g., N.Y. EDUC. LAW § 6530(7), (8) (McKinney 1985); 1992 CODE OF MEDICAL ETHICS, supra note 37, § 8.15.


71. See, e.g., Mike v. Maxwell, 577 So. 2d 1090, 1093 (La. Ct. App. 1991) (plaintiff fails in effort to show that defendant's lack of experience led to malpractice in performance of radial keratotomy). Some commentators have argued that a malpractice claim could be based on a risky physician's performance of a procedure under "[t]he theory . . . that, in certain cases, a provider's decision to perform a procedure at which she is substantially worse than the relevant market is, itself, negligence apart from the question of whether the procedure was performed competently." Twerski & Cohen, supra note 12, at 13; see also Sharrott, supra note 12, at 143-46 (1992) (discussing use of success rates in malpractice claims).

72. See generally infra notes 107-10, 168 and accompanying text.


75. See, e.g., CNA Ins. Co. v. Scheffey, 828 S.W.2d 785, 787 n.6 (Tex. Ct. App. 1992)
Providers with transmissible conditions might fail to take appropriate protective action to prevent transmission in the course of providing care. Plaintiffs must show that a particular provider's drug addiction, lack of experience, or infection actually caused injury.

In some circumstances, it might be possible to argue injury from mere exposure to the risk created by the provider's characteristic. Patients of HIV-infected health care providers have sought to recover for the fear that HIV might have been transmitted in the course of receiving health care. Some courts confronting these "fear of disease" cases have been willing to impose liability, despite the fact that malpractice law ordinarily does not protect patients from the mere fear that injury might have occurred.

76. A careful reader will note that the claim with respect to infected physicians is slightly different from the others considered here. The infected physician might be held to breach the standard of care by merely engaging in the conduct because the infection itself is the risk of harm to the patient. A plaintiff does not have to find some intermediary risk to carry the provider's personal characteristic into harm for the patient.

77. See, e.g., Hidding v. Williams, 578 So. 2d 1192, 1194 (La. Ct. App. 1991) (discussed infra at notes 258-73 and accompanying text); see also 2 TREATISE ON HEALTH CARE LAW, supra note 62, § 12.09(2)[b] (use of res ipsa loquitur doctrine often restricted in malpractice cases).

This is a general problem in cases of this type: a plaintiff may be able to show that the defendant might generally have a performance deficit without being able to tie that characteristic to particular conduct causing the plaintiff's injury.

78. Courts have reached varying results in "fear of disease" cases although plaintiffs generally must at least show that their fear was reasonable. See, e.g., Nesom v. Tri-Hawk Int'l, 985 F.2d 208, 210-11 (5th Cir. 1993) ("Louisiana law does not permit a party to maintain an action for mental anguish based on an alleged 'fear' of contracting a disease in the future absent a showing that the party was actually exposed to a contaminated agent"); showing that person "may" have been exposed is insufficient); Marchica v. Long Island R.R., 810 F. Supp. 445, 449 (E.D.N.Y. 1993) (Federal Employers' Liability Act "does encompass a cause of action for fear of contracting the AIDS virus where the basis of the claim is a documented physical injury sustained by the plaintiff" even if the plaintiff is unable to prove actual exposure to HIV); K.A.C. v. Benson, No. C-93-1203, 1993 Minn. App. LEXIS 1201 (filed Dec. 1, 1993) (permitting patients of HIV-infected physician to pursue actions for intentional infliction of emotional distress, negligent infliction of emotional distress, consumer fraud, battery, and negligent non-disclosure); and Lubowitz v. Albert Einstein Medical Ctr., 623 A.2d 3, 5 (Pa. Super. 1993) (plaintiff's "rational basis" for believing she had been exposed to HIV held insufficient to support negligence claims in the absence of actual exposure or transmission); Carroll v. Sisters of St. Francis Health Servs., Inc., No. 02S01-9302-CV-00011, 1993 Tenn. LEXIS 447 (filed Dec. 20, 1993) ("In order to recover emotional damages based on the fear of contracting AIDS, the plaintiff must prove, at a minimum, that he or she was actually exposed to HIV"); plaintiff's claim insufficient as a matter of law because "she cannot prove that the needles which pricked her were contaminated with HIV"); Howard v. Alexandria Hosp., 429 S.E.2d 22, 25 (Va. 1993) (plaintiff entitled to pursue traditional medical malpractice action against hospital after operation in which unsterilized instruments were used; plaintiff suffered physical injuries from post-operation antibiotic treatment and emotional injury from fear of HIV transmission); Johnson v. West Va. Univ. Hosps., 413 S.E.2d 889, 894
2. Economic Incentives

A physician's economic agreements may give her an incentive to provide or to deny care. Yet, reported malpractice decisions based on economic incentives are rare because the economic incentive itself is not the basis of liability. A provider's liability is, instead, determined by her deviation from the standard of care.

A physician in a traditional fee-for-service practice has an economic incentive to provide a high volume of services for patients, some of which might not be "necessary." A patient who is able to show that the care provided was completely unnecessary will likely be able to recover damages for the cost of the procedure as well as compensation for pain and suffering, lost wages, and the like. Thus, a surgeon who removes a healthy appendix without medical provocation would be liable for malpractice.

Yet, it is rare for a physician to perform a completely baseless procedure. It is more often true that the provider's services lie in a gray area in which they may be justified on some medical basis. A physician who eagerly performs hysterectomies or back surgeries might have

(W. Va. 1991) (plaintiff whose broken skin was exposed to HIV-infected blood was entitled to recover under theory of negligent infliction of emotional distress).

80. The paucity of cases may also be explained by the same settlement incentives that were noted with respect to actions based on a provider's personal characteristics. See supra text accompanying note 67.

81. This assumes that the physician's rate of compensation for the service actually provides a profit margin. It also assumes that the physician benefits from providing services to patients, even when those services might not be necessary. This assumption could be questioned in some circumstances. If the procedure poses a risk to the patient, for example, then the expected profit from the procedure's performance must be weighed against the potential liability arising from improper performance. It might be expected that low procedural risks would be associated with higher rates of service delivery. On a slightly different tack, a physician might implicitly calculate that performing a few (necessary) services for many clients is more profitable than performing many (some perhaps unnecessary) procedures for fewer patients.


83. She might also be liable for fraud or misrepresentation, depending on the nature of her communications with the patient. See infra text accompanying notes 174-81.
some medical basis for arguing that each of the procedures was medically necessary, and she may argue that sound medical judgment supports the care provided.\textsuperscript{84} A complaining patient has two options in such circumstances: she may present complex and expensive medical expert testimony showing why the procedure itself should not have been performed; or, if the facts permit, she may show that she was injured by some separate act of negligence during the operation itself. The presence of economic incentives may be tangentially relevant in the first claim, but is completely beside the point in the second. Furthermore, malpractice actions are likely only for those procedures that are risky or expensive. Malpractice is unlikely to serve as a deterrent to the performance of numerous low-risk and (relatively) low-cost treatments or diagnostic procedures.

Where there are economic incentives to deny care, how does malpractice law respond to a failure to provide appropriate treatment? Again, clear violations of professional standards will lead to malpractice liability. The chief difficulty for plaintiffs is that the wide range of acceptable medical practice means that physicians who fail to provide some treatments, diagnostic tests, or referrals may find sanctuary in the "respectable minority" protections built into the standard of care.\textsuperscript{85}

The most common type of economic incentive to deny care arises out of recent cost containment mechanisms.\textsuperscript{86} Physicians practicing

\begin{footnotes}
\item[84.] See \textit{supra} text accompanying note 64.
\item[85.] See \textit{supra} note 65 and accompanying text.
\item[86.] Economic arrangements which directly require providers to deny care also carry a serious risk of malpractice liability. Physicians working for clinics receiving federal family planning funds under Bush Administration regulations were prohibited from providing abortion services and information. In \textit{Rust v. Sullivan}, the Supreme Court upheld this regulation despite the fact that its implementation clearly might lead to a denial of care for the clients of such agencies. 111 S. Ct. 1759, 1785 (1991) (Blackmun, J., dissenting) (noting effect of regulations on women's ability to obtain abortion services). From a malpractice perspective, the issue is whether the denial of abortion-related information and referrals could have led to liability. The Court did not directly consider the liability question, yet its opinion suggests that malpractice liability was unlikely, in part because the doctor-patient relationship established in the clinics might not have carried with it the enforceable expectation of comprehensive medical advice. \textit{See id.} at 1776. This narrow view of the doctor-patient relationship in federally supported health programs seems objectionable on its face. \textit{Id.} at 1785 n.5 (Blackmun, J., dissenting).

The prevalence of third party payments to physicians could make such denials of care more common in the future. This is so particularly if the third party payers seize the opening noted by the Supreme Court and attempt specifically to limit the scope of some doctor-patient relationships. This technique would resemble that proffered by contract-oriented reformers of health care, who suggest that consumers ought to be able to enter into doctor-patient relationships whose scope is limited by the agreement of the parties. \textit{See infra} notes 326-27 and accompanying text. More generally, economic incentives which directly circumscribe the care received should lead to liabil-
\end{footnotes}
under various cost containment regimes, such as those employed by HMOs, may have different styles of practice when compared with fee-for-service physicians. Commentators are divided on whether the respectable minority rule will protect cost-conscious physicians from malpractice liability which might flow if the physicians' actions were merely compared with those of fee-for-service physicians. The courts have not focused nearly as much attention on this issue as the commentators. A denial of care—a physician's failure to refer, to diagnose, or to treat—could arise out of a provider's lack of knowledge, her momentary lapse of judgment, or her economic motivations, but most litigants and courts have not emphasized the cause so much as the result. Eco-

ity where there is a doctor-patient relationship and where the care delivered deviates from that which is medically appropriate. The role of disclosure in limiting this liability will be discussed in Part IV. See infra notes 286-309 and accompanying text.

87. The research discussed in Part II, supra, for example, suggests that HMO physicians do not hospitalize their patients as frequently as fee-for-service physicians and do not order as many medical tests. See supra text accompanying notes 53-55.


Those who believe that the standard of care will be affected by economic rationing often focus on the use of informed consent or mandatory disclosure to protect unwary patients from economically motivated alterations in the standard of medical care. See, e.g., Blumstein, supra, at 1392-95; Furrow, supra, at 1029-30; Rosenblatt, supra, at 1419; Schuck, supra, at 1423. The legal basis for a disclosure duty will be discussed infra in the text accompanying notes 171-253. Those commentators arguing that physicians may be held liable for malpractice when following cost containment policies have advocated either legislative or contractual responses. Legislative action could explicitly establish protection for cost-conscious practice by establishing immunity from liability for practitioners who follow certain sanctioned treatment protocols. See, e.g., Clark C. Havighurst, Prospective Self-Denial: Can Consumers Contract Today to Accept Health Care Rationing Tomorrow?, 140 U. Pa. L. Rev. 1755, 1771, 1774-75 (1992) (patients participating in cost-conscious health delivery systems have voluntarily agreed to the norms of practice developed by such entities); Eleanor D. Kinney & Marilyn M. Wilder, Medical Standard Setting in the Current Malpractice Environment: Problems and Possibilities, 22 U.C. Davis L. Rev. 421, 446-50 (1989); see also Me. Rev. Stat. Ann. tit. 24, § 2975 (West Supp. 1992) (application of practice parameters in malpractice claims).
nomic motivations behind the failure to provide proper care have been treated as nearly irrelevant for malpractice claims against individual providers.\footnote{89} There are few published decisions in economic incentive cases.\footnote{90} In \textit{Bush v. Dake},\footnote{91} the plaintiff claimed that the defendant HMO's system of financial incentives was the proximate cause of a delayed diagnosis of cervical cancer. The plaintiff had sought care for unusual vaginal bleeding and discharge in August of 1985, but was not diagnosed with cervical cancer until May of 1986.\footnote{92} Her HMO physicians were given an economic incentive to reduce referrals, and were not paid additional fees for performing pap smears.\footnote{93} In Mrs. Bush's case, her physician referred her to a specialist once, but refused to do so again when her condition remained unresolved.\footnote{94} Her physician never obtained a pap smear, which would have revealed the cancer at an earlier stage.\footnote{95} The trial court refused to enter summary judgment for a defendant HMO on claims that the HMO's system of financial incentives was the proximate cause of the plaintiff's injuries.\footnote{96}

\footnote{89. Information about economic incentives was even excluded from evidence in one case. In \textit{Madsen v. Park Nicollet Medical Ctr.}, 419 N.W.2d 511 (Minn. Ct. App.), \textit{rev'd en banc on other grounds}, 431 N.W.2d 855 (Minn. 1988), the plaintiffs brought suit against various physicians, claiming that an infant's birth-related injuries could have been prevented if the mother had been hospitalized. The plaintiffs had attempted to introduce evidence that the patient's status as an HMO enrollee meant that "her hospitalization could have adversely affected [the defendant doctor's] profits." \textit{Id.} at 515. The Minnesota appeals court upheld the exclusion of this evidence, noting that "[t]his evidence was only marginally relevant, and potentially very prejudicial." \textit{Id.}

\footnote{90. Courts also have considered whether there might be institutional liability for cost containment mechanisms affecting patient care, and in the process, they have indicated concern about the intrusion of economics into professional judgment. \textit{Compare Wickline v. California}, 239 Cal. Rptr. 810, 820, 819 (Cal. Ct. App. 1986) ("While we recognize, realistically, that cost consciousness has become a permanent feature of the health care system, it is essential that cost limitation programs not be permitted to corrupt medical judgment. . . . [T]he physician who complies without protest with the limitations imposed by a third party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care.") \textit{with Wilson v. Blue Cross of S. Cal.}, 271 Cal. Rptr. 876, 885 (Cal. Ct. App. 1990) (holding that utilization review entities can be held liable, along with treating physicians, for negligent determinations).}
In summary, malpractice law presents an uncertain remedy for the risks created by providers' personal characteristics or economic entanglements. It provides the possibility of compensation only where the personal characteristic or incentive creates a recognized deviation from the standard of care, and only where that deviation causes a legally cognizable injury. Most personal characteristics of a provider are unlikely to directly create malpractice liability. Further, the practice style created by economic incentives might be incorporated into the standard of practice and therefore insulated from patient challenges. Finally, malpractice liability only affords relief where the provider's characteristic or interest actually causes injury serious enough to attract the legal system's attention. There is rarely any recovery for exposing a patient to the risk of injury itself; the overall risks absorbed by patients are not recognized within the system.

B. Legislative Prohibitions: Fencing the Fox

Legislative prohibitions are another method of confronting the risks created by provider characteristics and economic incentives. States may directly regulate provider risks through licensing or by codifying standards governing the practice of medicine. Such regulation is most often justified as necessary to protect health and safety, and will

97. Many injuries will not be sufficiently rewarding to litigate. There are, of course, numerous other problems with the malpractice system that have been identified by careful researchers. See generally Paul C. Weiler et al., A Measure of Malpractice: Medical Injury, Malpractice Litigation, and Patient Compensation (1993).
be virtually immune from constitutional attack so long as it is substantially related to serving these goals. Nonetheless, federal or state statutes might provide other important limitations on the state's regulation of providers. One particularly important recent development is the federal Americans with Disabilities Act ("ADA"). Under this statute, states are prohibited from discriminating against providers based on some types of personal characteristics—those that constitute a protected disability under the Act—unless the state can show that the discrimination is necessary because the provider poses a direct threat to health and safety. Physicians with contagious diseases and recovering illegal drug users may be considered to be disabled under the statute.

Legislative attempts to protect health care consumers from provider-associated risks of injury share three common characteristics. First, these regulations are often prospective transaction bars, providing a clearer alternative to the more uncertain retrospective sanctions imposed by the malpractice system. Second, government regulations, where they exist, tend to focus directly on the provider's characteristics or economic relationships. Third, physicians may be liable for violating transaction bars even when no specific patient injury can be shown.

98. FRANK P. GRAD, THE PUBLIC HEALTH LAW MANUAL 99 (2d ed. 1990). In addition, state economic regulation that does not infringe on some constitutionally protected right and that does not discriminate based on some protected classification will be upheld so long as it bears a rational relationship with some legitimate state interest. See Williamson v. Lee Optical of Okla., Inc., 348 U.S. 483, 488 (1955).

Requiring that physicians make certain disclosures to their patients raises a slightly different set of constitutional considerations. See infra text accompanying notes 137-70.


101. Subchapter II of the Act prohibits discrimination in the provision of public services: 
"[N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." Id. § 12132. "Public entities" include state or local government agencies or departments. Id. § 12131. See also id. § 12202 (Eleventh Amendment does not immunize states from suits under the Act).

States are just beginning to grapple with the ADA's implications in the medical licensure process. Licensure Questionnaires Reviewed for Compliance with Disability Law, 2 HEALTH L. RPTR. (BNA) 783 (June 17, 1993) (discussing recent guidelines from Department of Justice).

102. "The term 'disability' means, with respect to an individual—(A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment." 42 U.S.C.A. § 12102 (West 1993). Current users of illegal drugs are not considered to have a protected disability. Id. § 12210(a). See generally LAURA F. ROTHSTEIN, DISABILITIES AND THE LAW 386-398 (1992).
1. Personal Characteristics

Government regulation of providers' personal characteristics has, until recently, been almost the exclusive purview of states.¹⁰³ States have paid little attention to the problems posed by a provider's other personal characteristics. The provider's "experience" is, in some minimal sense, established by a state's licensure provisions. All states require that applicants complete a specified educational program, including clinical practice, and successfully pass an examination before being licensed to practice medicine.¹⁰⁴ A license to practice generally means that a physician is permitted to engage in the practice of medicine; there are no further experience requirements imposed as a condition of performing particular procedures.¹⁰⁵ Providers naturally gain additional experience through practicing on patients, just as new lawyers practice on their clients and as new law teachers practice on their students. State regulation in this area is primarily retrospective, with state disciplinary proceedings providing a mechanism for weeding out grossly incompetent physicians.¹⁰⁶

State regulatory schemes often contain provisions affecting physicians who abuse drugs and alcohol, or physicians infected with contagious diseases.¹⁰⁷ A few states with particularly broad statutes refer only to unenumerated unprofessional conduct, or conduct posing a dan-

¹⁰³. States are the sole licensing authorities for health care professionals, for example, and establish educational requirements, professional norms of conduct, and other regulatory standards. See generally ROBERT C. DERBYSHIRE, MEDICAL LICENSURE AND DISCIPLINE IN THE UNITED STATES (1969).


¹⁰⁵. Of course, expertise in certain types of practice may be established by membership in one of the boards or colleges of particular practice specialties. Such certifications are largely private, however, and are not required for practice in those areas. Patients might nonetheless be interested in information about such certifications, and states will become involved in false or misleading claims by physicians that they possess certain qualifications.

¹⁰⁶. But see, Official 1992 Federation Summary of Reported Medical Board Actions Released; Actions Continue Upward Trend, BUSINESS WIRE, Apr. 21, 1993 (summarizing activity by medical boards, total of only 3,370 actions against physicians in all of 1992). A physician's "success rate" with a particular procedure is not a subject of prospective state regulation.

¹⁰⁷. A physician infected with a transmissible disease or who has a history of alcohol or drug addiction might be protected from discrimination by state or federal statutes prohibiting discrimination against persons with disabilities. See supra text accompanying notes 100-02.
ger to the public, as grounds for revoking a license. Most states have licensure and professional disciplinary codes which make physical or mental impairment grounds for license revocation. These general impairment provisions are often supplemented by sections specifically dealing with impairments arising from drug or alcohol use or from infection with some contagious disease.

The regulatory situation is particularly complex with respect to the risks presented by physicians infected with contagious conditions. Such physicians are subject to disciplinary action if their physical impairment could pose a sufficient risk to patients, although it may be difficult to determine which infectious diseases pose significant risks to patients.

108. Where necessary, these general provisions could be interpreted to include coverage of alcohol or drug addiction. See, e.g., CAL. BUS. & PROF. CODE § 2234 (West 1990); see also Composite State Bd. of Medical Examiners v. Hertell, 295 S.E.2d 223, 225 (Ga. Ct. App. 1982) (general unprofessional conduct provision could be applied to the conduct of a physician who "made a medical judgment while under the influence of alcohol and drugs").


under current statutes. The federal government recently mandated state restrictions on health care workers infected with HIV or HBV.

State licensure standards differ significantly from the retrospective malpractice standard because no proof of specific patient injury is required: placing the patient at risk is deemed a sufficient basis for action. The disciplinary standards identify certain types of provider-associated risk that should not be imposed on patients. The current statutory framework may be both under- and over-inclusive. It contains large gaps in which many risky physicians may lie hidden from state regulation and, at the same time, may illegally penalize physicians with disabilities who do not pose significant risks to their patients.

2. Economic Incentives

Recent years have seen the growth of both state and federal regu-

111. Physicians with active tuberculosis who continued to practice could easily be subject to disciplinary action, for example, because of the high degree of infectivity. HBV and HIV pose more difficult problems because these diseases are not easily transmitted between physicians and their patients. See generally supra notes 28-34 and accompanying text. Transmission requires that patients be exposed to the blood of the provider, such as might occur during some dental or surgical procedures. The appropriate application of general state professional regulation is therefore uncertain; it is not clear whether HIV infection makes a surgeon unable to practice medicine "reasonably safely."

112. In July 1991, the federal Centers for Disease Control (CDC), issued guidelines designed to govern the practice of HBV- and HIV-infected physicians. Centers for Disease Control, U.S. Dept of Health & Human Serv., supra note 28. Congress required states to adopt the CDC guidelines, or their equivalent, by October 1992. Treasury, Postal Service and General Government Appropriations Act, 1992, Pub. L. No. 102-141, § 633, 105 Stat. 834, 876 (1991) (modifying the procedures of 42 U.S.C. § 300ee-2 (1988)). States are beginning to respond with legislative or regulatory action. Most state action thus far has followed the CDC approach, although there is significant dispute over the appropriate role of physician disclosure, as will be discussed in Part IV below. See generally Bobinski, supra note 27, at 213.

113. This is because government regulation may be permissibly based on the overall risk of harm created by the providers' characteristics, without the need to show individual injury in a specific case. The government's regulation must, of course, be rational. A legislative enactment must rationally respond to some risk of harm. But the courts are notoriously loose in their application of this requirement, permitting a wide range of economic regulation without a particularly searching inquiry as to the validity of its basis or the appropriateness of the means of regulation chosen. See, e.g., Williamson v. Lee Optical of Okla., Inc., 348 U.S. 483, 488 (1955) (rational basis review for economic regulation applied to regulation of opticians).

The state regulatory and tort systems also are clearly interrelated. Standards of conduct adopted in the statutory or regulatory scheme may in turn become a part of negligence per se claims within the tort system, with the legislature's action establishing a new malpractice standard of care. Yet malpractice claims will still be affected by the need to show injury caused by the claimed deviation from the standard of care. Conversely, successful disciplinary actions could be maintained merely on the threat, perhaps as yet unrealized, of patient injury.

114. See supra text accompanying notes 100-02.
lation of economic incentives in the doctor-patient relationship. There are two different sources of regulation: standards of professional conduct applicable to all physicians, and reimbursement-related codes relevant only to physicians seeking reimbursement for care from a particular funding source. Incentives to provide care have been more carefully regulated under both schemes than have incentives to deny care.

Both state and federal actors have been concerned about certain economic incentives to provide care. State regulation tends to be incorporated into the professional disciplinary code. States typically prohibit fraudulent conduct or the provision of unnecessary care. Most states have enacted legislation which prohibits kickbacks, fraud, or fee-splitting by physicians. State legislatures have also become involved

115. This article focuses on governmental prohibitions; however, the ethical prohibitions of professional organizations may also be an important factor in state regulation. The American Medical Association, for example, has struggled to define the appropriate limit of physician financial conflicts with patients for many years. See, e.g., Robert M. Veatch, Ethical Dilemmas of For-Profit Enterprise in Health Care, in The New Health Care for Profit: Doctors and Hospitals in a Competitive Environment 125, 127-34 (Bradford H. Gray ed., 1983); Hugh M. Barton, Texas Illegal Remuneration Statute Builds on Previous Law, 88 Tex. Med. 68 (1992) (discussing Texas Medical Association's ethical opinion on physician ownership); Arnold S. Relman, "Self-Referral": What's at Stake?, 327 New Eng. J. Med. 1522, 1522-23 (1992) (summarizing AMA's recent contortions over ethics of self-referral).

116. Transaction bars arising out of this concern will be discussed here. See infra text accompanying notes 236-53 for a discussion of federal and state disclosure requirements.

117. See, e.g., CAL. BUS. & PROFESSIONS CODE § 2234(e) (West 1990); FLA. STAT. ANN. § 458.331(1)(i), (k), (l) (West 1991); N.Y. EDUC. LAW § 6509(2); TEX. REV. CIV. STAT. ANN. art. 4495b, § 3.08(4) (West Supp. 1993); WASH. REV. CODE ANN. § 18.130.180(13) (West Supp. 1993).


Colorado prohibits fraudulent advertising, COL0. REV. STAT. § 12-36-128.5 (1991). The remaining states include in one licensing statute all four types of prohibited activity—general and specific impairment, general and specific fiduciary breach. See ALA. CODE § 34-24-360 (1991);
in regulating "self-referrals," in which a physician refers patients to other entities in which she has an ownership interest.\footnote{119} Under Michigan law, for example, a physician is guilty of professional misconduct if she refers a patient to a clinical laboratory in which she has an ownership interest.\footnote{120}

Federal regulation of these economic incentives to provide care has been more problematic, in part because of the absence of a ready statutory vehicle. The federal government, after all, has not historically regulated the licensure and discipline of physicians. Transaction bars adopted at the federal level have instead used the hook of funding: a provider's receipt of reimbursement under federally or state funded health programs such as Medicare or Medicaid is tied to conformity with a certain standard of conduct. The Medicare Fraud & Abuse statute prohibits providers from participating in certain economic arrangements which would give them an incentive to increase the number of services provided to Medicare and Medicaid recipients.\footnote{121} The most feared examples are the kickback provision, which prohibits the acceptance or payment of money in exchange for referrals,\footnote{122} and the Stark

\begin{itemize}
\item \footnote{119} See, e.g., \textit{MD. HEALTH-GEN. CODE ANN.} \textsection{} 19-1311.1 (Supp. 1993) (prohibiting utilization review entities from referring patients to facilities in which the private review agent has a significant beneficial interest or to his or her own practice); \textit{NEV. REV. STAT. ANN.} \textsection{} 652.235(3) (Michie 1991) (prohibiting physician referrals "to a medical laboratory in which the physician has a financial interest unless it is operated solely in connection with the diagnosis or treatment of his own patients."); \textit{N.J. STAT. ANN.} \textsection{} 45:9-22.5 (West 1991) (prohibiting most referrals to entities in which physician has a "significant beneficial interest"); Carolyn M. Pengidore, \textit{Comment, Dubious Practice? The Storm Over Physician Self-Referrals,} 31 \textit{DUQ. L. REV.} 167, 187-89 (1992) (discussing state legislative activity). See also \textit{Day v. Inland Empire Optical, Inc.}, 456 P.2d 1011 (Wash. 1969) (ophthalmologists prohibited from referring patients to dispensing optical corporation in which they had financial interest).
\item \footnote{120} \textit{MICH. COMP. LAWS ANN.} \textsection{} 333.16221(e)(iii), (iv) (West 1992).
\item \footnote{121} Violation of these general fraud and abuse provisions can lead to civil and criminal sanctions. See \textit{42 U.S.C.} \textsection{} 1320a-7a(a)(1)(A) (1988) (civil penalties for submitting claims for unprovided services); \textit{id.} \textsection{} 1320a-7b(b) (1988 & Supp. I1991) (criminal sanctions for illegal remunerations).
\item \footnote{122} \textit{42 U.S.C.} \textsection{} 1320a-7b(b)(1), (2) (1988). Section 1320a-7b(b)(2) imposes the same
Amendment, 123 which prohibits physicians from referring patients to clinical laboratories 124 in which they have an ownership interest. 125

penalties on one who “knowingly and willfully offers or pays any remuneration” under like circumstances.

Many of the blossoming financial linkages in the health care delivery system potentially violate these rules, including many financial arrangements between hospitals and physicians and between physicians and ancillary service providers. Liability concerns have sparked a cottage industry of publications designed to both inflame and soothe these fears. See, e.g., PAUL P. CACIOPPO, HEALTH CARE FRAUD AND ABUSE: A GUIDE TO FEDERAL SANCTIONS (1993). The Department of Health and Human Service’s Safe Harbor regulations, issued by Congressional mandate, have provided little comfort. 42 C.F.R. § 1001.952 (1991). The safe harbors established by the regulations are more like inlets, providing protection for only a narrowly defined set of transactions where the risk of improper incentives is non-existent. Some types of transactions are permissible outright, see id. § 1001.952(a)-(e), (i), (k); while others are permitted only if certain conditions and disclosure obligations are met, see id. § 1001.952(f)-(h), (j). New regulations will cover the specific concerns of HMOs and PPOs, who may engage in a variety of discounts, rebates, or other arrangements. 57 Fed. Reg. 52723 (Nov. 5, 1992).


124. Section 1395nn does, however, exclude some referrals from its prohibitions, despite the existence of potentially powerful economic incentives to provide additional services. Thus in-office and intra-group practice referrals for clinical laboratory services are permissible, as are those furnished by organizations providing pre-paid services to patients. See § 1395nn(b)(1), (2), (3); see also at § 1395nn(b)(4) (hospital financial relationships permitted where no relationship to clinical laboratory services). The statute is replete with references authorizing the Secretary of Health and Human Services to impose additional requirements for arrangements tentatively excluded from prohibition by Congress. See §§ 1395nn(e)(1)(C), (2)(D), (3)(C), (4)(C), (5)(B) (entitling Secretary to impose additional requirements “as needed to protect against program or patient abuse” in certain “other compensation arrangements”).

125. The statute applies where a “physician (or immediate family member of such physician) has a financial relationship with” a facility. See § 1395nn(a)(1). The requisite financial relationship can consist of an “ownership or investment interest in the entity” or a “compensation arrangement” with the entity. § 1395nn(a)(2). “An ownership interest . . . may be through equity, debt, or other means.” Id. “The term compensation arrangement means any arrangement involving any . . . remuneration directly or indirectly, overtly or covertly, in cash or in kind.” § 1395nn(h)(1).

Some ownership and compensation arrangements are not deemed sufficiently dangerous to either patients or the financial integrity of the program. Stock ownership in large corporations, for example, will not trigger the referral ban. See § 1395nn(e) (permitting ownership of publicly traded stock in corporation with assets of over $100,000,000). Certain compensation arrangements deemed unlikely to affect physician behavior are also permitted. See § 1395nn(e)(1) (office rental agreements where for fair market value); § 1395nn(e)(2) (employment arrangements with hospitals, where for fair market value paid for services rendered and where the volume of services referred by the physician is not, directly or indirectly, used to determine compensation); § 1395nn(e)(3) (employment or service arrangements with certain other entities, where the same fair market value and no-consideration-of-referrals tests are met); § 1395nn(e)(4) (physician recruitment agreements, where there is no referral requirement and where remuneration is determined without direct or indirect reference to physician referrals); § 1395nn(e)(5) (isolated finan-
Economic incentives to deny care to patients have received far less legislative attention. State laws may prohibit economic arrangements between providers and others which would require the denial of some types of care. A physician whose medical judgment was influenced by a non-physician third entity could be guilty of assisting in either the unlicensed practice of medicine or the unlawful corporate practice of medicine. Some states have begun to regulate the cost containment aspects of the new health care delivery system. Texas, for example, prohibits the use of certain financial incentive arrangements by PPOs.

Other ownership interests are permitted for policy reasons, even though they might pose some risk of inappropriate economic incentives. For example, the statute permits ownership interests connected with clinical laboratory services provided by Puerto Rico hospitals, or by rural hospitals, or by hospitals where a physician is authorized to perform services, so long as the physician's ownership interest is in the entire hospital. See § 1395nn(d). For other exclusions from the prohibitions of § 1395nn, see supra note 124 and accompanying text (discussing general exclusions of § 1395nn(b)).

Under the statute, payment for impermissible services will be denied and refunds may be collected. §§ 1395nn(g)(1), (2). Civil penalties of up to $15,000 may be imposed for each knowing or negligent submission of a claim for reimbursement for impermissible services. § 1395nn(g)(3). Physicians or entities knowingly or negligently entering into a cross-referral scheme for the “principal purpose of assuring [otherwise impermissible] referrals can be fined up to $100,000 per scheme. § 1395nn(g)(4). Physicians who are subject to penalties under §§ 1395nn(g)(1), (2) can also be excluded from further participation in the Medicare or Medicaid programs. See id.; 42 U.S.C. § 1320a-7a(a) (1988).


Intrusions into the doctor-patient relationship could also be challenged as interference with a contractual relationship, although courts have not responded favorably to this approach. See Phoebe Carter, Annotation, Liability for Interference with Physician-Patient Relationship, 87 A.L.R.4th 845 (1991).

Note that both these arguments assume that a doctor-patient relationship exists. Agreements to restrict the care given might be permissible where the physician is not in a doctor-patient relationship or where the relationship is limited from its inception. See supra note 86.

127. Texas prohibits the use of many negative economic incentives by PPOs: The referring practitioner may not be required to bear the expenses of referral for specialty care in or out of the preferred provider panel. Savings from cost-effective utilization of health services by contracting physicians or other practitioners may be shared with physicians or other practitioners in the aggregate. No payments may be made to reward a physi-
The federal fraud and abuse statute imposes civil monetary penalties for payments made by hospitals to physicians intended to induce a reduction in the services provided to Medicare or Medicaid patients. Congress initially signaled its intention to impose a similar prohibition on payments made by HMOs to physicians. It delayed implementation of the HMO penalties, however, and asked for a report on HMO economic incentives from the Secretary of the Department of Health and Human Services (HHS). Congress then backed away from the broad prohibition of HMO use of incentive plans and adopted a less

cient or other practitioner for not referring a patient to a specialist or for not treating a particular condition.[1]

TEX. ADMIN. CODE tit. 28, § 3.3703(3) (1993).

128. The Act prohibits certain direct or indirect payments by hospitals to physicians which are designed to induce a reduction in the amount of services provided. 42 U.S.C. § 1320a-7a(b) (1988 & Supp. III 1991). That section imposes the same penalty on hospitals which make payments or physicians who accept them. Id.


130. Congress asked for a detailed study of the issue:

The Secretary of Health and Human Services shall report to Congress, not later than January 1, 1988, concerning incentive arrangements offered by health maintenance organizations and competitive medical plans to physicians. The report shall—

(A) review the type of incentive arrangements in common use,

(B) evaluate their potential to pressure improperly physicians to reduce or limit services in a medically inappropriate manner, and

(C) make recommendations concerning providing for an exception, to the prohibition contained in section 1128A(b) of the Social Security Act [the 42 U.S.C. § 1320a-7a(b) prohibition of payments to induce care reductions], for incentive arrangements that may be used by such organizations and plans to encourage efficiency in the utilization of medical and other services but that do not have a substantial potential for adverse effect on quality.


(B) In this paragraph, the term "physician incentive plan" means any compensation arrangement between an eligible organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization.

§ 1395mm(i)(8)(B). This broad definition is limited in application, however. See infra note 133
stringent approach which permitted HMO use of incentives so long as they were not tied to specific patients, and so long as physicians were not placed at extreme financial risk, as defined by the Secretary of HHS.

State and federal regulation of the risks associated with economic incentives is more detailed for incentives to provide care than for incentives to deny it. This difference in regulatory intensity probably has two explanations: first, incentives to provide care have a longer history; and second, they directly increase the cost of medical care. Incentives to deny care are a more recent development and have been viewed as an important tool for reducing the rate of increase in health care expenditures. Regulating the risks of such incentives has thus been more problematic.

132. The statute contains a complete bar to incentives tied to the treatment accorded specific identifiable individuals.

Each contract with an eligible organization under this section shall provide that the organization may not operate any physician incentive plan . . . unless . . . [n]o specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the organization.

§ 1395mm(i)(8)(A)(i).

133. Congress’s prohibition of general (as opposed to patient-specific) economic incentives was considerably more limited than that which had initially appeared in the Medicare Fraud and Abuse provisions. These HMO incentive arrangements are permissible so long as the financial risk to physicians is not too great, as interpreted by the Secretary of HHS:

If the plan places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group, [a permissible incentive plan requires that] the organization . . . provide[] stop-loss protection for the physician or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or the physician group . . .

§ 1395mm(i)(8)(A)(ii)(I). The HMO using economic incentive arrangements must also gather information to ensure patient access and satisfaction, § 1395mm(i)(8)(A)(ii)(II), and must provide enough information to demonstrate to the Secretary the HMO’s compliance with these requirements, § 1395mm(i)(8)(A)(iii).

IV. THE DUTY TO DISCLOSE: PROVIDER PRIVACY AND PATIENT AUTONOMY

Disclosure obligations are a frequently discussed, and occasionally implemented, alternative to pure transaction bars.\textsuperscript{134} Theoretically, a duty to disclose would maximize the autonomy of both providers and patients. Providers who disclosed appropriate information would be free to practice regardless of the risks created by their personal characteristics or economic entanglements. Patients who received appropriate information could choose whether to encounter the risks presented by a particular provider. Patients might also be able to bargain for a reduced price in exchange for their acceptance of provider-associated risk.\textsuperscript{135} Disclosure mandates could thus reduce some of the broader social problems created by under- or over-inclusive transaction bars. Patients would not be forced to encounter risks that, given knowledge, they would choose to avoid. Physicians would not be barred from economic arrangements that might reduce health care costs or even improve the quality of care.

As is often the case in law, there is a large gap between the theoretical benefits of disclosure duties and the reality of their implementation. The chasm between theory and reality has several troublesome inhabitants, two of which merit attention here.\textsuperscript{136} Disclosure duties are an imperfect answer to the problem of provider-associated risk because they (1) threaten the privacy interests of providers, and (2) are not clearly authorized under existing legal doctrines or are uncertain in scope and effect.

A. Legal Recognition of Provider Interests

Disclosure obligations necessarily infringe provider First Amendment and privacy interests.\textsuperscript{137} In a sense, providers merely exchange the injuries caused by transaction prohibitions for the ones created by

\textsuperscript{134} In practice, disclosure duties most often supplement transaction bars, i.e., a transaction is prohibited unless the required disclosure is made.

\textsuperscript{135} The patient might also bargain for a lower price where the provider is extracting some additional, previously unrecognized, benefit from providing the patient services.

\textsuperscript{136} Other problematic aspects of disclosure duties will be considered \textit{infra} text accompanying notes 310-33.

\textsuperscript{137} Disclosure obligations are related to yet distinguishable from prohibitions against fraud that already regulate the physician-patient relationship. Under the former, a physician is required to affirmatively reveal some personal information. Under the latter, the physician is required to answer patient questions truthfully, or at least to truthfully refuse to answer. Both disclosure obligations and fraud prohibitions may result in the release of physician information.
disclosure obligations. The nature of the injury varies with the nature of the provider-associated risk. The greatest injuries seem likely when the physician is required to reveal information about her personal characteristics. The disclosure of sensitive information about HIV status or alcohol or drug use, for example, might cause great harm. Disclosure of financial information can also be injurious.

There are two major sources of constitutional regulation governing disclosure requirements: the right to free speech and the right of privacy. The First Amendment is implicated when the state requires speech. The standard of judicial review applied to mandatory speech varies depending on whether the state regulation affects commercial or "core" speech. Strict scrutiny will be applied to state-mandated disclosures when the speech is deemed to be "core" speech, fully within the First Amendment's protections. In contrast, mandatory disclo-

138. A disclosure obligation can become a transaction bar where the potential invasion of the provider's privacy interests is so great that she avoids the disclosure duty by choosing not to engage in the regulated transaction. Note that in such cases the performance of the transaction will ultimately depend on the injury to the provider caused by disclosure rather than the degree of potential injury to the patient.

139. There may actually be two different types of injury, occurring sequentially. The first occurs when the physician is required to reveal personal information to a patient. The second can occur if this information is then released to others by the patient.

140. The injury can be direct, through the release of information about personal financial transactions, or indirect, as the patient's perception of the doctor-patient relationship becomes tainted by knowledge of potential conflicts of interest. This alteration in perceptions may be felt as an injury by both physicians and patients, even if it merely results from improved ability to see reality.


142. See, e.g., Riley, 487 U.S. at 796 n.9 (noting differential treatment of required disclosures for traditional and commercial speech); Zauderer, 471 U.S. at 637.

143. In a recent case, the Supreme Court considered the constitutionality of a state law which required charitable fundraisers to disclose the percentage of contributions actually delivered to the charity in the recent past. Riley, 487 U.S. at 795. The solicitation of charitable contributions had previously been held to be protected speech rather than purely commercial speech. Id. at 787-88. The Court seemed to reject the claim that mandatory disclosures should be treated differently from other types of speech regulations:

North Carolina asserts that... the First Amendment interest in compelled speech is different than the interest in compelled silence; the State accordingly asks that we apply a deferential test to this part of the Act. There is certainly some difference between compelled speech and compelled silence, but in the context of protected speech, the difference is without constitutional significance, for the First Amendment guarantees "freedom of speech," a term necessarily comprising the decision of both what to say and what not to say.

Id. at 796-97 (first emphasis added). Under these circumstances, the Court explicitly held that
I...
First, if the physician's speech were deemed fully protected under the First Amendment, the Court would presumably permit some forced disclosures if narrowly tailored to serve a compelling state interest, such as the need to protect patient health. Second, if the speech is deemed to be commercial, mandatory disclosures would likely be upheld so long as they reasonably furthered the state's interest in protecting consumers from fraud and abuse, and would certainly be upheld to protect public health. The sole Supreme Court pronouncement on this issue supports the conclusion that broad state speech requirements will be upheld in the medical context. In its most recent foray into the constitutionality of abortion regulation, the Court upheld state mandated consent procedures over First Amendment attack:

All that is left of petitioners' argument is an asserted First Amendment right of a physician not to provide information about the risks of abortion, and childbirth, in a manner mandated by the State. To be sure, the physician's First Amendment rights not to speak are implicated . . . but only as part of the practice of medicine, subject to reasonable licensing and regulation by the state. . . . We see no constitutional infirmity in the requirement that the physician provide the information mandated by the state here.147

The standard applied by the Court is never explicitly stated, but the bottom line is clear: state regulation of physician speech will be permitted so long as it is "reasonable."

There are other legal doctrines that might apply to the problem of mandated disclosures by physicians. The right of privacy is commonly associated with the right to abortion, and thus is constantly under attack in the Supreme Court.148 Privacy jurisprudence, however, contains a second strand of cases that protects informational rather than decisional privacy.149 This constitutional right to privacy seems to have its roots in, but to go beyond, the explicit protections of the Fourth and Fifth Amendments.

The Fourth Amendment's protection from unreasonable searches and seizures has been interpreted to protect an individual's "reasonable


148. Planned Parenthood v. Casey represents the Court's most recent grappling with the constitutional status of abortion decisions. See also Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. 2841, 2851 (1990) (in dicta, terming right to make decisions about medical treatment a "liberty interest").

expectations of privacy." Despite this promising language, the Fourth Amendment is unlikely to restrict disclosure obligations because (1) they impose no "search and seizure;" (2) participants in the highly-regulated health care industry have few reasonable expectations of privacy; and (3) the government's interest in protecting public health would likely outweigh any privacy interest. The Fifth Amend-


151. There must be a search and seizure of some kind to spark Fourth Amendment protection. Government efforts to test providers for HIV infection, or to search physicians' offices for blood-stained invoices that might provide evidence of financial entanglements, would thus be subject to Fourth Amendment warrant or reasonableness requirements. Required disclosures of information do not fit as neatly within the doctrine. In Whalen v. Roe, 429 U.S. 589 (1977), physicians and patients challenged a New York statute requiring physicians to report certain information about drug prescriptions to the state. Id. at 604 n.32. But see Leckelt v. Board of Comm'rs of Hosp. Dist. No. 1, 909 F.2d 820, 832-33 (5th Cir. 1990) (applying Fourth Amendment analysis to uphold request of public hospital that an employee disclose his HIV test result).

152. The fact that the profession is highly regulated means that physicians may not have a "reasonable expectation of privacy" in the information sought to be disclosed. Physicians are already required to reveal a wide array of personal information for licensure purposes; it would seem at least arguable that they therefore have a diminished expectation of privacy in personal matters that could pose a risk to patients. Courts have pointed to this rationale in upholding testing and disclosure programs in other contexts. See, e.g., National Treasury Employees Union v. Von Raab, 489 U.S. 656, 671-72 (1989) (upholding warrantless drug testing of Customs Dept. employees in safety sensitive positions); Railway Labor Executives' Ass'n, 489 U.S. at 627-28 (upholding post-accident drug and alcohol testing of railway workers); Leckelt, 909 F.2d at 832-33 (5th Cir. 1990) (upholding mandated disclosure of HIV result, noting hospital's long-standing regulations requiring release of information about infectious conditions); Anonymous Fireman v. City of Willoughby, 779 F. Supp. 402, 415-16 (N.D. Ohio 1991) (upholding imposition of HIV testing on firefighters, noting highly regulated nature of employment); Kemp v. Claiborne County Hosp., 763 F. Supp. 1362, 1367 (S.D. Miss. 1991) (scrub technician in safety sensitive position and therefore subject to drug testing); Local 1812, American Fed'n of Gov't Employees v. United States Dep't of State, 662 F. Supp. 50, 53 (D.D.C. 1987) (privacy interest of Foreign Service employees not invaded by mandatory HIV tests). But see Glover v. Eastern Neb. Comm'y Office of Retardation, 867 F.2d 461 (8th Cir.), cert. denied, 493 U.S. 932 (1989) (rejecting argument that highly regulated nature of employment gives state health care workers a diminished privacy interest and therefore prohibiting mandatory HIV testing).

153. The fact that disclosure obligations would be imposed to protect public health suggests that courts might easily find that the government's interest in disclosure of some information outweighs the invasion of the provider's reduced privacy interest. Courts have upheld random drug and alcohol testing of health care workers because they occupy "safety sensitive positions." "The public safety rationale applies where a single misperformed duty could have irremediable consequences, such as where an employee could not rectify his mistake or other government employees would have no opportunity to intervene before harm occurs." Kemp, 763 F. Supp. at 1367; see
ment's proscription against compulsory self-incrimination is likely to be similarly unavailing.\textsuperscript{184}

The right to informational privacy is perhaps more directly applicable to the state's imposition of provider-associated disclosure requirements, but it, too, affords weak protection. The Court first discussed a specific informational privacy right in \textit{Whalen v. Roe}.\textsuperscript{185} The plaintiffs in \textit{Whalen} challenged the constitutionality of a New York statute requiring physicians to report the names and addresses of patients who were prescribed certain potentially addictive drugs.\textsuperscript{186} The Court found that there was a limited constitutional interest in "avoiding the disclosure of personal matters."\textsuperscript{187} Because the state's information collection

\textit{also} American Fed'n of Gov't Employees, Council 33 v. Barr, 794 F. Supp. 1466, 1472 (N.D. Cal. 1992) (physicians and dentists in safety sensitive positions because of risk to patient health from drug or alcohol use). Provider characteristics associated with risks to patient health might thus have little protection under a Fourth Amendment analysis.

\textsuperscript{154}. The Fifth Amendment protection against self-incrimination applies to the states through the Fourteenth Amendment. \textit{See, e.g., Malloy v. Hogan}, 378 U.S. 1 (1964). This privilege may protect certain aspects of an individual's privacy interest; this protection, however, is of limited utility because of the narrow application of the right and because of the nature of provider-associated risks. The privilege against self-incrimination extends only to government attempts to force individuals to provide information that might be used in criminal prosecutions. \textit{See, e.g., Marchetti v. United States}, 390 U.S. 39 (1968) (taxpayer's criminal protection for failure to disclose illegal income barred by assertion of privilege); \textit{see also LAURENCE H. TRIBE, AMERICAN CONSTITUTIONAL LAW § 12-26, at 1021-22 (2d ed. 1988)}. The threat of criminal prosecution simply does not exist for most provider-associated risks, rendering the Fifth Amendment's protections largely irrelevant. Criminal prosecution might be possible, however, under the fraud and abuse statutes. \textit{See supra} notes 121-25 and accompanying text. When information relating to criminal violations of the fraud and abuse statutes could be used in subsequent prosecutions, government agencies would be restricted from mandating its disclosure. \textit{Cf. American Fed'n of Gov't Employees v. United States R.R. Retirement Bd.}, 742 F. Supp. 450, 455-56 (N.D. Ill. 1990) (Fifth Amendment could bar government from requiring disclosures of information as a condition of employment where information could be released to any other government agency on request). Proposals to criminalize the practice of medicine by HIV-infection providers might also create Fifth Amendment defenses to disclosure obligations.

\textsuperscript{155}. 429 U.S. 589 (1977). The conflicting concurrences in \textit{Whalen}, \textit{see id.} at 606 (Brennan, J., concurring), 607 (Stewart, J., concurring) suggest that doctrine in this area rests on an unsteady base. Lower courts have attempted to build upon the framework established in \textit{Whalen}, but have had some difficulty agreeing on what that framework is. \textit{See, e.g., J.P. v. DeSanti}, 653 F.2d 1080, 1087-90 (6th Cir. 1981) (concluding no general constitutional protection for confidentiality); United States v. Westinghouse Elec. Corp., 638 F.2d 570, 577-80 (3d Cir. 1980) (discussing confidentiality safeguards under which government agency could compel production of occupational medical records); \textit{Railroad Retirement Bd.}, 742 F. Supp. at 453-55 (right of privacy applies and protects government employment applicants from required disclosure of some types of information). \textit{See also Chlapowski, supra} note 149, at 145-50 (discussing informational privacy case law).

\textsuperscript{156}. \textit{Whalen}, 429 U.S. at 591.

\textsuperscript{157}. \textit{Id.} at 599-600. Other courts have found that "personal matters" include financial or
system was carefully designed to prevent illegitimate disclosures,\textsuperscript{158} the Court upheld the statute's reporting requirements.\textsuperscript{159} Therefore, the collection of the information itself only needed to be rationally based on a legitimate governmental interest, a test it easily met.\textsuperscript{160}

Do disclosure obligations imposed under state law run afoul of \textit{Whalen}'s prohibitions? Disclosure obligations designed to protect the public health would appear to be constitutionally permissible.\textsuperscript{161} States

---

\textsuperscript{158.} \textit{Whalen}, 492 U.S. at 593-94.

\textsuperscript{159.} \textit{Id.} at 603-04.

\textsuperscript{160.} Under \textit{Whalen}, states have access to private information but may have a constitutional duty to maintain its confidentiality. The Court explicitly recognized the state's right to collect sensitive information, \textit{id.} at 602, but suggested nonetheless that there might be constitutional constraints on the dissemination of the information:

The collection of taxes, the distribution of welfare and social security benefits, the supervision of public health . . . all require the orderly preservation of great quantities of information, much of which is personal in character and potentially embarrassing or harmful if disclosed. The right to collect and use such data for public purposes is typically accompanied by a concomitant statutory or regulatory duty to avoid unwarranted disclosures. Recognizing that in some circumstances that duty arguably has its roots in the Constitution, nevertheless New York's statutory scheme, and its implementing administrative procedures, evidence a proper concern with, and protection of, the individual's interest in privacy.

\textit{Id.} at 605 (emphasis added). \textit{See also} Chlapowski, \textit{supra} note 149, at 146 (analyzing standard of review employed in \textit{Whalen}).

\textsuperscript{161.} Government reporting requirements have also been a continuing issue in state abortion legislation, where the courts have consistently required confidentiality of identifiable patient information. \textit{See, e.g.}, Planned Parenthood of S.E. Pa. v. Casey, 112 S. Ct. 2791, 2832-33 (1992) (upholding state recordkeeping and reporting provisions, with exception of reporting provision regarding women's reasons for failing to notify husbands); Thornburgh v. American College of Obsts. & Gyns., 476 U.S. 747, 765-67 (1986) (invalidating state abortion reporting requirements requesting information so detailed that identification of individual women is possible); Planned Parenthood of Central Mo. v. Danforth, 428 U.S. 52, 80 (1976) (state recordkeeping requirements in abortion context permissible if "reasonably directed to the preservation of maternal health and that properly respect a patient's confidentiality and privacy"). This suggests that states might require the collection of information about provider characteristics associated with risks to patients, but that dissemination of such information might be subject to restriction. \textit{See, e.g.}, Faison v. Parker, 823 F. Supp. 1198, 1205 (no violation of plaintiff's constitutional privacy right because state interest in including medical information in presentence report outweighed the privacy interest involved and sufficient safeguards were taken against disclosure of confidential information); Doe v. Borough of Barrington, 729 F. Supp. 376, 387-90 (D.N.J. 1990) (holding municipality liable for failure of police to maintain the confidentiality of HIV-related information and for failure to implement confidentiality training program); Woods v. White, 689 F. Supp. 874, 874-75 (W.D. Wis. 1988) (improper release of prisoner's AIDS status violates constitutional right to privacy).
could, consistent with *Whalen*, require physicians to report personal characteristics and economic entanglements where disclosure would be rationally related to some legitimate state interest, such as the protection of public health.\textsuperscript{162} *Whalen* holds that required disclosures to state entities will be upheld where confidentiality is maintained. Courts have created duties to disclose information to third parties without seriously considering the constitutional implications.\textsuperscript{163} Courts have also failed to consider whether disclosure obligations between private parties carry with them any protection of confidentiality.\textsuperscript{164} Where the state's inter-

---

\textsuperscript{162} *Whalen* suggests that the state's interest in the information need only be legitimate so long as confidentiality is maintained, but that the interest must be compelling if the information is not to be protected. See supra notes 158-60 and accompanying text. This standard would permit a wide range of disclosure mandates, but might be used to set an outside limit on the types of information subject to disclosure. A state would presumably be prohibited from requiring disclosure of some personal characteristic when there was no rational basis for tying that characteristic to the quality or cost of care. Required disclosures of a provider's sexual orientation, for example, would not bear any rational relationship to any legitimate state interest.

\textsuperscript{163} Fiduciaries have long been required to reveal financial conflicts of interest to their "entrustors." See, e.g., Restatement (Second) Agency §§ 389-390 (1958); Tamar Frankel, *Fiduciary Law*, 71 Cal. L. Rev. 795, 800 n.17 (1983) (suggesting use of term "entrustor" for one to whom a fiduciary duty is owed). These mandatory disclosures have not been subject to constitutional attack.

\textsuperscript{164} State reporting requirements seem similar to but are radically different from the imposition of disclosure obligations. The first gives the state the knowledge needed to act; the second gives private individuals knowledge from which they may act. The two mechanisms seem similar because they both depend on the transmission of information as the first step in protecting the public's interest.

The price to health care providers for patient empowerment by mandatory disclosure duties is greater than for empowerment by reporting requirements. This is so because requiring disclosure of sensitive information to ordinary citizens may create greater risks of confidentiality breaches. State employees are naturally subject to closer state supervision than ordinary citizens. Breaches of confidentiality may be more effectively punished through reprimands or other disciplinary action. Theoretically, the confidentiality of certain types of information will be protected even in the hands of private individuals. Some states, for example, specifically protect HIV-related information from disclosure by any person. See, e.g., Tex. Health & Safety Code Ann. § 81.103(a) (West 1992) ("[A]n HIV test result is confidential. A person that possesses or has knowledge of a test result may not release or disclose the test result or allow the test result to become known except as provided in this section.") (emphasis added). Yet individuals may be for all practical
est is compelling, such as when disclosure is sought to protect public health, then required disclosures to third parties are likely to be upheld.165

Common law and statutory rules do not significantly alter this result. The common law tort of invasion of privacy does not readily protect individuals from forced disclosures.166 There are a few scattered sources of statutory protection from forced disclosures, particularly for provider characteristics such as HIV infection167 or drug or alcohol abuse.168 Federal or state laws prohibiting discrimination against per-

pursposes remediless because of the difficulties of bringing an action or proving damages, particularly in common law tort actions. Statutes can help plaintiffs to bring actions. See, e.g., TEX. HEALTH & SAFETY CODE ANN. § 81.104 (West 1992) (providing for injunctive relief, civil penalties, actual damages, and attorneys fees in actions for breaches of HIV-related confidentiality).

165. See supra note 163 (discussing cases imposing duty to disclose on sexual partners).

166. The tort-based right to privacy does contain a strand of cases which protects against "unreasonable intrusion" into private matters. See W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 117, at 854-56 (5th ed. 1984). Yet this cause of action is premised on the private character of the information and on the behavior of the defendant in intruding upon the plaintiff's private matters or concerns. See, e.g., Lee v. Calhoun, 948 F.2d 1162 (10th Cir. 1991), cert. denied, 112 S. Ct. 2940 (1992) (doctor is not liable for tort invasion of privacy for disclosure of patient's HIV status to newspaper when patient had become a public figure by filing the $38,000,000 lawsuit). The imposition of a legal duty to disclose some types of information would clearly eliminate both the information's private character and the need for intrusive behavior by patients.

167. Several states have statutes specifically protecting the confidentiality of HIV-related information. See supra note 164. These statutes typically provide that disclosures must be voluntary or, where involuntary, must conform to one of the statutory exceptions to confidentiality. See also In re Milton S. Hershey Medical Center, 595 A.2d 1290, 1294 (Pa. Super. Ct. 1991), appeal granted, 611 A.2d 712 (Pa. 1992) (permitting hospital disclosure of physician's HIV status to other physicians and more limited disclosure to patients). Mandated disclosures of HIV-status from doctors to patients might require specific legislative authorization in such states.


Virtually all states have granted licensing boards or medical societies the authority to investigate and eventually rehabilitate impaired physicians. The statutes that govern the identification and discipline of impaired physicians vary in the degree of confidentiality afforded the physician. See, e.g., CAL. BUS. & PROF. CODE § 2355 (West 1990). Records of medical society proceedings and any other records of a physician's participation are strictly confidential, are not subject to discovery or subpoena. See, e.g., ALA. CODE § 34-24-404 (all information privileged and confidential); ME. REV. STAT. ANN. tit. 24, § 2510(3) (West 1990) (barring impaired physician information from discovery in malpractice actions); MICH. COMP. LAWS ANN. § 331.533 (West 1992 & Supp. 1993) ("all proceedings, reports, findings and conclusions of review entities" confidential and non-discoverable); N.C. GEN. STAT. § 90-21.22 (1990) ("[a]ny non-public information" confidential and non-discoverable). Several exceptions to the general rule of confidentiality exist. Some statutes only apply if the physician remains cooperative. See, e.g., CONN. GEN. STAT. ANN. § 20-13e (West Supp. 1993). Some states permit disclosure to specifically named parties. See, e.g.,
sons with disabilities might prohibit mandatory disclosures of some dis-
abilities unless they constitute a significant risk to the health or safety
of others. 169 There may also be some state protection against unautho-
rized breaches of confidentiality, such as those that would arise if a
patient disclosed information about a physician's personal characteris-
tics to other persons. 170 There is, thus, only weak constitutional, statu-
tory, and common law support for a provider's right to privacy with
respect to her personal characteristics or economic relationships. These
legal theories generally do not pose a serious impediment to state man-
dated disclosures that can be clearly tied to the protection of patients
from provider-associated risk.

B. The Duty to Disclose Provider-Associated Risk

The critical issue then becomes the need to understand the scope
of disclosure duties imposed under existing law. Common law theories
of contract, tort, and fiduciary principles may be applied to derive a
duty to disclose some provider-associated risks. Federal and state stat-
utes may either support or hinder the development of such duties.

MASS. GEN. LAWS. ANN. ch. 112, § 5 (West Supp. 1993) (expressly permitting disclosure of li-
censing board investigative findings to person filing complaint which led to the investigation).

169. See supra text accompanying notes 101-02.

170. There may be greater legal protection of confidentiality once sensitive information has
been disclosed to a patient. The tort of invasion of privacy may punish the public disclosure of
App. 1991) (allegations that hospital employees disclosed patient's HIV status to others in inva-
sion of privacy claim); see also KEETON ET AL., supra note 166, § 117, at 856-62. Commentators
have noted that this common law cause of action is vulnerable to constitutional attack under the
First Amendment. G. Michael Harvey, Confidentiality: A Measured Response to the Failure of
Privacy, 140 U. PA. L. REV. 2385, 2401-2422 (1992); Diane L. Zimmerman, Requiem for a
Heavyweight: A Farewell to Warren and Brandeis's Privacy Tort, 68 CORNELL L. REV. 291
(1983). Defamation actions may be brought where patients make false statements about provid-
ers. See generally KEETON ET AL., supra note 166, § 111, at 771-85 (background on defamation).
Specific statutes may protect the further dissemination of information about the provider to
others. See supra note 167. One commentator has suggested the recognition of a breach of confi-
dence tort. Harvey, supra, at 2422-2449.

These legal protections may help to reduce some of the injuries to providers caused by
mandatory disclosure obligations. Yet, legal rights to confidentiality will be difficult to enforce,
even where they exist. Providers may be justifiably wary of the utility of such confidentiality
protections, given the difficulties of proof inherent in bringing any legal claim alleging disclosure
and compensable loss. In addition, the physician who enters litigation must be willing to risk the
loss of confidentiality that might arise from merely bringing suit.
1. The Duty to Disclose Under Contract, Tort, and Fiduciary Principles

The relationship between a physician and patient is a contractual one. The first question, then, is whether a physician has an obligation to disclose information about provider-associated risks as a part of her contract with her patients. The short answer is no. Contract law gives legal force to the express or implied agreement of the parties. Disclosure duties are currently unlikely to be an express contractual term and are not implied as a matter of course in ordinary contracts. The parties to an ordinary contract are not required to disclose their skills, personal beliefs, physical health, or economic relationships with others. Such obligations might be imposed, but the source of authority is likely to be found outside contracts in the law of torts or fiduciary obligations.

General tort principles provide a cause of action where a defendant knowingly or negligently makes a false representation of some material fact, intending the plaintiff to rely on the assertion, and where the plaintiff justifiably relies on the assertion and suffers injury. This


172. See, e.g., Maxwell J. Mehlman, Fiduciary Contracting: Limitations on Bargaining Between Patients and Health Care Providers, 51 U. Pitt. L. Rev. 365, 385 (1990). As we will see, disclosure obligations may be imposed under tort law or may be implied because of the fiduciary character of the doctor-patient relationship. See, e.g., Stephen R. Feldman & Thomas M. Ward, Psychotherapeutic Injury: Reshaping the Implied Contract as an Alternative to Malpractice, 58 N.C. L. Rev. 63 (1979) (arguing that strengthening implied contractual duties could enhance ability of psychiatric patients to recover damages for misconduct). They are not imposed, however, as a matter of course in all contractual obligations.

Note that the parties to a contract could, of course, explicitly bargain for information disclosure. An express contractual term would have to be supported by consideration to be enforceable. See LaBarre v. Duke Univ., 393 S.E.2d 321 (N.C. Ct. App. 1990) (defendant's "assurance that if an epidural anesthetic became necessary during [the patient's] delivery, only he or another fully-trained faculty anesthesiologist would administer it . . . not supported by consideration" and therefore unenforceable).


174. Restatement (Second) of Torts §§ 525, 552 (1976); see also Keeton et al., supra note 166, §§ 107-110; John P. Ludington, Annotation, Medical Malpractice: Liability Based on Misrepresentation of the Nature and Hazards of Treatment, 42 A.L.R.4th 543 (1985.
fraud theory would easily provide an action for a patient whose physician affirmatively lies about some important personal characteristic, or for a patient whose physician knowingly recommends as medically necessary a worthless treatment or knowingly rejects as useless a treatment which would be beneficial. The theory might also be used to support a battery claim where a physician performs an operation or procedure with a patient's fraudulently induced consent. Fraud principles are of limited utility, however, for several reasons.

First, actions based on fraud or misrepresentation traditionally have required a statement of some kind by the defendant: mere failures to disclose were historically not considered actionable. Second, plaintiffs must typically show that a defendant had the required scienter, a difficult task where a physician may claim that some recommended or spurned treatment was not medically required. Third, the misrepresentation must have been about a material fact and must have led to justifiable reliance by the plaintiff. Defendants may claim that some provider-associated risks were not "material," or that a patient's reliance on the provider's words of reassurance was not justifiable.

---


176. See Rains v. Superior Court, 198 Cal. Rptr. 249, 251, 253-55 (Cal. Ct. App. 1984) (psychiatrists may be liable for battery where they fraudulently obtain patients' consent to "sluggo therapy" involving physical violence); Howell v. Carpenter, 172 N.W.2d 549, 550 (Mich. Ct. App. 1969) (finding assault and battery when a doctor performs an unnecessary operation without the patient's informed consent); Bartell v. State, 82 N.W. 142, 143 (Wis. 1900) (fraudulent representation to young girl that treatment required disrobing and other acts constituted criminal assault and battery); see also Ludington, supra note 174, §§ 7, 14; W.E. Shipley, Annotation, Liability of Physician or Surgeon for Extending Operation or Treatment Beyond That Expressly Authorized, 56 A.L.R.2d 695, § 2 (1957).

177. Keeton et al., supra note 166, § 106, at 737-39. Prosser and Keeton note the trend to impose disclosure obligations, particularly in fiduciary relationships. Id. at 739. This deviation from the traditional rule will be considered infra notes 216-21 and accompanying text.

178. Keeton et al., supra note 166, § 107, at 741-42.

179. Id. § 108, at 749-54.

180. See infra notes 189-92 and accompanying text.

181. Statements of "mere puffery," e.g., can easily be disguised in medical care as "therapeutic reassurance."
Luckily for patients, the courts have developed more flexible tort theories that incorporate higher standards of disclosure by physicians.

The informed consent doctrine provides the major theoretical basis for a duty to disclose provider-associated risks. Courts created a physician's duty to disclose as a mechanism for protecting a patient's right to autonomy. The obvious trend toward requiring some disclosures, however, obscures a lack of clarity in the disclosure doctrine's legal justification. The situation has become even more complex because of legislative intervention; a majority of states have codified and/or altered common law consent duties by statute.

182. See, e.g., Morreim, New Duties, supra note 88, at 289-93; Morreim, Cost Containment, supra note 88, at 1736-38.


183. See, e.g., Jones, supra note 182, at 385; Shultz, supra note 182, at 226.

184. Careful readers of the leading informed consent case, Canterbury v. Spence, 464 F.2d 772 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972), have long noted the court's reliance on seemingly disparate and contradictory lines of precedent to support its imposition of a disclosure duty. In Canterbury, a young clerk received a back operation without being informed of the procedure's risk of paralysis; left unattended during recovery in the hospital, he fell, and subsequently suffered from partial paralysis. Id. at 776. The court's discussion is a tour of a number of potentially relevant doctrines:

A reasonable revelation . . . is not only a necessity but, as we see it, is as much a matter of the physician's duty. It is a duty to warn of the dangers lurking in the proposed treatment, and that is surely a facet of due care. It is, too, a duty to impart information which the patient has every right to expect. The patient's reliance upon the physician is a trust of the kind which traditionally has exacted obligations beyond those associated with arms-length transactions. . . . [W]e ourselves have found "in the fiducial qualities of [the physician-patient] relationship the physician's duty to reveal to the patient that which in his best interests it is important that he should know." . . .

This disclosure requirement . . . reflects much more of a change in doctrinal emphasis than a substantive addition to malpractice law. . . . It is the settled rule that therapy not authorized by the patient may amount to a tort—a common law battery—by the physician. And it is evident that it is normally impossible to obtain a consent worthy of the name unless the physician first elucidates the options and the perils for the patient's edification. Id. at 782-83 (second alteration in original) (footnotes omitted) (quoting Emmett v. Eastern Dispensary & Casualty Hosp., 396 F.2d 931, 935 (D.C. Cir. 1967)).

185. See infra note 241.
The muddled doctrinal basis for informed consent has three important consequences for the purposes of this article. First, there is a deep division between jurisdictions in measuring the scope of a physician's disclosure obligations. Second, courts and legislatures have struggled to determine which types of medical care give rise to a disclosure obligation. Third, courts have tended to impose causation requirements that appear to conflict with the underlying theoretical justifications of the informed consent doctrine itself. This article will consider each problem in turn.

First, states have adopted at least two distinguishable measures of the scope of a physician's disclosure obligation: the malpractice and the objective patient standards. Provider-associated risks are likely to be treated quite differently under the two standards. The traditional and majority approach, much neglected by legal commentators, is the malpractice or reasonable physician standard. Physicians are required to disclose that which other minimally competent physicians would disclose in like or similar circumstances. The malpractice standard presents some formidable hurdles for plaintiffs, who must present expert medical testimony to show that minimally competent physicians would have disclosed the provider-associated risk at issue. If physicians do not generally disclose these risks, as is currently the case, it will be difficult to bring a claim. Plaintiffs have two choices: they may (1) point to an already-extant disclosure obligation created by statutory or ethical guidelines; or (2) argue that the minimally competent physician should be disclosing the information even when most physicians do not do so. The second argument follows the rationale made famous by Judge Hand in The T.J. Hooper, 60 F.2d 737 (2d Cir.), cert. denied, 287 U.S. 662 (1932):

[In most cases reasonable prudence is in fact common prudence; but strictly it is never its measure; a whole calling may have unduly lagged in the adoption of new and available devices. It may never set its own tests, however persuasive be its usages. Courts must in the end say what is required; there are precautions so imperative that even their universal disregard will not excuse their omission.]


188. If physicians do not generally disclose these risks, as is currently the case, it will be difficult to bring a claim. Plaintiffs have two choices: they may (1) point to an already-extant disclosure obligation created by statutory or ethical guidelines; or (2) argue that the minimally competent physician should be disclosing the information even when most physicians do not do so. The second argument follows the rationale made famous by Judge Hand in The T.J. Hooper, 60 F.2d 737 (2d Cir.), cert. denied, 287 U.S. 662 (1932):

[In most cases reasonable prudence is in fact common prudence; but strictly it is never its measure; a whole calling may have unduly lagged in the adoption of new and available devices. It may never set its own tests, however persuasive be its usages. Courts must in the end say what is required; there are precautions so imperative that even their universal disregard will not excuse their omission.

Id. at 740. One, much criticized, court has applied this reasoning to medical services. Helling v. Carey, 519 P.2d 981, 983 (Wash. 1974) (using Hand's reasoning in The T.J. Hooper to hold that
Under the objective patient-centered approach, in contrast, the scope of the physician’s disclosure obligation is measured by the patient’s right to information about material risks.\(^{189}\) Risks are material if a rational patient would consider them to be relevant in deciding whether or not to undergo a particular procedure.\(^{190}\) A growing number of jurisdictions have adopted this approach by judicial decision or legislative enactment.\(^{191}\) This standard more easily accommodates the provider-specific risks of interest here. If those risks are “material,” they should be disclosed.\(^{192}\)

The second area of jurisdictional disagreement concerns the types of medical care which give rise to disclosure obligations. Several states refuse to penalize physicians for failure to disclose risks associated with alternative therapies, or with foregone diagnostic tests, or with non-sur-

---

190. Canterbury, 464 F.2d at 787; Rozovsky, supra note 186, § 1.15.2, at 76-78. A risk's materiality is a product of its probability and the degree of associated harm. Canterbury, 464 F.2d at 788. A risk of very low probability might be material if the expected harm is great. Id. Medical experts are used to establish the nature of the risks, but are not required to establish the duty to disclose those risks. Id. at 791-92.
192. This conclusion is not indisputable for two reasons. First, courts might require only disclosure of material risks of the procedure rather than those posed by the provider. See, e.g., Shock v. United States, 689 F. Supp. 1424, 1426 (D. Md. 1988) (“Unlike a true ‘informed consent’ case, where the question is whether there has been adequate disclosure of the nature and consequences medically inherent in a course of treatment . . . claims that the competence of the attending surgeon was either not disclosed or affirmatively misrepresented . . . raise no question of informed consent, but, rather only camouflaged claims of misrepresentation. . . .”)

Second, courts could limit the kind of material risks subject to disclosure. Financial or psychological risks might lie outside the bounds of the informed consent doctrine in some states. For example, in Doe v. Dyer-Goode, 566 A.2d 889 (Pa. Super. Ct. 1989), a court rejected a plaintiff’s claim that he had been improperly tested for HIV infection, noting, in part, that the plaintiff had been “informed of the risks associated with the procedure he was about to undergo—the withdrawal of a blood sample by extraction through a needle.” Id. at 891-92. The court’s narrow approach suggests that only physical or medical risks of procedures need to be disclosed; the court failed to recognize the psychological and financial implications of HIV antibody testing for patients.
A physician's failure to disclose an economic incentive to order diagnostic tests would not be actionable in some jurisdictions.\(^4\)

Causation requirements constitute the third problematic area for physician disclosure. The informed consent doctrine theoretically protects a patient's autonomy interests; those interests are violated any time a physician fails to disclose information as required by state law.\(^5\) States, primarily through judicial decisions, have restricted the


Some jurisdictions have had difficulty determining when physicians must disclose the risks and benefits of alternative therapies. See, e.g., Hunter L. Prillaman, A Physician's Duty to Inform of Newly Developed Therapy, 6 J. CONTEMP. HEALTH L. & POL'Y 43, 46-52 (1990) (discussing judicial definition of alternative treatment subject to disclosure). These limitations are often related to the doctrinal basis for the informed consent obligation adopted by the court or to protective legislation enacted in response to physician liability concerns. For example, Pennsylvania's informed consent doctrine is rooted in its law of battery, and the courts there have resisted attempts to impose duties beyond the context of surgery. See, e.g., Doe v. Dyer-Goode, 566 A.2d at 891-92. California's informed consent doctrine is based on wider fiduciary principles; its courts have imposed obligations to inform patients about proposed treatments, alternative therapies, and proposed diagnostic tests. See, e.g., Truman v. Thomas, 611 P.2d at 902, 906 (physician has duty to inform patient of risk associated with foregoing a proposed diagnostic test); see also Shultz, supra note 182, at 229-232. Despite this apparent liberality, the California Supreme Court recently refused to disclose an unfavorable prognosis. Arato v. Avedon, 858 P.2d 598 (Cal. 1993).


194. See, e.g., Moure v. Raeuchle, 604 A.2d 1003, 1008 n.8 (Pa. 1992) (stating that the doctrine of informed consent is founded upon the intentional tort of battery, and that an action for informed consent is limited to issues regarding the surgical procedure itself); Dyer-Goode, 566 A.2d at 891 (informed consent concerns only the invasive procedure itself); Boyer v. Smith, 497 A.2d 646, 649 (Pa. Super. Ct. 1985) (informed consent doctrine extends only to surgical procedure and not to the prescription of therapeutic drugs). Even jurisdictions employing a negligence-based informed consent standard have restricted its application. See Schultz, supra note 182, at 232-248.

195. Several commentators have argued that individual autonomy would be better protected by a dignitary tort doctrine, in which causation of independent injury need not be shown. See, e.g., Alan Meisel, A "Dignitary Tort" as a Bridge between the Idea of Informed Consent and the Law of Informed Consent, 16 LAW, MED. & HEALTH CARE 210, 211-14 (1988); Aaron D. Twerski & Neil B. Cohen, Informed Decision Making and the Law of Torts: The Myth of Justiciable Causation, 1988 U. ILL. L. REV. 607, 655 (concluding that informed consent doctrine should be reformed to focus on decision-making process); Weisbard, supra note 182, at 763-64. The importance of autonomy is recognized in dicta even if not in doctrine. See, e.g., Canterbury v. Spence, 464 F.2d 772, 780 & n.12 (D.C. Cir.) (stating that "[t]he root premise [of the informed consent
application of the doctrine to cases in which the failure to disclose has caused some independent injury. There are two limitations to informed consent cases: the undisclosed risk must materialize and the patient must show that, had the risk been disclosed, the procedure would have been rejected.

The materialization of the risk requirement resembles the actual injury requirement of malpractice law. Under this rule, a physician's failure to disclose her abuse of alcohol could only be actionable if the provider's use of alcohol actually injured the patient. The materialization requirement is not easy to apply to other types of risks, such as those related to economic incentives. It would imply that patients could only recover where the risks presented by economic incentives actually ripen into fruition, such as in those cases where the care delivered is inadequate or excessive. The informed consent doctrine thus begins to resemble a traditional malpractice action.

This convergence of informed consent and malpractice is accelerated under the causation requirements adopted by most jurisdictions. There are two major causation tests in current use. A few courts have adopted a subjective causation standard. In these jurisdictions, plaintiffs need only show that they would have rejected the proposed treat-

---

196. *Canterbury*, 464 F.2d at 790 (stating that "[a]n unrevealed risk that should have been made known must materialize, for otherwise the omission, however unpardonable, is legally without consequence"); *Cobbs v. Grant*, 502 P.2d 11, 11 (Cal. 1972) (stating that the "uncommunicated hazard" must materialize); *Natanson*, 350 P.2d at 1106 (stating that a physician's failure to obtain the patient's informed consent is actionable as malpractice, therefore patient must prove that there was no informed consent to the risk that materialized); see also *Rozovsky*, supra note 186, § 1.15.5, at 81; *Frantz*, supra note 186, § 2[b], at 1015. Commentators generally have been critical of the causation requirements. See, e.g., *Shultz*, supra note 182, at 249-251.

197. *Canterbury*, 464 F.2d at 790; *Cobbs*, 502 P.2d at 11-12; see also *Rozovsky*, supra note 186, § 1.15.5, at 81; *Frantz*, supra note 186, § 2[b], at 1015.

198. See supra text accompanying notes 66-78.

199. See *Shultz*, supra note 182, at 229 ("if the informed consent action involved nondisclosures that led to reasonably avoided and significant harms, it would seem to be largely duplicative of an action in professional negligence").

ment had they been appropriately informed of the risks. The second test, adopted by a majority of jurisdictions, is the objective standard, under which a plaintiff must show that a reasonable patient would not have undergone the proposed treatment or test if she had received appropriate information. The objective patient standard drives the informed consent doctrine still further into the arms of a traditional malpractice claim.

The informed consent doctrine presents an initially promising, but inevitably troublesome, source of a duty to disclose provider-associated risk. Disclosures of such risks are unlikely in jurisdictions which have adopted the physician-centered standard. Even states with patient-centered approaches may have effectively limited the application of these principles to provider risks. Injury and causation requirements represent a substantial hurdle even where liability is theoretically imposed. Jurisdictions with more generous disclosure requirements typically rely, at least in part, on fiduciary principles as a basis for the disclosure obligation. Fiduciary law thus presents a possible avenue for future growth of a more vibrant disclosure duty.

Tort law and the law governing fiduciary relationships are similar in that they impose extra-contractual duties on individuals. The two

201. Id.

202. Courts defend this causation standard as necessary to avoid limitless physician liability; in the absence of an objective standard, patients might always claim that they would have rejected the proposed treatment had they known of the undisclosed risk. E.g., Canterbury v. Spence, 464 F.2d 772, 790-91 (D.C. Cir.), cert. denied, 469 U.S. 1064 (1972); Cobbs v. Grant, 502 F.2d 1, 11-12 (Cal. 1972); Sard v. Hardy, 379 A.2d 1014, 1025 (Md. 1977); Arena v. Gingrich, 748 P.2d 547, 548-49 (Or. 1988). See generally Rozovsky, supra note 186, § 1.15.4, at 78-80. Alabama has adopted a variant on the reasonable patient standard that attempts to incorporate some subjective components. Fain v. Smith, 479 So. 2d 1150 (Ala. 1985) (per curiam).

The causation issues are even more complex for plaintiffs challenging non-disclosure of a provider's personal characteristics. Here, plaintiffs must show that they would have chosen a different provider had they been informed of the relevant risk. But see Shock v. United States, 689 F. Supp. 1424, 1425 (D. Md. 1988) (stating that issues regarding the competence of a surgeon to perform a procedure are unrelated to the issue of informed consent).

203. Shultz, supra note 182, at 228-29.

204. A number of commentators have suggested the potential importance of fiduciary principles in the doctor-patient relationship. E.g., Frances H. Miller, Secondary Income From Recommended Treatment: Should Fiduciary Principles Constrain Physician Behavior?, in The New Health Care for Profit: Doctors and Hospitals in a Competitive Environment, supra note 115, at 153; Thomas H. Boyd, Cost Containment and the Physician's Fiduciary Duty to the Patient, 39 DePaul L. Rev. 131 (1989); Feldman & Ward, supra note 172, at 63 (arguing for recognition of fiduciary duties of psychiatrists); Mehlman, supra note 172, at 365; Morreim, supra note 88, at 296-301 (discussing physicians' fiduciary obligations); Shultz, supra note 182, at 280-263.
regulatory schemes, however, differ in conception of those duties. Tort law most often imposes general duties irrespective of the status of the parties.\textsuperscript{205} The law of fiduciaries, in contrast, is based on the special character of the relationship between two parties.\textsuperscript{206} Courts struggling to define the scope of tort-based disclosure duties have often noted the fiducial characteristics of the doctor-patient relationship as a justification for disclosure.\textsuperscript{207} This linkage between ordinary tort and fiduciary principles creates the opportunity for both growth and confusion. Ordinary tort duties may be expanded or amplified because of the perceived relevance of fiduciary principles. To date, few courts have explicitly considered the implications of wholesale acceptance of the doctor-patient relationship as one subject to fiduciary law. There has been little judicial analysis of the appropriateness of applying fiduciary-based disclosure obligations to the physician-patient relationship, and virtually no judicial analysis of the special problems presented by provider-associated risk.

The first question is whether the relationship between physicians and patients is a fiduciary one.\textsuperscript{208} Fiduciary relationships are generally

\begin{itemize}
\item 205. KEETON ET AL., supra note 166, at 4-5.
\item 206. The term “fiduciary” is defined as

[A] person holding the character of a trustee, or a character analogous to that of a trustee, in respect to the trust and confidence involved in it and the scrupulous good faith and candor which it requires. A person having a duty, created by his undertaking, to act primarily for another's benefit in matters connected with such undertaking.

A term to refer to a person having duties involving good faith, trust, special confidence, and candor towards another.

BLACK’S LAW DICTIONARY 625 (6th ed. 1990). There are problems defining what kinds of relationships should be defined as “special” enough to warrant regulation under fiduciary principles. See infra note 209 and accompanying text. There is, significantly, no common term used to name the person to whom the fiduciary owes duties. Frankel, supra note 163, at 795. This absence seems to arise from the scattered designations of fiduciary relationships, so that it is more common to speak of the fiduciary's duty to her client, her ward, etc. One commentator has suggested that the fiduciary's counterpart be called the “entrustor.” Id. at 800 n.17.

207. See infra note 210.

208. A fiduciary relationship is broadly defined as one where one person is under a duty to act for the benefit of another within the scope of the relationship. RESTATEMENT (SECOND) OF AGENCY § 13 cmt. a (1958); RESTATEMENT (SECOND) OF TRUSTS § 2 cmt. b (1959); DEBORAH A. DEMOTT, FIDUCIARY OBLIGATION, AGENCY, AND PARTNERSHIP 4 (West Publishing 1st ed. 1991); Deborah A. DeMott, Fiduciary Obligation, Agency, and Partnership 4 (West Publishing 1st ed. 1991); Deborah A. DeMott, Beyond Metaphor: An Analysis of Fiduciary Obligation, 1988 Duke L.J. 879, 882 (1988). The existence of a fiduciary relationship can be established by law or informally by a court where equity or a sense of fairness demands it. DeMott, supra, at 4; 36A C.J.S. Fiduciary 387 (1966); Austin W. Scott, The Fiduciary Principle, 37 CAL. L. REV. 539, 554 (1949).

Fiduciary relationships are similar to, but sometimes distinct from, “confidential relationships,” which are said to arise whenever an individual justifiably places her trust in another who
described as those in which some aspect of the relationship between the parties justifies the imposition of special obligations on one of them. Several treatises on fiduciary law name the physician-patient relationship as a fiduciary one and the courts have tended to concur.

then accepts and acts on that trust. Compare Hodges v. Hodges, 692 S.W.2d 361, 377 (Mo. Ct. App. 1985) (the terms confidential and fiduciary relationship are generally synonymous and apply when "one trusts in and relies on the other") with Wilson-Rich v. Don Aux Assocs., Inc., 524 F. Supp. 1226, 1234 (S.D.N.Y. 1981) (confidential and fiduciary relationships differ). Two somewhat diffuse and overlapping categories of relationships can be constructed: (1) fiduciary relationships; (2) informal fiduciary or confidential relationships. See Gregory B. Westfall, *But I Know It When I See It: A Practical Framework for Analysis and Argument of Informal Fiduciary Relationships*, 23 Tex. Tech. L. Rev. 835, 836 (1992) (equating informal fiduciary and confidential relationships). The most significant difference between fiduciary and confidential relationships is in the burdens of proof imposed on the parties. In informal fiduciary relationships and confidential relationships, the party seeking to have a transaction set aside has the burden of establishing the existence of the relationship and its breach by clear and convincing evidence. Vargas v. Esquire Inc., 166 F.2d 651, 653 (7th Cir.), cert. denied, 335 U.S. 813 (1948); DeMott, supra, at 12. By contrast, in fiduciary relationships, the defending party has the burden of establishing that she acted in good faith within the scope of the relationship. Vargas, 166 F.2d at 652-53; DeMott, supra, at 12. See also Mehlman, supra note 172, at 366 n.6

209. The fiduciary relationship may arise out of some imbalance of power or knowledge, as when guardians are considered to have fiduciary duties to their wards or when attorneys are held to owe fiduciary duties to their clients. *See generally* J.C. Shephard, *The Law of Fiduciaries* 21-34 (1981). There is no simple test for determining whether a fiduciary relationship exists; courts and commentators tend instead to rely on a laundry list of classic examples. See Frankel, supra note 163, at 795-97. Courts often apply fiduciary principles to specific fact patterns through analogy to more defined examples of fiduciary relationships. Vassiliades v. Garfinckel's Brooks Bros., 492 A.2d 580, 591-92 (D.C. Cir. 1985) (deciding that the fiduciary duties imposed in a physician/patient relationship are equivalent to the fiduciary duties imposed in an escrow agent/purchaser relationship); DeMott, supra, at 12. See also Mehlman, supra note 172, at 366 n.6

210. *E.g.*, Shephard, supra note 209, at 29; Boyd, supra note 204, at 135. The characteristics of the physician-patient relationship seem appropriate for an application of fiduciary principles. A physician arguably is entrusted with a valuable resource of the patient (the patient's person) and either directly or through advice controls the fate of the resource. In some cases this entrustment is literal, as when a patient is anesthetized for surgery. In other cases it is more metaphorical, emphasizing the physician's power in determining whether or not a patient will receive a particular kind of medical care. The patient is in a relatively powerless position in her dealings with her physician because of the gap in specialized knowledge. *See, e.g.*, Canterbury v. Spence, 464 F.2d 772, 780 & n.12 (D.C. Cir.) (noting that "[t]he average patient has little or no understanding of the medical arts, and ordinarily has only his physician to whom he can look for enlightenment. . . ."); cert. denied, 409 U.S. 1064 (1972); Cobbs v. Grant, 502 P.2d 1, 9 (Cal. 1972) (stating that the patient depends entirely on the physician for information with which to decide whether to seek treatment); Sard v. Hardy, 379 A.2d 1014, 1021 (Md. 1977) (acknowledging that the patient places her "body in the hands of the surgeon or physician"). The impact of this disparity on the patient's bargaining power with her physician is a source of much academic debate. *See generally* Mehlman, supra note 172, at 374-75. The impact of this disparity on issues of informed consent and a physician's disclosure obligations is less well developed. See id. at 384. Patients cannot independently check the validity of their physician's advice. These factors suggest that the physician could have fiduciary obligations, particularly with respect to transactions that involve either the patient's person or the exercise of expert medical knowledge.
Next, the fiduciary duties that physicians owe to patients must be determined. Generally, a fiduciary must act for the benefit of another, but the specific duties imposed on a fiduciary will vary with the scope of the relationship between the parties.212 The fiduciary owes a duty of

Some commentators, however, define the physician-patient relationship as a confidential relationship. E.g., 1 AUSTIN W. SCOTT & WILLIAM F. FRATCHER, THE LAW OF TRUSTS § 2.5, at 43 (4th ed. 1987). This distinction is unclear, and may result from the poorly defined boundaries regarding fiduciary and confidential relationships. See supra note 208; see also Mehlman, supra note 172, at 366 n.6.


As a final matter, it must be established when the physician's fiduciary duties begin in order to determine whether a physician is bound to disclose personal characteristics or financial matters before entering into a physician-patient relationship. Ordinarily, an individual does not have any fiduciary obligations at the time of the creation of the fiduciary relationship unless the relationship is one of “peculiar trust and confidence.” See Marin v. Heinold Commodities, Inc., 510 N.E.2d 840, 844-45 (Ill. 1987) (under some circumstances, a fiduciary duty with respect to compensation agreements can "be imposed upon a prospective agent prior to the formal creation of an agency relationship"); RESTATEMENT (SECOND) AGENCY § 389 cmt. b (1958). Physicians arguably have the peculiar trust and confidence of potential patients such that their fiduciary disclosure obligations should commence during the preliminary stages of contact with their patients. The Restatement does not provide much guidance with which to determine when there is a fiduciary obligation before the commencement of the formal relationship:

A person is not ordinarily subject to a fiduciary duty in making terms as to compensation with a prospective principal. If, however, as in the case of attorney and client, the creation of the relation involves peculiar trust and confidence, with reliance by the principal upon fair dealing by the agent, it may be found that a fiduciary relation exists prior to the employment and, if so, the agent is under a duty to deal fairly with the principal in arranging the terms of the employment. RESTATEMENT (SECOND) OF AGENCY § 390 cmt. e (1958). As a practical matter, the physician-patient relationship may already have been formed under implied contract by the time the physician arrives in the examination room and greets the patient for the first time. If this is so, then fiduciary constraints will be in place at the time that the physician makes her initial assessment and referrals or treatment advice.

212. RESTATEMENT (SECOND) OF AGENCY § 13 (1958); RESTATEMENT (SECOND) OF TORTS
loyalty, "good faith, trust, special confidence and candor" to the other party.²¹³ Obviously, it is not a breach of the fiduciary relationship for the fiduciary to receive compensation for her services.²¹⁴ However, the fiduciary can breach her duty by engaging in self-dealing, by receiving bribes or kickbacks, or by misappropriating that knowledge or property which belongs to the entrustor.²¹⁵

The role of disclosure in fiduciary law is somewhat complicated.²¹⁶ The fiduciary's failure to disclose information to the entrustor can constitute an independent breach of fiduciary duty when the information was gathered in the course of the fiduciary's duties.²¹⁷ Disclosure may

---

²¹³ BLACK'S LAW DICTIONARY 625 (6th ed. 1990). See also 1 SCOTT & FRATCHER, supra note 210, § 2.5 at 43; DeMott, supra note 208, at 882, 892-908; Shultz, supra note 182, at 260-61.

²¹⁴ See Lindland v. United Business Invs., Inc., 693 P.2d 20, 23 n.3 (Or. 1984) (en banc) ("The mere fact that the broker stands to earn a commission for his efforts on behalf of the principal does not, without more, establish that the broker is engaged in self-dealing or has a conflict of interest with the principal.").

²¹⁵ A fiduciary also has the duty to use reasonable care and skill in the execution of her duties towards the entrustor. RESTATEMENT (SECOND) OF AGENCY § 379 (1958); RESTATEMENT (SECOND) OF TRUSTS § 174 (1959).

²¹⁶ SHEPHERD, supra note 209, at 202-04.

²¹⁷ RESTATEMENT (SECOND) OF AGENCY § 381 (1958) (stating that the agent must use reasonable efforts to provide the principal with "information which is relevant to affairs entrusted to him and which, as the agent has notice, the principal would desire to have"); RESTATEMENT (SECOND) OF TRUSTS § 170(2) cmt. w (1959) (duty to communicate material facts). The typical example of this principle occurs in real estate transactions, where a fiduciary breaches her duty by failing to notify her entrustor of the existence of valuable mineral holding on the entrustor's land.
also help determine whether an apparent breach of fiduciary duties has been "cured" by the consent of the entrustor.\textsuperscript{218} The validity of the entrustor's consent will be the important question because the fiduciary's influence over the entrustor may make any consent presumptively invalid.\textsuperscript{219} Disclosure in these cases is of evidentiary significance; it may bolster the fiduciary's claim that the entrustor's consent to the transaction was valid.\textsuperscript{220} As a substantive matter, disclosure may not be sufficient where the fiduciary's influence over the entrustor makes any—even informed—consent illusory.\textsuperscript{221}

Commentators have suggested that a physician's fiduciary duty to her patients should bar the physician's participation in economic arrangements which present the risk of conflicts between the physician and patient.\textsuperscript{222} Judicial discussion of physicians' fiduciary duties to their patients, however, has tended to be fragmented and limited to a relatively small number of fact situations.\textsuperscript{223} In the largest grouping of cases, courts have noted the fiduciary character of the relationship when considering whether the malpractice statute of limitations should be

\textsuperscript{218} See, e.g., Construction Techniques, Inc. v. Dominske, 928 F.2d 632, 638 (4th Cir. 1991) (disclosure, even if limited, can cure conflict of interest that would otherwise constitute a breach of fiduciary duty); Reinhold v. Mallery, 599 A.2d 126, 129 (N.H. 1991) (more than mere disclosure required, must show principal's consent, and, in some cases, principal's understanding of implications of information); \textit{Lindland}, 693 P.2d at 24 (en banc) (broker can defend against claim of breach of duty of loyalty by proving full disclosure).

\textsuperscript{219} The Restatement specifically provides that the beneficiary's consent to an act precludes liability by the trustee for that act. \textit{RESTATEMENT (SECOND) OF TRUSTS} \textsection{216}(1) (1959). The consent will be invalid, however, if the beneficiary is incapacitated, not fully informed of his rights under the trust, or the consent was induced by improper conduct of the trustee. \textit{Id.} \textsection{216}(2)(c); see also Scott, supra note 208, at 541-42.

Courts have applied the fact that the entrustee must consent after a full disclosure to breaches of the fiduciary duty by the entrustor to the physician patient relationship in a variety of contexts such as ex parte hearings and sexual relationships, see infra note 226-29, and the doctrine of informed consent, see supra notes 182-84 and accompanying text. In addition, a physician's misrepresentations made to induce consent will not insulate the physician from future liability. \textit{E.g.}, Hondroulis v. Schuhmacher, 553 So. 2d 398, 419 (La. 1988) (stating that a physician's non-disclosure or misrepresentation of facts regarding a medical procedure will invalidate the patient's informed consent to the procedure).

\textsuperscript{220} \textit{Id.} \textsection{216}(2)(c); see also Scott, supra note 208, at 541-42.

\textsuperscript{221} Examples are where the entrustee is suffering from some incapacity, or where the entrustor has induced the entrustee's consent through improper conduct such as undue influence. \textit{See, e.g., RESTATEMENT (SECOND) OF TRUSTS} \textsection{216} (1959).

\textsuperscript{222} \textit{E.g.}, Boyd, supra note 204, at 159; Miller, supra note 204, at 157-65.

\textsuperscript{223} The courts almost turn the fiduciary analysis on its head, discussing the behavior contested by the patient (the claimed breach), noting its evils, finding a fiduciary relationship based on the risk of injury to the patient, and then concluding that there has been a breach.
tolled by a physician’s “fraudulent concealment” of her patient’s negligently induced injury. 224 By implication, courts have held that physicians have a duty to disclose to their patients the existence of medically-induced injuries. Here, the physician’s disclosure of information is required because it was obtained in the course of performing her fiduciary duties. Failure to release the information constitutes a breach of duty. 225 Another large group of cases involves a physician’s disclosure of information to a third party; here courts have nearly uniformly held that a physician breaches her fiduciary obligation to her patient in revealing medical information acquired during the course of treatment. 226


225. See, e.g., Nixdorf v. Hicken, 612 P.2d 348, 354 (Utah 1980) (physician-patient relationship creates duty to disclose to patient any material information concerning patient's condition); Trogun v. Fruchtman, 207 N.W.2d 297, 313 (Wis. 1973) (physician has duty to disclose ramifications of course of conduct).


In a smaller number of cases, courts have reached mixed results on whether a physician breaches her fiduciary duty by entering into a sexual relationship with a patient. Numerous courts have held that psychiatrists commit malpractice when they engage in sexual relationships with their clients; in some of these cases, courts have relied, in part, on fiduciary concepts. In a related category of cases, a physician or surgeon is held liable for engaging in sexual activity with a patient under the pretense of providing treatment. Courts finding that such relationships breach a fiduciary obligation sometimes implicitly suggest that a patient's consent is inadequate to cure the fiduciary breach.


229. E.g., Jennings v. Friedman, No. 88-6046, 1989 U.S. App. LEXIS 7352 at *3-4 (6th Cir. May 25, 1989) (per curiam) (physician's consensual sexual relationship with patient does not constitute malpractice unless initiated under guise of treatment; no discussion of fiduciary issues); Atienza v. Taub, 239 Cal. Rptr. 454, 458 n.3 (Cal. Ct. App. 1987) (no liability for consensual sexual activity between physician and patient; no discussion of pretext of treatment; no discussion of fiduciary duties noted but deemed inapplicable in this case); Odegard v. Finne, 500 N.W.2d 140, 143 (Minn. Ct. App. 1993) (no malpractice unless sexual relationship part of treatment; no discussion of fiduciary duties); Hoopes v. Hammargren, 725 P.2d 238, 242-43 (Nev. 1986) (holding that physician has violated his fiduciary duty where patient can prove by preponderance of the evidence that the physician "held a superior authoritative position in the professional relationship and that, as a result of her illness, she was vulnerable" and that the physician exploited this vulnerability); see also Gromis v. Medical Bd. of Cal., 10 Cal. Rptr. 2d 452, 458 (Cal. Ct. App. 1992) (physician's consensual sexual conduct between physician and patient can violate state statute where the "sexual conduct bears some relationship to the physician's qualifications, functions or duties"); Haley v. Medical Disciplinary Bd., 818 P.2d 1062, 1072 (Wash. 1991) (doctor is subject to professional discipline for using the trust and confidence reposed in him as a surgeon to develop a sexual relationship with a 16 year-old former patient); Hoopes, 725 P.2d at 242-43 (physician can be held liable for sexual activity despite apparent consent of patient); Omer, 685 P.2d at 636-37 (same). These decisions suggest that a physician's influence over the patient may vitiate even knowing, or informed, consent to the physician's service of her own interests. Cases dealing with gifts made by patients to physicians also suggest the importance of physician influence in apparently voluntary transactions. See generally Annotation, Undue Influence in Nontestamentary Gift...
This analysis of fiduciary principles assumes that a breach will provide some effective remedy for patients. A fiduciary is liable to the entrustor for a breach of fiduciary duties. A breach of a fiduciary obligation can be remedied by voiding a transaction, by payment by the fiduciary to the trusting party of any impermissible benefits or profits, or by payment by the fiduciary to compensate the other party for...

From Patient to Physician, Nurse, or Other Medical Practitioner, 70 A.L.R.2d 591 (1960).

Some states have established similar rules by statute or regulation. Florida, for example, authorizes disciplinary actions for "exercising influence within a patient-physician relationship for purposes of engaging a patient in sexual activity. A patient shall be presumed to be incapable of giving free, full, and informed consent to sexual activity with his physician." Fla. Stat. Ann. § 458.331(1)(j) (West 1991) (emphasis added).

230. Restatement (Second) of Torts § 874 (1977) states that "[o]ne standing in a fiduciary relation with another is subject to liability to the other for harm resulting from a breach of duty imposed by the relation." Id. This liability also extends to any third party "who knowingly assists a fiduciary in committing a breach of trust. . . ." Id. § 874 cmt. c. See also Feldman & Ward, supra note 172, at 85-91 (discussing damage remedies for breach of fiduciary duty in psychiatric relationship). Courts applying fiduciary principles to the physician-patient relationship have permitted the equitable tolling of statutes of limitation, see supra note 224, and have permitted recovery of tort-like damages for injuries arising from breaches of confidentiality or from exploitative sexual relationships, see supra notes 226-29 (listing cases).

231. See, e.g., Johnson v. Mansfield Hardwood Lumber Co., 159 F. Supp. 104, 118-19 (W.D. La. 1958) (holding that transactions between fiduciary and plaintiff are voidable when fiduciary breaches his duty), aff'd, 263 F.2d 745 (5th Cir. 1959), cert. denied, 361 U.S. 885; Hendricks v. James, 421 So. 2d 1031, 1042-43 (Miss. 1982) (holding that a transaction between fiduciary defendant and plaintiff is presumed voidable unless there is clear and convincing evidence that the fiduciary acted in good faith with full disclosure and independent consent of the entrustor); Becker v. Capwell, 527 P.2d 120, 122 (Or. 1974) ("equitable remedy of rescission is available whenever there is a breach of the agent's fiduciary duty by a failure to disclose material facts").

232. See Restatement (Second) of Torts § 874 (1977). The comments to this section clarify that the wronged entrustor may recover any damages that flow from the breach as well as any profits obtained by the fiduciary through her wrongful conduct. Id. § 874 cmt. b; see also Apollo Technologies v. Centrosphere Indus., 805 F. Supp. 1157, 1195 n.51 (D.N.J. 1992) (citing Restatement (Second) of Agency § 403) ("If agent receives anything as a result of a violation of the agent's duty of loyalty to the principal, the agent is subject to liability to deliver the thing, its value or its proceeds to the principal."); Burg v. Miniature Precision Components, Inc., 319 N.W.2d 921, 924-25 (Wis. Ct. App. 1982) (agent must account for profits); In re Estate of Daniel Swiecicki, 477 N.E.2d 488, 491 (Ill. 1985) (fiduciary who violated his duty of loyalty must pay plaintiff all profits he gained through the breach, regardless of the fact that the plaintiff could not have made the profits if the fiduciary relationship were properly conducted); Warsofsky v. Sherman, 93 N.E.2d 612, 615 (Mass. 1950) (fiduciary who breaches his duty to an entrustor must relinquish all benefits from the wrongful transaction).

Courts have applied these general principles in cases involving a physician's breach of her fiduciary duties. E.g., Hammonds v. Aetna Casualty & Sur. Co., 237 F. Supp. 96, 102 (N.D. Oh. 1965) (doctor who breached fiduciary duty by disclosing confidential information obtained from plaintiff is liable to the plaintiff for all profits made resulting from the disclosure). Courts may apply these principles to permit a patient to recover unjust enrichment received by a physician, such as through rebates or kickbacks.
actual damages, which may include compensation for personal injury. \(^{233}\) Courts are divided on whether the entrustor is required to show some specific injury flowed from the fiduciary’s breach of her duties. \(^{234}\)

The significant number of courts that have applied fiduciary principles to the physician-patient relationship can be deceiving. Most courts have failed to consider the broader policy implications of classifying the physician-patient relationship as a fiduciary one; most have also failed to analyze the range of physicians’ required fiduciary duties. Some courts have responded to these problems by hedging, noting that the relationship has fiducial “qualities” or “characteristics” or finding that it is a “confidential” relationship. \(^{235}\) The muddled heritage of the common law duties to disclose is complicated further by the existence of statutory disclosure obligations.

2. **Statutory Disclosure Mandates**

This article’s discussion of the common law sources of a physician’s duty to disclose has revealed both a doctrinal basis for common

---

233. Restatement (Second) of Torts § 874 (1977); see, e.g., Hoopes (doctor who breaches his fiduciary good faith duty to his patient by taking advantage of her sexually may be held liable for emotional and actual damages); Alberts v. Devine, 479 N.E.2d 113, 120 (Mass. 1985) (physician must pay plaintiff all damages that flowed from his wrongful disclosure of confidential information); see also Shepherd, supra note 209, at 35-42; Omer, 685 P.2d at 638 (patient may recover damages for emotional distress as well as any mathematically determinable damages resulting from psychiatrist’s breach of his fiduciary relationship with patient by engaging in sexual intercourse with her).

A breach of fiduciary duty has elements of both contract and tort claims, raising the issue of the appropriate statute of limitation to be applied in such cases. In one noteworthy case, a court found that such claims sounded in negligence rather than malpractice, thus permitting the application of the general negligence statute of limitations rather than the shorter malpractice limitations period. Tighe v. Ginsberg, 540 N.Y.S.2d 99, 100 (N.Y. App. Div. 1989).

234. Compare Lindland v. United Business Investments, 693 P.2d 20, 25 (Or. 1984) (en banc) (party claiming breach of fiduciary duty “must show that the breach caused an identifiable loss or resulted in injury to the party”) with Moore and Co. v. T-A-L-L, Inc., 792 P.2d 794, 800 (Colo. 1990) (broker not entitled to commission after breach of fiduciary duty even if seller did not suffer “any demonstrable harm as a result of the breach”). See generally Restatement (Second) of Agency § 469 cmt. a (1958).

235. In one important case, for example, the California Supreme Court noted:

In some respects the term “fiduciary” is too broad. In this context the term “fiduciary” signifies only that a physician must disclose all facts material to the patient’s decision. A physician is not the patient’s financial adviser. As we have already discussed, the reason why a physician must disclose possible conflicts is not because he has a duty to protect his patient’s financial interests, but because certain personal interests may affect professional judgment.

law disclosure obligations and a series of difficult, unresolved issues. Legislation is one possible source of supplementary or preemptive regulation in this area. State or federal statutes might enhance, restrict, or leave unchanged the common law disclosure duties.

State consumer protection or deceptive trade practices acts may regulate disclosure. These statutes reduce the effects of the harsh common law rule of *caveat emptor*, under which only fraudulent statements are prohibited, and often impose disclosure obligations on the sellers of goods or services. Physicians with ownership interests in other referral health care entities might be prohibited from "causing confusion or misunderstanding as to the source, [or] sponsorship of"

goods or services.” Physicians might also be required to affirmatively disclose “material information” about the good or service prior to the sale. The practical application of these provisions may be difficult because of specific exclusion of health care transactions from the statutory framework or because of problems of proof.
Aside from these general consumer statutes, states have been quite active in modifying physicians' common law disclosure obligations. Many states have altered or codified the tort-based informed consent duty. Legislation adopting the reasonable physician standard of disclosure might seriously limit claims where current medical practice does not support disclosure. Other statutes restrict the types of medical treatment to which disclosure obligations apply, while others specify the type of disclosure required.

Some states have begun to be active outside the bounds of traditional tort-based informed consent. A few states have enacted statutes regulating disclosure requirements for HIV or HBV-infected physicians. Texas was one of the first states to specifically require that such physicians obtain the consent of their patients before performing “exposure-prone procedures.” Statutory disclosure obligations for HIV-

nomic incentives that could affect the physician's judgment. Id. at 131-32 (stating that information is material if “most consumers” would not proceed with sale given knowledge). Arguably, the sale of unnecessary medical goods or services would be unconscionable. Id. at 125.


242. See supra text accompanying notes 187-88.

243. See supra note 241.

244. Compare Centers for Disease Control, U.S. Dep't of Health & Human Servs., supra note 28, at 1 with Tex. Health & Safety Code Ann. §§ 85.201-.206 (West 1992). The Texas statute essentially codified the guidelines issued by the Centers for Disease Control in July 1991. Health care workers who perform “exposure-prone procedures,” as defined by health professional associations or health facilities, have a duty to know their HIV and HBV status. Tex. Health & Safety Code Ann. §§ 85.201-.202 (West 1992). Those who are HIV positive or who have a particularly infectious form of hepatitis are prohibited from performing exposure-prone procedures
or HBV-infected physicians are controversial and potentially conflict with other federal or state legal mandates.

A small, but increasing, number of states require physicians to disclose their economic interests before referring patients to certain other organizations or providers. There are two major areas of controversy: defining the range of transactions subject to regulation, and determining whether a patient's knowing consent to the economic conflict of interest is sufficient protection. States typically regulate a physician's referral of patients to certain types of entities, such as clinical laboratories, diagnostic services, or other health care providers, in which the physician, or members of the physician's "immediate family," have a "significant" financial interest. The statutes require that

without, among other things, "notify[ing] a prospective patient of the health care worker's seropositive status and obtain[ing] the patient's consent before the patient undergoes an exposure-prone procedure, unless the patient is unable to consent." Id. at § 85.204(c).

245. The practical effect of disclosure requirements, where applied, is to prohibit practice of such procedures by infected workers. Physicians will leave their practices to avoid disclosure of such private information to patients and risk the patient's subsequent disclosure of the information to others, particularly when patients are unlikely to proceed with treatment once disclosure has occurred.

246. Any disclosure obligation imposed in this area would have to serve some legitimate governmental interest in the protection of public health; a state's imposition of irrational disclosure obligations would violate the constitutional right to informational privacy. See supra text accompanying notes 160-65. Cf. Centers for Disease Control, U.S. Dep't of Health & Human Servs., supra note 28, at 1 (discussing risks of HIV and HBV transmission in health care settings).

In addition, differential treatment of physicians with contagious diseases might violate federal and state laws prohibiting discrimination against persons with disabilities. See 42 U.S.C. § 12132 (Supp III 1991) (state or local governmental agencies may not discriminate against persons with disabilities). Finally, permitting the continued practice of infected health care workers, so long as they disclose their status, potentially conflicts with the typical state licensing code, which makes the continued practice of a physically and mentally impaired physician "unprofessional conduct." See supra text accompanying notes 107-10.

247. A number of states recently have considered or currently are considering enacting such disclosure regulations. See, e.g., H.B. 1188, 59th Gen. Ass'y, 1st Reg. Sess., Colo. (1993) (providing that referral of patients to health care facilities in which provider has a financial interest is unprofessional conduct); H.B. 2867, 175th Gen. Ass'y, Reg. Sess., Pa. §§ 4(a)(b), (l), (j), 7(c) (1992) (prohibiting some referrals, but permitting others accompanied by appropriate written disclosures to patients); Self Referral Act of 1992 S.B. 1813, 87th Gen. Ass'y, Reg. Sess., Ill. (1991) (providing for extremely detailed regulation of economic conflicts through written disclosure).

248. See, e.g., CAL. BUS. & PROF. CODE § 654.2(a), (d), (e) (West 1990) (providing that a physician or a physician's immediate family has a "significant beneficial interest" in any organization which includes interests of greater than $5,000 or 5% of the whole and which excludes, among other things, ownership in publicly traded stock); CONN. GEN. STAT. ANN. § 20-7a(c) (West Supp. 1993) (providing for disclosure where a physician has an "ownership or investment interest" in an entity which provides diagnostic or therapeutic services, excluding ownership of publicly traded securities); FLA. STAT. ANN. § 458.327(2)(c) (West Supp. 1992) (providing that
the referring physician disclose her financial interest to the patient, often in writing, and may require that the physician give information about other, alternative, providers of the service.249 States also occasionally explicitly establish substantive standards for appropriate refer-

the disclosure duty applies where a physician or a physician's employer has an "equity interest of 10 percent or more" in a business entity, excluding any ownership interest in publicly traded stocks and the physician's own practice, or lease agreements made at fair market value; Mass. Gen. Laws Ann. ch. 112, § 12AA (West Supp. 1993) (providing for disclosure where physician gives referrals to physical therapy services in which the physician has a "financial ownership interest," excluding HMO and PPO arrangements); Minn. Stat. Ann. § 147.091(1)(3), (4) (1992) (providing that physicians can be subject to disciplinary action if they refer patients to other health providers in which they have a "significant financial interest" unless this interest is disclosed to the patient; similar provision applies to "dispensing for profit any drug or device"); Nev. Rev. Stat. Ann. § 616.690(1) (workers' compensation statute; provides for disclosure where physician has a "financial interest" in health facilities or services); N.J. Stat. Ann. § 45:9-22.4 (West 1991) (providing for disclosure of a physician "significant beneficial interest" excluding leases at fair market value and ownership of publicly traded stock); Tenn. Code Ann. § 63-6-502(b)(1) (Supp. 1993) (providing for disclosure where physician has "ownership interest" in facility or therapy); Va. Code Ann. § 54.1-2964(A) (Michie Supp. 1993) (requiring disclosure where a physician has a "material financial interest" or ownership in referral facilities or clinical laboratories); Wash. Rev. Code Ann. § 19.68.010 (West 1989) (requiring disclosure where a practitioner has a "financial interest in [a] clinical laboratory or other services prescribed for medical, surgical or dental diagnosis"); W. Va. Code § 30-3-14(c)(7) (1993) (requiring disclosure where a physician refers patients to a clinical laboratory or pharmacist in which the physician has a "proprietary interest," excluding fair market value leases).

The statutes attempt to parse out some types of "interests" that are deemed not "significant" enough to adversely affect patients. Other transactions are protected because of the fear that disclosure requirements will impede access to care; statutes which exclude "rural" providers seem aimed at this problem. Finally, the restriction of some statutes to particular types of owned entities, such as clinical laboratories, seems founded on accident, history, and the current status of federal law more than on any statistical analysis of risk to patients. See, e.g., N.J. Stat. Ann. 45:9-22.5 (West 1991) (excluding radiation therapy pursuant to an oncological protocol, lithotripsy and renal dialysis referrals; statute generally prohibits referrals to covered entities, except that beneficial interests acquired before the statute's enactment may be retained but must be disclosed to the patient); see also 1991 Ill. S.B. No. 1813, 87th Gen. Ass'y, Reg. Sess., Ill. § 2(m)(3) (1992) (providing for exclusions for rural providers and a lengthy list of unregulated types of referrals, such as from a urologist to lithotripsy service center).

249. For example, Tennessee's new statutory scheme relies primarily on disclosure as the means to protect patients in such circumstances. Tenn. Code Ann. § 63-6-502 (Supp. 1993). The statute permits physicians "to enter lawful contractual relationships, including the acquisition of ownership interests in health facilities or equipment or pharmaceuticals," but recognizes the possibility of conflicts of interest, which can arise. Id. § 63-6-502(a). These are addressed by imposing on physicians the "duty to disclose to the patient or referring colleagues such physician's ownership interest in the facility or therapy at the time of referral and prior to utilization;" and by giving patients the free choice either to use the physician's proprietary facility or therapy or to seek the needed medical services elsewhere." Id. § 63-6-502 (b). The Medical Licensing Board was empowered to issue rules and regulations implementing this provision. Id. § 63-6-502(c).
rals. Statutes of this type reflect legislative concern about the effectiveness of disclosure alone as a tool to protect patients.

This skepticism is reflected in the minimal role of disclosure requirements under federal law. The federal government has imposed disclosure obligations on HMOs and certain other institutions in the health care marketplace. It has also supported the imposition of disclosure requirements on HIV or HBV-infected physicians. It has, however, rejected the use of disclosure requirements to remedy some of the problems associated with self referral and physician ownership.

3. Disclosures of Provider-Associated Risk

Both tort and fiduciary principles provide conflicted support for the disclosure of provider-associated risks. The scope of the disclosure obligation will depend on the scope of the tort-based informed consent doctrine in the jurisdiction, as well as on the state's acceptance of the physician as a fiduciary of her patients. States may also have supplemented these common law rules through specific statutory enactments. The disclosure requirement may vary for different types of provider-associated risk.

a. Personal Characteristics

There have been few cases dealing with the provider's duty to warn patients of risks connected to the provider's own characteristics. The informed consent doctrine would support the imposition of a disclosure obligation most readily in jurisdictions which employ the patient-centered definition of the scope of required disclosure. In these states, a plaintiff could attempt to show (1) that the provider's characteristic created a material risk; (2) that the risk of harm gave rise to injury; and (3) that a different, less risky, provider would have been chosen had the risk been disclosed. There may be some room for

250. Tennessee provides that a physician shall not exploit the patient in any way, as by inappropriate or unnecessary utilization, [must act], in strict conformity with the law, and [when confronted with a personal commercial interest] which conflicts so greatly with the patient's interest as to be incompatible, . . . shall make alternative arrangements for the care of the patient. Id. § 63-6-502(b)(2)-(3), (5).


252. See supra notes 244-46.

253. Compare, text accompanying note 221.

254. Each of these presents difficult hurdles for any prospective plaintiff. It may be difficult to show that the provider's characteristics created a material risk of harm. The data collected in
requiring disclosure of personal characteristics even in jurisdictions applying the more conservative standards for disclosure. Several courts have accepted the notion, for example, that a provider's experience and individual success rates should be disclosed.255

Fiduciary principles do not neatly apply to provider-associated risks based on personal characteristics. A physician's duty of loyalty and reasonable care is probably expansive enough to support a specific

Part II, supra, suggest that a provider's level of experience is associated with greater success rates. But this correlation does not confirm that a particular provider's relative lack of experience is a material risk.

It may be difficult for the plaintiff to prove that the provider's personal characteristic actually caused an injury. A negative surgical outcome may not be related to a provider's undisclosed personal characteristic.

Finally, the plaintiff may not be able to show that a reasonable patient would have refused the provider's care had she known of the risk. See Williams & Fost, supra note 16, at 221 (finding that 52% of surveyed patients indicate that they might be willing to be subjected to a student's first attempt at a spinal tap). The choice of caregivers is affected by many factors, including price, insurance coverage and personal relationship. What if the defendant surgeon was the only provider approved by the plaintiff's insurance company? Would the reasonable patient have preferred to use a different provider even though this would involve the loss of insurance coverage? Does the answer to this question make the remoteness of harm even more important?

255. In Gaston v. Hunter, 588 P.2d 326 (Ariz. Ct. App. 1978), for example, the court noted that a provider's experience and success rates were properly subject to disclosure even under the generally more restrictive battery theory:

[T]here are other types of information important to the patient's ability to give an informed consent. . . . including . . . the . . . treating physician's experience (or lack of experience) in performing the procedure, his prior results (if significantly different from the norm) . . . . In the present case, for instance, the fact that Dr. Hunter had limited experience with the procedure and was not an authorized investigator of chymopapain would be relevant to plaintiff's informed consent to the operation. Id. at 351. The court suggested, however, that experience and success rates might be more important for "new or unusual procedures" than for "established, common procedures." Id.; see Hales v. Pittman, 576 P.2d 493, 499-500 (Ariz. 1978).

In a New York case, one lower court refused to restrict disclosure of risks to those associated with the procedure itself:

Indeed, a prudent patient who was confident in the physician's skills would quite reasonably want to know whether an undesired result of surgery was beyond the physician's control or solely dependent upon the physician's skills. The risks of medical procedures vary depending upon a wide range of characteristics inherent to the patient, the physician, and the procedure . . . . A "very slight" risk to the general population could become a substantial risk to a somewhat susceptible patient, being treated by a physician of less than average competence or experience, using a procedure with which the physician was unfamiliar.

Nisenholtz v. Mount Sinai Hosp., 483 N.Y.S.2d 568, 571 (N.Y. Sup. Ct. 1984). See generally Sharrott, supra note 12, at 141-143; Twerski & Cohen, supra note 12, at 28-33. This disclosure rule is consistent with the already established principle that general practitioners have a duty to refer patients to specialists when their own training and experience is inadequate; otherwise, they will be held to a specialist's standard of care. See, e.g., Larsen v. Yelle, 246 N.W.2d 841, 844-45 (Minn. 1976).

1994] AUTONOMY AND PRIVACY 363
duty to inform the patient of other providers or services that could be of benefit to the patient. Yet, there is little case law support for the obligation of a fiduciary to inform an entrustor of the fiduciary’s personal failings. Both informed consent and fiduciary principles present formidable problems, yet two recent decisions indicate that courts might be willing to leap over some of the technical requirements to find liability.

The patient in *Hidding v. Williams* was a fifty-nine year old man who suffered “a loss of bowel and bladder control” after undergoing a laminectomy performed by Dr. Williams. The patient and his wife brought both a traditional malpractice action and an action based on a violation of informed consent. The district court found that Dr. Williams failed to obtain Mr. Hidding’s informed consent and awarded over $300,000 in damages. The lower court held that the defendant had violated his disclosure obligations by failing to specifically inform Hiddings of the risk of loss of bladder and bowel control and, more importantly for our purposes, by failing to inform the patient that his prospective surgeon was abusing alcohol.

The Court of Appeals affirmed, finding that Williams had a duty to disclose his alcohol abuse:

> Of equal if not more importance, the district judge found that Dr. Williams’ failure to disclose his chronic alcohol abuse to Mr. and Mrs. Hidding vitiated their consent to surgery. Because this condition creates a material risk associated with the surgeon’s ability to perform, which if disclosed would have obliged the patient to have elected another course of treatment, the fact-finder’s conclusion that non-disclosure is a violation of the informed consent doctrine is entirely correct.

The court noted that Williams had lost his medical license because of alcohol abuse, and cited testimony from Williams’ former wife as to the degree of his impairment. Mrs. Hiddings testified that she would have asked that Williams be assisted in the surgery had she been told

---

256. See infra notes 217 (defining materiality of fiduciary disclosure) & 211 (timing of fiduciary duty).
258. *Id.* at 1194. The surgery took place in 1984; the plaintiff died from other causes in 1990.
259. *Id.* at 1193-94, 1198. The disposition of the traditional malpractice claim of negligence in surgery is not clear from the appellate decision.
260. *Id.* at 1198.
261. *Id.* at 1196.
262. *Id.* at 1196-97.
that Williams was abusing alcohol.\textsuperscript{263} A medical expert testified that Williams should have informed his patients of his condition.\textsuperscript{264}

The appeals court, viewing the issue of liability as a matter of disputed fact, affirmed the district judge’s liability determination as not clearly erroneous.\textsuperscript{265} One judge concurred, but expressed concerns about the court’s lack of discussion of the injury requirement.\textsuperscript{266} The other member of the panel concurred in the liability determination

\textsuperscript{263} Id. at 1197.

\textsuperscript{264} The appeals court summarized the testimony of one medical expert:

At trial Dr. Russell Levy testified that it was the opinion of the medical review panel that, if Dr. Williams were under the influence of a foreign substance, it would have been a breach of the standard of care for him to have performed the surgery. When asked whether a doctor suffering from alcohol or drug dependency has an affirmative obligation to relay this to the patient, he answered, “I certainly think that if a physician or anybody in a position of life and death over someone knows that they’re suffering from this condition, they should at least let this person know that they have these problems.”

\textit{Id.} Testimony of this sort could be used to support a disclosure obligation even in a jurisdiction following the majority “reasonable physician” standard of disclosure. See supra note 187. It would not appear to be required where, as here, the patient-centered standard of materiality is the measure of the scope of disclosure.

\textsuperscript{265} The appeals court decision was truncated:

The district court judge found as a matter of fact that Dr. Williams abused alcohol at the time of Paul Hidding’s surgery. Based on both fact and expert testimony the court concluded that this condition presented a material risk to the patient, the increased potential for injury during surgery, that was not disclosed. Had the risk been disclosed, Mr. and Mrs. Hidding would have selected another course of treatment. Thus by failing to disclose his chronic alcohol abuse Dr. Williams violated the informed consent doctrine.

These factual findings are based on a determination of witnesses’ credibility and are entitled to great deference; they are not clearly wrong.

\textit{Id.} at 1198 (citation omitted).

\textsuperscript{266} Judge Grisbaum concurred in the court’s opinion with the following caveat: “Both the majority and the trial court seem to imply that, if there is a breach of the informed consent statute and a resulting injury, then (automatically) liability attaches. In other words, a cause-in-fact relationship between failure to disclose and injury appears unnecessary. On this conclusion, I disagree.” \textit{Id.} at 1198. Judge Grisbaum seems to have identified a basis for invalidating the informed consent claim as a matter of law. He nonetheless concurred with the court’s affirmance of the plaintiff’s award, although on seemingly irrelevant grounds:

After reviewing this record in its entirety, I am convinced that there was a reasonable factual basis to conclude that Dr. Williams, at the time of the operation in question, was a practicing alcoholic. From this factual scenario, I suggest the gut question proposed is simply this: whether a professed and practicing alcoholic can operate upon any patient without breaching his standard of care. In other words, if there is a resulting injury and the doctor performing the operation is a practicing alcoholic, and this alcoholism is not disclosed to the patient prior to surgery, do we have liability? Given this factual scenario and considering the record in its entirety, I say, “Yes.” Ergo, this question must be viewed on a case-by-case basis.

\textit{Id.}
based only on Williams’ failure to disclose the physical risks of surgery.267

The Hiddings decision glosses over several important problems in applying the informed consent doctrine to risks created by the provider’s personal characteristics. Must the plaintiff show that the provider’s personal characteristic caused injury? Where the characteristic causes injury, what is the difference between an informed consent and a traditional malpractice action? Is the provider liable only if she is consciously aware of the dangerous personal characteristic? The Hiddings court failed to discuss any of these issues.

The court noted that “the loss of bowel and bladder function as a result of lumbar laminectomy occurs once in 200,000 cases.”268 Nevertheless, neither the court nor the concurring judge explicitly tied the plaintiff’s loss of bladder and bowel control to the defendant’s alcohol abuse.269 The court noted that the plaintiff’s medical expert had testified that it would be a breach of the standard of care to perform surgery while impaired by alcohol.270 The court, however, did not explain why the action was appropriately framed as a violation of informed consent rather than traditional malpractice.271 Nor did the court explore what the implications of disclosure would be for the viability of a traditional malpractice action.272 Finally, the court affirmed the disclosure requirement despite the fact that the defendant did not consciously know that he abused alcohol.273

---

267. Judge Wicker “express[ed] no opinion as to whether a failure to disclose an alcohol abuse problem is a violation of the informed consent statute rather than actionable on negligence grounds [because he did] not view the resolution of this issue to be compelled by the present posture of this case.” Id. at 1198-1199.

268. Hidding, 578 So. 2d at 1195.

269. In fact, only Judge Grisbaum seemed aware of this potential flaw in the lower court’s reasoning. Id. at 1198. He noted that the causation requirement could be met on a case-by-case basis but then inexplicably failed to note the specific evidence of causation in this particular case. Id.

270. Id. at 1197.

271. This issue was indirectly raised by Judge Wicker, who did not join in the court’s resolution of the alcohol abuse issue. Id. at 1198-99.

272. Would a malpractice action have been barred if the Hiddings had known about and consented to the risks created by Williams’ alcohol abuse? See infra notes 322-33 and accompanying text.

273. Hidding, 578 So. 2d at 1192. This point raises two different issues (1) the legal question of whether a duty to disclose should be imposed regardless of the physician’s conscious awareness of the dangerous personal characteristic; and (2) the factual question of whether or not the physician knew or should have known of the risk she presented to her patients. The Hidding court failed to note that the plaintiff’s medical expert had limited the duty to disclose to those who “know[] that they’re suffering from this condition.” Id. at 1197. Judge Grisbaum, in his concur-
A Pennsylvania court recently rejected a similar claim. In *Kaski v. Wright*, the plaintiff-parents brought wrongful death and survival actions based on the death of their son. The plaintiffs claimed, in part, that there had been a violation of the informed consent doctrine because of the failure to disclose the physician's alcoholism and unlicensed status. Pennsylvania's informed consent doctrine is based on battery law and is quite narrowly defined; not surprisingly, therefore, the court rejected the plaintiffs' claims:

[T]here is no allegation here that appellants were uninformed about the particular procedures their son underwent irrespective of the surgeon performing them. . . . [W]e . . . refuse to expand the informed consent doctrine to include matters not specifically germane to surgical or operative treatment. To do so, where the absent information consists of facts personal to the treating physician, extends the doctrine into realms well beyond its original boundaries. Nor are limitations easily definable. Are patients to be informed of every fact which might conceivably affect performance in the surgical suite? Moreover, here, no clear nexus has even been established between injury and lack of knowledge.

The court suggested that the surgeon's deficiencies were more properly addressed through a corporate negligence claim brought against other entities.

The other recent judicial response to the risks created by a provider's personal characteristics incorporated both informed consent and fiduciary principles. In *Estate of Behringer v. Princeton Medical Center*; the New Jersey Superior Court considered whether a hospital could require a physician to disclose his HIV status as a condition of permitting his continued use of his hospital admitting privileges.

---

275. *Id.* at 214.
276. *Id.* at 217.
277. *Id.*
279. The medical center's board of trustees voted to require the use of a special informed consent form a little over a month after Behringer's HIV status became known. *Id.* at 1258. The
The surgeon, William Behringer, had contended that the disclosure requirement constituted unlawful disability-based discrimination. The court's resolution of the issue required it to consider whether physicians had a duty to disclose their HIV status to patients considering surgery. The court held that the hospital did not impermissibly discriminate against Behringer in requiring that he disclose his HIV status to prospective surgical patients. 280

Initially, the court determined that the surgeon's HIV infection constituted a material risk under the applicable informed consent standard. 281 The court then considered and rejected the plaintiff's contention that the informed consent doctrine covered only information about the proposed procedure and excluded disclosures of information about the surgeon. Provider-associated risks were deemed disclosable based on a prior New Jersey case in which "the court spoke of not only an evaluation of the nature of the treatment, but of 'any attendant substantial risks.'" 282 The court viewed the informed consent doctrine as a method of countering the self-interest and paternalism of medical pro-

Medical center also adopted a policy which barred "any procedures that pose any risk of virus transmission to the patient" though there remained some doubt about whether HIV-infected health care workers presented any risk. Id. at 1277. See also Stacey Turner Caldwell, Note, Discrimination or Protection of the Public: An Examination of Estate of Behringer v. Medical Center at Princeton, 14 GEO. MASON U. L. REV. 469 (1991).

It has been unclear whether HIV disclosures would be required under traditional informed consent law because of the lack of precedent for the disclosure of provider-associated risk and because of the extremely low levels of risk presented by such providers. See Marcia Angell, A Dual Approach to the AIDS Epidemic, 324 NEW ENG. J. MED. 1499-1500 (1991) (favoring disclosure); Bobinski, supra note 27, at 304-06 (arguing that broad disclosure requirements are not supportable); Daniels, supra note 17, at 32-39 (concluding that there should be no duty to disclose); Chai R. Feldblum, A Response to Gostin, "The HIV-Infected Health Care Professional: Public Policy, Discrimination, and Patient Safety," 19 LAW. MED. & HEALTH CARE 134 (1991) (stating that the risk is not material, and further, that provider-associated risks lie outside informed consent doctrine); Letter from Larry Gostin to JAMA, 264 JAMA 452 (1990) (saying that the risk is too small to be material).

280. Behringer, 592 A.2d at 1283.

281. Id. at 1279-80. The evidence in the record indicated that the risk of HIV transmission from a physician to patient was very small. Id. at 1264-1267, 1279-1281. There was a considerably larger risk that an exposure incident, such as a needlestick, could take place. These events might "subject a previously uninfected patient to months or even years of continual HIV testing." Id. at 1279. The court held that both these risks were material. Id. at 1279-80.

282. Id. at 1281. The court also cited "duty to warn" cases as support for a disclosure obligation: "If a physician has a duty to warn third parties of the HIV status of patients who may be, for example, sexual partners of the patient, it could legitimately be argued that the risk of transmission would similarly require the surgeon to warn his own patients." Id. at 1281 n.19.
professionals, who might otherwise permit HIV-infected health care workers to perform risky procedures. 283

The Behringer court confronted an employment discrimination claim, and was not directly concerned with the validity of an informed consent action. Its decision therefore has predictable gaps. The court did not consider the role of traditional malpractice actions in regulating provider-associated risk. Nor did the court address the problematic relationship between malpractice and disclosure obligations, perhaps because all parties agreed that the practical effect of the informed consent obligation was to bar Behringer’s performance of surgery. 284 There is thus no indication of whether a patient’s consent would be viewed as an assumption of the risk of HIV transmission. There is little information about what an informed consent claim would look like: whether, for example, a plaintiff would be able to bring a claim based on the undisclosed risk of repeated HIV-testing following a surgical accident even if HIV itself was not transmitted. The case is suggestive but not determinative of the nature and limits of an informed consent claim based on provider-associated risks. 285

283. The court’s discussion of physician self-interest was frank:

This court, too, must be concerned that the medical center decision-makers, while no doubt acting in good faith in the decision-making process, are acting with the knowledge that their decisions may well affect their ultimate ability to practice their chosen profession.

Nevertheless, there must be a way to free physicians, in the pursuit of their healing vocation, from possible contamination by self-interest or self-protection concerns which would inhibit their independent medical judgments for the well-being of their . . . patients.

There are principles of law that guard against the concern for self-interest, by including in the decision-making process the most critical participant—the patient. The doctrine of informed consent, as an adjunct to the adopted medical center “any risk” policy, provides the necessary element of patient control which is lacking from the policy standing alone.

Id. at 1278 (citations omitted).

The court returned to this theme in dismissing the plaintiff’s objections to forced disclosure of his HIV status:

Plaintiff urges that these issues should be dealt with on a case-by-case basis, wherein the hospital or medical staff monitors an HIV-positive surgeon and makes a determination as to the surgeon’s ability to perform a particular invasive procedure. . . . The position plaintiff seeks to implement is replete with the “anachronistic paternalism” rejected in both Canterbury v. Spence, . . . and by the [New Jersey] Supreme Court in Largey v. Rothman[.]

Id. at 1281.

284. Id. at 1258.

285. Several commentators have outpaced the courts in reaching and resolving these issues. Norman Daniels, HIV-Infected Professionals, Patient Rights, and the 'Switching Dilemma,' 267 JAMA 1368 (1992); Darrell Fun, HIV-Infected Healers: Do Patients Have a Right to Know?, 21 THE BRIEF, Summer 1992, at 6; Larry Gostin, Hospitals, Health Care Professionals, and AIDS:
b. Economic Relationships

Courts have rarely considered whether providers have a common law duty to disclose risks created by their economic entanglements. As with disclosure of risks created by personal characteristics generally, a duty to disclose economic arrangements might arise under traditional informed consent or fiduciary principles. Successful actions are more likely in jurisdictions adopting patient-centered tort or fiduciary approaches to regulating disclosures in the doctor-patient relationship. The implications of fiducial principles may be particularly controversial because physicians always have economic interests which create the potential for conflicts of interest. The existence of a conflict will not automatically breach the physician's fiduciary duty. The duty is breached if the physician permits the conflict to alter her duty of unswerving loyalty to her patient's interest or if the physician fails to disclose interests which "might affect" her behavior with respect to fiduciary matters. The physician's pursuit of her own interests might be cured by the consent of her patient; the extent of disclosure in such cases will be a relevant item of proof but, depending on the physician's influence, might not be sufficient to rebut the presumption that that patient's consent is invalid.


286. Commentators have been somewhat more active in this area. See, e.g., Matthew R. Gregory, Hard Choices: Patient Autonomy in an Era of Health Care Cost Containment, 30 JURIMETRICS J. 483, 494-497 (1990) (arguing that physicians have a duty to disclose helpful medical treatments even where insurance will not pay for them); James J. Pinto, Must You Bare Your Insurance Status to Your Patients?, LEGAL ASPECTS OF MED. PRACTICE, Jan. 1980, at 43 (discussing possibility that insurance status might be a required disclosure in the future).

287. Plaintiffs pursuing informed consent claims will have the most difficulties showing that the provider's economic arrangements with others presented a material risk to the patient, that the risk gave rise to an injury, and that a different provider would have been chosen if the risk had been disclosed.

288. Plaintiffs claims grounded in fiduciary principles will be more successful because of the long history of judicial regulation of economic conflicts of interest in fiduciary relationships. Even here, however, fiduciary principles could lead to conflicting results.

289. Traditional fee-for-service arrangements create a conflict to the extent that the physician's earnings are based on the provision of additional services to the patient. Similar problems arise where the physician profits from referring a patient to a different provider. New economic arrangements may give physicians an incentive to deny care or to refrain from referral.

290. See supra text accompanying note 213.

291. See supra text accompanying notes 217-18.
The only judicial consideration of common law economic disclosure obligations occurred in *Moore v. Regents of the University of California*.292 John Moore sought treatment for hairy-cell leukemia at the UCLA Medical Center in 1976.293 Moore agreed to have his spleen removed at the suggestion of Dr. David Golde, his attending physician.294 Moore also complied with Dr. Golde's recommendation that he return to the UCLA Medical Center for periodic tests, some of which involved blood or tissue samples.295 Moore continued to travel from his home in Seattle to UCLA until September of 1983.296

Moore's claim for damages arose out of his discovery that Golde and various other defendants297 had profited from the removal of his spleen and from his continued return to UCLA for tests.298 Moore also


293. 793 P.2d at 481.

294. *Id.*

295. *Id.*

296. *Id.*

297. There were five defendants: "(1) Dr. David W. Golde (Golde), a physician who attended Moore at UCLA Medical Center; (2) the Regents of the University of California (Regents), who own and operate the university; (3) Shirley G. Quan, researcher employed by the Regents; (4) Genetics Institute, Inc. (Genetics Institute); and (5) Sandoz Pharmaceuticals Corporation and related entities (collectively Sandoz)." *Id.* at 480-81.

298. Golde "established a cell line from Moore's T-lymphocytes" that was later patented by the defendants. *Id.* at 481-82. A cell line is a culture of cells that is capable of reproducing indefinitely. *Id.* at 481-82 n.2. The cell line could be used to produce lymphokines, which presented a potential economic benefit of millions of dollars. *Id.* at 482 (discussing Moore's contention that the lymphokine market might total "$3.01 Billion by the year 1990"). The court described the relationship between the Moore cell line of T-lymphocytes and the production of valuable lymphokines:

A T-lymphocyte is a type of white blood cell. T-lymphocytes produce lymphokines, or
claimed, in part, that the defendants had breached their duty of disclosure by failing to tell him of their interest in his spleen and body tissues. The California Supreme Court resurrected Moore’s disclosure claims under an admixture of fiduciary and traditional informed consent theories. The court derived the physician’s disclosure duty from three principles: the right of competent adults to consent to or reject medical treatment, the requirement that consent be an informed exercise of choice, and the physician’s “fiduciary duty to disclose all information material to the patient’s decision.”

Information about a physician’s research or economic interests was deemed to be material for two reasons. First, the court noted that conflicts of interest in the doctor-patient relationship were already regulated by statute in some circumstances. Second, the court concluded

proteins that regulate the immune system. Some lymphokines have potential therapeutic value. If the genetic material responsible for producing a particular lymphokine can be identified, it can sometimes be used to manufacture large quantities of the lymphokine through the techniques of recombinant DNA . . .

. . . Moore’s T-lymphocytes were interesting to the defendants because they overproduced certain lymphokines, thus making the corresponding genetic material easier to identify.

Id. 481-82 n.2 (citations omitted). Golde “negotiated agreements for commercial development of the cell line and products to be derived from it.” Id. at 482. Golde obtained stock options and cash payments, including a pro-rata share of his salary paid to the Regents. Id.

299. Id. at 483. Moore’s primary claim was for conversion; he contended that the defendants had misappropriated his property, in the form of his spleen and other tissues or cells, for their own benefit. The lower court decisions focused almost exclusively on the appropriateness of conversion actions involving body tissues. See Moore v. Regents of the University of California, 249 Cal. Rptr. 494 (Ct. App. 1988). The California Superior Court initially dismissed the complaint, finding that the conversion claim was defective and that this defect was fatal to all the plaintiff’s other claims. Moore, 793 P.2d at 482-83. The Court of Appeals reversed, finding that the conversion claim was viable. Id. at 483.

300. Id. at 497. The court’s analysis of the disclosure issue included both traditional informed consent and fiduciary principles, holding that the “cause of action [could] properly be characterized either as the breach of a fiduciary duty to disclose facts material to the patient’s consent or, alternatively, as the performance of medical procedures without first having obtained the patient’s informed consent.” Id. at 483.

301. The court recognized that this was an unusual application of informed consent theory: To be sure, questions about the validity of a patient’s consent to a procedure typically arise when the patient alleges that the physician failed to disclose medical risks, as in malpractice cases, and not when the patient alleges that the physician had a personal interest, as in this case. The concept of informed consent, however, is broad enough to encompass the latter. “The scope of the physician’s communication to the patient . . . must be measured by the patient’s need, and that need is whatever information is material to the decision.”

Id. (alteration in original) (citing Cobbs v. Grant, 502 P.2d 1 (1972)).

302. Id.

303. The court noted that California law already required certain disclosures as a condition of referring patients to entities in which a provider had an ownership interest and as a condition of
that reasonable patients would want to know about potential conflicts of interest:

The possibility that an interest extraneous to the patient's health has affected the physician's judgment is something that a reasonable patient would want to know in deciding whether to consent to a proposed course of treatment. It is material to the patient's decision and, thus, a prerequisite to informed consent.\textsuperscript{304}

The court then held that both the informed consent doctrine and fiduciary principles required that physicians "disclose personal interests unrelated to the patient's health, whether research or economic, that may affect his medical judgment."\textsuperscript{305}

The \textit{Moore} opinion's treatment of the causation and damages issues was somewhat problematic. Moore's disclosure claim with respect to the original splenectomy seemed vulnerable because the splenectomy provided a medical benefit.\textsuperscript{306} Would a reasonable patient with hairy-

\begin{itemize}
  \item \textbf{304.} \textit{Id.} at 483-84. The court found little case law support for this proposition. It noted that "the law already recognizes that a reasonable patient would want to know whether a physician has an economic interest that might affect the physician's professional judgment. . . . "[C]ertainly a sick patient deserves to be free of any reasonable suspicion that his doctor's judgment is influenced by a profit motive." \textit{Id.} at 483 (citing \textit{Magan Med. Clinic v. California State Bd. of Med. Examiners}, 57 Cal. Rptr. 256 (1967)). The court's conclusion about the informational needs of patients might be correct, but it cited for support a case involving the power of the state to prohibit conflicts of interest, not a case about disclosure. The court in \textit{Magan} was concerned with whether the legislature had constitutionally exercised its authority in prohibiting physicians and surgeons from owning pharmacies. 57 Cal. Rptr. at 256.

  \item \textbf{305.} \textit{Moore}, 793 P.2d at 485. The court noted that not all research or economic risks would require disclosure: "In some cases . . . a physician's research interest might play such an insignificant role in the decision to recommend a medically indicated procedure that disclosure should not be required because the interest is not material. By analogy, we have not required disclosure of 'remote' risks . . . ." \textit{Id.} at 485 n.9.

  \item \textbf{306.} The court concluded that Moore had alleged sufficient facts to support a disclosure claim for Golde's failure to disclose his research interests (1) before removing Moore's spleen and (2) before requiring that Moore return to UCLA for continued tissue "sampling." \textit{Id.} at 485-86. The two claims are arguably distinguishable, however, because the post-operative sampling only provided benefits to Moore insofar as it confirmed that his leukemia was in remission. This benefit could have been achieved without traveling to UCLA.

  The splenectomy, in contrast, carried with it a clear therapeutic benefit. The court rejected the relevance of this benefit, holding that "[e]ven if the splenectomy had a therapeutic purpose, it does not follow that Golde had no duty to disclose his additional research and economic interests." \textit{Id.} at 486. The problem is, of course, that the therapeutic benefit of the procedure likely would have led a reasonable person to undergo the procedure, despite the economic benefits to the physicians. \textit{Accord Id.} at 519-20 (Mosk, J., dissenting). Justice Broussard, in an opinion that concurred in part, suggested that this problem might be remedied by changing the informed consent requirements: "[I]n this context—unlike in the traditional 'informed consent' context . . . —a plaintiff should not be required to establish that he would not have proceeded with the medical treatment
cell leukemia refuse a splenectomy to remove a spleen that had enlarged and weighed fifteen pounds, even if informed of the surgeon's research interest in the spleen? Phrased another way, what was the undisclosed risk that came into fruition? The risk would appear to be that Golde had been influenced by research or economic interests to recommend an unnecessary operation, but here Moore failed to assert that the splenectomy was unnecessary.

The other issue left unresolved by the court's opinion concerned Moore's recoverable damages. As Justice Mosk noted in his dissent, the informed consent doctrine permits a patient to say "no" but does not provide a basis from which a patient could bargain for shared economic benefits in exchange for a "yes." Where the care delivered was unnecessary, plaintiffs could recover compensation for injuries from excessive or inadequate care. The majority does not provide a measure of damages for violations of the duty to disclose which involve necessary or appropriate care, although there is a suggestion in a concurring opinion that some type of compensatory or punitive damages might be the appropriate remedy for a breach of fiduciary duty. If the key to the claim is the impermissible benefit to the physician rather than the actualization of risk for the patient, then unjust enrichment principles might supply the measure of damages. Future courts might choose to rely more explicitly on fiduciary law to avoid some of the causation problems carried by the informed consent doctrine. A breach of fiduciary duty, for example, could be remedied by requiring that the fiduciary disgorge profits from an undisclosed transaction, even if the transaction also presented benefits to the entrustor.

in question if his physician had made full disclosure, but only that the doctor's wrongful failure to disclose information proximately caused the plaintiff some type of compensable damage.” 793 P.2d at 500 (citation omitted).

307. Id. at 520-21 (Mosk, J., dissenting).

308. The majority does not attempt to identify in advance of trial the various kinds of damage or injury for which plaintiff may properly recover in his breach-of-fiduciary-duty action, and that may be understandable. Nonetheless, it is worth noting that, in appropriate circumstances, punitive as well as compensatory damages would clearly be recoverable in such an action.

Id. at 500 (Broussard, J., concurring in part and dissenting in part).

309. See supra notes 230-34 and accompanying text.
V. ALLOCATING PROVIDER-ASSOCIATED RISK IN THE PHYSICIAN-PATIENT RELATIONSHIP

A. Prohibition and Disclosure

Prohibitions and disclosure obligations both present costs and benefits as mechanisms for dealing with the problem of provider risk. The retrospective prohibitions established under malpractice law are of limited utility because of the focus on patient injury. The more prospective prohibitions established by state licensure statutes are both under- and over-inclusive; they also may illegally discriminate against persons with disabilities. The prohibitory regulations restrict the autonomy of both patients and physicians, and can result in economic inefficiency.

Replacing transaction bars with disclosure mandates creates two different sets of problems. The first of these arises from the uncertain application and scope of the current disclosure mandates. It is unclear when disclosure obligations apply, and courts have not yet developed

310. Malpractice standards tend to punish physician conduct that has caused patient injury. These retrospective prohibitions will theoretically provide an important avenue for patient compensation and may deter similar physician conduct in the future. Yet the standards established under malpractice law will inevitably be underinclusive because patients are not compensated for bearing the risk created by certain provider characteristics and, often, will not have sufficient damages to attract legal redress even where the provider-risk creates an injury. See supra note 97 (discussing need to prove injury, problems presented by injuries without sufficient damages to attract legal representation).

311. Regulatory standards could be viewed as more protective of patients because they tend to punish physician conduct that has been determined to place patients at risk for injury without requiring proof that injury occurred. Yet these prospective prohibitions exist only in selected areas. See supra notes 98-133 and accompanying text. What legislative prohibitions exist may be either under- or over-inclusive, in part because they operate without the guidance of an risk-centered standard.

312. Malpractice standards restrict autonomy by imposing a standard of care that might differ from that which would be chosen by a patient and physician with an opportunity to negotiate. The power of patients and physicians to contractually alter the malpractice standard of care is discussed in more detail elsewhere. See infra notes 322-33 and accompanying text. Regulatory prohibitions present a potentially greater risk to autonomy because they impose restrictions even in cases where patients would not be harmed. Both patients and physicians might benefit from engaging in the prohibited transaction, as where a patient might receive better quality care at a clinical laboratory partially owned by a referring physician.

313. Physicians who are restricted from practicing because of some personal characteristic will not be able to contribute the benefits of their education, training and experience to society. Restrictions on economic transactions can introduce inefficiencies in an already troubled health care marketplace. Restricting the freedom of physicians as economic actors may result in less investment capital, along with less knowledgeable investment. It may also hamper the use of economic incentives to reduce some of the quality and cost problems endemic to our system of providing health care.
consistent rules to determine causation and damages. The second set of
problems is even more serious, and goes to the heart of the validity of
disclosure as a method of allocating risk.

The use of disclosure as a tool to protect patients from risk is bur-
dened by the uncertain scope and nature of the disclosure obligation.
The types of personal characteristics and economic incentives requiring
disclosure are undefined.314 This discussion has focused on a consistent
set of provider-associated risks. This should not obscure an enormous
slippery slope problem that is quite capable of torpedoing the preceding
eighty pages of analysis: we have no clear standard with which to dis-
tinguish between the risks to be ignored and those to be disclosed. Must
a physician disclose lack of experience, even where there is no specific
evidence that the physician’s actual performance differs from other
practitioners? Must a physician disclose other potential detractions
from performance, such as a lack of sleep or stress or an argument with
some significant other? Should a physician disclose financial incentives
that are tied to individual performance? What about incentives which
operate through global reward systems, in which the individual physi-
cian’s behavior is lumped in with those of other practitioners in deter-
mining payments?

We can construct a general rule to guide physicians and juries as
they determine which risks require disclosure—perhaps using the mate-
riosity of risk standard suggested by common law informed consent and
fiduciary analyses.315 Disclosure under these circumstances appears to
be an attractive alternative to the paternalistic imposition of state
prohibitions. The seductive appeal of disclosure mandates, however, is
an illusion: disclosure mandates create as many, or more, social costs
than the prohibitions they are designed to replace. These costs are real,
even if perhaps more hidden than those created by flat prohibitions, but

314. See supra notes 6-60 and accompanying text.

In addition, it is not clear which types of medical decisions and treatments give rise to a
disclosure obligation for physicians. States vary widely in determining whether traditional in-
formed consent disclosure obligations should apply to invasive medical treatments, diagnostic tests,
treatment alternatives, or decisions not to treat. Judicial invocation of fiduciary principles may
serve as an end run around these limitations, but the fiduciary principles seem to apply more
easily to economic incentives than to a provider’s personal characteristics.

315. Material risks must be disclosed under the informed consent theory, see supra text
accompanying note 192, and economic interests that might affect professional judgment must be
disclosed under the fiduciary theory adopted in Moore, see supra text accompanying note 302.
Yet, this standard is difficult to apply, either prospectively by physicians or retrospectively by
juries. Disclosure mandates could represent just a second bite at the apple for plaintiffs masquer-
ading as another fancy legal theory.
they are not weighed in the calculation of “materiality” under current disclosure principles. Disclosure obligations applied to persons with disabilities also run the risk of violating the ADA.

Causation and damages standards in these cases also remain unclear, in part because the few courts that have considered these claims have not applied traditional rules. May a patient recover for negligent non-disclosure even when she cannot prove that the provider’s undisclosed personal characteristic led to some injury? The *Hiddings* case suggests that the answer might be yes. What result when the physician claims that she would have chosen a particular course of treatment even in the absence of an economic incentive? What result when the patient would have chosen the treatment regardless of the physician’s economic interest? The *Moore* court suggested that a cause of action for breach of fiduciary duty could exist despite these facts. Further, courts have not had much experience determining the appropriate damage awards in these cases. Jurisdictions applying traditional causation rules might hold defendants liable for typical malpractice damages.

316. Even assuming that it can be applied in a predictable and consistent manner, the materiality of risk standard that seems so sensible for the disclosure of the risks and benefits of treatment may require too much disclosure of provider-associated risk. The reasonable patient might want information about a wide range of provider-associated risks, even those of very small magnitude, because the avoidance of risk appears to cost the patient little or nothing. Some critics of tort-based disclosure obligations have noted that courts and juries tend to err on the side of requiring disclosures because they mistakenly are viewed as “cost-free.” James A. Henderson & Aaron D. Twerski, *Doctrinal Collapse in Products Liability: The Empty Shell of Failure to Warn*, 65 N.Y.U. L. Rev. 265, 297 (1990) (“the visible monetary costs of additional warnings are typically quite low—a few pennies for a bit more paper and a little more ink—while the greatest part of the costs of overwarning are monetary and easily ignored”). Under a traditional cost-benefit test, then, the possible benefit of a required disclosure will outweigh the cost of taking care since disclosures are presumed to cost little or nothing.

Henderson and Twerski note that, in products liability cases, “[o]verwarning causes users and consumers to discount or ignore warnings that should be heeded, leading to higher accident costs which, though very real, are not before the court in failure-to-warn litigation. Overwarning also may scare some worthwhile users away, resulting in wastefully high avoidance costs.” *Id.* at 297 n.135.

Disclosures of personal characteristics can actually be quite costly to providers. See *supra* notes 137-40 and accompanying text (privacy section). Massive disclosure requirements also create the risk of overburdening the physician-patient relationship with an unmanageable and unrealistic burden. Disclosures of personal characteristics may ultimately diminish access to care as providers refrain from offering some services and as patient preferences for low risk providers reshapes the market for health care services. Cf. Daniels, *supra* note 285. Disclosures of provider-associated risks may be costly to both providers and patients, but in ways that the current informed consent doctrine standard of “materiality” ignores.

317. See *supra* text accompanying notes 101-02.

318. See *supra* notes 258-73 and accompanying text.

319. See *supra* note 306 and accompanying text.
This seems sensible because a successful claim means that the plaintiff suffered some compensable injury from an inappropriate procedure.\footnote{320} The damage remedy in the non-traditional causation cases is unclear, particularly in cases invoking fiduciary principles.\footnote{321}

The preceding problems can all be attributed to mere technical difficulties with the development of a coherent rule of disclosure. A second set of issues arise from an even more fundamental dilemma: Can the disclosure doctrine be used by providers as a shield to avoid liability to injured patients? Imagine that a physician informs a patient about her substance abuse history and that the patient, a recovering alcoholic herself, agrees to go forward with some medical procedure. The physician’s disclosure suggests that the patient has assumed the risk created by the provider, which could prevent the patient from recovering on a malpractice theory if the patient’s injury is related to the physician’s substance abuse problems.\footnote{322} A similar problem arises in fiduciary-based claims. Suppose that a physician who works for an HMO has a financial interest in restricting the number of referrals to specialists. The patient is informed of this potential conflict of interest and later suffers from a delayed diagnosis caused by her physician’s failure to refer her to a specialist. Does the physician’s disclosure of her conflict of interest bar the patient’s suit claiming a breach of the physician’s duty of loyalty and reasonable care?\footnote{323}

These hypotheticals reveal the troubling tension between patient consent and physician liability for breaches of tort or fiduciary duties. The role of consent is clear in the ordinary case of treatment-associated risk: a physician is required to disclose the risks and benefits of a particular treatment and may also be liable for negligent performance of that procedure. Disclosure of provider-associated risks seems closer to disclosure of the risk of negligence, and the patient’s agreement to proceed could be interpreted as a waiver of liability for that negligence. Similarly, a fiduciary’s apparent breach of the duty of loyalty might be cured by the entrustor’s consent, assuming that it is knowing and vol-

\footnote{320. Phrased another way, the plaintiff has suffered some injury that could have been avoided if the physician had made an appropriate disclosure. The plaintiff would therefore be entitled to recover damages based on the avoidable injury. See supra note 197 and accompanying text.}

\footnote{321. Unjust enrichment claims might be possible in cases where physicians have benefitted from an undisclosed financial interest in the patient’s treatment. See supra note 232 and accompanying text.}

\footnote{322. Keeton et al., supra note 166, at 480-92 (assumption of risk).}

\footnote{323. See supra note 229 and accompanying text.}
unary. There are at least three possible judicial responses to these arguments.

First, courts might find that not all disclosures of provider-risk are the equivalent of disclosures of the risk of negligence. Patients informed of a provider's previous success rate or her infection with a transmissible condition could be viewed as assuming only the risks of non-negligent conduct. Under this theory, patients who had been informed of a general provider-associated risk would still be permitted to sue for specific acts of negligence in performing a procedure or for negligently permitting the transmission of a disease. The disclosure would only protect physicians from suits claiming violation of disclosure obligations.324

Disclosures of other types of provider-associated risks are more problematic. A physician who discloses problems with substance abuse is essentially disclosing a risk of future negligence; it probably does not make sense to say that the patient has only waived recovery for injuries caused by alcohol use that are non-negligent. Disclosure mandates applied to these types of risks will create one of two unpleasant alternatives. Injured patients will be barred from bringing traditional negligence claims if their consent is viewed as a valid waiver. If the patient's consent does not constitute a waiver, then physicians who disclose these provider-associated risks will not gain any significant protection from liability and will probably choose to forego disclosure.325

The second possible judicial response, from advocates of a contractarian model of the physician-patient relationship, would favor both disclosure and waiver as tools to permit the consensual allocation of

324. Claims for non-negligent errors would clearly be barred under malpractice theory regardless of the disclosure.

325. An example will help to clarify this point. Suppose that a physician in a patient-consent-does-not-equal-waiver jurisdiction is considering whether or not to disclose to a patient that the physician is a recovering alcoholic. If the physician discloses the information she may lose the patient (along with other patients who may hear the information). If the patient agrees to continue treatment, she continues to have a right to sue the physician for negligence, even when the negligent act is related to her alcoholism. Now suppose that the physician fails to disclose her alcoholism. If there is no negligence then the plaintiff cannot assert either a traditional malpractice claim (because there is no negligence) or an informed consent claim (because the undisclosed risk did not come into fruition). If there is negligence related to the physician's use of alcohol, then the plaintiff can sue under either a malpractice or a non-disclosure theory, but the damages would likely be identical and duplicative. The physician who does not disclose is more likely to retain her patient and failure to disclose does not add to the total expected damages whether there is negligence or not. Theoretically, the physician would not disclose the information to the patient. But see Hidding v. Williams, 578 So. 2d 1192 (La. Ct. App. 1991) (holding physician liable for failure to disclose alcoholism in case where no proof that alcoholism caused patient injury).
risk in the relationship.\textsuperscript{326} Patients could use the risk information presented by providers to choose to avoid some risks or to bargain for price reductions consistent with the patient's acceptance of risk. This argument is consistent with the general tort principle of assumption of risk, as well as with the practice of permitting fiduciaries to maintain conflicts of interest so long as they are disclosed to willing entrustors.\textsuperscript{327}

Third, and finally, courts may refuse to enforce the patient's apparent consent to the specific provider-associated risk. Under general tort theory, waivers of liability for negligence are often disfavored by both courts and commentators as violative of public policy.\textsuperscript{328} Courts that refuse to enforce waivers of liability for negligence in the health care setting tend to note the inequality of bargaining power and the need to protect patients.\textsuperscript{329} Courts could continue to expand the application of fiduciary principles by refusing to enforce an entrustor's ratifi-


\textsuperscript{327.} See \textit{supra} note 218 and accompanying text.


\textsuperscript{329.} In insisting that the patient accept the provision of waiver in the contract, the hospital certainly exercises a decisive advantage in bargaining. The would-be patient is in no position to reject the proffered agreement, to bargain with the hospital, or in lieu of agreement to find another hospital. The admission room of a hospital contains no bargaining table where, as in a private business transaction, the parties can debate the terms of their contract.

\textit{Tunkl}, 383 P.2d at 447.
cation of her fiduciary’s breach of the duty of loyalty.330 After all, the same characteristics that create the need for fiduciary protection seriously undercut the ability of patients to knowingly and voluntarily consent to a physician’s maintenance of conflicting obligations.331 This is more than hyperbolic speculation; current research on physician disclosure at least suggests that disclosure alone is not sufficient to protect patients. Jurisdictions that permit physician self-referral so long as the physician’s interest is disclosed typically have high rates of referrals.332 Commentators have explained this result by pointing to patients’ reluctance to disturb their relationship with their physician.333

At the moment, courts seem to be reflexively applying disclosure rules developed in other contexts to the problems presented by provider-associated risk. The extension of current common law principles, moreover, threatens to be a haphazard process that could injure providers without providing appreciable benefits for patients. The ambiguities and uncertainties in the common law development of these claims suggest a role for statutory modification. Statutorily-created transaction bars and disclosure obligations have the virtue of clear legal authority and more carefully delineated scope.

B. Statutory Regulation of Provider-Associated Risk

This analysis of transaction bars and disclosure obligations has revealed a trend toward the adoption of disclosure duties as a method of regulating provider-associated risk. The problems with this approach—the uncertain scope of disclosure and its suspect ability to protect patients—suggest that legislative action might be necessary to allocate provider-associated risk between the provider and patient. The development of an appropriate statutory response requires careful consideration of provider, patient, and social interests.334 There are two

330. See supra notes 218-21 and accompanying text.
331. See supra notes 210-11 and accompanying text.
332. Rodwin, supra note 236, at 1405-06 (discussing weaknesses of physician disclosure).
333. Disclosures of economic interests might also be viewed as a marketing technique through which physicians advertise the availability of their services.
334. The term “social interests” is used to suggest the existence of certain norms or goals that might assist in weighing or choosing between the interests of physicians and patients when they conflict.

Research data on the effect of financial disclosures may not carry over to disclosures about personal characteristics. Patients may be more willing to breach the physician-patient relationship based on these factors, which may be more pointedly associated with risks to the patient’s health. Cf. Behringer v. Medical Ctr. at Princeton, 592 A.2d 1251 (N.J. Super. Ct. Law. Div. 1991) (patients flee doctor’s practice after learning of his HIV infection).
main tasks: (1) choosing between transaction bars and disclosure obligations; and (2) defining the types or degrees of risk subject to regulation.

First, both transaction bars and disclosure obligations injure the provider’s interests in protecting patients. Disclosure obligations intuitively seem more appealing to providers because they retain the freedom to engage in certain procedures once disclosure has been made. A disclosure regime would initially appear to optimize patient welfare. Yet, this article’s analysis of the Hiddings, Behringer, and Moore cases has demonstrated that, in practice, disclosure obligations are a vague and untrammeled source of retrospective liability that pose serious risks to provider interests. Simply put, a provider who fails to disclose a personal characteristic of minimal risk might be subject to liability, perhaps even where the risk does not cause injury. A physician’s disclosure of risk can also adversely effect patients, who might be held to have waived claims for injury based on the disclosed risk. These factors suggest that transaction bars, if carefully structured, might better protect both patient and provider interests.

This conclusion is supported by both ethical principles and the historic role of state regulation. Medical ethicists since Hippocrates have charged physicians with the duty to “at least . . . do no harm.” Physicians who pose serious risks to their patients should not be permitted to avoid this ethical mandate by merely disclosing potential injuries prior to their occurrence. Historically, states have protected patients through licensure by prohibiting the practice of some persons. Thus, states have rejected the alternative of merely educating patients about

---

335. See supra notes 258-73 and accompanying text.
336. See supra notes 279-84 and accompanying text.
337. See supra notes 292-309 and accompanying text.
338. RUTH R. FADEN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT 62 (1986). See also Norman Daniels, The Profit Motive and the Moral Assessment of Health Care Institutions, 10 Bus. & Prof. Ethics J., Summer 1991, at 3, 18-26 (discussing the risks created when physicians have interest adverse to those of their patients).
339. The ethical requirement to avoid harm must have a limit. The problem of defining the degree of harm that transgresses this ethical mandate is a difficult one. The American Medical Association’s response to HIV-infected health care workers might constitute an example of excessive risk regulation because it establishes a zero-risk tolerance: “A physician who knows that he or she is seropositive should not engage in any activity that creates a risk of transmission of the disease to others.” Council on Ethical and Judicial Affairs, Am. Med. Ass’n, Ethical Issues Involved in the Growing AIDS Crisis, 259 JAMA 1360, 1361 (1988). See infra notes 346-52.
340. See supra notes 98-133 and accompanying text.
the risks associated with some providers and permitting patients to choose to confront the risk.341

Theoretically, this reasoning would apply to both the risks associated with personal characteristics and with financial deals. Realistically, however, the social interest in reducing health costs could support physician participation in incentive arrangements designed to reduce the cost of care provided to patients. President Clinton's new health care reform proposals depend on HMO-type incentives to constrain the cost of care. Some states may, therefore, decide to impose disclosure obligations as an alternative to transaction bars in such cases.

The next difficult issue is that of determining which personal characteristics or financial arrangements should give rise to prohibitions, or, in the case of incentives to reduce costs, to disclosure obligations. Here it seems sensible to articulate slightly different standards that depend on the category of the provider-associated risk; that is, whether it is created by a personal characteristic or by a financial relationship.

State regulation of providers based on their personal characteristics must take into account more than the provider's privacy interest in retaining the confidentiality of personal information. Federal law prohibits disability-based discrimination unless the disabled person poses a significant risk to the health or safety of others.342 Physicians with risky personal characteristics have an interest in continuing to provide services.343 Patients have a general interest in avoiding unnecessary risks.344 Providers, patients and society have general interests in encouraging the development of physician skills and in permitting the continued practice of those with the required education and ability.

Risks associated with a provider's personal characteristics should lead to practice prohibitions when the risks are significant and substantial. States should adopt a practice prohibition rule that mirrors the current federal approach to continued employment or access to accom-

341. Indeed, the courts have upheld governmental restrictions on the ability of patients to consent to certain types of medical care, even where the medical evidence of dangerousness is equivocal. Cf. United States v. Rutherford, 442 U.S. 544 (1979) (permitting FDA to restrict access to laetrile for terminally ill cancer patients).

342. See supra text accompanying notes 101-02.

343. So long as the income generated by these services is greater than the expected cost of payments for injuries.

344. "Unnecessary risks" are those risks that are peculiar to a particular provider and that can be avoided without cost by choosing a different provider. See supra note 7 (discussing the problem of whether these risks are really avoidable, in Part II).
modations by persons with disabilities:345 a state would prohibit physicians from providing types of care in which the provider's personal characteristic poses a significant and substantial risk to the health or safety of the patient.346 In the alternative, states could establish a more detailed list of provider characteristics that have been legislatively determined to present significant risks to patients. A state could supplement its general licensure standards with specific provisions prohibiting continued practice by physicians who currently are using illegal drugs or who have contagious diseases such as tuberculosis.347

This practice standard is not perfect. Risk-averse patients are not protected from all risks of harm in the physician-patient relationship. It may be difficult for states (or physicians) to initially determine which types of provider-associated risks are significant or substantial.348 The proposed standard restricts the freedom of both patients and providers, because it does not permit patients to voluntarily accept significant and substantial risks created by providers.

This standard should, nevertheless, achieve better results than the materiality rule that currently underlies both the negligence and fiduciary duty approaches to measuring the scope of the duty to disclose for

346. The significance of the risk would be assessed consistent with the current Americans with Disabilities Act regulations. 29 C.F.R. § 1630.2(r) (1993). In particular, the regulations indicate that discrimination is unwarranted unless the person poses a "significant risk of substantial harm" to the patient that is determined by considering: (1) the duration of the risk; (2) the nature and severity of the potential harm; (3) the likelihood that the potential harm will occur; and (4) the imminence of the potential harm. Id. A provider's ability to reduce or eliminate this risk by employing some extra precaution would also be relevant. Id.
347. Compare 42 U.S.C. § 12114(a) (Supp. III 1991) (excluding individuals who are currently using illegal drugs from Americans with Disability Act protections when employers discriminate based on current drug use) with 42 U.S.C. § 12113 (Supp. III 1991) (permitting employers to discriminate based on risk to health and safety where individual poses a direct threat to the health or safety of other individuals in the workplace).
348. This difficulty can be demonstrated by analyzing the provider-associated risks discussed thus far. The significant risk standard would be relatively easy to apply to risks created by physician illness or addiction. There may not be sufficient data, however, to determine whether some risks are significant and providers must be able to determine whether or not some personal characteristic requires some alteration of their practice. A physician's success rate with a particular procedure, for example, is affected by the condition of her patients as much or more than by the physician's own level of skill. Thus, a physician may not know if she presents a significant risk to her patients in performing a particular procedure, even if she knows (as is unlikely) her numerical success rates. These problems suggest that states might wish to establish bright line categories of risks that cannot be imposed on patients, such as those relating to drug/alcohol use or infectious conditions, and may wish to indirectly regulate other risks through traditional malpractice actions. Patients injured by a surgeon's lack of experience would then be free to sue in malpractice. A state taking this approach might wish to statutorily limit disclosure actions as well.
several reasons. First, "materiality" appears to be a patient-centered standard but fails to give any weight to the interests of providers and indirectly underestimates the cost of the information to patients. Second, the new standard may be easier to apply because of parallel precedent in the employment discrimination area. Third, particularly risk averse patients would be able to reduce the probability of harm still further by simply asking their physicians about specific provider-associated risks. Finally, this rule appears to be more consistent with our general social posture about shared risks. We all bear small risks every day created by the actions of other members of our society; social welfare is maximized not when risk is reduced to zero, but when the benefit to be achieved by creating the risk exceeds the expected harm.

Ideally, financial entanglements would be regulated through a slightly more specific and protective transaction bar. A more patient-protective standard for financial risks is justified because of the reduced injury to providers: prohibition of risks based on personal characteristics might sometimes bar continued practice; prohibition of risks based on financial arrangements with others merely requires the physician to choose between the financial and the provider relationship. Under this approach, states would prohibit physicians from providing treat-

349. See supra notes 189-92, 216-21 and accompanying text.
351. Physicians could choose whether or not to respond to patient requests for information. Physicians who choose to lie in response to patient inquiries would be liable in fraud. See supra note 174-81 and accompanying text. This rationale might seem illusory because patients may not know what questions to ask their providers. But the current rules do not provide much assistance to providers in detailing what must be spontaneously disclosed either.
352. Cf. Keeton et al., supra note 166, at 170-173. One need not be a strict adherent of law and economics analysis to recognize that individual efforts to reduce risk to zero may injure society when applied to restrict the actions of others.
353. Accord, Rodwin, supra note 236, at 1407 (stating that "[d]isclosure may help in dealing with physicians' conflicts of interest, but by itself is insufficient to protect patients, and may even place them at a disadvantage"). Rodwin's recently published book expands upon his position. MARC A. RODWIN, MEDICINE, MONEY AND MORALS, 213-19 (1993). Rodwin's new analysis of financial conflicts of interest is thoughtful and comprehensive; his proposed remedies differ from those suggested in this article. Id. at 234-47.
ment to patients when a financial incentive might unreasonably adversely affect the physician’s exercise of medical judgment about whether treatment is necessary. The physician’s primary duty would be to her patient, but this standard recognizes that not all conflicts of interest are impermissible. Patients would be protected by the rule even if they could not prove that a particular financial interest actually affected the provider’s medical judgment. This ideal-in-the-abstract standard is vulnerable to attack on at least two fronts.

The first problem is definitional: which financial incentives might “adversely” affect medical judgment? After all, many physicians would refuse to provide services in the absence of payment; economic incentives to provide care are not usually considered suspect. Yet, we cannot merely single out incentives to deny treatment for attention because excess medical care causes injuries to individual patients and to our collective pocket book. One possible plank across this quagmire is found in the limitation that the financial incentive must be of the type which “might unreasonably” affect physician judgment; this standard would permit consideration of the amount of the incentive at stake and whether the incentive is necessary to ensure the provision of services generally. The focus on the medical necessity of treatment is also helpful because it shifts the focus from whether the financial incentive led to the provision of care to the more objective (if perhaps still muddy) question of whether the care was medically appropriate.

The second problem arises because of the current social interest in reducing health care costs. Private insurers currently use financial incentives with the hope that they will affect medical judgment by changing the types of care provided to patients. Current plans to expand access to care also seem linked to attempts to use incentives to change the types of care given to patients. States are therefore quite unlikely to impose transaction bars on financial incentives to reduce or

354. This standard is very similar to the fiduciary approach taken by the California Supreme Court in Moore v. California Regents, 793 P.2d 479 (Cal. 1990), cert. denied, 111 S. Ct. 1388 (1991). See supra text accompanying notes 302-09.

355. In the end, a statute implementing this approach might appear much like an expansion of the Stark Amendment which currently bans certain referrals to clinical laboratories in which physicians have an ownership interest. See supra text accompanying notes 122-25. The Stark Amendment permits such referrals where necessary to provide access to care generally, such as in rural areas.

356. See Hall & Anderson, supra note 42 (discussing problems in determining medical necessity under insurance contracts).

357. See supra notes 60-61 and accompanying text.
deny certain types of care. Having peered out from our ivory tower long enough to recognize this political reality, the next best approach would consist of a bifurcated transaction bar-disclosure standard. That is, states could prohibit physicians from providing treatment to patients when a financial incentive to provide care might unreasonably adversely affect the physician's exercise of medical judgment about whether treatment is necessary.\textsuperscript{358} States could then merely require affirmative disclosure of financial incentives to deny care which could adversely affect the physician's exercise of medical judgment about whether treatment is necessary.\textsuperscript{359} The standard would change as it moves from prohibition to disclosure: financial incentive disclosures would be required whenever they "could" affect medical judgment, regardless of whether the effect was "reasonable."\textsuperscript{360}

This bifurcated treatment of the risks associated with physician provider arrangements appears to protect patients while recognizing the important role that physician incentives play in the restructuring of the health care marketplace. Disclosure may be a particularly important tool to protect consumers as our health care system evolves: patients currently recognize physician incentives to provide care, and the disclosure obligation will help to educate patients about the need to actively seek care once access for all has theoretically been obtained.

VI. CONCLUSION

The social allocation of risk in the physician-patient relationship threatens the interests of providers, patients, and the broader society. Physicians are injured by practice restrictions or disclosure duties. Patients are injured by their providers, either through the creation of pro-

\textsuperscript{358} Cf. McDowell, supra note 45 (proposing limitations on physician investments).


\textsuperscript{360} The imposition of a disclosure duties might be considered a blessing or a curse from a societal perspective. Private and public efforts to control costs focus on the physician as the source of health care expenditures; conflicts of interest are intentionally created in an effort to constrain health care expenditures. The imposition of fiduciary responsibility with respect to these conflicts of interest could be viewed as a blessing to the extent that they swing the balance of the physician's concern back to the patient's interests. Accord Boyd, supra note 204, at 156; Mehlman, supra note 172, at 416-17. Fiduciary duties are a curse to the extent that they invalidate efforts to control costs. Disclosure may be the mediating device between these outcomes. Courts may view disclosure as a device to validate cost control while maintaining the more palatable view of the physician as the fiduciary of her patients.
vider-associated risks or through the failure to disclose those risks, or both. Larger interests are implicated as society attempts to foster autonomy or cost containment or other social values through the physician-patient relationship. The legal resolution of these issues has been as conflicted and confused as the nature of the doctor-patient relationship itself.

Current practice prohibitions do not adequately protect either patients or providers because of the gaps and uncertainty in their application. Courts have recently begun to rely on disclosure mandates as a method of allocating risk in the physician-patient relationship. In doing so, they have failed to consider some of the doctrinal difficulties that limit the utility of this means of protecting patients. In addition, courts have tended to accord identical treatment to all types of provider-associated risks.

The rules allocating provider-risk should be revised to reflect this analysis. Risks arising from providers' personal characteristics should be regulated through improved transaction bars rather than through the imposition of additional disclosure obligations. Improved regulation in this area will protect both provider privacy interests and patient health. The risks associated with providers' economic interests require a different response. Current social policies incorporate the use of economic incentives to direct and control the use of health care resources. The imposition of transaction bars to some types of economic incentives would conflict with these social policies. Disclosure of a provider's economic relationships would provide important benefits to patients as cost containment pressures move our physicians and patients into an even more conflicted relationship.