AFTER THE GAG EPISODE: PHYSICIAN COMMUNICATION IN MANAGED CARE ORGANIZATIONS

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I. Introduction

The growing prevalence of managed care organizations (MCOs) has created numerous changes in the delivery of health care, but none of these changes seems to have caused more alarm than conflicts over physician communications.[1] Disputes have arisen over communications such as the disclosure of treatment options not covered by a health plan, physician complaints to patients or to the media about an MCO, and physician contact with patients subsequent to the physician's termination by the MCO.[2]

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[1] *See, e.g., Outlook 97: Consolidation Remains Top Legal Issue for Healthcare Industry in New Year*, 6 BNA'S HEALTH LAW REPORTER, No. 1, 5-8 (Jan. 2, 1997). The BNA's HEALTH LAW REPORTER annual survey of its advisory board members ranked regulation of health plans on issues such as "gag clauses" as the third most important legal issue for health care in 1997, after industry consolidation and Medicare reform. *See id.*

[2] *See Contract Terms Between Physicians and Health Plans: Submitted to The Health Subcomm. of the House Comm. on Ways and Means*, 104th Cong., 2d Sess. (July 30, 1996) (statement by Peter Kongstvedt, M.D., F.A.C.P., Partner, Ernst & Young LLP). The prevalence of gag clauses in physicians' contracts has been a matter of considerable disagreement. If the amount of media attention devoted to the issue or the amount of attention from organized medicine is a reliable indicator of the prevalence of such clauses, they are widespread. The American Medical Association claims to have found gag clauses in every one of 200 physician-MCO contracts it reviewed. However, if congressional testimony by some physicians working for the managed care industry is reliable, such contract clauses are rare. Dr. Peter Kongstvedt of Ernst

These conflicts have resulted in a flurry of anti-health maintenance organization (HMO) legislative activity at the state and federal levels, as well as litigation and a great deal of political activity on the part of professional and industry organizations.[3] Anti-gag bills have already been passed in half the states.[4] Indeed, legislators continue to introduce and consider bills even though some commentators have observed that gag clauses are already beginning to lose their prevalence.[5] Several thousand articles about gag clauses have appeared in newspapers, magazines, and professional and scholarly journals. A great deal of ink has been spilled on a topic that many believe touches the heart of the physician-patient relationship.[6] It is therefore useful to evaluate

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& Young, having reviewed several hundred contracts, characterized gag clauses as "the Sasquatch of managed care: it is large, ugly, hairy and scary, however, producing the actual thing [is] quite difficult." *Id.* The GAO released a report in September 1997 which stated that it had found no "gag clauses" in contracts from 529 HMOs. United States General Accounting Office, *Managed Care: Explicit Gag Clauses Not Found in HMO Contracts, But Physician Concerns Remain*, GAO/HEHS-97-175, *available at* http://www.gao.gov). The report did not find any contract clauses "that specifically restricted physicians from discussing all appropriate medical options with their patients." *Id.* It noted that most health plans, in fact, use anti-gag clauses "in an effort to mitigate any impact of clauses that physicians say hinder treatment discussions with patients." *Id.* It found that 60% of the contracts contained clauses "that some physicians might interpret as limiting communication about treatment options." *Id.*; *see also Managed Care Monitor Gag Clauses: GAO Report Discounts Problems*, 6 AM. HEALTHLINE, Sept. 25, 1997; *GAO Report Finds No "Gag Clauses" to Prevent Physician-Patient Communications in Health Plans*, PR NEWSWIRE, Sept. 26, 1997; Noel Cohen, *Spurred by Legislation, HMOs Act to End Gag Clauses*, 14 MED. MALPRACTICE L. & STRATEGY 5 (1996).

[3] *See AAHP Announces First Phase of "Patients First" Plan, Including "Gag Rule" Ban*, MEALEY'S LITIG. REP.: MANAGED CARE (Jan. 22, 1997) (discussing the industry's response).

[4] *See* 1997 Ark. Acts 1196; CAL. BUS. & PROF. CODE § 2056.1 (West 1994); COLO. REV. STAT. ANN. § 10-16-121 (West 1996); 1997 Conn. Legis. Serv. 97-99 (West); DEL. CODE ANN. tit. 18, § 6407 (1997); 1996 D.C. Stat. 11-235; GA. CODE ANN. § 33-20A-6 (Supp. 1996); IND. CODE ANN. § 27-13-15-1 (West 1997); 1997 Kan. Sess. Laws 190; 1997 Md. Laws 35; 1997 Minn. Sess. Law Serv. 237 (West); 1997 Mont. Laws 527; 1997 Neb. Laws 279; 1997 Nev. Stat. 140; 1997 N.J. Sess. Law Serv. 192 (West); 1997 Okla. Sess. Law Serv. 289 (West); 1997 Or. Laws 343; 1997 R.I. GEN. LAWS § 97-352 (1997); 1997 Tex. Sess. Law Serv. 1026 (West); 1997 Utah Laws 227; VT. STAT. ANN. tit. 18, § 9414 (1996); WASH. REV. CODE ANN. § 48.43.075 (West 1996).

[5] *See* Harold J. Bursztajn et al., *Medical Negligence and Informed Consent in the Managed Care Era*, 9 THE HEALTH LAWYER, No. 5, 14, 16 (1997).

[6] For one of the earliest newspaper reports, *see* Tim Bonfield, *ChoiceCare to Docs: Hush!*, CIN. ENQ., Dec. 8, 1992, at A1 [hereinafter Bonfield, *Hush!*]; Tim Bonfield, *Doctors' Council, HMO to Meet*, CIN. ENQ., Dec. 13, 1992, at B2. During the last few years,

the results of these efforts.

Part II of this article will describe several current communication conflicts between physicians and MCOs.[7] Parts III-VII summarize the law prior to the gag controversy and the responses to perceived gag practices in each of five areas of conflict: treatment options, criticism of the health plan, plan operations (particularly physicians' incentives), advocacy, and termination.[8] Part VIII assesses the outcomes and implications of the gag episode for physician-patient communication.[9]

II. Communication Conflicts Between Physicians and MCOs

As physicians have become part of MCOs, several kinds of conflicts have arisen over what they may say to patients and to others.[10] These conflicts have arisen over communications with patients about treatment, criticisms of the MCO, disclosures to patients of the financial incentives under which physicians practice, communications with patients when physicians' contracts are to be terminated, and advocating for patients within the MCO. This article will focus on these five key conflicts arising from perceived gag practices.[11] Physicians, MCOs, and patients have important stakes in each of these conflicts.

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media coverage has been extensive. A recent LEXIS search generated more than 2,000 newspaper articles about gag practices. Scholarly treatment of gag practices has been comparatively sparse. *See, e.g.*, Tracy R. Miller, *Managed Care Regulation in the Laboratory of the States*, 278 JAMA, No. 13, 1102 (Oct. 1, 1997); Jennifer D'Isidori, *Stop Gagging Physicians*, HEALTH MATRIX 7:187 (1997); Julia Martin & Lisa K. Bjerknes, *The Legal and Ethical Implications of Gag Clauses in Physician Contracts*, 22 AM. J.L. & MED., No. 4, 433 (1996); Howard Brody & Vence L. Bonham, *Gag Rules and Trade Secrets in Managed Care Contracts*, 157 ARCHIVES OF INTERNAL MED. 2037 (Oct. 13, 1997); David S. Kaplan, *Managed Care: Gag Clauses and Doctor-Patient Communication: State Responses*, 25 J.L. MED. & ETHICS 213, 215 (1997).

[7] *See infra* Part II.

[8] *See infra* Parts III-VII. Current bills, including the federal Patient Right to Know Act, H.R. 586, 105th Cong., § 1 (1997), are beyond the scope of this article.

[9] *See infra* Part VIII.

[10] For commentary and studies of physician communication in managed care from medical perspectives, *see* Geoffrey H. Gordon et al., *Physician-Patient Communication in Managed Care*, 163 W.J. MED. 527 (1995); Roulidis, Z. C. & Schulman, K. A., *Physician Communication in Managed Care Organizations: Opinions of Primary Care Physicians*, 39(5) J. FAM. PRAC. 446 (1994).

[11] *See, e.g.*, Miller, *supra* note 6; Martin & Bjerknes, *supra* note 6; D'Isidori, *supra* note 6 (categorizing gag clauses in various ways).

A. *Conflicts over Communications with Patients about Treatment and Referral Options*

The most widely publicized restrictions on physician communication affect disclosure of information about treatment options to patients. For example, a contract clause from the Kaiser Permanente OB/GYN Best Practice Program reminds physicians to "not discuss proposed treatment with Kaiser Permanente members prior to receiving authorization."[12] Such a clause has the potential to inhibit spontaneous and open discussion of treatment options between physicians and patients, and to trigger physicians' fears about informed consent. A physician who has signed such a clause might delay discussion of any treatment until she was certain about plan coverage. If authorization were not given by the plan, the physician might avoid discussing the options not covered.[13]

Such restrictive clauses may seem to physicians to not only interfere with the physician-patient relationship, but also to expose them to potential liability for negligence in failing to disclose treatment alternatives.[14] As a result, physicians signing contracts that include such clauses may fear on the one hand that they are legally and ethically bound to disclose treatment alternatives so as to meet the requirements of informed consent, and on the other hand that they are contractually prohibited from disclosing the same treatment alternatives to MCO patients.

Just as physicians have good reasons for resisting restrictions

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[12] Diane M. Gianelli, *Bound and Gagged: AMA: Unethical Managed Care Rules Stifle Communication*, AM. MED. NEWS, Feb. 5, 1996.

[13] As Dr. Robert McAfee, past president of the AMA, claims, such restrictions seem "designed . . . to control physician behavior and to limit a patient's access to the full range of information that is needed for them to make informed decisions and provide informed consent about the proper course of medical treatment." *Statement of the American Medical Association to the Subcomm. on Health and Environment Comm. on Commerce Before the U.S. House of Representatives on Contract Issues and Quality Standards for Managed Care*, 104th Cong., 2d Sess. (May 30, 1996) (statement of Robert E. McAfee, M.D.) [hereinafter Statement of McAfee].

[14] *See generally* Canterbury v. Spence, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972). The court held that every sane adult has the right to determine what shall be done with her own body. *See id.* This right obligates the physician to provide adequate information including not only the material risks of a proposed treatment, but also alternatives to that treatment, as well as the consequences of refusing treatment. *See id.*

on communications with patients, MCOs have good reasons for modifying physician-patient communication. Economically, it makes sense for MCOs to ensure that physicians are providing the most cost-effective health care to enrollees. In order to do so, some aspects of physicians' practice styles, including recommendations to patients that are not cost-effective or are of doubtful efficacy, must be changed.[15] For example, requiring physicians to obtain pre-authorization before they recommend a hysterectomy or cesarean section to a patient could reduce the number of unnecessary surgeries and potentially cut costs while improving the quality of care.[16] In addition, requiring physicians to obtain consultations on particularly complex cases can increase quality by preventing medical mistakes.[17]

B. *Conflicts over Criticisms by Physicians about the MCO*

A second kind of conflict centers on criticisms of the MCO made by physicians to patients or to the public. Some physicians believe it is a professional responsibility to inform patients and the public about the quality of health plans.[18] A health plan, by

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[15] *See* David Orentlicher, *Paying Physicians More to Do Less: Financial Incentives to Limit Care*, 30 U. RICH. L. REV. 155, 159-60 (1996).

[16] *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); Benjamin Barnes et al., *Report on Variation in Rates of Utilization of Surgical Services in the Commonwealth of Massachusetts*, 254 JAMA 371 (1985); Robert K. DeMott & Herbert F. Sandmire, *The Green Bay Cesarean Section Study: The Physician Factor as a Determinant of Cesarean Birth Rates*, 162 AM. J. OBST. & GYN. 1593, 1598 (1990); W. Pete Welch et al., *Geographic Variation in Expenditures for Physicians' Services in the United States*, 328 NEW ENG. J. MED. 621 (1993).

[17] *See Statement on Patient Right to Know Act of 1996 Before the U.S. House of Representatives Comm. on Ways and Means*, 104th Cong., 2d Sess. (July 30, 1996) (statement of Chris L. Jagmin, M.D., Medical Director, Pacificare in the Southwest) [hereinafter Statement of Jagmin]. For example, in testimony before the House Committee on Ways and Means on the Federal Patient Right to Know Act, the medical director of Pacificare in the Southwest described a patient whose physician had initially recommended a kidney transplant, but who was ultimately found by Pacificare to need a more complex, and more costly, kidney-pancreas transplant. *See id.* Without Pacificare's "interference" in physician-patient communication about appropriate treatment options, the patient might have died as a result of physician error. *See id.*

[18] *See Testimony Before the Subcomm. on Health and Environment of the House Comm. On Commerce Patient Right to Know Act of 1996*, 104th Cong., 2d Sess. (May 30, 1996) (statement of Steven Buie, M.D.). For example, a Kansas City family physician testified before Congress:

contrast, wants its physicians to take their complaints through the proper channels, not to patients. MCOs claim that some so-called gag clauses are intended to prevent physicians from complaining to their patients or others about the MCO, to prevent them from encouraging patients to join another plan with which they are affiliated and from which they receive higher levels of compensation, and to encourage in-house resolution of conflicts.[19]

> In 1992, our practice signed on with a major Kansas City health plan. We had some initial concerns about the plan – in our opinion, the plan had gaps in its specialty network, and some specialties could not admit patients to our admitting hospital. But plan representatives assured us they were actively recruiting physicians for the network, and many of our patients encouraged us to join so they would not have to change doctors. So, we joined – provisionally. Unfortunately, months passed and despite repeated attempts no improvements occurred. In the meantime, our patients with complex medical conditions were hospitalized and not allowed to see both primary and specialty doctors. . . . Finally, we felt we could no longer in good conscience be associated with this plan. In a heart-breaking decision, we had to drop patients from our practice – even though our bottom-line suffered and doctor/patient relationships were disrupted. We wrote a letter to each patient explaining why they could no longer see us due to the deficiencies of this plan. We believed it was the ethical thing to do. We still believe that, even though we received a call from the plan's administrator a short time after the letters were mailed. He claimed the letter to patients violated the plan's disparagement clause. . . .

Id. The clause cited by the Kansas City plan administrator stated the following: "Physician agrees not to disparage plan or its processes, programs, or policies to any persons, including members or other participating providers. Disparagement of plan will be treated as an administrative compliance failure." *Id.* The offending physician's desire was to fulfill what he believed was a professional obligation to inform his patients in at least general terms about the reasons for leaving the plan, if not to identify specific weaknesses of the plan.

[19] *See* Statement of Jagmin, *supra* note 17; *Statement on Contract Issues and Quality Standards for Managed Care for Pacificare of California Before the U.S. House of Representatives Comm. on Commerce Subcomm. on Health and Environment*, 104th Cong., 2d Sess. (May 30, 1996) (statement of William J. Osheroff, M.D., Medical Director, Pacificare of California); *Statement on Issues and Standards for Managed Care Before the Subcomm. on Health and Environment House Comm. on Commerce*, 104th Cong., 2d Sess. (May 30, 1996) (statement of Karen Ignagni, President and CEO, American Association of Health Plans) [hereinafter Statement of Ignagni].

Larry Rambo, president and chief executive officer of PrimeCare Health Plan Inc., was quoted as saying "[w]e don't believe it's the physician's role to solicit patients to disenroll from the health plan they're participating in. If a physician doesn't like working with a particular health plan . . . they have the option of discontinuing the relationship with that health plan." Erik Gunn, *Federal Effort Underway to Eliminate HMO "Gag Clauses,"* BUS. J.-MILWAUKEE, Mar. 30, 1996, at 20. Similar sentiments were expressed by Margaret O'Kane, president of the National

C. *Conflicts over Physicians' Disclosures of Details about Plan Operations, Including Financial Incentives*

Conflicts have also arisen when physicians have discussed with patients the operation of health plans, such as the incentives under which they practice. MCO physicians are paid under programs of capitation and risk-sharing.[20] In a capitation system, a physician receives a fixed amount each month for caring for each of his or her patients or enrollees, regardless of whether the patient actually receives any treatment, or how expensive or inexpensive that treatment might be.[21] The risk-sharing provision allows the MCO to withhold a portion or percentage of the provider's monthly capitation payment, pool it with that of other providers, and use it to pay for the costs of specialist referrals, lengthy hospital stays, or expensive medical tests or procedures.[22] This percentage is returned to the provider through periodic

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Committee for Quality Assurance, an MCO accreditor, when she said, "[t]he underlying idea that if somebody is badmouthing the HMO, the HMO has the right to terminate the contract... [is] fundamental for a company that's trying to be in [the health care] business." Gianelli, *supra* note 12. A more conciliatory approach is attributed to Susan M. Pisano, spokesperson for the Group Health Association of America, who said the purpose of any restrictions on communications were to "discourage doctors from disparaging HMOs and encourage them to discuss their concerns about payment and treatment policies with... the health plan, rather than with patients." Robert Pear, *Doctors Say HMOs Limit What They Can Tell Patients*, N.Y. TIMES, Dec. 21, 1995, at A1 [hereinafter Pear, *HMOs Limit*].

Some express bewilderment that physicians disparage the MCOs and HMOs for whom they work. Dr. Daniel Gregorie, ChoiceCare's chief executive officer in 1992, was quoted as saying, "if [the doctor is] going to be part of this organization, it doesn't make sense to be publicly disparaging it." Bonfield, *Hush!*, *supra* note 6, at A1. Ellen Moskowitz, a bioethicist with the Hastings Center remarked:

> If health care reform is going to work, these doctors have to learn how to voice their concerns within a corporate structure. I think too many doctors have the notion that having a moral obligation to protect the reputation of the company you work for is foreign and strange. But it is possible to meet that obligation and still act responsibly.

David R. Olmos & Shari Roan, *HMO Gag Clauses on Doctors Spur Protest*, L.A. TIMES, Apr. 14, 1996, at A1. Many different MCO groups have asserted that their clauses are simply non-disparagement clauses. *See* Bonfield, *Hush!*, *supra* note 6, at A1; Gunn, *supra*, at 20; Rachel Kreier, *N.Y. Suit Fights Increasingly Common HMO "Gag Rules,"* AM. MED. NEWS, Dec. 11, 1995, at 5; Olmos, *supra*, at A1; Pear, *HMOs Limit*, *supra*, at A1.

[20] *See* Deven C. McGraw, *Financial Incentives to Limit Services: Should Physicians be Required to Disclose These to Patients*, 83 GEO. L.J. 1821, 1827 (1995); Orentlicher, *supra* note 15.

[21] *See* McGraw, *supra* note 20.

[22] *See id.* at 1827-28; Orentlicher, *supra* note 15, at 158-60.

provider assessments, which can be made annually or more frequently. If the provider keeps expenditures low enough, she will receive a portion of the money returned.[23]

Some have suggested that financial incentives are among the main targets of communication-limiting contract clauses.[24] MCOs, for their part, have argued that detailed information about physician incentives, along with information about clinical management protocols, constitutes protected proprietary information, or a trade secret. They contend that some information is the property of the health plan. In other cases they claim that the information is the property of a third-party vendor with which the MCO has contracted.[25]

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[23] *See* McGraw, *supra* note 20, at 1827-28; Orentlicher, *supra* note 15, at 160.

[24] *See, e.g., Statement to the Subcomm. on Health of the House Comm. on Ways and Means on The Patient Right to Know Act of 1996*, 104th Cong., 2d Sess. (July 30, 1996) (statement of Mark E. Rust, Partner, Kamensky & Rubinstein) [hereinafter Statement of Rust]. In testimony before the U.S. Congress, an attorney who represents physicians and physician groups recounted the following incident:

> A managed care organization that accounted for approximately 25%-30% of patients in the city decided unilaterally that it would switch all of its obstetrician and gynecologist providers from fee-for-service to capitation payment. The payment was to be provided to each obstetrician and gynecologist individually, rather than through a legitimate network that could accept actuarial risk. . . . Most physicians did not feel they could afford to lose 30% of their practice. Even if they could, their loyalty to their obstetrical patients prevented them from doing so. As a result, most continued to be providers. But many physicians fully informed their patients of the new compensation policy of the MCO. Because it was open enrollment season for most employers at that time, and because women inevitably drive the decision to choose a health care plan on behalf of themselves and their family, the MCO began to notice an immediate loss of customers. In response, the MCO, through its agents, contacted large numbers of those obstetricians and advised them of the possibility that the MCO could end the relationship shortly without having to state a reason. It appeared from my observation that the advice had its desired effect. The obstetricians and gynecologists discontinued discussing the matter with patients.

Id.

[25] *See* Statement of Ignagni, *supra* note 19; *see also* Gunn, *supra* note 19, at 20; Kreier, *supra* note 19, at 5; Pear, *HMOs Limit*, *supra* note 19, at A1. As the president and CEO of the American Association of Health Plans argued before a congressional subcommittee:

> First, competition among health plans is intense, and the release of such information about one plan can give its competitors an unfair advantage, erode any competitive advantage it has achieved, and eliminate the incentive to find more effective methods for delivering care. Second,

D. *Conflicts over Restrictions on Physician Communication with Patients at Contract Termination*

Communication conflicts do not necessarily come to an end when a physician leaves an MCO. When physicians' contracts are terminated, some physicians are asked to not contact their former patients to inform them of their impending departure, and to not solicit former patients to join other health plans.[26] MCOs understandably want to protect their membership bases, and utilize these clauses as a means of doing so.

But physicians have similar economic concerns. They want to protect their patient bases just as MCOs want to protect their

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> plans themselves are often bound by contract not to disclose coverage decision procedures and other protocols that are licensed by companies that have developed them as commercial products. Preventing plans from requiring their affiliated providers to respect this confidentiality will make it difficult, if not impossible, to comply with such obligations and to protect intellectual property appropriately. Setting aside, for the moment, the issue of whether clauses protecting proprietary information are an appropriate part of provider contracts, we would like to emphasize that releasing proprietary decision procedures will do little to help patients understand the particulars of their case. These documents are frequently highly complex, sometimes voluminous, and almost always involve extremely technical terminology. Likewise, disclosure of precisely how much a physician is paid per member per month will do little to help patients answer the question that is foremost in their minds: am I receiving quality care?

Statement of Rust, *supra* note 24.

[26] *See, e.g.*, James J. Unland, *The Emergence of Providers as Health Insurers*, 23 J. HEALTH CARE FIN. 57, Appendix A (1996). One such restriction reads as follows:

> In consideration of Plan providing current plan Members . . . to the Provider, provider acknowledges and agrees that in the event this agreement should terminate for any reason, plan will suffer irreparable harm and injury if the Provider attempts to, or does, communicate with Members in any way concerning said termination. Understanding this, the Provider expressly waives Provider's rights to contact plan Members in any way about the termination of this agreement . . .; the options such Members may have to join other health care service plans . . .; or the fact that the Provider will no longer be the Member's health care provider.

Id. A similar clause addresses the perceived threat to MCOs more directly: "Nor shall Consulting Physician, directly or indirectly, solicit or counsel any Member to disenroll from or cancel Member in the health plan during the term of this Agreement and for a period of twelve (12) months following the termination of this Agreement." *Id.*

enrollee bases. Often, patients are quite loyal to their physicians, and may want to follow a physician who is leaving a managed care plan. If the physician leaves the plan and is unable to disclose to her patients information concerning her departure, the physician's patient base, and income, will consequently decrease.

E. *Conflicts Over Advocating for Patients*

Other communications have also been the source of conflict between physicians and MCOs. Particularly, physicians fear termination of their contracts for speaking their minds or for zealously advocating for their patients in MCOs.[27] Advocating for patients in this context may mean appealing a decision to deny payment for a health service, protesting a decision, policy or practice, or even whistleblowing.[28]

In a health care system that increasingly relies on managed care, many physicians need a particular MCO more than an MCO needs any particular physician.[29] For their part, MCOs are interested in recruiting and retaining physicians who can work in a cost-effective manner for as long as the organization needs their

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[27] *See* Statement of Rust, *supra* note 24.

[28] *See* Statement of McAfee, *supra* note 13. In testimony on behalf of the AMA before a congressional subcommittee, Robert McAfee related the following incident. *See* Statement of McAfee, *supra* note 13. Dr. Michael J. Haugh, a neurologist from Tulsa, Oklahoma, wrote to his patient explaining that the health plan refused to authorize a magnetic resonance arteriogram (MRA) because the plan considered the procedure "investigational." Statement of McAfee, *supra* note 13. He also explained that the alternative test, a cerebral arteriogram, required injecting dye into the arteries and entailed more risk than the proposed MRA. *See* Statement of McAfee, *supra* note 13. He concluded by telling the patient that he considered the MRA "medically necessary" in order to detect a possible cerebral aneurysm, and suggested she schedule her plans to have the test taken in a timely fashion. Statement of McAfee, *supra* note 13. Finally, Dr. Haugh provided copies of this letter to the health plan and the Oklahoma Insurance Commissioner. *See* Statement of McAfee, *supra* note 13.

In response to this letter, the Medical Director of the health plan wrote to Dr. Haugh reiterating its decision to deny authorization for payment for an MRA because it considered the test to be investigational. *See* Statement of McAfee, *supra* note 13. The medical director stated that he considered Dr. Haugh's actions to be "significantly inflammatory" and concluded with the following statement: "You should be aware that a persistent pattern of pitting the HMO against its member may place your relationship with the plan in jeopardy. In the future, I trust you will choose to direct your concerns to my office rather than in this manner." Statement of McAfee, *supra* note 13.

[29] *See* Statement of Rust, *supra* note 24.

services. MCOs want to build a physician network of cooperative team players. They want to be able, with minimal transaction costs, to end relationships with physicians who are not "working out" because of communication conflicts or other reasons.[30] In these situations, physicians, patients, and MCOs have important and sometimes conflicting interests.[31] Before gag conflicts arose, the law balanced those interests in one set of ways, and has since balanced them in a new manner.

III. Disclosure of Treatment Options

A. *The Law Prior to the Gag Controversy*

Communication between physicians and patients was regulated long before the gag controversy. Even those communications thought to be at the heart of physician-patient relationships, communications about treatment options, have been structured by the law for decades. The doctrines of informed consent and misrepresentation, which require that certain information be disclosed to patients and that patients not be misinformed, have been used to set boundaries for appropriate physician-patient communications.

Under the doctrine of informed consent, physicians may not maintain silence regarding patient treatment, but rather have a legal obligation to communicate information.[32] In general, a physician must disclose the patient's diagnosis, the nature and purpose of the proposed treatment, the risks of the treatment, the consequences of the treatment, and the probability of success, along with alternatives to the treatment.[33] Precisely what must be

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[30] *See* Statement of Rust, *supra* note 24.

[31] *See generally* Marc A. Rodwin, MEDICINE, MONEY AND MORALS: PHYSICIANS' CONFLICTS OF INTEREST (1993); Clifton B. Perry, *Conflicts of Interest and the Physician's Duty to Inform*, 96 AM. J. OF MED. 375 (1994); Martin Gunderson, *Eliminating Conflicts of Interest in Managed Care Organizations through Disclosure and Consent*, 25 J.L. MED. & ETHICS 192, 192-198 (1997); Kate T. Christensen, *Commentary: A Physician's Perspective on Conflicts of Interest*, 25 J.L. MED. & ETHICS, 199, 199-201 (1997); R. G. Spece, Jr. et al., eds. CONFLICTS OF INTEREST IN CLINICAL PRACTICE AND RESEARCH (1996).

[32] *See generally* Canterbury v. Spence, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); BARRY R. FURROW ET AL., HEALTH LAW, §§ 6-9 (1995).

[33] *See generally* Canterbury v. Spence, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); BARRY R. FURROW ET AL., HEALTH LAW, §§ 6-9 (1995).

disclosed depends upon the jurisdiction. The professional standard of disclosure, which establishes the duty to disclose according to what a reasonable medical practitioner similarly situated would disclose, is used in some jurisdictions.[34] Other jurisdictions use the reasonable patient standard, which measures the duty to disclose by what a reasonable person would find material to the decision to undergo treatment.[35] A physician may also be required to disclose the patient's prognosis if treatment is refused.[36] In some jurisdictions, physicians are required to disclose facts that put their interests in direct conflict with those of the patient, such as their financial conflicts of interests or their HIV-positive status.[37] In addition to common-law obligations, several states have passed statutes reinforcing or adding to physicians' disclosure obligations.[38]

There are limits, however, to the duty of disclosure. First, informed consent is typically practiced only for invasive

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[34] *See* Woolley v. Henderson, 418 A.2d 1123, 1125 (Me. 1980). The court held that the Nebraska legislature holds physicians to a professional standard of disclosure. *See id.* The court also requires proof that a reasonable person would have declined consent upon disclosure. *See id.; see also* Smith v. Weaver, 407 N.W.2d 174, 175 (Neb. 1987) (setting forth a standard of disclosure based on the community standard set by physicians); Wheeldon v. Madison, 374 N.W.2d 367, 368 (S.D. 1985) (adopting a standard of disclosure that looks to a reasonable physician under the same or similar circumstances).

[35] *See* Korman v. Mallin, 858 P.2d 1145, 1146 (Alaska 1993) (holding that what a reasonable person would consider material is determined by extent of patient's request, but at minimum must include information concerning the "nature and severity of risk and likelihood of its occurrence" presented in lay terms); Festa v. Greenberg, 511 A.2d 1371, 1372 (Pa. Super. Ct. 1986), *appeal denied*, 527 A.2d 541 (Pa. 1987) (holding that "the scope of a physician's duty to disclose risk and alternatives [are] governed by the patient's informational needs").

[36] *See* Truman v. Thomas, 611 P.2d 902 (Cal. 1980) (holding that informed consent requires disclosure of all the benefits of a proposed test and the risks of its refusal, not just the physician's recommendation).

[37] *See* Moore v. Regents of the Univ. of Cal., 793 P.2d 479 (Cal. 1990), *cert. denied*, 499 U.S. 936 (1991) (mandating disclosure of financial conflicts of interest); Estate of Behringer v. Medical Ctr. at Princeton, 592 A.2d 1251, 1253-54 (N.J. Super. Ct. Law Div. 1991) (mandating disclosure of positive HIV status).

[38] *See, e.g.*, GA. CODE ANN. §§ 31-9-6, 31-9-6.1 (1996) (listing requirement for informed consent in general and for certain procedures respectively); HAW. REV. STAT. § 671-3 (1996) (listing required disclosures for informed consent generally); IOWA CODE ANN. § 147.137 (1995) (detailing requirements of consent in writing); TEX. HEALTH & SAFETY CODE ANN. § 578.003 (1995) (concerning electroconvulsive therapy); VA. CODE ANN. §§ 54.1-2971, 54.1-2971.1 (Michie 1996) (dealing with treatment of breast tumors and infertility, respectively).

procedures and at critical junctures in the course of treatment, and not for minor, uninvasive acts.[39] When a health plan does not offer a benefit that a physician would recommend were it covered by the plan, a physician has no clear legal obligation to disclose the treatments that are not covered by the plan.[40]

Second, although physicians are not permitted to keep completely silent about treatment options, they are limited as to what they communicate to patients. The tort of negligent misrepresentation provides a remedy for false information negligently provided by a physician to a patient who relies on it to his or her detriment.[41]

Physicians have been held liable for several kinds of miscommunication about treatment options, including affirmative misrepresentations about the nature or hazards of treatment.[42] Liability may attach for misrepresenting facts about treatment options, for unfounded predictions about the patient's future condition, or for statements of opinion made without any knowledge of the validity of the opinion. Surgeons can be held liable for misrepresenting unnecessary surgery as valid treatment when a patient relies on the misrepresentation and is injured, or when surgeons tell patients that they have more experience with a procedure than is actually the case.[43]

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[39] *See* Mark A. Hall, *Informed Consent to Rationing Decisions*, 71 MILBANK Q. 645 (1993).

[40] *See* Alice Gosfeld, *The Legal Subtext of the Managed Care Environment: A Practitioner's Perspective*, 23 J.L. MED. & ETHICS 230 (1995).

[41] RESTATEMENT (SECOND) OF TORTS § 311 (1977). Section 311 of the Restatement (2nd) of Torts summarizes:

> 1. One who negligently gives false information to another is subject to liability for physical harm caused by action taken by the other in reasonable reliance upon such information, where such harm results, a) to the other, or b) to such third persons as the actor should expect be put in peril by the action taken.
> 2. Such negligence may consist of failure to exercise reasonable care a) in ascertaining the accuracy of the information, or b) in the manner it is communicated.

Id.

[42] See John P. Ludington, Annotation, Medical Malpractice: Liability Based on Misrepresentation of the Nature and Hazards of Treatment, 42 A.L.R. 4th 543, 561 (1981).

[43] *See* BARRY R. FURROW ET AL., HEALTH LAW, § 6-13 (1995). Furrow points out that "since patients rely on the assurances of their physicians, they may be influenced by statements that are outside the scope of the physician's duty to disclose under

B. *Recent Legal Responses*

In response to the gag controversy, physicians' disclosure of treatment options has received strong support from state legislatures. Statutes in twenty-one states prohibit MCOs from interfering with disclosure of medically important information.[44] The scope of protection these statutes offer physicians varies from protection for any information the physician deems appropriate[45] to protection of only that information that is not "slanderous, defamatory, or intentionally inaccurate."[46]

At the federal level, in January 1997, the Health Care Financing Administration (HCFA) sent official policy letters to MCO directors mandating full disclosure of treatment options to recipients.[47] The HHS stated that HMO patients are entitled to all the benefits available in the standard Medicare programs,

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informed consent principles." *Id.*

[44] *See* 1997 Ark. Acts 1196; CAL. BUS. & PROF. CODE § 2056.1 (West 1994); COLO. REV. STAT. ANN. § 10-16-121 (West 1996); 1997 Conn. Legis. Serv. 97-99 (West); DEL. CODE ANN. tit. 18, § 6407 (1997); 1996 D.C. Stat. 11-235; GA. CODE ANN. § 33-20A-6 (Supp. 1996); IND. CODE ANN. § 27-13-15-1 (West 1997); 1997 Kan. Sess. Laws 190; 1997 Md. Laws 35; 1997 Minn. Sess. Law Serv. 237 (West); 1997 Mont. Laws 527; 1997 Neb. Laws 279; 1997 Nev. Stat. 140; 1997 N.J. Sess. Law Serv. 192 (West); 1997 Okla. Sess. Law Serv. 289 (West); 1997 Or. Laws 343; 1997 R.I. GEN. LAWS § 97-352 (1997); 1997 Tex. Sess. Law Serv. 1026 (West); 1997 Utah Laws 227; VT. STAT. ANN. tit. 18, § 9414 (1996); WASH. REV. CODE ANN. § 48.43.075 (West 1996).

[45] *See, e.g.*, 1997 Ark. Acts 1196 § 7.

> No participating provider may be prohibited, restricted or penalized in any way from disclosing to any covered person any health care information that such provider deems appropriate regarding the nature of treatment, risks or alternatives thereto, the availability of alternate therapies, consultations, or tests, the decision of utilization reviewers or similar persons to authorize or deny services, the process that is used to authorize or deny health care services or benefits, or information on financial incentives and structures used by the insurer.

Id.

[46] *See, e.g.*, 1997 Or. Laws 343 §15.

> No insurer may terminate or otherwise financially penalize a provider for . . . [p]providing information to or communicating with a patient in a manner that is not slanderous, defamatory or intentionally inaccurate concerning . . . [a]ny aspect of the patient's medical condition [or] [a]ny proposed treatment or treatment alternatives, whether covered by the insurer's health benefit plan or not."

Id.

[47] *See* Pear, *Clinton Prohibits HMO Limits on Advice to Medicaid Patients*, N.Y. TIMES, Feb. 21, 1997 at A1, A22 [hereinafter Pear, *Clinton Prohibits*].

including advice about "medically necessary" treatment options.[48] On February 20, 1997, President Clinton extended these requirements to HMO Medicaid providers.[49] Again, HCFA sent official policy letters, this time to the various heads of state Medicaid programs.[50] Both of these letters clarify existing law, which requires full informed consent and disclosure of treatment options for Medicare and Medicaid recipients.[51] The federal budget reconciliation bill signed by President Clinton in August, 1997, also prohibits Medicare plans from using gag clauses in provider contracts.[52] Since the gag controversy emerged, the only court to have directly addressed the issue has supported the notion that information about treatment options must be disclosed to patients.[53]

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[48] *See id.* at A22.

[49] *See id.*

[50] *See id.*

[51] *See id.*

[52] *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 496 (Aug. 5, 1997).

> Protection of Enrollee-Provider Communications – (A) In General – Subject to subparagraphs (B) and (C), under a contract under section 1903(m) a medicaid managed care organization (in relation to an individual enrolled under the contract) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D)) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the contract, if the professional is acting within the lawful scope of practice.

Id.

[53] *See Weiss v. CIGNA Healthcare, Inc.*, 972 F. Supp. 748 (1997). In *Weiss*, the plaintiff brought a class action suit in the Southern District of New York seeking declaratory and injunctive relief pursuant to the Employee Retirement Security Income Act of 1974 [ERISA], § 29 U.S.C. § 1001. *See* 972 F. Supp. at 750. The plaintiff alleged that CIGNA had limited the extent to which its participating physicians could discuss medical treatment with plan members. *See id.* She argued that the plan prevented its physicians from "advising patients of treatment options which [are] not compensated by the HMO," and that it enforced a gag-order policy by "reprimand[ing] or even terminat[ing] physicians who disclose that CIGNA will not cover particular forms of treatment that might be useful to the patient." *Id.* at 751. Weiss claimed *inter alia* that the policy had caused CIGNA to breach its fiduciary obligations. *See id.* The defendants' motion to dismiss was denied with regard to this claim. *See id.* at 756. The court reasoned that when the factual allegations in the complaint are taken as true, the plaintiff has stated a cause of action pursuant to ERISA. *See id.* at 751.

The court held that a person is a fiduciary of a benefit plan for the purposes of

IV. Criticism of the Health Plan

A. *The Law Prior to the Gag Controversy*

Several legal principles that predate managed care have shaped the category of communications into which the criticism of health plans fall. An individual who makes a false statement discrediting the quality of another's intangible property in a way that causes damages may be liable for disparagement.[54] To count as disparagement, a statement must be false, it must have been made under circumstances in which a reasonable person could foresee that vendibility would be impaired, it must have caused financial loss, and it must not be privileged.[55] In addition, liability for some kinds of criticism could attach based on a theory of tortious interference with contractual or prospective contractual

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ERISA to the extent she exercises discretionary authority or responsibility in the plan's administration. *See id.* at 751. ERISA requires plan fiduciaries to "discharge [their] duties with respect to a plan solely in the interest of the participants and beneficiaries." ERISA § 404(a)(1), 29 U.S.C. § 1104(a)(1). Given this,

> CIGNA acts in a fiduciary capacity – and therefore comes under the obligations of loyalty imposed by ERISA – to the extent that it exercises discretionary control over the communication of medical information to Plan participants by their physicians. CIGNA's alleged policy of restricting the disclosure of non-covered treatment options would, if true, directly undermine the ability of plan participants to have unfettered access to all relevant information relating to their physical or mental condition and treatment options. Such a policy would thereby constitute a breach of CIGNA's duty under ERISA to manage the plan 'solely in the interest of the participants.'

Id.; see also ERISA §404(a)(1), 29 U.S.C. § 1104(a)(1); American Medical Association Council on Ethical and Judicial Affairs, *Ethical Issues in Managed Care, Council Report*, 273 JAMA 330 (Jan. 25, 1995). The American Medical Association's *Ethical Issues in Managed Care* states that "[p]hysicians also should continue to promote full disclosure to patients enrolled in managed care organizations." *Ethical Issues in Managed Care, supra.* This obligation to disclose treatment alternatives to patients, according to the report, "is not altered by any limitations in the coverage provided by the patient's managed care plan." *Id.* Full disclosure includes informing patients of all their treatment options, even those that may not be covered under the terms of the managed care plan. Patients may then determine whether an appeal is appropriate or whether they wish to seek care outside the plan for treatment alternatives that are not covered. *See id.*

[54] *See* Annot., *Disparagement of the Quality of Intangible Property*, 74 A.L.R. 3d 298 (1976).

[55] *See id.*

relations.[56] If a physician intentionally and improperly interfered with the contractual relations between a patient and a health plan and thereby caused a pecuniary loss to the health plan, he or she could be held liable for that loss.[57] Finally, if a physician negligently supplied false information ostensibly for the guidance of a patient, he or she could be held liable for pecuniary loss caused to the patient who relied on that information.[58]

However, prior to the advent of managed care, physicians did not voice criticisms of health plans to their patients as frequently. Therefore, little case law emerged that could provide a baseline from which to assess current developments. However, the case of *Patlovich v. Rudd* illustrates the limits of common law protection for physician criticisms of a corporation, particularly the limits of the physician's appeal for release from a contractual nondisparagement agreement.[59]

In *Patlovich*, the plaintiff, who was president of a small corporation made up of pathologists, claimed that one of the corporation's former members had violated the nondisparagement clause of his severance agreement.[60] The defendant had sent hundreds of memos and notes to various

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[56] *See, e.g.*, RESTATEMENT (SECOND) OF TORTS §§ 766, 766A, 766B (1977) (setting forth standards for intentional interference with performance of contract by third person, intentional interference with another's performance of his own contract, and intentional interference with prospective contractual relation).

[57] *See* RESTATEMENT (SECOND) OF TORTS §§ 766, 766A, 766B.

[58] *See* RESTATEMENT (SECOND) OF TORTS § 552 (1977). Section 552 states, in pertinent part:

> One who, in the course of his business, profession or employment, or in any other transaction in which he has a pecuniary interest, supplies false information for the guidance of others in their business transactions, is subject to liability for pecuniary loss caused to them by their justifiable reliance upon the information, if he fails to exercise reasonable care or competence in obtaining or communicating the information.

Id.

[59] 949 F. Supp. 585 (1996); *see also* U.S. Healthcare, Inc. v. Blue Cross of Greater Philadelphia, 898 F.2d 914, 914-15 (3rd Cir.), *cert. denied*, 498 U.S. 816 (1990) (holding that "[i]n the context of government restriction of speech, false and misleading speech" arising out of comparative advertising between an insurance company and an HMO "have no First Amendment value").

[60] *See Patlovich*, 949 F. Supp. at 585. That clause read, "[y]ou agree that you will not at any time engage in any action either directly or indirectly that disparages or results in the disparagement of [the corporation], its shareholders or its employees." *Id.* at 594.

hospitals and medical labs, stating that the pathologists were sacrificing quality for high volume and high profits and routinely engaged in unethical practices.[61] When the defendant moved for dismissal of this claim on the ground that the non-disparagement clause of the agreement was void as contrary to public policy, the court rejected his argument.[62] The court reasoned that although public policy favors physician communication about the quality of medical services and patient care, the policy could not be stretched to encompass the defendant's attacks on the corporation, which were not reasonably related to patient treatment or to the improvement of medical care.[63] Thus, *Patlovich* indicates that not all physician criticisms of health care organizations serve important public policy goals.

Previously, publicly employed physicians litigated their First Amendment rights to free speech before the gag controversy. Issues related to communicating to the media, criticizing an employer, criticizing a superior, and communicating with patients have all been adjudicated.[64] Some of the protections gained through this litigation were extended to private employees in the landmark case *Novosel v. Nationwide Insurance Co.*[65] In addition, First Amendment rights of health care professionals in the abortion context have been litigated all the way to the Supreme Court.[66]

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[61] *See id.* at 589.

[62] *See id.* at 595.

[63] *See id.* at 594.

[64] *See* Martin J. McMahon, Annotation, *First Amendment Protection for Public Hospitals or Health Employees Subjected to Discharge, Transfer, or Discipline Because of Speech*, 107 A.L.R. FED. 21 (1977); *see also* Mary-Kathryn Zachary, *Is Free Speech Free in the Nursing Profession?* 26 JONA 36 (Nov. 1996).

[65] 721 F.2d 894 (3d Cir. 1983) (holding that the legal protection of public employees in exercising First Amendment rights applies with equal force to private employees).

[66] Most abortion cases that have reached the Supreme Court have not concerned statutes that regulated physician-patient communication. *But see* Rust v. Sullivan, 111 S. Ct. 1759 (1991); Planned Parenthood v. Casey, 112 S. Ct. 2791 (1992). For extensive commentary on *Rust* and *Casey*, *see* Paula Berg, *Toward a First Amendment Theory of Doctor-Patient Discourse and the Right to Receive Unbiased Medical Advice*, 74 B.U. L. REV. 201 (1994); Mary Anne Bobinski, *Autonomy and Privacy: Protecting Patients from their Physicians*, 55 U. PITT. L. REV. 291 (1994); Michael Fitzpatrick, Note, *Rust Corrodes: The First Amendment Implications of Rust v. Sullivan*, 45 STAN. L. REV. 185 (1992).

B. *Recent Legal Responses*

Responses to physicians' criticisms and comparisons of health plans have been far less protective than the consistently physician-protective responses to conflicts about disclosing treatment options. Only a few states have passed legislation shielding physician criticism of health plans.[67] That protection is limited to good faith communications,[68] to communications that are not motivated by financial gain,[69] to communications that are not false, maliciously critical, or misrepresentations of the plan,[70] to communications that involve no conflict of interest,[71] and to communications about the relation of the plan to the patient's

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[67] *See* CAL. BUS. & PROF. CODE § 2056.1 (West 1994); COLO. REV. STAT. ANN. § 10-16-121 (West 1996); 1997 Idaho Sess. Laws 204 § 30; 1997 Minn. Sess. Law Serv. 237 § 3 (West); 1997 R.I. Pub. Laws 352 § 1; 1997 Tex. Sess. Law Serv. 1026 § 18A (West); WASH. REV. CODE ANN. § 48.43.075 (West 1996).

[68] *See* 1997 R.I. Pub. Laws 352 § 1. Section 1 states, in pertinent part:

> No health maintenance organization shall refuse to contract with or compensate for covered services an otherwise eligible health care provider solely because such provider has *in good faith* communicated with one (1) or more of his or her current, former, or prospective patients regarding the provisions, terms, requirements, restrictions or other treatment options not provided by the health maintenance organization as well as of the health maintenance organization's products and/or services as they relate to the needs of such provider's patients.

Id. (emphasis added).

[69] *See* CAL. BUS. & PROF. CODE § 2056.1(b) (West 1994).

> Health care service plans and their contracting entities shall not include provisions in their contracts that interfere with the ability of a physician and surgeon or other licensed health care provider to communicate with a patient regarding his or her health care, including, but not limited to, communications regarding treatment options, alternative plans, or other coverage arrangements. Nothing in this section shall preclude a contract provision that provides that a physician and surgeon, or other licensed health care provider, may not solicit for alternative coverage arrangements for the primary purpose of securing financial gain.

Id. (emphasis added).

[70] *See* COLO. REV. STAT. ANN. § 10-16-121(2) (West 1996).

> Nothing in subsection (1) of this section shall be construed to prohibit a carrier from: (a) Including in its provider contracts a provision that precludes a provider from making, publishing, disseminating, or circulating directly or indirectly or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature *that is false or maliciously critical of the carrier and calculated to injure such carrier.*

Id. (emphasis added).

[71] *See* 1997 Minn. Sess. Law Serv. 237 § 3 (West).

medical needs.[72] Only the state of Washington offers virtually unqualified protection to physicians who criticize or make unfavorable comparisons of plans.[73] No federal regulations protect criticisms of health plans. Furthermore, to date there has been no litigation over physicians' criticisms of managed care health plans, nor have any professional or industry organizations advocated in favor of protecting this kind of communication with patients.

V. *Plan Information, Specifically Physicians' Incentives*

A. *The Law Prior to the Gag Controversy*

Even prior to the advent of managed care, state law in several jurisdictions required physicians to disclose some of the financial incentives involved in their practice. In some states, a physician who refers a patient to a health care entity in which she has a significant financial interest, and who fails to disclose that financial interest, is subject to disciplinary action for unprofessional conduct.[74] Under certain circumstances, common law has also required physicians to disclose their financial interests. For example, in California, the existence of research or

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[72] *See* MASS. ANN. LAWS ch. 176G § 6 (Law. Co-op. 1996); R.I. GEN. LAWS § 23-17.13-3 (1996).

[73] *See* WASH. REV. CODE ANN. 48.43.075 (West 1996).

> (1) No health carrier subject to the jurisdiction of the state of Washington may in any way preclude or discourage their providers from informing patients of the care they require, including various treatment options, and whether in their view such care is consistent with medical necessity, medical appropriateness, or otherwise covered by the patient's service agreement with the health carrier. No health carrier may prohibit, discourage, or penalize a provider otherwise practicing in compliance with the law from advocating on behalf of a patient with a health carrier. Nothing in this section shall be construed to authorize providers to bind health carriers to pay for any service.
>
> (2) No health carrier may preclude or discourage patients or those paying for their coverage from discussing the comparative merits of different health carriers with their providers. This prohibition specifically includes prohibiting or limiting providers participating in those discussions even if critical of a carrier.

Id.

[74] *See, e.g.*, James C. Dechene & Karen P. O'Neill, *"Stark II" and State Self-Referral Restrictions*, 29 J. OF HEALTH & HOSP. L. 65, 69-71 (1996). Thirty-two states have statutes prohibiting various types of physician referrals. *See id.*

economic interests that may affect professional judgment must be disclosed.[75] But there are limits to what must be communicated; only the existence of a conflict, and not its details, must be disclosed. Details about the operation of a business owned by someone else have not, of course, been one of the required disclosures.[76] Their disclosure has under many circumstances been restricted as proprietary information.[77]

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[75] *See* Moore v. Regents of the University of California, 793 P.2d 479 (Cal. 1990), *cert. denied*, 499 U.S. 936 (1991). A patient suffering from leukemia visited a physician at the UCLA Medical Center, who both treated him for the leukemia and conducted research on leukemia. *See id.* In the research, the physician used Moore's body cells, including blood cells, bone marrow, sperm, and spleen cells after the successful removal of Moore's spleen. *See id.* The physician did not inform Moore of this research, of the use of Moore's cells for this research, or of the eventual creation of a patent-worthy and potentially lucrative cell-line from Moore's T-lymphocytes. *See id.* When Moore discovered these facts, he sued for both lack of informed consent and breach of fiduciary duty, and the Supreme Court of California eventually decided both issues.

The court analyzed the history of informed consent and of physicians' fiduciary duties, and ultimately allowed both claims, stating that:

> (1) a physician must disclose personal interests unrelated to the patient's health, whether research or economic, that may affect the physician's professional judgment; and (2) a physician's failure to disclose such interests may give rise to a cause of action for performing medical procedures without informed consent or breach of fiduciary duty.

Id. at 483. The court's rationale was that a "reasonable patient" would want to know if a physician had financial interests that might affect his professional judgment. The court then drew an analogy between the physician with a research interest related to his patients, and the physician who refers a patient to a lab or clinic in which he has a significant financial stake, without revealing that fact of that financial interest to his patients. *See id.* Both physicians have acted inappropriately. *See also* Marc A. Rodwin, *Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System*, 21 AM. J.L. & MED. 241, 247-51 (1995).

[76] *See, e.g.*, RESTATEMENT (SECOND) OF AGENCY, § 395 (1958).

> Unless otherwise agreed, an agent is subject to a duty to the principal not to use or to communicate information confidentially given him by the principal or acquired by him during the course of or on account of his agency or in violation of his duties as agent, in competition with or to the injury of the principal, on his own account or on behalf of another, although such information does not relate to the transaction in which he is then employed, unless the information is a matter of general knowledge.

Id.

[77] *See id.*

B. *Recent Legal Responses*

The gag controversy has produced few state statutes that address the disclosure of proprietary information by physicians.[78] Those states with such legislation have placed significant restrictions upon the ability of providers to disclose proprietary information.[79] Only Minnesota now requires physicians to disclose their financial incentives when patients request that information.[80] More states have protected physicians' disclosure of their financial incentives within health plans if physicians wish to do so.[81]

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[78] *See, e.g,* 1997 Mont. Laws 527 §§ 2-4; N.H. REV. STAT. ANN. § 420-A:8-aII (1996).

[79] *See, e.g.,* 1997 Mont. Laws 527 §§ 2-4; N.H. REV. STAT. ANN. § 420-A:8-aII (1996). Montana's statute states that its restrictions on gag clauses do not apply to:

> an oral or written contract, direction, requirement, or financial inducement or penalty prohibiting a provider from disclosing a trade secret, as defined in [its state code], to the same extent as other employees or contractors of the health carrier or managed care organization are prohibited from disclosing the trade secret.

1997 Mont. Laws 527 §§ 2-4. New Hampshire's statute similarly refrains from protecting health care providers who disclose a health plan's trade secrets. *See* N.H. REV. STAT. ANN. § 420-A:8-aII (1996).

> No contract between a health service corporation and a health care provider shall limit what information such health care provider may disclose to patients or to prospective patients regarding the provisions, terms, or requirements of the health service corporation's products as they relate to the needs of such provider's patients except for trade secrets of significant competitive value.

Id.

[80] *See* 1997 Minn. Sess. Law Serv. 237 § 4 (West). Section 4 states, in pertinent part:

> (b) Health plan companies and providers *must, upon request,* provide an enrollee with specific information regarding the reimbursement methodology, including, but not limited to . . .
>
> (2) a written description *of any incentive to the provider relating to the provision of health care services to enrollees,* including any compensation arrangement that is dependent on the amount of health coverage or health care services provided to the enrollee, or the number of referrals to or utilization review of specialists. . . .

Id. (emphasis added).

[81] *See* 1997 Ark. Acts 1196 § 7; IND. CODE § 27-13-15-1 (1997); 1997 Minn. Sess. Law Serv. 237 § 3 (West); 1997 Mont. Laws 527 §§ 2-4; 1997 Or. Laws 343 § 6. For example, Indiana's statute states that "a contract between a health maintenance organization and a participating provider of health care services . . . may not prohibit the participating provider from disclosing the terms of the contract as it relates to financial or other incentives to limit medical services by the participating provider." IND. CODE § 27-13-15-1 (1997). Minnesota's statute prohibits "any agreement or directive that prohibits a health care provider from informing an enrollee about the nature of the reimbursement methodology used by an enrollee's health plan

The most common response to conflicts about disclosing physicians' financial incentives has not been to protect physicians' disclosures, but rather to mandate that health plans disclose the incentives.[82] At the federal level, regulations governing Medicare patients in HMOs require disclosure of incentive plans, but only if the patient specifically requests it.[83]

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company, health insurer, or health coverage plan to pay the provider." 1997 Minn. Sess. Law Serv. 237 § 3 (West).

[82] *See* ARIZ. REV. STAT. § 20-1076 (enacted April 1997); 1997 Ark. Acts 1196 § 7; 1997 Conn. H.B. 6883 § 5 (enacted June 1997); GA. CODE ANN. § 33-20A-6 (Supp. 1996); ME. REV. STAT. ANN. tit. 24-A, § 4302 (West 1996); 1997 Mass. H.B. 1927, a.k.a. Amendments to 1995 Mass. H.B. 5917 (1995); 1997 Minn. Sess. Law Serv. 237 § 4 (West); 1997 Or. S.B. 21 § 6 (enacted 1997); Act of June 19, 1996, § 1, 1996, R.I. Pub. Laws ch. 41, § 1 (to be codified at R.I. GEN. LAWS § 2317.13-3); 1997 Tenn. H.B. 520; VT. STAT. ANN. tit. 18, § 9414 (1996); Act of May 22, 1996, ch. 180, § 1, 1996 Vt. Act & Resolves 815 (to be codified at VT. STAT. ANN. tit. 3, § 253); WYO. STAT. ANN. § 26-34-109 (Michie 1995). Minnesota's statute, for example, requires that

> [a] health plan company . . . shall, during open enrollment, upon enrollment, and annually thereafter, provide enrollees with a description of the general nature of the reimbursement methodologies used by the health plan company, health insurer, or health coverage plan to pay providers. This description may be incorporated into the member handbook, subscriber contract, certificate of coverage, or other written enrollee communication. The general reimbursement methodology must be made available to employers at the time of open enrollment.

1997 Minn. Sess. Law Serv. 237 § 4. Upon request, the plan must provide an enrollee with:

> specific information regarding the reimbursement methodology, including, but not limited to, the following information:
> (1) a concise written description of the provider payment plan, including any incentive plan applicable to the enrollee;
> (2) a written description of any incentive to the provider relating to the provision of health care services to enrollees, including any compensation arrangement that is dependent on the amount of health coverage or health care services provided to the enrollee, or the number of referrals to or utilization of specialists; and
> (3) a written description of any incentive plan that involves the transfer of financial risk to the health care provider.

Id.

[83] *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 496 (Aug. 5, 1997).

> (2) Disclosure upon Request.—Upon request of a Medicare+Choice eligible individual, a Medicare+Choice organization must provide the following information to such individual:
>
> > (A) The general coverage information and general comparative plan information made available under clauses (i) and (ii) of section 1851(d)(2)(A).
> >
> > (B) Information on procedures used by the organization to control

Federal courts also have begun to require disclosure of physicians' incentives. For example, in *Shea v. Esenstein*, the Eighth Circuit was the first to directly address the issue of incentive disclosure with regard to ERISA plans.[84] Although it is clear that an MCO is a fiduciary under ERISA,[85] the *Shea* court reaffirmed that an HMO is an ERISA fiduciary and, as such, must disclose physician financial incentives that discourage referrals.[86]

VI. Advocacy

A. *The Law Prior to the Gag Controversy*

Before the gag controversy, the obligation of physicians to advocate on their patients' behalf by trying to appeal or protest the plans' coverage decisions was not well established in law.

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utilization of services and expenditures.
(C) Information on the number of grievances, redeterminations, and appeals and on the disposition in the aggregate of such matters.
(D) An overall summary description as to the method of compensation of participating physicians.

Id.

[84] 107 F.3d 625 (8th Cir., 1997).

[85] *See* 29 U.S.C. § 1002 (21)(a)(1994); O'Reilly v. Ceuleers, 912 F.2d 1383 (11th Cir. 1990) (holding that because they act as both insurer and provider and are not always subject to the regulations of state insurance commissions, HMOs are not considered by ERISA to be insurers).

[86] 107 F.3d at 629. "When an HMO's financial incentives discourage a treating doctor from providing essential health care referrals for conditions covered under the plan benefit structure, the incentives must be disclosed and the failure to do so is a breach of ERISA's fiduciary duties." *Id.*

The American Medical Association also supports disclosure of incentives by plans but does not currently call for disclosure by physicians. *See id.* In 1990, the AMA called for disclosure of financial incentives and stated that physicians must disclose this information to patients. *See id.* The AMA's 1995 report, *Ethical Issues in Managed Care*, supported only disclosure of physicians' incentives by the plan. *See* American Medical Association Council on Ethical and Judicial Affairs, *Ethical Issues in Managed Care*, *supra* note 53, at 335. "Any incentives to limit care must be disclosed fully to patients by plan administrators on enrollment and at least annually thereafter." *Id.* American Medical Association delegates voted in August 1997 to reject a resolution to disclose to patients the financial incentives under which they work. *See* CODE OF MEDICAL ETHICS: REPORTS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS OF THE AMERICAN MEDICAL ASSOCIATION, Chicago, IL: American Medical Association, 130-35 (1997). Abigail Trafford, *For Some Doctors Today, Mum's the Word*, WASH. POST, Mar. 12, 1996. Other physician and industry groups have not addressed the issue.

However, dicta in *Wickline v. California* touches upon the issue of advocacy. [87] In *Wickline*, a California appeals court held that negligent implementation of cost containment mechanisms, such as Medi-Cal utilization review, can lead to liability for the reviewing body.[88] Although the court ultimately found Medi-Cal not liable for Ms. Wickline's injury, it did state that third party payors of health care services can in fact be held liable when cost containment mechanisms result in medically inappropriate decisions.[89] The court also suggested, but did not hold, that physicians had a duty to protest coverage decisions.[90] The *Wickline* court's suggestion has not been taken up by courts in other jurisdictions. Even subsequent California courts have rejected the suggestion, labeling it "overbroad" and in "error."[91] Since the *Wickline* dicta has not been adopted, this suggests that courts do not want to expand physicians' responsibilities to encompass all the health-related needs of their patients. Therefore, when physicians decline to protest coverage denials, they may not be taking all possible steps towards obtaining medical treatment for their patients, but they are acting within the bounds of the law.

B. *Recent Legal Responses*

More than a dozen states have passed legislation that would protect physicians who advocate for their patients within an MCO.[92] Some statutes protect any advocacy on behalf of patients,

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[87] 239 Cal. Rptr. 810, 819 (Cal. Ct. App. 1986).

[88] *Id.*

[89] *See id.*

[90] *See id.*

> [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. He cannot point to the health care payor as the liability scapegoat when the consequences of his own determinative medical decision go sour.

Id.

[91] *See* Wilson v. Blue Cross of Southern California, 271 Cal. Rptr. 876 at 885 (Cal. Ct. App. 1990) (holding that third party payor "could be at least partially liable if negligent conduct was a substantial factor in bringing about harm").

[92] *See* COLO. REV. STAT. ANN. § 10-16-121 (1996); 1997 Idaho Sess. Laws 204 § 30; 1997 Kan. Sess. Laws 190; ME. REV. STAT. ANN. tit. 24-A, § 4303 (enacted 1996); 1997 Md. Laws 35; 1997 Minn. Sess. Law Serv. 237 (West); 1997 Mo. H.B. 335 § 5 (enacted 1997); 1997 Mont. Laws 527; 1997 Neb. Laws 279; 1997 Nev. Stat. 140; 1995 N.Y. A.B. 3105 (enacted October 1996); 1997 Okla. Sess. Law Serv. 289 (West); 1997 Tex. Sess.

while others specify what communications are protected.[93] No statute requires physicians to advocate for patients. Similarly, no litigation to date has specifically addressed the physician's advocacy duty in MCOs.[94]

VII. Termination and Continuity

A. *The Law Prior to the Gag Controversy*

Tort law has set minimum standards for physician-patient

Law Serv. 1026 § 18A (West); WASH. REV. CODE ANN. 48.43.075 (West 1996).

[93] For example, Colorado's statute protects providers who "express disagreement with a carrier's decision to limit benefits to a covered person" or who "assist the covered person to seek reconsideration of the carrier's decision." COLO. REV. STAT. ANN. § 10-16-21. By contrast, Maine's statute forbids MCOs from retaliating against a physician who advocates for "medically appropriate" care. *See* ME. REV. STAT. ANN. tit. 24-A, § 4303(3). Advocating for medically appropriate care means:

> to discuss or recommend a course of treatment to an enrollee; to appeal a managed care plan's decision to deny payment for a service . . .; or to protest a decision, policy, or practice that the provider . . . reasonably believes impairs the provider's ability to provide medically appropriate care to the provider's patients.

Id.

[94] The AMA, however, strongly urges its members to advocate for patients, stating in its report on managed care:

> The duty of patient advocacy is a fundamental element of the physician-patient relationship that should not be altered by the system of health care delivery in which physicians practice. Physicians must continue to place the interests of their patients first . . . Adequate appellate mechanisms for both patients and physicians should be in place to address disputes regarding medically necessary care. In some circumstances, physicians have an obligation to initiate appeals on behalf of their patients. Cases may arise in which a health plan has an allocation guideline that is generally fair, but in particular circumstances results in unfair denials of care, i.e., denial of care that, in the physician's judgment, would materially benefit the patient. In such cases, the physician's duty as patient advocate requires that the physician challenge the denial and argue for the provision of treatment in the specific case. Cases may also arise in which a health plan has an allocation guideline that is generally unfair in its operation. In such cases, the physician's duty as patient advocate requires not only a challenge to any denials of treatment from the guideline, but also advocacy at the health plan's policy-making level to seek an elimination or modification of the guideline. Physicians should assist patients who wish to seek additional appropriate care outside the plan when the physician believes the care is in the patient's best interests.

Ethical Issues in Managed Care, *supra* note 53.

communication when a relationship is to be terminated. The law of abandonment requires that a physician who is ending a physician-patient relationship give the patient proper notice so as to enable the patient to secure an alternative source of care.[95] If the physician fails to give notice and the patient suffers harm as a result of a lack of continuity in medical care, the physician may be liable for damages.[96] Before a physician can abandon or withdraw from a case, he or she must either give reasonable notice or provide a competent physician as a replacement.[97] However, a patient cannot demand that a physician remain indefinitely available once the requirement of notification has been met. When a patient is not in need of immediate medical attention, supplying the patient with a list of substitute physicians to replace the attending physician is enough to avoid liability.[98] The duty is therefore a limited one, that protects both patients' health-related interests as well as physicians' legal interests.

B. *Recent Legal Responses*

Responses to the communication conflicts arising out of termination of a physician's relationship with an MCO have been few and far between. No state legislation specifically protects physician-patient communication concerning termination. However, some legislation defines physicians' protected communication broadly enough to include communication with

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[95] *See* 61 Am. Jur. 2d § 235 (1981).

> It is well recognized that a physician has a right to withdraw from a case, but if he would discontinue his services before the need for them is at an end, he is bound first to give due notice to the patient and afford the latter ample opportunity to secure other medical attendance of his own choice.

Id.; see also Payton v. Weaver, 131 Cal. App. 3d 38, 46, 182 Cal. Rptr. 225, 229 (1st Dist. 1982).

[96] *See* 61 Am. Jur. 2d § 236 (1981).

> [A] physician cannot discharge himself from a case and relieve himself of responsibility for it by simply abandoning it or staying away without notice to the patient.... The plaintiff must show that such abandonment was a proximate cause of the injury for which redress in damages is sought, and a mere showing of negligence on the part of the physician is not sufficient to sustain the action.

Id.; *see also* Payton, 131 Cal. App. 3d at 46, 182 Cal. Rptr. at 229.

[97] *See* Allison v. Patel, 211 Ga. App. 376, 438 S.E.2d 920 (1993).

[98] *See Payton*, 182 Cal. Rptr. at 229; 61 Am. Jur. 2d § 236.

"former patients."[99]

Legislation in several states requires MCOs to detail plans for continuity of treatment, including advance notice to patients of impending provider termination. However, bills and statutes in Florida, Kansas, Minnesota, and Texas require MCOs to create a plan to allow a patient to continue to see a provider at the preferred provider rate for a specified number of days after termination when the patient has special circumstances such as a disability, an acute condition, a life-threatening illness, is past the twenty-fourth week of pregnancy, or, in Minnesota, when there are cultural or language barriers.[100] In Arkansas, the enrollee may continue to receive care from a provider until a current episode of treatment for an acute condition is completed or for ninety days, whichever comes first.[101] In the Texas scheme, it is the treating physician who identifies which patients have "special circumstances" and who requests continuity of care.[102] MCOs may challenge this determination by the physician.[103] Therefore, regulations require MCOs to establish and initiate procedures for resolving disputes about whether continuity of care is needed or not, and to include those procedures in provider contracts.[104] In the Minnesota scheme, health plans must explain who will identify enrollees with special medical needs or who are at special medical risk, and the criteria that will be used in this

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[99] *See, e.g.*, 1997 Tex. S.B. 385 § 18A (1997). "A health maintenance organization shall not, as a condition of a contract with a physician or provider or in any other manner, prohibit, attempt to prohibit, or discourage a physician or provider from: Discussing with or communicating to a current, prospective, or former patient. . . ." *Id.*

[100] *See* FLA. STAT. ANN. § 641.51(7) (West 1997); Kan. Sess. Laws 169 (1996); Minn. S.B. 960 (1997); Tex. Sess. Law Serv. 1026 § 18A (West 1997).

[101] *See* Ark. Acts 1196 § 8. The plan must ensure that a patient "may continue to receive treatment as an in-network benefit from that provider until the current episode of treatment ends or until the end of ninety (90) days, whichever occurs first." *Id.*

[102] *See* Tex. Sess. Law Serv. 1026 §18A. "The special circumstance shall be identified by the treating physician or provider, who must request that the enrollee be permitted to continue treatment under the physician's or provider's care. . . ." *Id.*

[103] *See* Tex. Sess. Law Serv. 1026 § 18A. "Contracts between a health maintenance organization and physicians or providers shall provide procedures for resolving disputes regarding the necessity for continued treatment by a physician or provider." *Id.*

[104] *See id.*

determination.[105]

Under a Virginia statute, similar opportunities would be available not only for patients in special circumstances, but for all managed care patients.[106] The statute requires MCOs to specify procedures for notifying patients of the termination of their primary care provider's contract in advance, and to inform each patient of the right to continue to see their primary care provider for up to sixty days from the date of the provider's notice of termination, except when that provider is terminated for cause.[107] Since the Virginia law also mandates at least a sixty-day notice to the provider prior to termination, the effect is that providers may continue to see their patients for the sixty days between when they are most likely to receive notice of termination and the time of the actual termination.[108] Though this apparently applies to all physicians and patients, language in a provider-oriented paragraph of the legislation suggests that for a provider to

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[105] *See* 1997 Minn. Sess. Law Serv. 237 § 12.

> The health plan company shall prepare a written plan that provides a process for coverage determinations for continuity of care for new enrollees with special needs, special risks, or other special circumstances. . . . The written plan must explain the criteria that will be used for determining special needs cases, and how continuity of care will be provided.

Id.

[106] *See* Va. Legis. 776 § 38.2-3407.10(C)-(F) (1996).

> C. A carrier that uses a provider panel shall establish procedures for:
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> 1. Notifying an enrollee of:
>
> a. The termination from the carrier's provider panel of the enrollee's primary care provider who was furnishing health care services to the enrollee . . .
>
> 2. Notifying a provider at least sixty days prior to the date of the termination of the provider, except when a provider is terminated for cause. . . .
>
> F. 1. For a period of at least sixty days from the date of the notice of a provider's termination from the carrier's provider panel, except when a provider is terminated for cause, the provider shall be permitted by the carrier to render health care services to any of the carrier's enrollees who:
>
> a. Were in an active course of treatment from the provider prior to the notice of termination; and
>
> b. Request to continue receiving health care services from the provider.

Id.

[107] *See id.*

[108] *See id.*

continue to care for a patient, the patient must request the continuation and also be in an active course of treatment from the provider prior to notice of termination.[109]

No litigation has thus far addressed communication conflicts between physicians and MCOs at the time a physician leaves a health plan. Moreover, no professional or industry organizations have addressed these issues.

VIII. Conclusion: Outcomes and Implications

Now that the legal and political dust generated by the gag controversy is beginning to settle, it is worth investigating what the controversy has resolved, and what remains unresolved, as well as how issues in physician-patient communication have been reformed by this episode. Physician-patient communication is influenced by many factors, but legal responses to perceived gag practices will be among the most important of these factors in the future; they have significantly modified the environment in which health care is delivered.[110]

Several outcomes are fairly clear. First, physicians will not be legally excused from disclosing to patients all treatment options—even uncovered options—just because they practice in a managed care environment. Second, health plans, rather than physicians, will be expected to disclose physicians' financial incentives. These clear outcomes of the debate reinforce the status quo, but nevertheless raise important questions about physician communication in the evolving health care system.

A third trend, also suggested by this debate, is that health plans rather than physicians may be expected to ensure continuity of care for medically vulnerable patients. This potential outcome of the controversy would be a significant change from the status quo.

Fourth, patients' expectations that physicians will "press the system" will conflict with the need to place realistic limits on physicians' obligations to patients. Finally, physicians will learn to

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[109] *See id.* at § 38.2-3407.10(F)(1).

[110] For an insightful discussion of how internal and external managed care regulations may be perceived by health care providers, *see* Sandra H. Johnson, *Managed Care as Regulation: Functional Ethics for a Regulated Environment*, 23 J.L. MED. & ETHICS, 266 (1995).

temper their criticism of health plans in clinical settings or to make their criticisms in other settings.

A. *Uncovered Treatment Options and Economic Informed Consent*

The gag debate appears to have brought at least temporary closure to the question of whether physicians should disclose uncovered treatment options to their patients. When the issue was raised in debate, legal and extralegal support for physician disclosure of treatment options was unequivocal. Therefore, even physicians who have willingly signed gag clauses prohibiting disclosure of uncovered treatment options will not be excused for failing to communicate those options to patients.

This part of the gag controversy has been paralleled by vigorous debate in the legal and ethical literature about whether physicians must disclose uncovered treatment options. There is consensus in this literature that in the current health care economy, patients cannot insist that insurers pay for all beneficial medical treatment. There is less certainty, however, that the requirements of informed consent mandate that all treatment options be disclosed to patients. Therefore, the results of the gag episode are in line with traditional thinking about informed consent, which has insisted on full disclosure.

Traditional informed consent dialogue has supported and perhaps even driven patients' expectations for expensive health care. More than a decade ago, scholars recognized that the doctrine of informed consent was driven by the economic principle of consumer sovereignty.[111] They predicted that U.S. citizens enrolled in HMOs would soon face the conflict between rationing health care and patient sovereignty: there can be no informed consent where the patient-consumer cannot have a choice of health care options.[112] The industry needs to examine whether the law should reflect the shift towards personal autonomy and medical care.[113]

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[111] *See* Robert Schwartz & Andrew Grubb, *Why Britain Can't Afford Informed Consent*, HASTINGS CENTER REP. 19 (Aug. 1985) [hereinafter Schwartz & Grubb].

[112] *See id.* at 25.

[113] *See* George J. Annas & Frances H. Miller, *The Empire of Death: How Culture and Economics Affect Informed Consent in the U.S. the U.K. and Japan*, 20 AM. J.L. & MED. 357 (1994). Should adaptation be deemed appropriate, they suggest, the doctrine of

If the appropriate disclosures were made at the time of enrollment, it could satisfy the theoretical requirements of informed consent law. [114] Whether nondisclosure of treatment options is legitimate would depend on the nature of the disclosure at the time of enrollment and on the range of choices subscribers had within the plan and among plans. Perhaps economic informed consent could work if the notions of prior consent and waiver of informed consent were employed.[115] The concept of prior consent suggests that when patients make informed decisions to purchase less expensive forms of health insurance, they consent in advance to a bundle of unspecified refusals of marginally beneficial treatment.[116] The concept of informed waiver suggests that subscribers could voluntarily give up the right to be told of particular nontreatment decisions.[117]

If disclosure at the time of enrollment meets the standards that commentators have articulated, it would be ethically and legally acceptable for physicians to not disclose uncovered treatment options in the clinical setting. But responses to the gag phenomenon, traditional in nature, have probably postponed the day when such a change actually would be accepted. The energy expended during the gag controversy to reinforce traditional

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informed consent "offers a convenient vehicle for modifying legal analysis as social values crystallize in response to more overt health care rationing." Frances H. Miller, *Denial of Health Care and Informed Consent in English and American Law*, 18 AM. J.L. & MED. (1992).

[114] *See* Mark A. Hall, *A Theory of Economic Informed Consent*, 31 GA. L. REV. 511, 524 (1997) [hereinafter Hall, *A Theory*]; MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS, AND ECONOMICS OF HEALTH CARE RATIONING MECHANISMS (Oxford University Press) (1997).

[115] *See* Hall, *A Theory*, *supra* note 114, at 538.

[116] *See* Hall, *A Theory*, *supra* note 114, at 511.

[117] Tristram Engelhardt has suggested that subscribers to insurance programs should be asked "to check which standard of disclosure they wish used in their treatment... [and to] review their choices semiannually or annually." ENGELHARDT, H.T., THE FOUNDATIONS OF BIOETHICS 275, 279 (New York: Oxford U. Press) (1986). Other discussions of the possibility of modifying informed consent to fit new economic realities include E. Haavi Morreim, *Economic Disclosure and Economic Advocacy: New Duties in the Medical Standard of Care*, 12 J. LEGAL MED. 275 (1991) [hereinafter Morreim, *Economic Disclosure*]; Mary Ann Bobinski, *Autonomy and Privacy: Protecting Patients from their Physicians*, 55 U. PITT. L. REV. 291, 370 (1994); E. Haavi Morreim, *Diverse and Perverse Incentives of Managed Care: Bringing Patients into Alignment*, 1 WIDENER L. SYMP. J. 89, 123 (1996) [hereinafter Morreim, *Incentives*]; Clark Havighurst, *Prospective Self-Denial: Can Consumers Contract Today to Accept Health Care Rationing Tomorrow?*, 140 U. PA. L. REV. 1755 (1992).

disclosure standards is unlikely to soon be followed by an equivalent effort to modify them.

The approach to informed consent that has been reinforced by the gag controversy is not entirely compatible with the realities of health care economics. Stringent enforcement of informed consent law fits well with open-ended reimbursement, but not with a system of managed care. This gap between patients' expectations, which will continue to be fueled by reinforcement of traditional informed consent, and the limitations imposed in managed care plans, will likely result in increased conflict between enrollees and their health plans.

The United States now stands in the difficult position of having strict informed consent requirements without any recognized "economic" exceptions. Great Britain, by contrast, has much lower disclosure standards of informed consent that are shaped, in part, by economic realities.[118] As a result, patients there are not continually reminded by physicians about the treatment options that are unavailable to them. By increasing the probability that the expectations attached to the notion of informed consent will not change with the changing realities of health economics, the gag controversy has probably exacerbated conflict between insurers and patients.

B. *Financial Incentives: The Plan, not the Physician, Discloses*

There has been no agreement in the legal and ethical literature about whether physicians should disclose the financial incentives under which they work in managed health care plans. Some commentators view disclosure of financial incentives as part of the fiduciary aspect of the physician-patient relationship.[119] Other commentators point to the practical problems that would arise if physicians disclosed their incentives. For example, disclosure by a physician occurs too late for enrollees to change to a health plan that does not have the incentives they find troubling.[120] In addition, if physicians disclose financial incentives

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[118] *See* Schwartz & Grubb, *supra* note 111.

[119] *See, e.g.*, Morreim, *Economic Disclosure, supra* note 117; Bobinski, *supra* note 117, at 370; Morreim, *Incentives, supra* note 117, at 123.

[120] *See* Devon C. McGraw, Note, *Financial Incentives to Limit Services: Should Physicians be Required to Disclose These to Patients?* 83 GEO. L.J. 1821, 1845-47 (1995).

to patients, they will have to keep track of the details of not just one contract, but of many. Further, those incentives will shift to the foreground of medical practice more so than if disclosure were not expected.[121]

Like the legal and ethical commentary, the gag controversy has left unresolved whether physicians should disclose their financial incentives to patients. The unresolved nature of the problem has important implications for the future. Those physicians who do initiate conversations with patients or who respond to patients' inquiries about incentives will not, for the most part, be supported and protected by anti-gag efforts. Therefore, participation in this kind of communication will be risky for physicians and less likely to occur than had the gag controversy generated support and protection for disclosure.

C. *Advocacy: Rhetoric v. Legal Duty*

Another outcome of the gag episode, a corollary of the episode's affirmation of traditional informed consent, is that patients will increasingly expect physicians to advocate for them within managed care plans, so that they can receive all potentially beneficial treatments. In the immediate future, physicians may be able to deflect toward health plans their patients' frustration and resentment about denials of coverage. But eventually, patients will learn that the success of some appeals depends, at least in part, on the zealousness with which their physicians advocate for them within the health plan. The long-term result is likely to be increased friction between physicians and patients about how much time and energy physicians should spend to help the patient fight the health plan. If physicians choose to advocate for

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[121] *See* Hall, *A Theory*, *supra* note 114, at 525. This may be poor policy, as Mark Hall points out:

> Ideally, financial incentives should have only an implicit, background influence on physicians' clinical judgment. Doctors should think generally about resource constraints before ordering expensive treatment, but not specifically about how much this particular treatment or patient is costing or earning them. To require them to describe the financial details of their arrangements with particular managed care plans could force into mind the very factors we hope they are keeping at a distance.

Id.

patients within health plans, they will have to balance their efforts to do so against other duties that require their time and energy, including those duties that are clearly legally required. If physicians choose to not advocate vigorously, they will eventually face angry patients and families.

That expectation would conflict with some, but not all, of the ethical and legal commentary on advocacy within an MCO. It has been argued that physicians have a fiduciary obligation to advocate for the patient against his or her health plan.[122] Similarly, some advocate that *Wickline* should be extended to require a physician to demand payment from an MCO for the care she feels is necessary, at the risk of malpractice liablility.[123] However, an opposing view is that physicians should vigorously advocate, "press the system," only after considering what would happen if all other physicians did the same under similar circumstances.[124] This opinion is rooted in the belief that physicians can no longer be expected to go to heroic lengths to take on MCOs for the sake of their patients.[125] The gag episode may thus have left patients with unrealistic and unwarranted expectations about the efforts physicians must make on their behalf.

D. *Continuity of Care for Medically Vulnerable Patients*

The gag controversy portends another change in physician-patient communications, that of a sharing of responsibility for continuity of care between the physician and the health plan. Health plans, along with and perhaps instead of physicians, may become responsible for communicating to medically vulnerable patients that their relationship with the physician is coming to an end. In addition, health plans may be made responsible for providing continued coverage with the same physician provider. If this trend becomes stronger, it will have implications not only for

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[122] *See* Susan L. Goldberg, *A Cure for What Ails? Why the Medical Advocate is Not the Answer to Problems in the Doctor-Patient Relationship*, 1 WIDENER L. SYMP. J. 325 (1996).

[123] *See* Barry R. Furrow, *The Ethics of Cost-Containment: Bureaucratic Medicine and the Doctor as Patient-Advocate*, 3 NOTRE DAME J.L. ETHICS & PUB. POL'Y, 187, 215 (1988).

[124] *See* E. HAAVI MORREIM, BALANCING ACT: THE NEW MEDICAL ETHICS OF MEDICINE'S NEW ECONOMICS 93 (Kluwer Academic Publishers 1991).

[125] *See* Maxwell J. Mehlman, *Medical Advocates: A Call for a New Profession*, 1 WIDENER L. SYMP. J. 299, 315 (1996).

physician-patient communications, but also for the cost of health care. The potential costs for health plans include both the administrative costs of determining who is eligible for extended coverage and for extension of the arrangement with existing physicians, as well as the actual costs of extending coverage for the enrollee.

For physician-patient communication, this trend may mean that patients come to rely more on health plans to communicate the limits of the physician-patient relationship. Like the new legal requirements that health plans rather than physicians disclose financial incentives, this trend creates new duties of communication for health plans. In the long term, it is likely that physicians' communication duties in this area will decrease in proportion to the increase in plan duties.

E. *Criticism*

The gag controversy has not resulted in an outpouring of support for physicians' criticisms of health plans within the physician-patient relationship. That lack of support is consistent with legal and ethical commentary, which focuses on support for speech that occurs in other settings. That commentary has focused on the physician's right to participate in public debate[126] and the physicians' duty to work within the health plan to improve policies and practices.[127] As a result, physicians may begin to exercise more restraint in criticizing health plans or shift the forum in which they criticize plans to one that is better protected legally.

F. *Conclusion*

Managed care has changed the legal environment for physicians' communications with patients and on behalf of patients.[128] The change has not occurred quietly, but has been

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[126] *See* Martin & Bjerknes, *supra* note 6, at 443.

[127] *See* MORREIM, BALANCING ACT: THE NEW MEDICAL ETHICS OF MEDICINE'S NEW ECONOMICS, *supra* note 124, at 93.

[128] Legislative responses to managed care have included reactions against a variety of health plan practices. *See* STATE HEALTH WATCH, June 1996, at A1; *Bills on Managed Care Reforms, Abortion, HIPAA Changes Approved*, 5 HEALTH CARE POLICY REPORT 19, d35 (May 12, 1997); *Managed Care: Broader Proposals, Growing Support*

accompanied by a great deal of public debate and significant regulation of MCOs. This new legal environment for physician communication differs significantly from both the pre-managed care era and the era of gag practices.

For some, the protections generated by the gag episode represent an important step in maintaining quality health care, as physicians have traditionally associated quality with the ability to practice in an unencumbered manner.[129] For others, more regulation represents yet another layer of health care costs.[130]

The long-term effects of the gag episode on the cost and quality of health care remain to be seen. In the short term and for the forseeable future, however, physicians and patients will communicate within this newly modified legal environment, for the issues raised during the gag controversy are unlikely to command such attention again anytime soon.

Raise Stakes in Congressional Debate, BNA HEALTH CARE DAILY, Mar. 3, 1997; *Forty States Passed Laws to Protect Consumers Enrolled in HMOs During 1996*, 5 HEALTH CARE POLICY REP. 14, d44 (Apr. 7, 1997); *Lawmakers Begin Deliberating Omnibus Managed Care Legislation*, 5 HEALTH CARE POLICY REP. 15, d27 (Apr. 14, 1997).

[129] *See* HEALTH LAW SECTION OF THE AMERICAN BAR ASSOCIATION, *Introduction*, ACHIEVING QUALITY IN MANAGED CARE: THE ROLE OF LAW (John Blum, ed., 1997).

[130] *See Managed Care: Broader Proposals, Growing Support Raise Stakes in Congressional Debate*, BNA HEALTH CARE DAILY (Mar. 3, 1997).