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Countering Pay-for-Performance's Unintended Consequences by Rethinking the Physician's Duty to Disclose

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COUNTERING PAY-FOR-PERFORMANCE'S UNINTENDED CONSEQUENCES BY RETHINKING THE PHYSICIAN'S DUTY TO DISCLOSE

Mariah Dick

CONTENTS

I.	INTRODUCTION	403
II.	UNDERSTANDING MACRA'S KEY FEATURES AND VULNERABILITIES	405
	<i>A. Design Elements Common to All Health Care Pay-for-Performance Models</i>	405
	<i>B. MACRA's P4P Design Elements</i>	407
	<i>C. Examining MACRA's Potential Vulnerabilities to Unintended Consequences</i>	408
	1. Influenza Vaccines.....	409
	2. High Blood Pressure.....	410
	3. Sinusitis.....	412
III.	UNINTENDED CONSEQUENCES ASSOCIATED WITH PAY-FOR-PERFORMANCE COMPENSATION MODELS	413
	<i>A. Negative Effects Associated with Non-Health Care Pay-for-Performance Models</i>	413
	<i>B. Unintended Consequences Associated with Health Care P4P Models</i>	415
IV.	PHYSICIAN DISCLOSURE STANDARDS AND THEIR ROLE IN COUNTER-BALANCING P4P'S UNINTENDED CONSEQUENCES.....	418
	<i>A. Background on Informed Consent</i>	418
	<i>B. History of Informed Consent as a Legal Doctrine</i>	420
	1. The Purely Professional Standard of Physician Disclosure	421
	2. The Reasonable Patient Standard of Physician Disclosure	421
	3. Modern Standard for Physician Disclosure	423
	<i>C. Adopting the Reasonable Patient Standard of Disclosure in All Jurisdictions</i>	424
V.	CONCLUSION	427

I. INTRODUCTION

Beginning in the early 2000s, pay-for-performance compensation models started garnering more attention as more individuals expressed

dissatisfaction with the fee-for-service model then in place.¹ At the same time that pay-for-performance models began gaining traction in the health care industry, they were also being implemented in the corporate sector.²

Though researchers studying pay-for-performance models in the health care industry have focused mainly on the efficacy of these programs, a slew of scandalous headlines in the corporate sector have clued us into the inherent flaws present in the pay-for-performance compensation model. In September 2016, Wells Fargo employees, in response to an incentive compensation structure, opened millions of new customer accounts without permission.³ Wells Fargo has since eliminated the performance goals that inspired the scandal.⁴ Incentive compensation schemes, like pay-for-performance, have also been identified as a root cause of the 2008 credit crisis and the UBS tax fraud scandal.⁵ But, these ill-effects have not been relegated to the corporate sector. In 2013, thirty-five school district employees in Atlanta were indicted based on accusations that they conspired to cheat on state standardized tests.⁶ Teachers and administrators allegedly inflated scores to meet performance metrics and to receive financial rewards tied to meeting those goals.⁷

These scandals, and others like them, point to an inherent flaw present in all pay-for-performance models: though pay-for-performance models are often ineffective in achieving their stated goals, they are very effective motivators of undesirable and unethical behaviors.⁸ Reviewing the unintended effects of pay-for-performance compensation

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1. Uwe E. Reinhardt, *The Uncertainties of Pay-for-Performance*, N. Y. TIMES (Oct. 8, 2010), <https://economix.blogs.nytimes.com/2010/10/08/the-uncertainties-of-pay-for-performance/>.
 2. Lynn A. Stout, *Killing Conscience: The Unintended Behavioral Consequences of "Pay For Performance,"* 39 IOWA J. CORP. L. 525, 532 (2014).
 3. *Wells Fargo Changes Employees' Pay Structure, Incentive Plan*, THE WASH. POST (Jan. 10, 2017), https://www.washingtonpost.com/business/economy/2017/01/10/277e00ee-d751-11e6-9a36-1d296534b31e_story.html?utm_term=.152047689c92.
 4. *Id.*
 5. Stout, *supra* note 2, at 526-27.
 6. Molly Bloom, *Why Atlanta Schools are Trying Performance Pay Again*, THE ATLANTA J.-CONSORTIUM (Oct. 19, 2014), <http://www.myajc.com/news/local-education/why-atlanta-schools-are-trying-performance-pay-again/jTZ6aOeJ0msp6FLME6CrJN/>.
 7. *Id.*
 8. Roomy Khan, *There's a Problem with 'Pay for Performance,'* BUSINESS INSIDER (Oct. 12, 2016), <http://www.businessinsider.com/theres-a-problem-with-pay-for-performance-2016-10>.

models is particularly timely because the Medicare Access and CHIP Reauthorization Act of 2015 (“MACRA”) switched Medicare providers to a pay-for-performance compensation model in 2017.⁹ If this pay-for-performance compensation model in the health care sector leads to the same unintended and unethical behaviors that have occurred in the corporate and education industries, it would be wise to adopt counter-incentives aimed at re-enforcing professional values and behaviors. This Note proposes counter-incentives that should provide an effective safeguard against what appears to be the most common negative behaviors associated with pay-for-performance models.

Part II of this Note begins with an overview of MACRA. This section will explain MACRA’s key features and identify those attributes that make it vulnerable to the same types of unintended behaviors that have plagued pay-for-performance models in other industries. Part III begins with an examination of the unintended consequences associated with pay-for-performance in non-health care industries. This section will also discuss the research on unintended consequences present in non-MACRA health care pay-for-performance models, and ultimately makes the argument that the small negative consequences observed in the health care sector are symptoms of a systemic disease in pay-for-performance generally. Part IV identifies physician disclosure standards as an area of law where counter-incentives could be particularly effective in safeguarding against these negative behaviors. This section provides a brief history of the evolution of physician disclosure standards in malpractice law, before suggesting that all courts and states adopt a reasonable patient standard designed to incentivize patient-centered care and patient autonomy—even in the face of countervailing financial incentives.

II. UNDERSTANDING MACRA’S KEY FEATURES AND VULNERABILITIES

A. *Design Elements Common to All Health Care Pay-for-Performance Models*

In order to better understand MACRA’s incentives and structures, it is helpful to first understand the design elements present in most health care pay-for-performance compensation models (“P4P”). Pay-for-performance compensation models in health care aim at “improving

9. *Frequently Asked Questions: Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)*, AM. ACAD. OF FAM. PHYSICIANS (last updated Dec. 2016), <http://www.aafp.org/practice-management/payment/medicare-payment/faq.html> (last visited Mar. 20, 2017).

the quality, efficiency, and overall value of health care.”¹⁰ In theory, they accomplish these goals by providing health care providers with financial incentives for carrying out quality improvement activities and achieving more beneficial outcomes for patients.¹¹ Because P4P programs alter the way in which health care providers are paid, they are primarily payment programs as opposed to quality improvement programs.¹² Though there have been many P4P experiments in health care,¹³ all of them have the same three central design elements: 1) performance measurement, 2) incentives, and 3) transparency and consumer engagement.¹⁴

Performance measures used in P4P programs in the health care world fall into three distinct categories: 1) structure, 2) process, and 3) outcome.¹⁵ Structural measures focus on a health care provider's capacity, systems, and overarching processes.¹⁶ Process measures indicate the steps that a provider takes to maintain or improve the health of patients.¹⁷ And, outcome measures reflect the overall effect of the service rendered on the health status of patients.¹⁸ In other words, structural measures describe what a particular health care practice looks like, process measures describe what the provider actually does during a patient consultation, and outcome measures describe what happens to the patient after an encounter with the provider. P4P programs usually use a combination of structural, process, and outcome performance measures.¹⁹

The incentives associated with a P4P program can be either positive or negative.²⁰ Positive financial incentives can take a variety of forms,

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10. *Health Policy Briefs: Pay-for-Performance*, HEALTH AFFAIRS (Oct. 11, 2012), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=78.
 11. *Id.*
 12. *See id.*
 13. *Id.*
 14. *Pay for Performance—Models*, HEALTH CARE INCENTIVES IMPROVEMENT INSTITUTE, <http://www.hci3.org/thought-leadership/why-incentives-matter/pay-performance/pay-performance-models> (last visited Nov. 4, 2017).
 15. *Id.*
 16. *Types of Quality Measures*, AGENCY FOR HEALTHCARE RES. & QUALITY (Feb. 2015), <https://www.ahrq.gov/professionals/quality-patient-safety/talkingquality/create/types.html>.
 17. *Id.*
 18. *Id.*
 19. *See Pay for Performance—Models*, *supra* note 14.
 20. *Id.*

but always involve the award of additional funds as a result of provider compliance with performance measures.²¹ Negative financial incentives, however, result in a loss of income due to the provider's failure to achieve the performance objectives.²² While positive financial incentives appear more common generally, Medicare demonstrations that experimented with P4P often included negative financial incentives as well.²³

Lastly, P4P programs also, through transparency and consumer engagement activities, try to incentivize patients to choose high-quality providers.²⁴ Transparency and consumer engagement efforts focus on presenting cost and quality evidence to patients in an easy-to-understand manner so that patients will switch from low-quality providers to high-quality providers.²⁵

B. MACRA's P4P Design Elements

MACRA institutionalizes P4P concepts on a nationwide scale by requiring Medicare-eligible providers who meet certain criteria²⁶ to participate in the Merit-Based Payment Incentive System ("MIPS").²⁷ In doing so, MACRA utilizes all three of the major components of P4P programs—performance measurement, incentives, and consumer engagement and transparency.²⁸

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21. *Id.*; Courtney Baird, *Top Healthcare Stories for 2016: Pay-for-Performance*, COMM. FOR ECON. DEV. (Mar. 8, 2016), <https://www.ced.org/blog/entry/top-healthcare-stories-for-2016-pay-for-performance>.
 22. See Aaron E. Carroll, *The Problem with 'Pay for Performance' in Medicine*, N. Y. TIMES (Jul. 28, 2014), https://www.nytimes.com/2014/07/29/upshot/the-problem-with-pay-for-performance-in-medicine.html?_r=0; *Top Healthcare Stories*, *supra* note 21.
 23. See Carroll, *supra* note 22.
 24. *Pay for Performance—Models*, *supra* note 14.
 25. *Id.*
 26. See *Quality Payment Program*, CMS <https://qpp.cms.gov/> (last visited Jan. 24, 2017) [hereinafter *Quality Payment Program*](stating physicians who bill Medicare more than \$30,000 per year and who provide care for more than 100 Medicare patients a year are in the Program); see also *MIPS Overview*, QUALITY PAYMENT PROGRAM, <https://qpp.cms.gov/learn/qpp> (last visited Jan. 24, 2017)[hereinafter *MIPS Overview*].
 27. See *Quality Payment Program*, *supra* note 26; see also, *MIPS Overview*, *supra* note 26.
 28. See John Santilli & F. Randy Vogenberg, *Healthcare Decision-Making and Stakeholder Roles in the New Marketplace*, 8 AM. HEALTH & DRUG BENEFITS 15, 16-17 (2015); see also *Pay for Performance—Models*, HEALTH CARE INCENTIVES IMPROVEMENT INST. (last visited Nov. 4, 2017), <http://www.hci3.org/thought-leadership/why-incentives-matter/pay-performance/pay-performance-models>.

Physicians participating in MIPS are graded on data that they report to the Center for Medicare and Medicaid Services.²⁹ Following this reporting, providers are assessed a final score that is used to determine whether the physician receives a positive or negative financial incentive.³⁰ Under the MIPS framework, providers are graded based on their performance relative to other providers.³¹ In addition to relative grading, MIPS implements a zero-sum financial incentive system where the total dollar amount of positive financial rewards paid out to high-quality providers cannot exceed the total dollar amount subtracted from the income of low-quality providers.³² It is also possible that a provider's compensation will not be altered by his MIPS score if that provider achieves an absolutely average score.³³

The MIPS framework implemented by MACRA also relies on consumer engagement and transparency efforts to incentivize provider performance and improve overall health care quality.³⁴ Providers are assigned quality ratings that correspond to their final scores, and these quality ratings are published to the general public.³⁵ MIPS, then, is a comprehensive P4P program that rewards and penalizes providers both financially and in the public eye based on adherence to pre-determined performance measures.

C. Examining MACRA's Potential Vulnerabilities to Unintended Consequences

Though performance measures are a necessary component of all P4P compensation models, quality measures or clinical guidelines used as performance measures are particularly vulnerable to unintended

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29. See *How to Report Quality Measures for MIPS in 2017*, AM. ACAD. OF PHYSICAL MED. & REHAB. (Dec. 2016), https://www.aapmr.org/docs/defaultsource/qualitypractice/mips_2017qualitymeasures_1212b74c36bb7f361518d86ff0000187796.pdf?sfvrsn=0.
30. See 42 C.F.R. § 414.1405 (2016).
31. Charles Saunders, *Optimizing Financial Performance Under Value-Based Care*, HEALTHCARE FIN. MGMT. ASS'N (Oct. 2, 2017), http://www.hfma.org/Leadership/Archives/2017/October/Optimizing_Financial_Performance_Under_Value-Based_Care/.
32. See 42 C.F.R. § 414.1405 (2016).
33. *Id.*
34. See 42 C.F.R. § 414.1335 (2016); Quality Payment Program, *10 FAQs about the Merit-Based Incentive Payment System (MIPS)*, SAIGNITE (Oct. 2016), <http://www.saignite.com/resources/faq-about-merit-based-incentive-payment-mips> [hereinafter Saignite].
35. Saignite, *supra* note 34.

consequences.³⁶ An examination of some of MACRA's quality measures demonstrates their potential pitfalls. Though the quality measures are usually supported by clinical evidence, these guidelines are not infallible, and there are reasonable clinical alternatives that providers, without MACRA's incentives, may choose to use instead, were MACRA not providing them a reward to do otherwise. Pointing out alternative clinical options to those incentivized by the P4P program demonstrates one potential ill-effect: that providers will adhere to guidelines despite the existence of reasonable alternatives that a patient might prefer.

1. Influenza Vaccines

Figure 1, below, shows an example of one of the preventive screening measures used as a performance measure by MIPS. It requires physicians to report either the percentage of patients six months and older who received an influenza vaccine during an appointment between October 1 and March 31, or the percentage of those patients who reported that they had previously received the influenza vaccine.³⁷

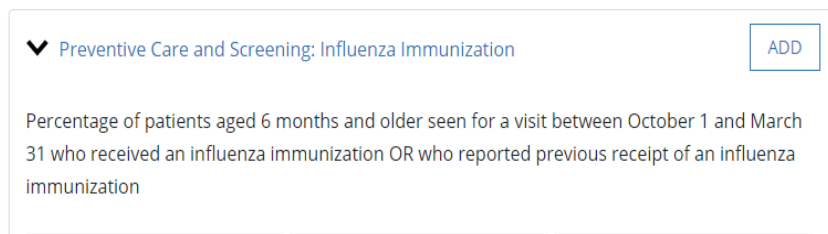


Figure 1: *Influenza Immunization*. Merit-Based Incentive Payment System, 81 Fed. Reg. 77,008, 77,686 (Nov. 4, 2016) (to be codified at 42 CFR Parts 414 and 495).

Physicians who choose to report this quality measure³⁸ have an incentive to ensure that their patients choose to be vaccinated against the flu. However, many patients choose to forego the flu vaccine each season for a wide variety of reasons.³⁹ And, despite providing patients

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36. See Louise C. Walter et al., *Pitfalls of Converting Practice Guidelines Into Quality Measures: Lessons Learned from a VA Performance Measure*, 291 J. AM. MED. ASS'N. 2466, 2466 (2004).
37. Merit-Based Incentive Payment System, 81 Fed. Reg. 77,008, 77,686 (Nov. 4, 2016) (to be codified at 42 CFR Parts 414 and 495).
38. For the 2017 reporting period, providers must select six quality measures to submit data on, including at least one outcome measure. See 42 C.F.R. § 414.1335 (2016).
39. See Rae Ellen Bichell, *Many Americans Believe They Don't Need the Flu Vaccine*, NPR (Nov. 27, 2015), <http://www.npr.org/sections/health->

with a number of excellent reasons to be vaccinated, no doctor can force a patient to be vaccinated if the patient chooses not to be.⁴⁰

Considering that 38 percent of those polled during the 2015 flu season indicated that they would not get the influenza vaccine, it stands to reason that doctors who choose to report this quality metric could be faced with patients who refuse to comply with their recommendation that they receive the vaccine.⁴¹ While physicians are afforded a choice as to which measures they report, it is possible that a physician will not know whether they are treating a particularly non-compliant or compliant patient population ahead of selecting their quality measures. And, if a high enough percentage of patients are non-compliant with a particular physician's recommendation, that physician could receive less compensation due to his patient's choices. This potential outcome provides a strong incentive for the physician to do whatever he can to influence his patient's clinical choices.

2. High Blood Pressure

Figure 2, below, shows another quality measure adopted as a performance measure through MACRA. This particular measure requires physicians to report the percentage of patients eighteen and older who were screened for high blood pressure annually, and who had a follow-up plan based on their blood pressure reading documented in their medical record.⁴²

*	N/A/317	22v 5	Communit y/Populati on Health	Claims, Registry, EHR	Process	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented: Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Centers for Medicare & Medicaid Services
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Figure 2: Preventive Screening for High Blood Pressure. Merit-Based Incentive Payment System, 81 Fed. Reg. 77,008, 77,618 (Nov. 4, 2016) (to be codified at 42 CFR Parts 414 and 495).

The U.S. Preventive Task Force, however, does not recommend that the follow-up take place in a clinical setting;⁴³ instead, its guidelines

shots/2015/11/27/456202280/many-americans-believe-they-dont-need-the-flu-vaccine.

40. *Schloendorff v. Soc'y of N.Y. Hospital*, 105 N.E. 92, 93 (N.Y. 1914) (overruled on other grounds).

41. Bichell, *supra* note 39.

42. Merit-Based Incentive Payment System, 81 Fed. Reg. 77,008, 77,618 (Nov. 4, 2016) (to be codified at 42 C.F.R. pts. 414 and 495).

43. Comments and responses to comments on this measure during the rulemaking process clearly indicated that CMS believes the follow-up

recommend that a diagnosis of high blood pressure be confirmed in the patient's home through the use of home-testing.⁴⁴ The quality metric, however, by requiring physicians to document a follow-up plan in the patient's medical record, incentivizes physicians to require in-office testing and follow-through. Physicians who choose to implement at-home testing and follow-ups, as recommended by the U.S. Preventive Task Force may lack the documentation required to meet the metric. Additionally, patients are known to be especially non-compliant when it comes to showing up for follow-up appointments and follow-up testing.⁴⁵ Nonetheless, this quality measure incentivizes physicians to increase in-office follow-ups, despite other experts' recommendations to the contrary. Physicians who treat patients that choose not to set follow-up appointments may see their compensation decline and their reputation damaged because of their patients' non-compliance. This potential outcome encourages physicians to tell patients that follow-ups must be done in the office, despite the existence of an alternate clinical method that the patient would probably prefer. This is a small example of the type of unethical behavior that MACRA, as a pay-for-performance model, incentivizes. But, when aggregated, these small unethical behaviors, if left unchecked, represent a serious incursion and disrespect for patient autonomy and the right of patients to participate in their decisions regarding their care.

The main difficulty with MACRA's performance measures is that they tend to measure physician performance based on patient compliance. While physicians are incentivized to achieve certain outcomes, patients receive no additional incentive to comply. It is well-established that patient outcomes are the best when patients are effectively involved in the decision-making process.⁴⁶ Indeed, "patients who have more knowledge, skill, and confidence in managing their health, and who are more adept at navigating and using the health care system" often experience significantly lower health care costs as well as better health outcomes.⁴⁷ But, a system that merely supplies physicians

should take place in the office, though the language of the measure does not explicitly state as much. *See id.* at 77,208.

44. *See* Albert L. Siu, *Screening for High Blood Pressure in Adults: U.S. Preventative Services Task Force Recommendation Statement*, 163 ANN. INTERN. MED. 778, 781 (Nov. 2015) (recommending blood pressure testing that is outside of a clinical setting).
45. *See* Barron H. Lerner, *When Patients Don't Follow Up*, N. Y. TIMES (Nov. 13, 2014), http://well.blogs.nytimes.com/2014/11/13/when-patients-dont-follow-up/?_r=0.
46. Judith H. Hibbard & Jessica Greene, *What the Evidence Shows About Patient Activation: Better Health Outcomes and Care Experiences; Fewer Data on Costs*, 32 HEALTH AFFAIRS 207, 208-09 Page (Feb. 2013).
47. *Id.*

with a small set of narrow performance measures that they have to adhere to or suffer a penalty incentivizes physicians to work around patients instead of with them.⁴⁸

3. Sinusitis

Figure 3, below, shows two quality measures related to the treatment of sinusitis (sinus infections) in adults. The performance measures incentivize physicians 1) to wait ten days after the onset of symptoms before prescribing an antibiotic, and 2) to prescribe Amoxicillin or Augmentin if a patient still has symptoms after ten days.⁴⁹

331	N/A	Registry, Measures Groups	Efficiency and Cost Reduction	Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Overuse): Percentage of patients, aged 18 years and older, with a diagnosis of acute sinusitis who were prescribed an antibiotic within 10 days after onset of symptoms
332	N/A	Registry, Measures Groups	Efficiency and Cost Reduction	Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use) Percentage of patients aged 18 years and older with a diagnosis of acute bacterial sinusitis that were prescribed amoxicillin, with or without clavulanate, as a first line antibiotic at the time of diagnosis

Figure 3: Adult Sinusitis. Merit-Based Incentive Payment System, 81 Fed. Reg. 77,008, 77,624 (Nov. 4, 2016) (to be codified at 42 CFR Parts 414 and 495).

Patients are often unwilling, or unable to wait ten days before receiving relief from severe cold and flu symptoms.⁵⁰ And, clinical knowledge that antibiotics are unnecessary for treating colds, earaches, and most sinus infections, does little to dissuade patients from desiring a quick resolution to their ailment that will allow them to return to work and their lives sooner.⁵¹ The guideline imposing a wait period on the prescription of antibiotics, if followed, will likely lead to a high number of unhappy patients who, when filling out patient experience surveys, may believe they were given low-quality care when, in reality,

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48. Judith H. Hibbard et al., *Does Compensating Primary Care Providers to Produce Higher Quality Make them More or Less Patient Centric?*, 72MED. CARE RES. & REV. 481, 491-92 (2015).
 49. Merit-Based Incentive Payment System, 81 Fed. Reg. 77,008, 77,624 (Nov. 4, 2016) (to be codified at 42 C.F.R. pts. 414 and 495).
 50. Kristine Crane, *Do You Really Need that Antibiotic?*, U.S. NEWS & WORLD REP. (Jun. 9, 2014), <http://health.usnews.com/health-news/patient-advice/articles/2014/06/09/do-you-really-need-that-antibiotic>.
 51. *Id.*

they received high-quality care. This is worrisome because it presents a no-win situation for the provider. If he prescribes antibiotics sooner than the measure allows in order to meet the patient's expectation of clinical care, his pay may be docked for non-compliance. But, if he adheres to the quality measure, then the patient may give him a negative review that could also damage his livelihood.

On the other hand, the path is not any easier for physicians who elect to follow the prescribing guidelines. One study found that 94 percent of patients who believe they are allergic to penicillin (or amoxicillin, penicillin's close relative) actually have no allergy to penicillin, or its cousins, at all.⁵² But, patients who have gone their entire lives believing that they are deathly allergic to the drug may be unwilling to undergo allergy testing or to try a distant relative of the drug for fear of a severe allergic reaction.⁵³ This measure, then, represents another clinical situation in which performance measures, for better or worse, incentivize physicians to work against patient choices and preferences—a hard road for the physician to travel and another possible incentive for engaging in unethical behavior.

III. UNINTENDED CONSEQUENCES ASSOCIATED WITH PAY-FOR-PERFORMANCE COMPENSATION MODELS

A. *Negative Effects Associated with Non-Health Care Pay-for-Performance Models*

Research suggests that individuals who have a pre-existing and internal motivation to engage in an activity become less motivated when extrinsic motivators (like financial incentives) are introduced.⁵⁴ This research is important in the pay-for-performance context because it indicates that financial incentive schemes designed to encourage high-quality work performance are ineffective in producing the desired behavior outcome, but very effective in producing an undesired behavioral change.

Researchers studying the effect of P4P compensation models on employee behavior in the corporate sector have determined that these

52. *Allergic to Penicillin? You're Probably Not*, NBC NEWS (Nov. 7, 2014), <http://www.nbcnews.com/health/health-news/allergic-penicillin-youre-probably-not-n243161>.

53. *Id.*

54. See Edward L. Deci, Richard Koestner & Richard Ryan, *A Meta-Analytic Review of Experiments Examining the Effects of Extrinsic Rewards on Intrinsic Motivation*, 125 PSYCHOL. BULL. 627, 653 (1999); Michael D. Hanus & Jesse Fox, *Assessing the Effects of Gamification in the Classroom: A Longitudinal Study on Intrinsic Motivation, Social Comparison, Satisfaction, Effort, and Academic Performance*, 80 COMPUTERS & EDUC. 152, 159 (2015).

payment structures increase the intensity of work.⁵⁵ This increase in intensity tends to correspond with poor workplace attitudes and a general feeling of unfairness as employees feel increased pressure to perform at the same time that they feel inadequately compensated for their efforts.⁵⁶ These types of workplace attitudes played out with disastrous results at Wells Fargo.⁵⁷ In that setting, “hourly targets, fear of being fired and bonuses kept employees selling even when the bank started cracking down on abuses.”⁵⁸ Despite organizational indicators that employees should abandon the incentivized behaviors, the misbehaviors continued until the incentives were actually removed.⁵⁹

Additionally, psychology studies have found that providing extrinsic rewards, like financial rewards, had a negative effect on behavior overall.⁶⁰ Studies focusing on classroom behavior found that using extrinsic rewards and incentives decreased students’ levels of intrinsic motivation, satisfaction, and empowerment that ultimately resulted in declining test scores.⁶¹ The same study suggests that providing rewards for behaviors that individuals already find valuable or interesting without the reward, causes individuals to feel controlled, less satisfied with the activity, and less motivated in general.⁶² These findings are important because they suggest that pay-for-performance models that provide extrinsic financial rewards likely decrease the employee’s desire to engage in the incentivized conduct on its own merits. Instead of engaging in the conduct to attain an intrinsic value, like altruism or interest, the intrinsic value associated with the conduct falls away leaving only the profit motivation.⁶³ It is this self-interested profit motivation that, when left unchecked, creates the opportunistic

55. Chidiebere Ogbonnaya, Kevin Daniels & Karina Nielsen, *Does Contingent Pay Encourage Positive Employee Attitudes and Intensify Work?*, 27 HUM. RESOURCE MGMT. J. 94, 109 (2017).

56. *Id.*

57. Khan, *supra* note 8.

58. *Id.* at 2.

59. *Id.*; *Wells Fargo Changes Employees’ Pay Structure, Incentive Plan*, *supra* note 3.

60. *See generally* Deci et. al., *supra* note 54.

61. Hanus, *supra* note 54, at 159.

62. *Id.*

63. *See id.*; *see also* Aaron E. Carroll, *The Problem with ‘Pay for Performance’ in Medicine*, N. Y. TIMES (Jul. 28, 2014), https://www.nytimes.com/2014/07/29/upshot/the-problem-with-pay-for-performance-in-medicine.html?_r=0.

and unethical behavior demonstrated in the Wells Fargo and Atlanta public school scenarios.⁶⁴

These behavior modifications, if they occur in health care as a result of the financial rewards created by physician pay-for-performance compensation models could have disastrous results for the health of patients and their autonomy.

B. Unintended Consequences Associated with Health Care P4P Models

Studies of health care P4P compensation models suggest that these types of unsavory and unintended behaviors are not only present in the corporate sector. When physicians receive financial incentives to adhere to clinical quality measures, they are quickly frustrated by non-compliant patient behaviors, resulting in an increased inclination to bypass established informed consent procedures, one of the most important safeguards of patient autonomy.⁶⁵

A study of Californian and United Kingdom (UK) physicians participating in a P4P program conducted in 2009 found that the quality-based payment program had negative effects on the patient-physician relationship.⁶⁶ In some cases, physicians suggested that non-compliant patients find another provider so that the physician's score would not suffer.⁶⁷ The study confirms that participation in the program "appeared to increase pressure to cajole and persuade patients to secure their compliance."⁶⁸ Other physicians in the study reported accusing patients of hurting their ratings and being dishonest with about their financial interest in patient compliance with a prescribed treatment plan.⁶⁹

Additionally, in the same study, in order to meet chlamydia screening targets, some physicians bypassed informed consent altogether.⁷⁰ Instead of informing patients about the screening, physicians simply requested a urine sample, did not inform patients why they were requesting a urine sample, and ran the test without the patient's permission.⁷¹ A physician who admitted to bypassing informed

64. See Tamara C. Bellifanti, *Beyond Economics in Pay for Performance*, 41 HOFSTRA L. REV. 91, 134-35 (2014); Stout, *supra* note 2, at 534.

65. Hibbard et al., *supra* note 48, at 483; McDonald et al., *Pay for Performance in Primary Care in England and California: Comparison of Unintended Consequences*, 7 J. HEALTH SERV. RES. & POL. 121, 123-24 (2009).

66. McDonald et al., *supra* note 65, at 123.

67. *Id.* at 123.

68. *Id.*

69. *Id.*

70. *Id.* at 123-24.

71. See *id.* at 124.

consent in this manner stated that his office originally sent out letters to patients informing them that they were overdue for the chlamydia screen.⁷² But, out of a few hundred letters sent to patients, only about five patients total responded to the letter and scheduled an appointment to receive the necessary screening.⁷³ Consequently, the physician bypassed informed consent procedures in order to shore-up his own quality rating and the quality-rating of his medical group.⁷⁴ Though patients suffered no bodily injury as a result of this physician's actions, his choices still harmed the patient because he took away the patient's opportunity to consent to the diagnostics. The physician's actions are particularly dangerous because he knew that his patients did not want that particular screening. If they did, they could have, and probably would have, responded to the mailing notifying them that the test was available.

When a physician has reason to know what the patient wants—either from the patient directly, or through circumstances of which the physician is aware—and acts contrary to the patient's known wishes, he violates the patient's right of self-designation and autonomous choice that was established in *Schloendorff v. Soc'y N.Y. Hospital* when Justice Cardozo, laying the groundwork for modern informed consent malpractice claims, wrote that “[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body.”⁷⁵

A second study conducted in Minnesota found that primary care physicians, when faced with the implementation of a quality-based payment program, were least likely to focus their efforts on improving patient engagement and patient involvement in treatment planning.⁷⁶ The physicians who participated in the study reported that one of the factors causing the most frustration was “the fact that patients' lifestyle behaviors influenced their salaries.”⁷⁷ Indeed, 70 percent of the physicians who participated in the study viewed patient behavior as a significant obstacle to improving their quality metrics.⁷⁸ One physician reported his frustration that “[y]ou can't make people come in. You can't make them eat healthy, stop smoking, take their medication. But you can be punished as a physician if your numbers don't look good.”⁷⁹

72. *Id.*

73. *Id.*

74. *See id.*

75. *Schloendorff*, 105 N.E. at 93.

76. Hibbard et al., *supra* note 48, at 487.

77. *Id.* at 490.

78. *Id.*

79. *Id.* at 491.

Additionally, the study found that those physicians who focused on patient activation and engaging patients in the decision-making process reported the most frustration with patient behavior.⁸⁰

A systematic review of the literature surrounding the United Kingdom's health care pay-for-performance model found that the program encouraged physicians to focus inappropriately on those aspects of patient care that were rewarded.⁸¹ The study goes on to note that this clinical tunnel vision caused quality of care to decline for those conditions that did not have incentives attached to them.⁸²

Studies of the UK program also indicate that providers are increasingly experiencing competing agendas.⁸³ The provider has one agenda created by desire to adhere to performance measures and the patient has another agenda related to their personal health.⁸⁴ One physician described the competing agendas this way: "[a]nd there have been 1 or 2 occasions where I went through the cholesterol, the depression, the CHD, and everything else, and 'Oh, that's wonderful, I'm finished now,' and the patient said 'Well, what about my foot then?' 'What foot?'"⁸⁵ Some of the physicians interviewed also indicated that they were less willing to give patients what they want and were less willing to accept a patient's refusal of recommended treatments.⁸⁶ While most doctors indicated that they would not pursue the measures if they thought they would be bad for the patient, other physicians indicated that they experienced a tension between doing what was best for the patient and doing what the indicator required of them.⁸⁷ Overall, studies of the UK pay-for-performance compensation model indicate that the clinician-patient relationship was decidedly altered by the implementation of the program and that the alterations were not always positive.⁸⁸

These studies reveal the tension that providers feel between adhering to traditional professional values and following performance

80. *Id.* at 491-92.

81. Martin Roland & Stephen Campbell, *Successes and Failures of Pay for Performance in the United Kingdom*, 370 *NEW ENG. MED. J.* 1944, 1947 (2014).

82. *Id.*

83. Stephen M. Campbell, Ruth McDonald & Helen Lester, *The Experience of Pay for Performance in English Family Practice: A Qualitative Study*, 6 *ANNALS FAM. MED.* 228, 231 (2008).

84. *Id.*

85. *Id.*

86. *See id.* Interviewed physicians also emphasized that the patient's wishes ultimately comes first.

87. *Id.*

88. *See id.* at 233.

measures associated with financial incentives. Though the health care industry has yet to experience the kinds of devastating consequences experienced in other industries, the indicators of additional unethical behavior are present in health care. For example, Wells Fargo's incentive program was based on the idea that employees should be rewarded for reaching sales targets.⁸⁹ On the surface, such a plan appears innocuous. But, soon one employee casts aside ethical principles and opens an account without a customer's permission, and then someone else did the same thing, and before you know it, employees harmed millions of consumers with their fraudulent scheme.⁹⁰

In health care, the building blocks for this type of behavior are already present. At least one doctor ran hundreds of chlamydia screenings without patient permission.⁹¹ Providers are forgetting that patients have their own agendas and values associated with health care services.⁹² And, as a result, the provider-patient relationship is being altered in a way that minimizes patient involvement in the care and decision-making processes.

IV. PHYSICIAN DISCLOSURE STANDARDS AND THEIR ROLE IN COUNTER-BALANCING P4P'S UNINTENDED CONSEQUENCES.

A. *Background on Informed Consent*

Informed consent, as a legal requirement in all American jurisdictions, is composed of the following legal duties: physicians must 1) disclose medical and treatment information to patients, and 2) obtain the patient's consent before administering treatment.⁹³ Though specific jurisdictions may impose different requirements, the legal requirement of informed consent is usually considered to be met so long as physicians inform patients of "[1] the nature, purpose, risks and benefits of any treatment they propose to perform, . . . [and 2)] any alternative forms of treatment that may exist for the patients' conditions."⁹⁴

89. Nick Clements, *The Wells Fargo Reminder: Incentives Can Be Dangerous*, FORBES (Sep. 27, 2016), <https://www.forbes.com/sites/nick-clements/2016/09/27/the-wells-fargo-reminder-incentives-can-be-dangerous/#402d03023d13>.

90. *Id.*; see also Matt Egan, *5,300 Wells Fargo Employees Fired Over 2 Million Phony Accounts*, CNN: CNN MONEY (Sept. 9, 2016), <http://money.cnn.com/2016/09/08/investing/wells-fargo-created-phony-accounts-bank-fees/index.html>

91. McDonald et al., *supra* note 65, at 124.

92. See Campbell, *supra* note 83, at 231.

93. JESSICA W. BERG ET AL., *INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE* 12 (2nd ed. 2001).

94. *Id.*

Physicians receive extensive training before being licensed to practice medicine in the United States. Patients rely on their physician's medical knowledge in order to make informed decisions regarding their care. And, informed consent has traditionally been viewed as a method of protecting patients from abuse by physicians who act contrary to the patient's best interests.⁹⁵ By protecting patient autonomy and autonomous choice, informed consent allows patients to safeguard their own well-being and welfare.⁹⁶ Deriving its roots from ethical theory and the civil and criminal laws of assault and battery, informed consent protects the bodily integrity and individual autonomy of patients.⁹⁷

A patient's autonomy is protected when he is given the opportunity to make educated decisions regarding his health and well-being.⁹⁸ But, because it is not possible for every individual to possess, independently, the specialized medical knowledge required to make informed health choices, patients must rely on physician expertise when making their decisions. This reliance allows physicians to remain in control of the patient-physician relationship, setting its tone, and controlling the content of consultations.⁹⁹ As a result, if a physician decides to withhold information regarding risks, benefits, or alternate therapies, the patient is unable to make a truly informed decision and his autonomy is undermined.

Unfortunately, not all patients are comfortable interacting with doctors and advocating for a particular treatment plan.¹⁰⁰ And, giving patients free-reign to determine their own course of treatments would undoubtedly lead to higher healthcare costs. But, patients need not be given the ability to demand whatever treatments they want in order to support patient autonomy and empowerment. Supporting patient autonomy does not have to mean sky-rocketing costs, nor does it have to mean forcing those who are uncomfortable advocating for themselves (due to lack of knowledge, confidence, etc.) to do so. Instead, it means ensuring that all patients have the option of making their own informed decisions regarding their medical care instead of having to accept, without question, their physician's recommendations.

95. *Id.* at 20.

96. *Id.*

97. *Id.* at 11.

98. *See id.* at 240-42.

99. *See id.* at 161.

100. *See* Elizabeth Renter, *6 Ways to Be Your Own Health Advocate*, U.S. NEWS & WORLD REPORT (Feb. 2, 2015), <http://health.usnews.com/health-news/patient-advice/articles/2015/02/02/6-ways-to-be-your-own-health-advocate>.

B. History of Informed Consent as a Legal Doctrine

Informed consent, as a legal doctrine in the United States, has its roots in the tort theories of assault and battery.¹⁰¹ In 1914, in his opinion in *Schloendorff v. Soc'y of N.Y. Hosp.*, Justice Cardozo wrote that “[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent, commits an assault, for which he is liable in damages.”¹⁰² It was not until 1960 that courts began to look towards the tort theory of negligence as an alternate foundation for the doctrine of informed consent.¹⁰³ In one of the first cases to adopt the theory of negligence, the Kansas Supreme Court recognized that physicians have a duty to disclose the same information that a “reasonable medical practitioner would make under the same circumstances.”¹⁰⁴ And, while the court in that case stated that determining what constituted a suitable disclosure was largely a question for medical judgment, it also acknowledged that physicians have a duty to disclose potential risks associated with the physician’s proposed treatment plan.¹⁰⁵

In 1972, the California Supreme Court seized upon the Kansas Supreme Court’s decision in *Natanson*, and explained that most courts treated a failure to secure informed consent to a medical treatment as a violation of the physician’s professional duty of due care.¹⁰⁶ Viewing a failure to obtain informed consent as the dereliction of a professional duty fits it squarely within the purview of a negligence theory of tort liability because it corresponds exactly to the first element of any negligence claim.¹⁰⁷ The negligence theory was applied by courts in instances where a previously undisclosed potential risk of an appropriate treatment ultimately occurred.¹⁰⁸ The California Supreme Court held that the battery theory of liability should be reserved for those instances in which the patient consents to one treatment and receives a different treatment altogether or instances in which there is no consent to treatment at all.¹⁰⁹ Under this theory of informed consent

101. ARNOLD J. ROSOFF, *INFORMED CONSENT: A GUIDE FOR HEALTH CARE PROVIDERS*, 1 (1981).

102. *Schloendorff*, 105 N.E. at 93..

103. *See* *Cobbs v. Grant*, 502 P.2d 1, 8 (Ca. 1972). *See also*, *Natanson v. Kline*, 350 P.2d 1093, 1101 (1960).

104. *Natanson*, 350 P.2d at 1106.

105. *Id.*

106. *Cobbs*, 502 P.2d at 8.

107. *Id.*

108. *Id.*

109. *Id.*

malpractice, all jurisdictions originally adopted the purely professional standard of disclosure.¹¹⁰

1. The Purely Professional Standard of Physician Disclosure

Under the purely professional standard, a physician is only required to disclose those alternatives to a proposed treatment that are generally recognized and accepted by reasonably prudent physicians.¹¹¹ Thus, the purely professional standard allows the medical community to self-select the information that must legally be disclosed to a patient regarding treatment risks, benefits, and alternatives.¹¹² In *Culbertson v. Mernitz*, for example, a patient with cervical fibroid tumors underwent surgery for treatment, but the physician did not inform the patient that the surgery could cause her cervix to adhere to the wall of her vagina.¹¹³ The undisclosed risk actually occurred and as a result the patient had to have both ovaries removed.¹¹⁴ The court in *Culbertson* determined that the physician's non-disclosure did not constitute a failure to comply with the purely professional standard of disclosure because a medical review panel at the physician's hospital determined that it was not a risk usually disclosed by local physicians.¹¹⁵ Though the patient in *Culbertson* suffered a serious injury that could have been avoided with the choice of an alternate treatment method, the patient was not given enough relevant facts so that she could properly choose one type of surgery over another. But, because it was not common practice for physicians to disclose that particular risk before operating, the patient was unable to recover. This case demonstrates the dangers of the purely professional standard of disclosure—poor habits by physicians that undermine informed choice and patient autonomy can legally be allowed to continue so long as enough physicians have the same poor habits.

2. The Reasonable Patient Standard of Physician Disclosure

In the early 1970s, some jurisdictions began to question the wisdom of the purely professional standard and instead adopted a reasonable

110. *Id.* at 9; David M. Studdert, et al., *Geographic Variation in Informed Consent Law: Two Standards for Disclosure of Treatment Risks*, 4 J. EMPIRICAL LEGAL STUD. 103, 104 (2007).

111. *See e.g.*, GA. CODE ANN. § 31-9-6.1(a)(5)(LexisNexis 2017); *Culbertson v. Mernitz*, 602 N.E.2d 98, 100 (In. 1992); *Cobbs*, 502 P.2d at 9; *Canterbury v. Spence*, 464 F.2d 772, 783 (D.C. Cir. 1972).

112. *See Canterbury*, 464 F.2d at 783; Rosoff, *supra* note 101, at 34-35.

113. *Culbertson*, 602 N.E.2d at 99.

114. *Id.*

115. *Id.* at 104.

patient standard of disclosure.¹¹⁶ Based on the notion that “the patient’s right of self-decision shapes the boundaries of the duty to reveal,” the court in *Canterbury* decided that the physician’s communications to the patient must be determined based on the patient’s need.¹¹⁷ Thus, under the reasonable patient standard adopted in *Canterbury* and *Cobbs*, the physician has a duty to disclose all of the information that is relevant to a patient’s meaningful choice regarding treatment.¹¹⁸ A physician, therefore, has the duty to disclose all information that is material to the patient’s decision so that the patient can weigh the risks of the proposed treatment against his or her “subjective fears and hopes.”¹¹⁹

The reasonable patient standard expands physician disclosure standards substantially. It requires physicians to disclose not only all the material risks of a recommended invasive treatment, but also the risks and benefits of not recommended, but reasonable, noninvasive treatments, diagnostics, and other forms of clinical care.¹²⁰ *Jandre v. Wis. Injured Patients & Families Comp. Fund* provides a clear picture of the desirability of this standard.

In *Jandre*, a patient presented to the emergency room with symptoms that could be either Bell’s palsy or stroke.¹²¹ The physician treating the patient performed a series of diagnostic tests before diagnosing the patient with Bell’s palsy.¹²² A few days later, the patient suffered a stroke that could have been detected at the time of his emergency room visit had the physician used an alternate diagnostic tool.¹²³ At the time of the emergency room visit, the physician did not inform the patient of the existence of an alternate and more reliable diagnostic tool that could more conclusively rule out the possibility of a stroke.¹²⁴ The court held that the physician breached her duty to disclose when she failed to inform the patient of the existence of an alternate diagnostic tool because she had reason to know that the patient would value that information in making decisions about his clinical care.¹²⁵

116. Studdert et al., *supra* note 110, at 104-05.

117. *Canterbury*, 464 F.2d at 786-87.

118. *Cobbs*, 502 P.2d at 9-10; *Canterbury*, 464 F.2d at 787.

119. *See Cobbs*, 502 P.2d at 9-10.

120. *See Allen v. Harrison*, 374 P.3d 812, 817 (Okla. 2016); *see also Jandre v. Wis. Injured Patients & Families Comp. Fund*, 813 N.W.2d 627, 636 (Wisc. 2012).

121. *Jandre*, 813 N.W.2d at 634.

122. *See id.*

123. *Id.*

124. *Id.*

125. *Id.* at 666.

3. Modern Standard for Physician Disclosure

Though support for the reasonable patient standard initially grew quickly, only about half of the states have adopted that standard.¹²⁶ The other half of the states retained the purely professional standard.¹²⁷ According to one study, in those states that apply the reasonable patient standard of disclosure, plaintiffs were significantly more likely to prevail in their informed consent cases.¹²⁸ The authors of the study indicate that “cases with very similar clinical facts” are decided differently depending on the jurisdiction in which the suit is brought.¹²⁹ While attorneys are used to the legal variations that exists in different states, the authors suggest that this kind of geographic variation sends mixed messages to physicians about their legal obligations and may prevent the medical community from effectively implementing standardized disclosure guidelines.¹³⁰ For example, the Ethics Manual published by the American College of Physicians follows the purely professional standard, even though it is undoubtedly used in jurisdictions that apply the reasonable patient standard.¹³¹ This text instructs physicians to disclose potential alternative treatments to the patients, but it does not suggest that physicians may have a duty to disclose treatment options that the physician does not actually recommend.¹³² Physicians who rely

126. Studdert et al., *supra* note 110, at 105-06.

127. *Id.* The authors of the geographical study indicate that Colorado and Georgia have adopted standards that are not easily categorized as either a purely professional or reasonable patient standard. D.C. adopted the reasonable patient standard. *Id.* at 105.

128. *Id.* at 103, 120.

129. *Id.* at 121.

130. *Id.*

131. See AM. C. OF PHYSICIANS, ACP ETHICS MANUAL (6th ed., 2011), <https://www.acponline.org/clinical-information/ethics-and-professionalism/acp-ethics-manual-sixth-edition-a-comprehensive-medical-ethics-resource/acp-ethics-manual-sixth-edition#disclosure>.

Though the manual notes that any “information that is essential to and desired by the patient must be disclosed,” the manual does adopt the purely professional standard because the onus is placed on the patient to request additional information or to make their specific wishes known to the physician. For example, the manual states that the “practice of informed consent rel[ies] on patients to ask questions when they are uncertain about the information they receive.” This practice is in contrast to the patient-centered standard which requires physicians to make a complete and full disclosure based on their patient’s values and places the onus on the physician to be sure that the patient understood the risks and benefits of the procedure as well as the availability of any alternative treatment options. *Id.*

132. See *id.*

on this resource to outline their ethical obligations to their patients may end up ignoring their legal obligations of disclosure.

C. Adopting the Reasonable Patient Standard of Disclosure in All Jurisdictions

In light of the types of unintended behavioral consequences regularly associated with pay-for-performance compensation models, and in order to counter-balance MACRA's probable effects and therefore preserve patient autonomy, all jurisdictions should adopt the reasonable patient standard of physician disclosure. Adhering to the purely professional standard, because of its reliance on professional consensus, is likely to perpetuate the ill behavioral effects of the pay-for-performance model.

Adopting the reasonable patient standard would require physicians to disclose all methods of clinical intervention—and their attendant risks and benefits—that are medically reasonable and appropriate given the patient's condition.¹³³ The duty to disclose would not be triggered only by invasive procedures, but also by noninvasive treatments or procedures.¹³⁴ The reasonable patient standard of disclosure, in part because it is divorced from the norms present within the medical community, requires physicians to consider patient's individual circumstances and values. This emphasis on individual patient circumstances encourages physicians to think about patients as people instead of as clinical conditions.¹³⁵ Evidence from the UK's pay-for-performance physician compensation program indicates that shortly after the introduction of a P4P model in health care, physicians are more likely to focus on checking boxes, prescribing the indicated medication, and are significantly less likely to spend time counseling patients.¹³⁶ Adopting a disclosure standard that requires physicians to learn what their patients value in order to avoid an increased risk of liability should effectively counter this kind of unintended effect associated with P4P programs.

The danger of financially incentivizing physicians to adhere to a government-issued standard of care is that physicians may be less inclined to disclose the existence of alternative treatments to patients, especially given that alternative treatments would no longer be simply

133. *Jandre v. Wis. Injured Patients & Families Comp. Fund*, 813 N.W.2d 627, 636 (Wis. 2012).

134. *See id.*

135. *Id.* at 818.

136. *See* Kath Checkland, et al., *Biomedicine, Holism, and General Medical Practice: Responses to the 2004 General Practitioner Contract*, 30 SOC. HEALTH & ILLNESS 788, 800 (2008) (discussing the increased prevalence of the biomedical model of health at the expense of the holistic model of health).

alternative; instead, alternative treatments, were they to be selected, would represent a clear deviation from the prevalent standard of care.

The MACRA payment scheme means that physicians are incentivized to adhere to certain treatment standards developed and implemented by the government. The quality measures, and the obligation of physicians to adhere to those quality measures, replaces independent physician judgment. From the administrative perspective, replacing independent medical judgment with uniform quality standards can only be a positive—it will standardize the care that patients receive and it will increase the quality of care received by patients.

Informed consent and the duty to disclose currently play a strong role in protecting patient autonomy and encouraging the patient-physician relationship to be interactive.¹³⁷ Indeed, informing the patient of “alternatives to the recommended treatment is crucial to medical decision making.”¹³⁸ And, while physicians should inform the patient of the medical treatment that is medically preferable, a patient may choose an alternative treatment based on “values, preferences, goals, and needs.”¹³⁹ A patient is under no obligation to choose the medically superior treatment or to agree to any treatment whatsoever.¹⁴⁰

Under MACRA, however, physicians run the risk of decreasing their compensation if the patient elects a non-standard option. Therefore, physicians have a significant financial incentive to ensure that all of their patients select the standard treatment option. It stands to reason, therefore, that physicians have a strong incentive to bypass informed consent procedures or coerce patients to comply with a specific treatment option that the patient may have otherwise refused. While existing medical malpractice laws provide some deterrence to physicians, if a physician who conducts himself in this way happens to live in one of the states that still applies the purely professional standard of physician disclosure, it is unclear that, in the event that patient suffers an injury, that the patient will be able to prevail in his medical malpractice suit since the purely professional standard affords such a high degree of discretion to the medical community in determining what must legally be disclosed to a patient.

Evidence of the unintended consequences associated with pay-for-performance in other industries is particularly relevant to this point. Unethical behavior by one individual participating in the P4P program is likely to cause others to adopt the same behaviors to receive the same

137. See Berg, *supra* note 93, at 3.

138. *Id.* at 59.

139. *Id.*

140. See *id.*

rewards.¹⁴¹ This is a particular danger under MACRA's particular pay-for-performance scheme since physicians are graded relative to their colleagues. If one physician manages to engage in productive and profitable unethical behavior, there is an increased incentive for other physicians to do the same to receive a financial reward or avoid being assessed a financial penalty.

Some might suggest that so long as the quality measures are good, there is no harm in withholding information from patients or engaging in other unethical behaviors. But, when these negative behaviors are aggregated, the cost to patients could be enormous. If all physicians lie to patients about their treatment options, then soon informed consent may become an antiquated legal relic. Also, research studies consistently report that health care outcomes and costs improve when patients are effectively engaged in the clinical process.¹⁴² By encouraging gaming behaviors that effectively limit the patient's involvement in the clinical process, the P4P system may actually be working against its own objectives of improving quality and reducing costs.

In order to prevent the unintended consequences caused by the creation of strong financial incentives for physicians to adhere to the government-mandated standard of care, the physician's duty to disclose within the context of informed consent should be strengthened considerably. As it currently stands, physicians have a general duty to disclose basic information about any given treatment or procedure, but the standard is the most lenient when it comes to the physician's duty to disclose alternative treatment options to the patient.¹⁴³

Though the concept of alternatives is extremely important within the doctrine of informed decision-making, "the requirement that they be disclosed is sometimes absent in case law and statutes."¹⁴⁴ And, among jurisdictions, there is little conformity as to what constitutes an alternative treatment.¹⁴⁵ By strengthening the duty to disclose to include a requirement that physicians disclose all medically-feasible alternative treatment options to patients, informed consent procedures may provide

141. See Clements, *supra* note 89.

142. See Hibbard & Greene, *supra* note 46, at 208-09.

143. See MICHAEL H. COHEN, *BEYOND COMPLEMENTARY MEDICINE* 44-45 (Univ. of Mich. Press eds., 2000).

144. Berg, *supra* note 93, at 60.

145. Bryan Murray, *Informed Consent: What Must a Physician Disclose to a Patient?*, 14 AM. MED. ASS'N J. OF ETHICS 563, 564 (2012); Nat. Inst. of Health, *Complementary, Alternative, or Integrative Health: What's in a Name?*, NAT. CTR. FOR COMPLEMENTARY & INTEGRATIVE HEALTH, <https://nccih.nih.gov/health/integrative-health> (last updated June 28, 2016); Ken LaMance, *Doctor's Duty to Disclose*, LEGALMATCH, <https://www.legalmatch.com/law-library/article/doctors-duty-to-disclose.html> (last updated July 28, 2015).

an important counter-incentive for physicians to respect patient autonomy.

Though patients are free to consent or not to consent to medical treatments, there are concerns about the societal costs of a patients' non-compliance with medical directives. For example, it is often argued that parents who refuse to vaccinate their children expose society at large to increased risks of contracting disease.¹⁴⁶ But, there is little to no evidence that P4P programs are actually effective in improving population health.¹⁴⁷ Therefore, implementing these programs and allowing the unintended consequences to occur unchecked, will probably not improve public health. But, failing to adopt counter-incentives that re-enforce professional values could have a strong societal cost all on its own.

Expanding the physician's duty to disclose to remove the physician's discretion in choosing what information is relevant to disclose is necessary in response to the new financial incentives created by MACRA. Under the FFS payment model, physicians still receive compensation if patients select an alternative treatment model; however, under a pay-for-performance compensation model, physicians, if their patients refuse the government-prescribed treatment, are in danger of receiving less compensation. Thus, physicians have a strong incentive to limit disclosure about other treatment options to patients.

V. CONCLUSION

MACRA called for the adoption of a quality-based payment system with the dual goals of cutting costs and improving the quality of care that patients receive from all physicians.¹⁴⁸ MACRA, as a pay-for-performance compensation models, assigns physicians financial rewards or penalties based on their compliance with specific performance measures. Like all pay-for-performance programs, MACRA will likely have serious unintended consequences.

In MACRA's case, physicians have a strong incentive not to disclose all medically feasible treatment and diagnostic options to their

146. *If You Choose Not to Vaccinate Your Child, Understand the Risks and Responsibilities*, CTRS. FOR DISEASE CONTROL & PREVENTION (Mar. 2012), <https://www.cdc.gov/vaccines/hcp/conversations/downloads/not-vacc-risks-color-office.pdf>.

147. Roland & Campbell, *supra* note 81, at 1947 (stating the clinical care probably improved after the introduction of the Quality and Outcomes framework, but the effects were not compelling).

148. CTRS. FOR MEDICARE & MEDICAID SERVS., CMS-5517-FC, MEDICARE PROGRAM; MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) AND ALTERNATIVE PAYMENT MODEL (APM) INCENTIVE UNDER THE PHYSICIAN FEE SCHEDULE, AND CRITERIA FOR PHYSICIAN FOCUSED PAYMENT MODELS at 4 (2016).

patients. And, research studies suggest that in addition to failing to disclose alternatives to patients, physicians may also engage in fraudulent behaviors in order to achieve performance goals and reap rewards.¹⁴⁹ These results are not surprising given the many public scandals in the corporate sector as a result of compensation incentives.¹⁵⁰ Given the high probability of these sorts of negative behaviors, and given that these negative behaviors tend to act in a way that degrades patient autonomy, counter-incentives aimed at increasing professional respect for patient autonomy are highly desirable.

Because informed consent evolved as a legal doctrine with an eye towards protecting patient autonomy, strengthening its standards should act as an effective safeguard against the anticipated negative behaviors associated with pay-for-performance systems. To this end, all jurisdictions should adopt the reasonable patient standard of physician disclosure.

Though all jurisdictions presently recognize that physicians have a legal duty to disclose certain information to their patients prior to initiating treatment, jurisdictions are divided on which standard should be employed to determine if the physician has actually met his duty to disclose.

The variation between jurisdictions makes it more difficult to be certain that all patients are given the opportunity to participate in the formulation of their own treatment plan. In roughly half of all jurisdictions, physicians are only required to disclose the information that a reasonably prudent physician in the same practice area would disclose.¹⁵¹ Now, if all physicians are incentivized to comply with the government-issued standard of care, then requiring physicians to disclose only what a similarly situated reasonably prudent physician would disclose does not ensure that a patient will hear about the medically feasible alternatives that lie outside of that standard of care.

In order to ensure that all patients have the opportunity to make informed decisions regarding their own care, all jurisdictions should adopt the reasonable patient standard of physician disclosure. The reasonable patient standard requires physicians to disclose all information that they have reason to know is material to the patient's

149. See McDonald, *supra* note 65, at 123; Hibbard, et al., *supra* note 48 at 483.

150. See Stout, *supra* note 2, at 33 (discussing public scandals and suggesting that it is dangerous for corporate employers to use material incentives to motivate their employees because it is easier "to meet a performance metric through unethical or illegal behavior rather than hard work.").

151. Edward L. Raab, *The Parameters of Informed Consent*, 102 TRANS. AM. OPHTHALMOLOGY SOC'Y 225, 226 (Dec. 2004); GA. CODE ANN. § 31-9-6.1(a)(5)(LexisNexis 2017).

decision regarding treatment.¹⁵² Jurisdictions that have adopted this standard require physicians to disclose not just the physician's recommended treatment with its attendant risks and benefits, but also treatment options that the physician would not recommend.¹⁵³ By following this standard, patients are afforded a more complete picture of their health care choices and then are free to choose to accept their physician's recommendation or pursue another course of clinical action. The important point to note is that under the reasonable patient standard, the choice of clinical treatment is completely the patient's own, and the physician-patient relationship serves to educate the patient so that they can make an informed decision.¹⁵⁴

152. *Cobbs*, 502 P.2d at 9-10; *Canterbury v. Spence*, 464 F.2d 772, 783 (D.C. Cir. 1972).

153. *Allen*, 374 P.3d at 817; *Jandre*, 813 N.W.2d at 636.

154. *Allen*, 374 P.3d at 818.