Patient Autonomy 

in the Age of 

Consumer-Driven Health Care: 

Informed Consent and Informed Choice 

Marshall B. Kapp, J.D., M.P.H., FCLM* 

I. INTRODUCTION 

The philosophical principle of individual autonomy, or personal self-determination, lies at the heart of modern American bioethics.1 This ethical precept has been transformed slowly but steadily in the United States into the enforceable legal doctrine of informed consent, reflecting the phenomenon that “[t]he law is society’s mechanism for establishing boundaries for conduct.”2 

As interpreted and applied by a panoply of courts,3 legislatures,4 administrative agencies,5 and professional organizations,6 this doctrine requires health care providers to obtain a patient’s (or a surrogate’s, in the situation of a decisionally incapable patient)7 voluntary, competent, and informed consent prior to carrying out a clinical intervention 

* Garwin Distinguished Professor of Law and Medicine, Southern Illinois University Schools of Law and Medicine. Professor Kapp is the founding editor of the Ethics, Law, and Aging Review (formerly the Journal of Ethics, Law, and Aging) and currently serves as the Review’s editor. Additionally, Professor Kapp is presently the editor of the Journal of Legal Medicine, the official scholarly publication of the American College of Legal Medicine. 

1 See, e.g., JERRY MENIKOFF, LAW AND BIOETHICS 356 (2001) (referring to patient autonomy as “that leading principle in the philosopher’s world of bioethics”). 


3 See infra notes 33-39. 

4 See IOWA CODE § 147.137 (2005); VT. STAT. ANN. tit. 18 § 1852 (2005). 


6 See, e.g., Snyder & Leffler, supra note 2, at 563-64. 

Legally valid informed consent is mandated in the clinical sphere for diagnostic and therapeutic,\(^9\) as well as research-related,\(^{10}\) interventions. Breach of the health care provider's obligation to obtain informed consent as a condition precedent for proposed clinical interventions gives rise to potential tort liability of the provider.\(^{11}\)

However, in addition to exercising the right to make choices about which diagnostic or screening tests,\(^{12}\) therapeutic\(^{13}\) procedures or medications, and research protocols to undergo or participate in, individuals in the United States increasingly enjoy (or are confronted with, depending on one's perspective) other, non-clinical decisions that may well affect their health care deeply. As this country now experiments in earnest with various aspects of consumer-driven health care,\(^{15}\) large numbers of Americans are being asked to select the details of their own health care financial packages from among an array of insurance, personal savings, and managed care options that continue to grow in both numbers and complexity. Individuals' decisions about the specifics of how their health care will be paid for may exert an obvious influence on the accessibility, affordability, and quality of the health care those individuals seek out for themselves and receive.

The advent of consumer-driven health care has revealed an interesting and distressing paradox in the thinking of a large proportion of contemporary American bioethical, health law, and health policy scholars and advocates. Specifically, many of the strongest proponents of recognizing and enforcing patients' decision making

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9 See id.
15 See infra Section III A.
autonomy in the clinical arena are vocally critical of the consumer-driven health care movement, in significant part because of their antipathy to the health coverage choices entailed for the consumer in the consumer-driven health care model. For these commentators and advocates, individuals’ remarkable capacity to make autonomous, authentic choices in the clinical sphere somehow seems to evaporate completely when the choices are prospective and involve health care financing arrangements rather than particular medical tests, surgeries, or drugs.

This article identifies and takes issue with this paradoxical mode of thinking in contemporary bioethics and health policy on the grounds that it is inconsistent and illogical at best, and disingenuously driven by philosophical and political ideology rather than sound reasoning at worst. In place of this paradoxical attitude, I promote a unified approach to patient autonomy. Under this unified approach, the same considerations supporting respect for an adult patient’s right to make voluntary, informed decisions about clinical matters ought to be applied to the sorts of non-clinical consumer choices about enrollment in particular insurance plans, savings accounts, and managed care arrangements that are embodied in the concept of consumer-driven health care.

Put bluntly, I argue that, as a society, we either believe adults are capable (with sufficient help) of exercising health care-related autonomy or we do not. Hence, policy makers and the legal system either should expand the doctrine of autonomous decision making to apply to health care choices across the board (including the non-clinical aspects of one’s own health care), or not allow patients to make health care decisions at all; it is erroneous, even counterproductive, to attempt to pick and choose among different categories of health care choices and then apply the autonomy principle selectively (i.e., politically).

In the next section, I commence by outlining the parameters of the traditional informed consent doctrine, founded on the ethical principle of autonomy, as applied in clinical situations. Although this brief discussion is limited to the United States, where autonomy is the preeminent bioethical value, it should be remembered that the contemporary American focus on autonomy is not universally embraced. Different cultures vary quite substantially in their preferences and expectations regarding particular ethical values, and especially concerning the validity—let alone centrality—of autonomy.16

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I then go on to note some of the problems and limits that critics have identified as interfering with the realistic and effective implementation of informed consent by the patient regarding diagnostic, therapeutic, and research matters. Nonetheless and centrally, I observe that, despite these acknowledged problems and limits, the solid weight of bioethical and legal opinion continues to support a prohibition on the conduct of medical interventions unless the patient has tendered permission in accordance with the legally-enunciated trappings of the informed consent doctrine.

In the ensuing section, I define and illustrate the concept of consumer-driven health care in the United States today, and identify some of the particular kinds of choices that this movement presents to individual consumers. Arguments in favor of and in opposition to respect, and even enthusiasm, for application of the patient autonomy principle to the consumer context are explored; the consumer context, although new, is in important respects analogous to the clinical context with which informed consent proponents are very familiar. I conclude that ethical, legal, and policy considerations compel an extension of the autonomy principle from the clinical sphere to that of consumer-driven health care.

II. INFORMED CONSENT AND ITS DISCONTENTS

A. Autonomy and Informed Consent

"Informed consent has been at the heart of medical ethics in the modern era. In fact, one could argue that the emergence of informed consent is the hallmark of the modern era in medical ethics." The informed consent concept emanates from the principle of autonomy and envisions a shared, interactive decision-making process.

[Japanese Case Law, 14 INT'L. RISK & SAFETY IN MED. 59 (2001).]

[1] The use of the term “consumer” to refer to individuals in the purchasing role and “patient” to refer to individuals in the direct care receiving role is purposeful. See Wendy K. Mariner, Can Consumer-Choice Plans Satisfy Patients? Problems with Theory and Practice in Health Insurance Contracts, 69 BROOK. L. REV. 485, 491-92 (2004) [hereinafter Mariner] (suggesting that terminology has substantive import for health policy and law). “Individuals can be both consumers and patients, although they are rarely both at the same time. People act like consumers when choosing what health plans to buy and like patients when deciding what treatment to undergo.” Id. at 494-95.

[18] See Alan Meisel & Mark Kuczewski, Legal and Ethical Myths About Informed Consent, 156 ARCH. INTERN. MED. 2521, 2521 (1996) [hereinafter Meisel & Kuczewski].


[20] Autonomy is understood as a cluster of notions including self-determination, freedom, independence, liberty of choice and action. In its most general
It is driven by:

[the] culture of consumerism in the United States [that] encourages the public to exercise control over life choices. This trend and the ethical imperative to respect patient autonomy have shifted the locus of control in the clinician-patient relationship toward a patient-centered model that eschews paternalism and invites patients to engage actively in the decision-making process.

Informed consent is not a newfangled idea. Plato referred to the requirement of informed consent to distinguish between the treatment of slaves and freemen. The informed consent concept was opposed by Hippocrates, interest in it was renewed generally in 17th century political philosophy, but opposition to it by the American Medical Association led to its dormancy in the American medical context until the 20th century. Today, there is broad consensus that, in the arena of clinical medicine,
“[i]nformed consent is more than a legal doctrine and a trap for unwary practitioners, it is a concept central to American beliefs about individual rights and the proper relationship between patients and providers.”25 In addition to autonomy, the informed consent doctrine also has been supported by reference to the ethical principles of authenticity,26 privacy,27 and beneficence.28

In their legal formulation, the substantive components of the informed consent doctrine have evolved on a case-by-case basis as a matter of individual state common law.29 Additionally, the majority of states have enacted statutes and/or promulgated regulations enumerating their jurisdiction’s specific details regarding informed consent, either for clinical care generally30 or within particular settings such as nursing facilities31 or public mental institutions.32

The doctrinal basis underlying a health care provider’s liability for performing a what their diagnosis was. Patients were even forbidden to look at their own medical records: it wasn’t their property, doctors said. They were regarded as children: too fragile and simple-minded to handle the truth, let alone make decisions. And they suffered for it. ATUL GAWANDE, COMPLICATIONS: A SURGEON’S NOTES ON AN IMPERFECT SCIENCE 210 (2003).

25 LEBLANG ET AL., supra note 8, at 349.
26 FADEN & BEAUCHAMP, supra note 23, at 262-68.
27 Id. at 40-41.
28 MAKING HEALTH CARE DECISIONS, supra note 20, at 42-44. “Since well-being can be defined only within each individual’s experience, it is in most circumstances congruent to self-determination...” Id. at 44; accord David I. Shalowitz & Michael S. Wolf, Shared Decision-Making and the Lower Literate Patient, 32 J.L. MED. & ETHICS 759, 762 (2004) [hereinafter Shalowitz & Wolf] (“The model of shared decision-making is intended to provide a balanced structure for clinical consultations that both promotes patient autonomy and improves health outcomes.”); HELEN W. WU ET AL., NATIONAL QUALITY FORUM, IMPROVING PATIENT SAFETY THROUGH INFORMED CONSENT FOR PATIENTS WITH LIMITED HEALTH LITERACY (2005), available at http://www.qualityforum.org/publications.html (last accessed March 1, 2006); see also Karin I. Kjellgren et al., Antihypertensive Medication in Clinical Encounters, 64 INT’L J. CARDIOLOGY 161 (1998) (linking patient participation in decision making and treatment efficacy); Erika Szabo et al., Choice of Treatment Improves Quality of Life: A Study on Patients Undergoing Dialysis, 157 ARCH. OF INTERN. MED. 1352 (1997) (linking patient participation in decision making and treatment efficacy); Carol Golin et al., Impoverished Diabetic Patients Whose Doctors Facilitate Their Participation in Medical Decision Making Are More Satisfied With Their Care, 17 J. GEN. INTERN. MED. 857 (2002) (linking patient participation in decision making and treatment efficacy).
29 See generally FADEN & BEAUCHAMP, supra note 23.
30 See supra notes 4 & 5.
32 See, e.g., ALASKA STAT. ANN. § 47.30.837 (2005); HAW. REV. STAT. § 327G-10 (2005).
medical intervention without first obtaining valid patient consent has evolved from its original battery theory. Early American cases predicated on a battery (intentional, unconsented-to touching) theory ordinarily involved factual situations in which there was no semblance of consent at all. The exact term “informed consent” first appeared in a judicial opinion in 1957. By 1960, the doctrinal framework for informed consent liability had begun its steady movement from the intentional tort of battery toward negligence theory.

A watershed in this doctrinal movement took place in 1972 with the District of Columbia Circuit Court’s opinion in *Canterbury v. Spence.* In that case, the plaintiff/patient presented no evidence of negligence by any health care provider in the diagnosis or treatment of his medical problem. The court recognized that bad outcomes sometimes just result even when there is no negligence in the performance of associated clinical activities. Nonetheless, the court held the physician negligently breached his fiduciary or trust duty to act in the patient’s best interests, by failing to make certain that the patient’s consent to undergo a risky and invasive diagnostic procedure was based on proper information.

Moreover, *Canterbury* pointedly rejected the prevailing (and still slight majority) medical custom/reasonable physician standard of information disclosure enunciated by the Kansas Supreme Court in *Natanson v. Kline,* in favor of a patient-oriented/materiality disclosure standard. The medical custom standard asks what information a reasonable, prudent physician would have disclosed to the patient under similar circumstances. By contrast, the more recently announced materiality standard asks what information might have made a difference (that is, been material) in the decision making calculus of a reasonable patient in similar circumstances. The philosophical rationale, promoted by patients’ rights advocates, for the progression in informed consent doctrine from a reasonable physician to a patient-oriented standard of information disclosure is the belief that the latter approach better promotes the ethical ideal of patient autonomy, while the former approach reinforces the negative practice of physician paternalism that tends to impinge on patient autonomy. A fundamental

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37 *Canterbury,* 464 F.2d at 782.
38 LEBLANG ET AL., supra note 8, at 350-51.
distinction between the two approaches is reflected in the following observation:

When calculating the value of an intervention, physicians want to know what percentage of the target population benefits from it—to what degree, at what cost, and at what risk of harm—and, more important, how the intervention's value is modified by a specific patient's age, sex, health status, family history, and so forth. Patients [by comparison] want to know to what extent they are at risk for a particular condition, what the personal significance of that condition would be, what they can do to offset their risk, and what costs and possible harms would be associated with that action.  

Under the autonomy principle, "[t]he patient's utilities must be factored into the decision analysis."

Under the materiality standard (as well as the reasonable physician standard), the basic elements of information disclosure included within the health care provider's fiduciary obligations include the following: diagnosis or nature of the problem; nature and purposes (that is, expected benefits) of the proposed intervention; reasonably foreseeable risks associated with the intervention, and specifically their likelihood of happening and potential severity if they do materialize; reasonable alternatives and their benefits and risks; and the probable risks and benefits of not undergoing the proposed intervention.

There are other informational items whose relationship to informed consent obligations and liabilities is unsettled. Courts and commentators have differed regarding whether health care providers legally must communicate the following, among other informational items, as part of the informed consent process: complementary and alternative medicine alternatives; cost implications of the proposed intervention; the

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42 See Arato v. Avedon, 858 P.2d 598, 607 (Cal. 1993) (regarding the level of precision required in communicating information about risks to patients).

43 Truman v. Thomas, 611 P.2d 902, 906 (Cal. 1980) (recognizing a “right of informed refusal”).

44 James A. Bulen, Jr., *Complementary and Alternative Medicine: Ethical and Legal Aspects of Informed*
particular provider’s personal experience and success rate with the specific intervention; the provider’s financial incentives arguably impacting the patient’s care, the level of uncertainty in the medical community regarding the particular intervention; and the role, if any, of defensive medicine considerations are playing in how the health care provider is proposing the patient be treated.

Several specific factual assumptions undergird the informed consent doctrine. First, there is the supposition that “informed medical decision making” really can be translated into shared medical decision making, as opposed to “transferred” medical decision making. Put differently, informed consent proponents believe in the transformative power of the legal doctrine of informed consent as the catalyst for a “collaborative process” rather than a solitary “event” wherein the patient exclusively exercises the right to choose.

There also is an assumption by informed consent advocates that physicians have accurate, current knowledge of material risks and benefits to impart. It is believed that physicians can, and will, effectively and objectively communicate this information to patients.

Consent to Treatment, 24 J. LEGAL MED. 331 (2003).


53 Annette Moxey et al., Describing Treatment Effects to Patients: How They Are Expressed Makes a Difference, 18 J. GEN. INTERN. MED. 948 (2003).
Legislatures and courts adhering to patients’ rights precepts posit, with some empirical support, that patients want information about their personal health care and the right to choose among competing alternatives. Moreover, according to this prevailing ethical and legal viewpoint, patients are capable of understanding the often complex and voluminous medical information communicated to them by physicians and placing that information into accurate, clinically usable perspective. Furthermore, patients’ medical decisions are based on the information (that is, the factual content) with which the patients are provided. Although patients’ comprehension and utilization of medical information certainly is not perfect, there is confidence that the use of decision aids such as story boards, picture books, and interactive videos to communicate the information can improve patient decision making demonstrably.

B. Realists’ Critiques of Informed Consent

Patients’ rights proponents who embrace these sorts of factual assumptions and the lofty ethical aspirations they inspire, and who have been substantially successfully in incorporating these assumptions and precepts into legal doctrine, have for a long time been admonished by legal realists to recognize the significant shortcomings of attempting to integrate informed consent theory into actual clinical practice. According to those who distinguished the theoretical “law in books” from either the “law in the mind” of physicians or the “law in action” in the real world, physicians frequently do not truly grasp, let alone enthusiastically embrace, the goals of informed consent nor sincerely try to implement those goals in their regular interactions with patients. Under this view, informed consent in practice equals little more than a legally
worthless\textsuperscript{60} piece of paper with signatures obtained and filed away in the medical record.\textsuperscript{61} There exists some empirical evidence to support this skeptical perspective on clinical practice.\textsuperscript{62}

Realists' critiques of informed consent in practice vigorously question the validity of the fundamental factual premises underlying the doctrine. For instance, critics question the literacy levels, both generally and particularly pertaining to medical matters, of large segments of the patient population. They contend that prevailing low literacy rates\textsuperscript{63} pose substantial barriers to realization of a shared decision making ideal built on the assumption that patients are capable of comprehending and manipulating often complex data about the risks, benefits, and alternatives associated with discrete clinical choices.\textsuperscript{64} In general terms, "[i]nadequate health literacy skills prevent people from being involved and active participants in their care."\textsuperscript{65} More particularly, "[i]f the consenting process is about informing patients so they can make balanced and reasoned decisions, and the logic behind those decisions is statistical, many cannot give informed consent."\textsuperscript{66}

In addition, even assuming patients were equipped to understand and convert clinical information into a productive shared decision making process, informed consent realists "have—in the dead of night—asked whether patients wish to be involved in

\textsuperscript{60} See Meisel & Kuczewski, \textit{supra} note 18, at 2522 ("Perhaps the most fundamental and pervasive myth about informed consent is that informed consent has been obtained when a patient signs a consent form. Nothing could be further from the truth, as many courts have pointed out to physicians who were only too willing to believe this myth.").


\textsuperscript{62} See Clarence H. Braddock, III et al., \textit{Informed Decision Making in Outpatient Practice: Time to Get Back to Basics}, 282 JAMA 2313 (1999) (finding informed decision making among the group of primary care physicians and surgeons studied was often incomplete); Clarence H. Braddock, III et al., \textit{How Doctors and Patients Discuss Routine Clinical Decisions: Informed Decision Making in the Outpatient Setting}, 12 J. GEN. INTERN. MED. 339 (1997) (finding discussions leading to clinical decisions in the primary care settings studied did not fulfill the criteria considered integral to informed decision making).

\textsuperscript{63} Regarding low literacy rates, see generally Barry D. Weiss & Cathy Coyne, \textit{Communicating With Patients Who Cannot Read}, 337 NEW ENG. J. MED. 272 (1997) [hereinafter Weiss & Coyne].

\textsuperscript{64} See Shalowitz & Wolf, \textit{supra} note 28.


decision making at all." At least, there is clear evidence that people vary quite substantially in their preferences for participation in clinical decision making, with the variance explained by both personal characteristics of particular patients and the severity of the medical problem involved. In other words, many individuals do not wish to be extensively informed about the details (especially the risks) of some of their clinical care or intimately included in every decision making process, opting instead for a clinical decision making model characterized by heavy doses of physician paternalism. This situation constitutes:

... the blessing and the burden of being a modern patient. A generation ago, patients argued for more information, more choice and more say about treatment. To a great extent, that is exactly what they have received: a superabundance of information, often several treatment options and the right to choose among them. As this new responsibility dawns on patients, some embrace it with a sense of pride and furious determination. But many find the job of being a modern patient, with its slog through medical uncertainty, to be lonely, frightening and overwhelming.

For physicians, even when the philosophical commitment to informed consent principles is present:

the busy pace of patient care leaves little time for long discussions and detailed presentations of options and statistics. Few clinicians can quote accurate data or divorce themselves from personal biases to ensure a balanced presentation of options. Many lack the time or aptitude to consider patients' risk profiles, to predict preferences, or to

68 See, e.g., Wendy Levinson et al., Not All Patients Want to Participate in Decision Making: A National Study of Public Preferences, 20 J. GEN. INTERN. MED. 531 (2005); Woolf et al., supra note 21, at 294; Dorcas Mansell et al., Clinical Factors that Influence Patients' Desire for Participation in Decisions About Illness, 160 ARCH. INTERN. MED. 2991 (2000); Geraldine M. Leydon et al., Cancer Patients' Information Needs and Information Seeking Behaviour, 320 BR. MED. J. 909 (2000) (finding cancer patients' attitudes to cancer and their strategies for coping with their illness can constrain their wish for information and their efforts to obtain it); Robert F. Nease, Jr. & W. Blair Brooks, Patient Desire for Information and Decision Making in Healthcare Decisions: The Autonomy Preference Index and the Health Opinion Survey, 10 J. GEN. INTERN. MED. 593 (1995).
69 See Gurmankin et al., supra note 55.
help patients apply these values to select the best personal choice... Clinicians, caught in a struggle for economic survival, receive little reimbursement for this effort.71

C. Optimism Despite the Barriers

Despite the practical barriers to meaningful informed consent in the clinical context noted in the preceding section, American bioethical, health law, and health policy scholars and advocates remain overwhelmingly, staunchly in support of the informed consent doctrine and optimistic about its serious implementation in clinical practice. Patients’ rights proponents argue that the problems identified by informed consent realists, while not without merit, can be overcome and therefore the essential ethical goals and legal requirements of informed consent doctrine are attainable in practice as well as theory.

Defenders of the autonomy principle in the clinical context suggest there are a variety of strategies that can be successfully employed to realize informed consent objectives for their intended beneficiaries, namely, patients. For example, it is contended that more focused, sincere attention by physicians on improving their communication techniques can foster the sort of trustful, respectful patient/professional relationship within which patient self-determination in clinical decision making is likely to flourish.72 Physicians are instructed to “take steps to recognize patients with limited literacy skills and learn how to communicate with them in a supportive manner.”73

Additionally, much faith is placed by informed consent supporters in the potential effectiveness of various educational tools to empower patients to comprehend and manage adequately the basic information needed to satisfy informed consent aspirations. These tools include, among other things: more sophisticated decision aids in the form of information technology,74 the provision of written handouts to patients;75

71 See Woolf et al., supra note 21, at 295.
73 See Shalowitz & Wolf, supra note 28, at 762.
74 Woolf et al., supra note 21, at 295-96; Thomas Bodenheimer & Alicia Fernandez, High and Rising Health Care Costs, Part 4: Can Costs Be Controlled While Preserving Quality?, 143 ANNALS INTERN. MED. 26, 29 (2005) (“High-quality shared decision making requires patients who can engage in discussions as informed partners, which in turn requires use of patient decision aids. These are evidence-based tools that allow physicians to accurately inform patients of available options and their consequences.”).
presentation of information in qualitative, quantitative, and graphic formats, simplified to reach the lower literate patient; and the showing of videotapes.

Another illustration of confidence in the potential for achieving meaningful informed consent is the federal Centers for Medicare and Medicaid Services' initial launching in the fall of 2005 of a pilot program to provide chronically ill Medicare patients with access to health coaches. These coaches advise the Medicare beneficiaries on medical choices, for example by telling patients what questions they should ask their physicians. According to a health educator associated with this program, coaches try to help reduce patients' confusion when "they are fearful of something, they don't understand what's going on... We help them digest what's going on. Just like with a personal trainer, if you teach the right technique, you get better." The underlying assumption is that the right technique for making informed choices about one's own clinical care really can be taught.

In sum, the prevailing view is that important challenges notwithstanding, ultimately information can be presented properly, and such properly presented information can intelligently influence patients' choices about their clinical care. Hence, patients are educable about difficult, complex matters and able to use that education to achieve personal autonomy in the care of their own bodies. There is faith that informed consent not only is ethically better than paternalistic decision making that imposes someone else's (in the clinical context, the physician's) choices on the patient, but that it is achievable in both theory and practice. Physicians are optimistically admonished to somehow, some way succeed in making informed consent become more than just psychiatrist Jay Katz's unfulfilled "fairy tale":

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77 Shalowitz & Wolf, supra note 28, at 762.
78 Robert J. Volk et al., A Randomized Controlled Trial of Shared Decision Making for Prostate Cancer Screening, 8 ARCH. FAM. MED. 333 (1999); Richard A. Deyo et al., Involving Patients in Clinical Decisions: Impact of an Interactive Video Program on Use of Back Surgery, 38 MED. CARE 959 (2000).
80 Id.
81 See Michael Pignone et al., Patient Preferences for Colon Cancer Screening, 14 J. GEN. INTERN. MED. 432 (1999) (finding patient preferences for colon cancer screening were sensitive to information about test performance and out-of-pocket costs).
82 See the works by Jay Katz, supra note 61.
While it is clear that patients want direction and it is true that medicine, as now practiced, is not structured to help patients with their decisions as much as needed, these shortcomings should not interfere with the best course of action for decision making. Patients will learn to accept the responsibility of choosing and physicians will have to restructure their practice patterns to ensure that patients make their best choices. Physicians cannot deny patients the opportunity and means to make their own choices.\(^{83}\)

Simply telling patients something or giving them a handout is quite different from making sure that they understand what they have been told. A key responsibility of clinicians, and an important characteristic of effective clinicians, is to make sure, by whatever means are needed and in whatever time is required, that patients are given medical information that is clear and understandable, and that they understand it.\(^{84}\)

Despite the substantial evidence and arguments to the contrary, “[n]evertheless, we believe that by understanding the problems that affect specific groups of patients, steps can be taken to move them towards greater participation in the provision of their health care and ultimately better health outcomes.”\(^{85}\)

### III. AUTONOMY AND CONSUMER-DRIVEN HEALTH CARE

In stark contrast to the prevailing optimism about, and commitment to, promoting the autonomy ideal in the context of patients’ informed consent for individual clinical decisions, there stands a strong current of pessimism and criticism among some regarding the perils of allowing persons to make autonomous decisions about the financial and organizational details of their own health plans. In place of the self-determination commitment characterizing the informed consent discussion in the clinical sphere, many health policy analysts and policy makers would substitute governmental paternalism and protectionism when the conversation shifts to the context of consumer-driven health care. This incongruity of approaches to the potential of autonomy, as realized through application of the doctrine of informed consent, is morally and legally erroneous and should be rejected.

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\(^{83}\) See McNutt, supra note 52, at 2518.

\(^{84}\) Weiss & Coyne, supra note 63, at 273.

\(^{85}\) See Shalowitz & Wolf, supra note 28, at 763.
It must be observed that critics of consumer-driven health care have assembled a variety of forceful arguments against reliance by governmental and private policy makers on the concept of consumer-driven health care. These critics contend, among other reasons, that consumer-driven health care is objectionable because "[i]t will endanger the health and well-being of the chronically ill (those most reliant on health coverage)," it will fail to contain health care costs, it will not resolve the problem of large numbers of uninsured persons, and it dangerously undermines the social safety net essential to maintaining a political culture of social solidarity in the face of threatening life contingencies such as illness. Criticizing the "market metaphor" of consumer choice generally, influential legal commentator George J. Annas (who is best known for his strong advocacy of patients’ rights) complains:

Consumer choice becomes the central mantra of the market metaphor... Like the mythologized military metaphor, the market metaphor is also a myth... The consumer-patient is not always right. The market metaphor conceals inherent market imperfections,
ignores the medical commons, and disregards the inability of the market to distribute goods and services whose supply and demand are unrelated to price. It pretends that there is such a thing as a free market in health insurance plans, and that purchasers can and should be content with their choices when an unexpected injury or illness strikes them or a family member.91

These points constitute legitimately troubling (albeit often ideologically inspired)92 concerns, which deserve to be debated fully and resolved on their own terms. The present article does not take on overarching questions about the wisdom of consumer-driven health care as a public/private policy strategy. Rather, the present discussion confines itself to an attempt to refute only one of the positions taken by critics of consumer-directed health care—that consumers are not intellectually and emotionally capable of handling the role of decision maker in this context, despite their ability to overcome barriers and exercise autonomy in the clinical arena through their right to give, or withhold, informed consent to particular medical interventions.

A. Consumer-Driven Health Care

Professional observers of, and especially direct participants in, the American health care system have grown steadily impatient with the demonstrated shortcomings of both command-and-control regulation93 and managed care94 as strategies to improve

92 See, e.g., Robinson, Politics, supra note 89, at 350 (suggesting the push for consumer-driven health care appeals primarily to “right-wing activists”); Sara Rosenbaum et al., Foreword: National Health Reform and America’s Uninsured, 32 J.L. MED. & ETHICS 386, 388 (2004) (characterizing the difference between “the concept of social contract” and an openness to trying a high degree of “privatization in both program design and administration” as “a historical conflict between two fundamentally different world views”); Bruce C. Vladeck, The Struggle for the Soul of Medicare, 32 J.L. MED. & ETHICS 410, 412 (2004) [hereinafter Vladeck] (commenting on “the considerable ideological division about approaches to” the problem of escalating health care costs between “defenders of the welfare state” and economic conservatives); id. at 413 (opining that “the power of ideology is clearly dominant, and should not be underestimated”); Jacobi, Chronically Ill, supra note 86, at 548 (implicitly endorsing the analytic framework of philosopher John Rawls, which subjugates individual liberty to the goal of egalitarian redistribution of resources); see JOHN RAWLS, A THEORY OF JUSTICE 303 (1971).
94 See, e.g., William D. White, Market Forces, Competitive Strategies, and Health Care Regulation, 2004 U.
the quality and affordability of, as well as access to, health care for the general population. In large part out of the restlessness with—indeed, the backlash to—failed attempts to significantly change the cost-effectiveness of physician behavior (as the chief driver of health care expenditures) through legal requirements or financial incentives directed at physicians, there has evolved a new willingness in both the public and private sectors to try new financing and delivery models. These are models in which the individual consumer exercises a higher degree of personal choice, direction, and control over the financial and structural arrangements that constitute the context within which that consumer’s decisions about particular medical interventions get made.

In a 2005 Harris Interactive survey, eighty percent (80%) of employers believed that consumer-driven health models “would help to control costs by forcing consumers to spend more wisely on health care services.” In a 2005 article, a legal scholar observed that “consumer driven care has recently received boosts from [sic] Council of Economic Advisors to the President, the Internal Revenue Service, academic commentators, and the popular press.”

I.L. Rev. 137, 158 (2004) (“In the wake of rapid increases in costs and a rise in the number of uninsured, a consensus has emerged that managed care is no longer working as a cost containment mechanism . . . At the same time, fundamental questions exist about managed care’s ability to address the effects of technological change and underlying problems with quality of care in an environment of growing consumerism.”); John V. Jacobi, After Managed Care: Gray Boxes, Tiers and Consumerism, 47 St. Louis U. L.J. 397 (2003); Vladeck, supra note 92, at 413 (“What changed the tone of the debate about privatization—although not the efforts to promote it—was the growing popular dissatisfaction with HMOs . . .”). For ethical critiques of managed care, see, e.g., Frank M. McClellan, Is Managed Care Good for What Ails You? Ruminations on Race, Age and Class, 44 Vill. L. Rev. 227 (1999); Sharna Hoffman, Unmanaged Care: Towards Moral Fairness in Health Care Coverage, 78 Ind. L.J. 659 (2003). For a critique of managed care plans from the consumer’s perspective, see, e.g., Weighing Your Health Plan Choices, Consumer Reports, Sept. 2005, at 44. But see NAT’L COMM. FOR QUAL. ASSURANCE, THE STATE OF HEALTH CARE QUALITY: INDUSTRY TRENDS AND ANALYSIS (2005), available at http://www.ncqa.org (reporting on a positive trend in the quality of care received by consumers in managed care plans).

95 See Victor R. Fuchs, Health Care Expenditures Reexamined, 143 Annals Intern. Med. 76, 77 (2005) (reflecting the traditional understanding that it is physicians “whose decisions about drugs, tests, and hospitalization determine the bulk of health care costs at any given time”).


99 Jacobi, Chronically Ill, supra note 86, at 532 (citations omitted).
Consumer-driven models of health care are intended to enable consumers to more directly exercise the right to choose health coverage arrangements within their own framework of personal priorities. Through their defined financial contributions to their own medical care, consumers gain the power "to control their health care resources and therefore health care decision making" within a competitive, one size does not fit all, marketplace of competing services and service providers. Thus, advocates of consumer-driven health plans:

hope that they will do more than shift part of the increase in health care costs to the patient: they believe that financial incentives will turn patients into 'activated consumers' who exert pressure on health care providers to improve the efficiency and quality of care.

The elements of consumer choice and control distinguish consumer-driven health care from the earlier, more limited concept of consumer-centered health care.

The paradigm shift toward consumer-driven health care is manifested in an

100 See Martha P. Patterson, Defined Contribution Health Plan to Consumer Driven Health Benefits: Evolution and Experience, 20 BENEFITS Q. 49 (2004) [hereinafter Patterson].
102 Lee & Zapert, supra note 98, at 1202.
103 See generally THROUGH THE PATIENT’S EYES: UNDERSTANDING AND PROMOTING PATIENT-CENTERED CARE (Margaret Gerteis et al. eds., 1993). According to these editors, “What we hope to accomplish, . . . is to help health care providers keep the patient’s perspective in mind as they [the providers] respond to the pressures of the ‘real’ world.” Id. at xiii (emphasis added). But see Karen Davis et al., A 2020 Vision of Patient-Centered Primary Care, 20 J. GEN. INTERN. MED. 953 (2005), identifying as a core practice of patient-centered primary care:

*Patient engagement in care* option for patients to be informed and engaged partners in their care, including a recasting of clinical roles as advisors, with patients or designated surrogates for incapacitated patients serving as the locus of decision making (when desired by patients): information for patients on condition/treatment options/treatment plan; . . . patient education . . . Id., at 954.

104 See, e.g., Alan Murray, Case Study: Former AOL Chief Seeks Health-Care Revolution, WALL. ST. J., Oct. 5, 2005, at A2 (regarding the movement toward consumer-driven health care as a paradigm shift, and describing a series of investments in health care designed, according to former America Online chief executive officer Steve Case, “to change the world” by “put[ting] patients at the center of the health system, with more choices, more convenience, more control”).
almost infinite variety of tangible forms. The details of these diverse incarnations of the emerging paradigm have been described very amply elsewhere.

To vastly oversimplify, the most common version of the consumer-driven model consists of three separate but interwoven components (described by one commentator as "two parts and a gap"). The first part is a high-deductible (at least $1,000 for an individual and $2,000 for a family) health insurance product, often but not necessarily managed by a Preferred Provider Organization (PPO), purchased by the individual's employer or union (or the employer or union of the person of whom the insured individual is a dependent), the government, or the individual personally. The insurance product is intended to protect the insured individual against the risk of catastrophic health care costs. These insurance products may differ regarding provider networks, specific services covered or excluded, benefit packages, and cost-sharing arrangements (that is, co-pay requirements).

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105 See, e.g., Advertisement, Custom Choice—Individual Health Plans as Individual as You Are, SOUTHERN ILLINOISAN, Aug. 28, 2005, at 15A (advertising "a customizable health plan that suits you" and that "lets you pick the coverage and premium that makes sense for you").


107 For descriptions, see, e.g., Robinson, Reinvention, supra note 96, at 1882; Robinson, HSAs, supra note 106.

108 Jacobi, Chronically Ill, supra note 86, at 549.


110 See J.M. Razor, Health Savings Accounts: Increasing Health Care Access in America?, 17 LOY. CONSUMER L. REV. 419, 428 (2005) [hereinafter Razor] (finding that over half of all Americans have an employment-based health insurance policy in his or her own name); Mariner, supra note 17, at 489.

111 See John V. Jacobi, Government Reinsurance Programs and Consumer-Driven Care, 53 BUFF. L. REV. 537 (2005) [hereinafter Jacobi, Consumer-Driven].

112 E.g., Jack Lewin & Ronald A. Williams, Cover Yourself, WALL ST. J., Aug. 19, 2005, at A12 (regarding individually purchased health insurance policies); see also John Shadegg, Editorial, Cheaper Health Insurance, WALL ST. J., July 25, 2005, at A14 (advocating legislation permitting Americans to buy health insurance from vendors in any of the 50 states).
This part of the consumer-driven model is coupled with an individually managed, tax-exempt, interest-bearing health savings account (HSA) whose funds could be either used to pay out-of-pocket for routine and preventive (including complementary, dental, and vision) health services falling below the deductible amount specified in the insurance contract and or rolled over and accumulated if not used:

It is a central insight of the consumer driven health care movement that pieces of health insurance can be addressed separately, and in particular, that the catastrophic coverage can be provided by one entity, while the more routine and preventive services can be covered by another.

The third component of the consumer-driven health care archetype is the so-called gap or doughnut hole. This component is called into play when, after exhausting the funds in one's HSA to pay for medical care, an individual then uses personal, after-tax income until expenses reach the deductible threshold and the insurance product begins to contribute.

The arrangements just described have been called, variously, “consumer-directed,” “consumer-choice,” and “defined contribution” plans. For purposes of manageability, in this article I label all plans that give consumers the right to buy medical care directly or to design their own health benefit structures “consumer-driven” plans.

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113 See Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-172, 117 Stat. 2066 (2003) (outlining the fact that consumers were given the opportunity to fund their HSAs with pre-tax dollars).

114 See generally Razor, supra note 111; Kaplan, supra note 109, at 548-50, 553-56. HSAs are distinct from the Medicare Health Accounts idea that has been proposed as a mechanism for Medicare beneficiaries to save for health costs not covered by Medicare. Regarding this idea, see Sara R. Collins et al., Medicare Health Accounts: A New Policy Option to Help Adults Save for Health Care Expenses Not Covered by Medicare (Commonwealth Fund Pub. No. 842, 2005).

115 Id. at 539.

116 Id.

117 Id.

118 CATO INST., HEALTHY COMPETITION: WHAT'S HOLDING BACK HEALTH CARE AND HOW TO FREE IT x-xi (Michael F. Cannon & Christopher T. Erb eds., 2005).


120 See Patterson, supra note 100.

121 I borrow this simplification technique from Professor Mariner, although she prefers the term “consumer-choice” plans. Mariner, supra note 17, at 496-97.
insurance coverage and thereby sensitizing consumers more directly to the costs of their own health care, represent “part of a vision that would increase authority for the individual in all aspects of society, with a commensurate reduction in authority for employers and government.” Outside of certain elite intellectual and political circles, where “the libertarian obsession with ‘choice’ by individual consumers” is condemned, the vision of an “Ownership Society” has broad popular appeal, both generally and as applied specifically to consumer control exercised in the health care context.

As a general matter, “Americans... tend to be skeptical of both big business and big government.” “The American workforce,” in one commentator’s phrasing, “has become infatuated with individual control over a range of benefits, from pension to health care.” Speaking broadly, the astute observer of social trends George Will wrote a few years ago:

A country in which personal computers are selling at the pace of one every two seconds and Internet usage is doubling every hundred days (and accounts for 13 percent of electricity consumption) is a country comfortable with, and insistent upon, more choices. The country has a rapidly broadening sense of competence and empowerment.

Regarding health care particularly, there is a growing (albeit begrudging) public recognition that resources are finite and therefore rationing of available resources via some mechanism is both necessary and inevitable. “If resources for providing

123 Robinson, HSAs, supra note 106, at 1201.
125 Vladeck, supra note 92, at 413.
127 Robinson, HSAs, supra note 106, at 1201.
128 Kaplan, supra note 109, at 562.
health care are not unbounded, rights also cannot be unbounded.”¹³¹ There is an especially acute and painful recognition of “the imperative to adjust pay-as-you-go entitlement programs according to the demographic realities of an aging population and the budgetary realities of costly technology.”¹³²

A business pundit explains:

Managed care always sounded great on paper: It would impose best practices on doctors, minimize costs by herding patients into preventive care, and make sure they take their drugs and control their chronic conditions. That is, if you believe Americans should basically become chattels of the health-care “system.” Missing from the picture, though, was an individual deciding how much of his resources he really wants to spend on health care. Missing too was the sense of individual control that goes a long way toward reconciling us to the mixed outcomes that are endemic to health care.¹³³

Accordingly, consumer-driven “designs are compatible with consumers’ desires for control in a world where someone needs to decide which patients will receive which health care services now, which later, and which never,” and “[m]any believe that the individual citizen is the appropriate setter of health care priorities.”¹³⁴

Professor Richard Kaplan explains the situation thusly:

In the health care field especially, the focus on individual control is especially appealing to many people, in part as a reaction to control of medical decisions by managed care companies. With a HSA, the account-holder makes the decision whether to undergo an additional medical procedure. The HSA account-holder—and not some “faceless bureaucrat”—negotiates the price with the health care provider and makes his or her own cost-benefit analysis of whether a given medical service is worth the expense involved. This sense of empowerment in an area as vital and personal as health care is heady stuff indeed. It may even be irresistible.¹³⁵

¹³¹ Jacobi, Consumer-Driven, supra note 111, at 550.
¹³² Robinson, HSAs, supra note 106, at 1203.
¹³⁴ Robinson, HSAs, supra note 106, at 1201.
¹³⁵ Kaplan, supra note 109, at 563.
Commenting on the willingness of patients to do without marginal benefits, one set of authors notes:

One of the least controversial mechanisms for rationing could be to allow patients to make their own choices as to which kinds of care they would be willing to forgo. This is appealing because it preserves individual freedom of choice regarding health care in a way that other rationing mechanisms do not.\(^{136}\)

For those of us\(^{137}\) who believe in maximizing the role of individual rights and responsibilities in all facets of health care delivery, the concept of consumer-driven health care has great philosophical appeal. The key question, however, is whether this concept can and will work in practical application to enhance quality, access, and affordability. As noted earlier, several kinds of objections to consumer-driven health care have been voiced by its critics. I concentrate my aim in this article on responding to objections to, or skepticism about, this new paradigm predicated on the argument that consumers are not capable of making, and ought not be trusted by society to make, the sorts of choices that consumer-driven health care expects private individuals to make concerning their own health plans.

**B. Informed Consent-Based Objections to Consumer-Driven Health Care and Responses to Those Objections**

Some of the most ardent proponents of informed consent in the sphere of choices about medical tests, procedures, and treatments have attacked the consumer-driven health care model on the grounds that it imposes impossible expectations and burdens on the decision-making capabilities of most consumers.\(^{138}\) Despite their championing of the primacy of the patient's role in situations calling for frequently very complicated and emotionally wrenching clinical situations, these critics of consumer-driven health care provide a generally negative response to the key issue: "First, are consumers capable of assuming the majority of the responsibility for making decisions about their own health care?"\(^{139}\) or, stated more directly, "[i]s it realistic to expect

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\(^{138}\) See ANNAS, CHOICE, supra note 91.

\(^{139}\) Lee & Zapert, * supra* note 98, at 1202.
consumers to take more responsibility for medical care [that is, health plan] choices?"

This claimed contrast between the patient as an autonomous, competent clinical decision maker, on one hand, and the consumer as a helpless, incompetent, "babe-in-the-woods" would-be purchaser of a personal health plan, on the other, is a false dichotomy. Certainly, there are challenges to be confronted and overcome in order to prepare consumers to effectively execute their vital decision making role within the consumer-driven health care paradigm. However, these challenges are not fundamentally distinguishable in kind from the kinds of process challenges confronting patients and their professional caregivers when clinical decisions must be made. The kinds of responses that autonomy proponents have cited in the clinical arena to support their ultimate optimism about patients achieving meaningful informed consent for medical treatment decisions ought to apply with full force (or even a fortiori) to the arena of consumer capabilities concerning health plan choices.

The argument that consumers are incapable of effectively driving their own health plan choices takes several forms, but it essentially boils down to claims that the task of obtaining and intelligently assimilating the amount and complexity of information needed to make meaningfully informed personal decisions about competing health plans would psychologically and intellectually overwhelm most consumers. This argument, consistent with the underlying premise of the managed care movement whose demise has led to the current popularity of consumer-driven health care, assumes widespread patient ignorance and confusion. Sentiments frequently expressed are in the nature of:

[m]ost consumers will never be able to evaluate the myriad individual physicians, products, and procedures in medicine any more than they can evaluate the detailed components of their computer or automobile.141

Concern also has been expressed about "prohibitive information costs regarding consumer-choice plans."142

Recognition of the volume, complexity, and often restricted availability of

140 Katherine Swartz, Informed Consumer—Caveat Emptor, 42 INQUIRY 3, 3 (2005).
141 Robinson, Reinvention, supra note 96, at 1885; see also John C. Goodman, Designing Health Insurance for the Information Age, in CONSUMER-DRIVEN HEALTH CARE: IMPLICATIONS FOR PROVIDERS, PAYERS, AND POLICYMAKERS 224, 224-26 (Regina Herzlinger ed., 2004).
142 Mariner, supra note 17, at 507.
information necessary for a consumer to make intelligent health plan decisions is accurate and well-taken, and surely individuals (especially those with poor or limited general and health-specific literacy deficiencies) need careful guidance and support to enter and wend their ways through the informational thicket. Continual innovation and improvement in approaches to the presentation of information to consumers is imperative. The charge that "[c]onsumer-driven health care rejects the notion (central to managed care) that consumers need expert help to make health purchasing decisions" is not correct; advocates of consumer-driven health care are very sensitive to this need.

Nevertheless, the same concerns about patients’ needs for informational help and support apply in the context of clinical decision making, where ultimately, according to the courts, most medical ethics scholars, and many health policy analysts and change agents, patient autonomy ordinarily trumps those concerns. After all:

[m]uch of contemporary medical care involves an element of discretion in the decision to seek care and in decisions about the type of provider (e.g., generalist or specialist), the care setting (inpatient or outpatient) and the type of product (e.g., brand-name or generic drug).

Just as physicians and other health care professionals are expected to empower patients to make intelligent clinical choices by stripping away extraneous data and honing in on the presentation of material information (that is, information that might make a difference to the decision of a reasonable patient in similar circumstances) in relevant, understandable form, "[w]ell-designed insurance products can decrease the large number of trivial choices and provide information and incentives to support a smaller number of significant choices."

143 Regarding the general and health-specific illiteracy problem, see generally Weiss & Coyne, supra note 63; see also JESSICA GREENE ET AL., HOW MUCH DO HEALTH LITERACY AND PATIENT ACTIVATION CONTRIBUTE TO OLDER ADULTS’ ABILITY TO MANAGE THEIR HEALTH? (AARP Public Policy Institute, Paper No. 2005-05, 2005).
146 Jacobi, Consumer-Driven, supra note 111, at 552.
147 Robinson, HSAs, supra note 106, at 1201.
148 Id.
Additionally, health care professionals themselves can, and should, take on an educational role that assists their patients to partake fully of the rights and responsibilities associated with consumer-driven health care.\textsuperscript{149} Other potential sources of consumer information include government agencies (most prominently the federal Department of Health and Human Services), the employers who offer health plans to their employees and retirees (and those employees’ and retirees’ dependents), and independent non-governmental agencies such as AARP\textsuperscript{150} and various religious congregations. Voluntary educational activities can take the form of printed materials prepared for distribution, website postings of data comparing competing health plans and/or providers,\textsuperscript{151} and individual counseling sessions—exactly the same sorts of techniques that patients use to educate themselves about clinical choices in order to exercise meaningful informed consent.

These voluntary educational efforts may need to be supplemented by consumer protection laws that compel the disclosure of particular facts about competing health plans.\textsuperscript{152} One legal scholar argues for the importance of consumer protection laws by noting the following patient versus consumer contrast:

In the medical context, one might compare consumer disclosure laws to the physician’s duty under the tort doctrine of informed consent to disclose sufficient information to permit informed consent to medical care. The physician’s duty arises from the patient’s personal right of self-determination, which entitles the patient to whatever information she needs and wants to make medical care decisions. In contrast, consumers have no comparable personal right to information by virtue of their status as consumers. Consumer disclosure laws are designed to fill gaps in general knowledge in a population of undifferentiated consumers, and the seller’s duty is imposed to protect fair commercial exchanges.\textsuperscript{153}

A corollary to the concern about ignorant and/or overwhelmed consumers is


\textsuperscript{150} See, \textit{e.g.}, http://www.aarp.org/health/medicare/drug_coverage/medicarers_coverage.html (featuring AARP’s \textit{Guide to the New Medicare Prescription Drug Coverage}).

\textsuperscript{151} See, \textit{e.g.}, http://www.medicare.gov/; http://www.cms.hhs.gov/quality/hhqi.


\textsuperscript{153} Mariner, \textit{supra} note 17, at 493.
the apprehension among critics of consumer-driven health care that consumers will make bad choices that will later disadvantage them as patients, particularly if they need chronic care for their medical condition(s).\textsuperscript{154} The issue is put in the following terms: “[w]hether consumer choice will ‘work’ depends on whether consumers can, and will, choose \textit{wisely} when given the power to do so.”\textsuperscript{155} An emphasis on \textit{wise} and “sensible”\textsuperscript{156} consumer choices reveals an important misunderstanding (or at least an insufficient appreciation) of the autonomy principle.

Such misunderstanding or insufficient appreciation of the consumer’s right to run the risk of decisions that turn out later to yield unfortunate results easily translate into the sort of paternalism that is no longer tolerated when clinical care choices are at stake. According to one set of consumer-driven health care skeptics:

[W]e believe that health care providers should invest in information systems and other programs to keep track of populations with chronic disease and to ensure that they receive needed [as determined by providers] care and adhere to their regimens [even if members of those populations would choose to trade away the opportunity to purchase, with dollars they are responsible for managing, insurance to cover the costs of such adherence].\textsuperscript{157}

Bad medical choices, some of which the patient may regret later with the benefit of hindsight, also pose a real risk in the clinical arena, but that possibility ordinarily is not held to be a sufficient justification for health care providers, employers, government agencies, or other external actors to infringe on the patient’s decision making prerogative. In the final analysis, if patients—assuming they are competent, adequately informed about alternatives, and acting voluntarily—are afforded the right to make clinical choices that entail medical risks that later materialize and lead to regrettable clinical outcomes, there is no principled reason to deny informed consumers the right to take risks regarding the selection of their own health plans and to then hold those consumers to the bargains they have made.

At its heart, pessimistic speculation about the inability of private individuals to

\textsuperscript{154} Jacobi, \textit{Chronically Ill}, supra note 86 (predicting that consumer-driven health care “will endanger the health and well-being of the chronically ill...those most reliant on health coverage”). \textit{Id.} at 533.
\textsuperscript{155} \textit{Id.}, at 556
\textsuperscript{156} Id., at 557.
\textsuperscript{157} Lee & Zapert, \textit{supra} note 98, at 1204.
discharge successfully the autonomous consumer role when (but only when) important health plan decisions must be made rests on the vision that, in (but only in) the health plan selection context, people become too frail, weak, dependent, or otherwise vulnerable to exploitation or reasoning deficiencies to survive and prosper in a marketplace-of-choice environment. This disdainful attitude toward the same individuals whose decision making autonomy is fiercely defended when it comes to clinical choices is reflected in the claim:

[A]n informed choice by consumers, which results in efficiency, according to market theory, is a mirage in health care. Many patients (e.g., frail elderly patients and those who are seriously ill, who account for the largest proportion of hospital care) cannot comparison shop, reduce their demand for services when suppliers raise prices, or accurately appraise quality.\textsuperscript{158}

Skeptics about the ability of most consumers\textsuperscript{159} to shop as intelligently as government or managed care bureaucrats should consider the excellent results emanating from consumer-driven home and community-based long term care (HCBLTC) programs for disabled persons and the elderly.\textsuperscript{160} Although these rapidly proliferating\textsuperscript{161} programs differ regarding a variety of details, they typically feature individual budgets (with a finite quantity of dollars supplied by various levels of government) to be managed by the consumer (who is supported educationally and

\textsuperscript{159} Admittedly, there are a small percentage of individuals who lack sufficient intellectual and/or emotional capacity to function as autonomous decision makers, for either clinical care matters or health plan selection purposes. Even for such persons, though, some version of personal surrogate-driven health care may be possible, just as we sometimes need to rely on surrogates to make clinical decisions on behalf of incapacitated medical patients. See Kapp, supra note 130. See generally, Marshall B. Kapp, \textit{From Medical Patients to Health Care Consumers: Decisional Capacity and Choices to Purchase Coverage and Services}, 3 AGING & MENTAL HEALTH 294 (1999); Marshall B. Kapp, \textit{Consumer Choice in Health Care and Long Term Care: What the United States Can Teach and Learn From Others About Decisionally Incapacitated Consumers}, 24 INT'L J. L. & PSYCHIATRY 199 (2001); Marshall B. Kapp, \textit{Consumer Choice in Home and Community-Based Long Term Care: Policy Implications for Decisionally Incapacitated Consumers}, 19 HOME HEALTH CARE SERV. Q. 17 (2001).
administratively to handle this role), as well as free (or at the least very broad) choice of providers. The unifying theme of HCBLTC is:

a philosophy and orientation to the delivery of home and community-based services whereby informed consumers make choices [within a fixed budget assigned to them personally] about the services they receive.162

A full discussion of consumer-driven HCBLTC is beyond the scope of this article.163 Suffice it to say the following, for purposes of analogizing clinical decision making and health plan decision making in terms of the viability of informed consent exercise in both contexts: the overall national experience thus far with trusting, and thereby empowering, (often quite) disabled and older persons to make their own long term care choices—within their personal, government-supplied budgets—and arrange for the implementation of those choices has been overwhelmingly positive in several respects, including the promotion of individual autonomy and dignity for program participants.164

IV. CONCLUSION

I fully agree with the commentator who has suggested, “It is too early to say whether any of [the consumer-driven health plans] are the wave of the future, a niche market product, or a flash in the pan.”165 For a variety of psychological, political, and

162 Judith E. Heumann, Consumer-Directed Personal Care Services for Older People, at 1 (AARP Public Policy Institute, Series IB 64, 2003) (quoting the National Institute on Consumer-Directed Long-Term Services).
163 See generally Consumer-Directed Care and the Older Person, 6 ETHICS, L. & AGING REV. 3-187 (Marshall B. Kapp ed., 2000); Consumer Direction in Long-Term Care, GENERATIONS, Fall 2000, at 1-99.
164 See generally www.consumerdirection.org (containing information about a project sponsored by the Robert Wood Johnson Foundation, entitled “Promoting Consumer Direction in Aging Services,” and conducted through a partnership of the National Association of State Units on Aging and the National Council on the Aging). See also NATIONAL COUNCIL ON DISABILITY, CONSUMER-DIRECTED HEALTH CARE: HOW WELL DOES IT WORK?, http://www.ncd.gov/newsroom/publications/2004/consumerdirected.htm (finding “[b]oth studies and interviews indicate that best outcomes occur when consumers can make their own choices among service options. Even in nursing homes and other institutional settings, there is room for choice about activities and services”). Regarding the empowerment of nursing facility residents, see JOEL F. HANDLER, DOWN FROM BUREAUCRACY: THE AMBIGUITY OF PRIVATIZATION AND EMPOWERMENT 149-55 (1996).
165 Mariner, supra note 17, at 498.
logistical reasons, the theoretical underpinnings of this paradigm of health care financing and delivery may eventually crumple at the implementation stage. Having run its course for a time, consumer-driven health care may be replaced by yet the next in a long series of public/private sector quests to attain an unattainable utopia of simultaneous excellent health care quality and unlimited and universal access, all at a level of affordability that requires neither individuals, employers, unions, nor governments to ever have to prioritize their values and make any difficult, unpleasant choices about resource allocation.\textsuperscript{166}

However, the consumer-driven health care paradigm should not be undercut, certainly not at this early stage, by arguments predicated on the incompetence of Americans to fend for themselves adequately in terms of choosing among various health plans offered within a competitive marketplace environment. Autonomy is a privileged moral value in our society, as reflected in the health care context by the informed consent doctrine pertaining to individual medical decisions. This moral value and its legal embodiment should be fully respected and applied in the realm of decisions about the details and permutations of one’s health plan. To honor autonomous informed consent in one context but not the other would be both inconsistent and foolish.

\textsuperscript{166} For historical and philosophical insight regarding this continuous, futile attempt, see DANIEL CALLAHAN, FALSE HOPES: WHY AMERICA’S QUEST FOR PERFECT HEALTH IS A RECIPE FOR FAILURE (1998); MICHAEL B. KATZ, THE PRICE OF CITIZENSHIP: REDEFINING THE AMERICAN WELFARE STATE 257-92 (2001).