Twerski & Cohen's Second Revolution: A Systems/Strategic Perspective

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TWERSKI AND COHEN'S SECOND REVOLUTION:
A SYSTEMS/STRATEGIC PERSPECTIVE

Lynn M. LoPucki*

A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment.


State health data organizations are . . . weapons of revolution. Their common purpose is to take power away from the . . . providers of care and give it to the buyers.

MICHAEL L. MILLENSON, DEMANDING MEDICAL EXCELLENCE 355 (1997)

In a pathbreaking article published in 1992, Aaron Twerski and Neil Cohen suggested that basic principles of the law of informed consent required medical providers—doctors, hospitals, and health maintenance organizations (HMOs)—to tell their patients about competing providers who could perform the same procedures better or more safely. ¹ In its 1996 decision in Johnson v. Kokemoor, the Supreme Court of Wisconsin cited Twerski and Cohen's article in holding a neurosurgeon liable for not telling a patient of such a competitor. ² Twerski and Cohen’s most recent article, published in this issue of the Northwestern University Law Review, focuses on the legal issues left undecided in that case. ³ They argue convincingly that existing legal doctrine compels recognition of the new duty and that the unresolved legal issues are manageable. Only in their title and a single dry sentence in their conclusion do they acknowledge the potential magnitude

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2 545 N.W.2d 495 (Wis. 1996).
of the change they propose: "We recognize that our conclusions will engen-
der controversy because they may lead to significant changes in the delivery
of health care."4

The new duty Twerski and Cohen propose has potentially shocking
implications for the health care system. Empirical studies show meaningful
differences among medical providers on such important parameters as the
proportion of patients who survive treatment.5 If the least successful pro-
viders must advise their patients of the identities of the most successful, the
latter may be swamped and the former may end up with no patients at all.
Careers and institutions may be destroyed in the process.6 Given that the
"comparative provider statistics" that would drive the process are far from
perfect, the careers and institutions destroyed may not always be the right
ones.7 With careers and institutions at stake, at least some medical provid-
ers will respond strategically by fudging the data they report and refusing
treatment to patients whose limited prospects may adversely affect the pro-
viders’ rankings.8

Such problems pale, however, in comparison with the benefits that
could flow from the new duty. Public rankings delivered to the consumer at
the point of decision have the potential to directly save lives by facilitating
good choices among alternative providers,9 and to improve care overall by
providing incentives for providers to make constructive changes.10

In a legal system frightened of "judicial activism," implications such as
these are generally considered irrelevant. The court’s job is to determine
the requirements of the law, not what will work best. Accordingly, the Ko-
kemoor court stated the facts of the case, reviewed Wisconsin’s law of in-
formed consent, outlined the standards for review, and then considered the
defendant’s legal contentions regarding proper application of the law to the
facts. The social and economic implications referred to above made only a
cameo appearance in the court’s opinion, in the form of the familiar "slip-
pery slope" argument: “Finally, the defendant argues that if his duty to
procure the plaintiff’s informed consent includes an obligation to disclose
that she consider seeking treatment elsewhere, then there will be no logical

4 Id. at 42.
5 See, e.g., NEW YORK STATE DEP’T OF HEALTH, CORONARY ARTERY BYPASS SURGERY IN NEW
with adjusted mortality rates of less than 2% and others with adjusted mortality rates of greater than 5%).
6 See sources cited infra note 44 and accompanying text.
7 See Jesse Green, Problems in the Use of Outcome Statistics to Compare Health Care Providers,
8 See infra notes 80-81 and accompanying text.
9 See Susan C. Maerki et al., Selecting Categories of Patients for Regionalization: Implications of
the Relationship between Volume and Outcome, 24 MED. CARE 148 (1986) ("concentrating patients in
hospitals with high volumes of such patients could avert more than 60% of all hospital deaths [from se-
lected procedures]").
10 See infra notes 44-45 and accompanying text.
Twerski and Cohen's Second Revolution

stopping point to what the doctrine of informed consent might encompass. The court responds in an equally formalistic manner that "[i]n the vast majority of significantly less complicated cases, such a referral [to another physician] would be irrelevant and unnecessary."12

Although the social and economic implications of judicial choices are rarely taken formally into account, even first-year law students understand that such implications run beneath the surface and exert enormous effect on judicial decisions. No matter how compelling the formal legal case for Twerski and Cohen’s proposal, judges will not accede to it if they anticipate dire consequences for the medical care delivery system. Judges speculate about the social and economic implications of their decisions, but for the most part each does so on his or her own, with inadequate information and without the benefit of training or methodology.13

In a series of publications beginning in 1994, my co-authors and I have developed and applied a method for analyzing the social, economic, and other policy implications of legal decisionmaking.14 This method, generally referred to as the “systems/strategic approach,” is based on principles of systems analysis as applied in engineering and computerized business information systems.15 This Article applies the systems/strategic approach to evaluate Twerski and Cohen’s proposal.

The approach compares the two alternative systems under consideration as wholes. They are the medical care delivery system as it operates today and the same system as it would exist after implementation of the proposed duty. Part I of this Article describes the system as it operates today. Part II describes the system as it is likely to operate after implementation of the proposed duty. To project that operation, Part II specifies the change under consideration, projects the likely strategic responses of medical providers and patients, considers how the system might respond to those strategies, and then speculates on the direction the system will likely take in the future. Part III compares the two systems, based on each’s ability to achieve accepted goals of the health care system. Part IV concludes that the medical care delivery system can best serve the interests of patients if the courts require providers to disclose comparative provider statistics.

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11 Kokemoor, 545 N.W.2d at 510.
12 Id. The court’s response is formalistic rather than empirical because the court makes no attempt to support its claim regarding the effect of its decision.
13 With regard to methodology, at least, law and economics provides an exception. With generous funding from the Olin Foundation, proponents of that methodology have been conducting workshops for judges for almost two decades, and elements of it have been making their way into legal opinions.
15 See LoPucki, The Systems Approach to Law, supra note 14, at 481.
The first steps in conducting a systems/strategic analysis are to identify the system to be analyzed, differentiate it from its environment, and describe it at the level of specificity necessary for analysis. While Twerski and Cohen’s proposal might apply to nearly any procedure performed in the medical care delivery system, that system is too large and too differentiated to be described in its entirety at the required level of specificity. Instead, this Article describes and analyzes a single subsystem likely to be representative of only part of the medical delivery system: the coronary artery bypass graft (CABG) surgery delivery system.

Limiting the analysis to CABG surgery is appropriate for two additional reasons. First, the comparative provider statistics driving Twerski and Cohen’s proposed duty to disclose presently are available for only a small number of highly distinctive medical procedures. Analysis of application of the proposal in other parts of the medical care delivery system would be highly speculative because it would assume conditions not yet present. Second, the systems that deliver CABG surgery are highly differentiated from their environments. Only a small percentage of medical practitioners perform this type of surgery. They generally do so in parts of hospitals (heart units) that are specialized to the task. The components of the system for delivery of these procedures are differentiated from their environments in the sense that the surgeons, surgical nurses, technicians, equipment, physical spaces, patients, and virtually every other system component are dedicated to CABG surgery. Some elements such as the hospital’s financial administration, heating and air conditioning system, and food service may be common to the heart unit and the rest of the hospital. But the literature suggests little reason to believe that they have a significant bearing on the mortality and success rates of the heart unit. Thus, their inclusion in or exclusion from the analysis would likely make little difference.

Accordingly, for the purpose of this analysis, the systems under consideration will be (1) the heart unit of a hospital and (2) an individual surgeon in that unit. Each will stand as representative of the more than one thousand heart units in hospitals throughout the United States and of the individual surgeons in any of them. The results of this analysis can be generalized only to similarly differentiated medical units performing easily identifiable procedures with easily identifiable goals or objectives. This probably extends far enough to include nearly all of the procedures subject to Twerski and Cohen’s proposal.

16 See Second Revolution, supra note 3.
17 In 1996, for example, 32 hospitals performed CABG surgery in New York State. NEW YORK REPORT, supra note 5, at 8. The corresponding number for Massachusetts in the period 1990-94 was 13. See William A. Ghali et al., Statewide Quality Improvement Initiatives and Mortality After Cardiac Surgery, 277 JAMA 379, 379 (1997).
I. THE CURRENT SYSTEM

Two relevant kinds of subsystems are present in current CABG surgery delivery systems. Subsystems that deliver the surgery are discussed in subpart A, and subsystems that provide the information that patients use in selecting providers are discussed in subpart B. (Both kinds of subsystems would, of course, continue to be present in the proposed system.)

A. The CABG Surgery Delivery Subsystem

CABG surgery is performed at slightly over one thousand hospitals in the United States. Patients come to the heart units of these hospitals in a variety of ways. Some suffer heart attacks and are delivered to the heart unit by ambulance. Most are referred by cardiologists who have determined that they may need CABG surgery. Rarely has the referring cardiologist discussed comparative outcome statistics with the patient, or even taken them into account. Shortly after admission to the heart unit, the patient typically receives a heart catheterization. The catheterization is a diagnostic procedure with its own considerable risk. Of those who are diagnosed as needing CABG surgery, about forty-three percent remain in the same hospital until the surgery is performed. About thirty-eight percent of all patients who have CABG surgery have it within three days of their decision to do so, and another thirty-three percent have the surgery within three to seven days. Considering the speed of these procedures, the fragile health of many of the patients, and the psychological distress that generally accompanies the diagnosis, this schedule leaves little time to shop for hospitals or surgeons.

The cardiologist may give the patient a brief explanation of the procedure before referring the patient to the heart unit. But the “conversations” that have informed consent as their purpose do not really begin until the patient is in a hospital bed with an intravenous unit (IV) in his or her arm. The formal procedure for informed consent typically will not take place until the night before the surgery, which is too late for the consideration of

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19 See, e.g., Eric C. Schneider et al., Influence of Cardiac-Surgery Performance Reports on Referral Practices and Access to Care, 335 NEW ENG. J. MED. 251 (1996) (reporting on the referral practices of cardiologists with regard to CABG cases).
20 Eric C. Schneider & Arnold M. Epstein, Use of Public Performance Reports, 279 JAMA 1638, 1640 (1998) (only 1% of Pennsylvania CABG patients reported having discussed the Pennsylvania comparative statistics with a surgeon or other physician before surgery).
21 See id. at 1640.
22 See id. at 1641.
23 Id. at 1640.
alternatives. During the surgery, patients are sufficiently anesthetized to be incapable of either giving further consent or objecting to whatever is done.

On average, about 2.4% of patients who undergo open heart surgery die before leaving the hospital, but for particular hospitals the death rates range from as low as about one percent to as high as about five percent.25 About an equal number of patients suffer brain damage sufficiently severe that they will never be able to resume their normal lives.26 About ten percent of the veins implanted in bypass surgeries fail during the first year; more than fifty percent fail within ten years.27 Failure may mean that the patient dies, that the procedure must be repeated, or that some other solution must be found. Hence a significant number of patients go through the procedure for informed consent more than once.

A heart unit is an adaptive system. The unit, through “review committees” and the like, studies the outcomes of the procedures it performs and attempts to determine and correct the causes of its failures.28 Among other things, these committees compile and analyze data on mortality, success, and perhaps other factors. They then give that information to the surgeons in the unit. In addition, physicians and others working in the unit study the techniques employed and the outcomes obtained in other heart units in an attempt to discover better ways of doing things. Even basic aspects of the methods employed continue to evolve.29 Over time, the performance of a particular unit is more likely to improve than to decline.

This does not mean that a unit’s death rate will be inexorably reduced. The average presenting condition of patients may become worse, perhaps because the general population is older or because people are living longer. Providers with good success rates on younger, relatively healthier patients may become willing to operate on older, relatively sicker patients who would previously have been refused treatment on the ground that the risks of surgery outweighed the possibility of improvements in their health. Either change can cause an increase in a unit’s death rate even as the quality

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25 See NEW YORK REPORT, supra note 5, at 10.
26 See Gary W. Roach et al., Adverse Cerebral Outcomes After Coronary Bypass Surgery, 335 New Eng. J. Med. 1857, 1859 (1996) (finding that 3.1% of CABG patients had severe brain damage at time of discharge from the hospital and an additional 3% of CABG patients had mild brain damage). Rates varied from 1% to 14% at different institutions. Id.
29 See, e.g., Sandy Campbell, Searching for the Right “Keyhole” in Heart Surgery, HEALTH CARE STRATEGIC MGMT., June 1, 1997 (discussing the new “port access” and “minimally invasive direct” coronary artery bypass techniques).
of care remains the same or improves. But continual improvement in the quality of care should inexorably reduce the risk-adjusted death rate.  

The choice of a heart unit is generally made by the patient, by the referring physician, through a consultation between the two, or by the patient's HMO. Each of these participants will be concerned with the quality of care and other factors. For example, the patient may be concerned with the timing or cost of the procedure in a particular unit, or with the unit's proximity to friends and relatives. The referring physician may be concerned with the timing (for the benefit of the patient) without being concerned about the cost (either because the physician does not know the details of the patient's financing or because the physician considers cost relatively unimportant). The HMO's principal concern may be with the cost; quality may be only a secondary concern.

As is true generally of the medical care delivery system, the quality of care in the CABG delivery system is regulated in a variety of ways. State governments test and license physicians and hospitals.  

The federal government imposes quality restrictions indirectly through Medicare. Through their review committees, hospitals and HMOs examine the work of, and outcomes obtained by, affiliated doctors. The legal system imposes damages on medical providers in extreme cases. But there is another, increasingly important control, namely, that providers must attract patients in an already highly competitive environment.

B. The Decision Support Information Subsystem

Given the ability and enough time, substantial numbers of CABG patients and their representatives will seek the "best" providers, or at least the best they can afford. To do that, patients and their representatives must have information upon which to base a comparison. Such information comes in two forms: subjective, "reputation-based" information and statistical, "outcome-based" information. Though some reputation-based information consists merely of the opinions of patients who have little basis for evaluation besides personal experience, most reputation-based information is ultimately derived from the opinions of experts about the quality of the treatment that various providers deliver. This information may be informal and direct, as where a nurse or physician who works in a heart unit advises a patient which of the surgeons in the unit is best. It may be informal and indirect, as where a cardiologist in a distant city has heard discussions of the "reputations" of providers by persons who do not themselves have direct knowledge. Reputation-based information may be formalized, as

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30 A risk-adjusted death rate is a death rate that has been adjusted to take account of patient characteristics that have been shown to make death more or less likely for the particular patient.

31 See, e.g., Timothy Stoltzfus Jost, Oversight of the Quality of Medical Care: Regulation, Management, or the Market?, 37 ARIZ. L. REV. 825, 859-61 (1995) (describing the system for licensing physicians).
where a surgeon is granted privileges at a prestigious hospital on the basis of reputation. Reputation-based information usually will be based in some part on outcomes, but by definition, those outcomes are not comprehensively collected or statistically compared.

Outcome-based information (sometimes referred to as “evidence-based” information) is derived from scientific study of the measurable consequences of care. In its purest and most useful form, outcome-based information is in the form of “comparative provider statistics” specifically designed to facilitate comparison of the outcomes achieved by different providers.

Comparative provider statistics are a product of the computer age and therefore a relatively recent phenomenon. The first large-scale comparison of medical outcomes was an analysis of mortality in heart bypass operations completed in 1986.\textsuperscript{32} The data analyzed had not been collected for the purpose of comparing outcomes. It was collected by the U.S. Health Care Financing Administration (HCFA) for the purpose of controlling Medicare reimbursements. But it contained sufficient descriptions of outcomes to permit researchers to crudely calculate and compare the risk-adjusted mortality rates for particular heart units.\textsuperscript{33} By the early 1990s, a number of developments had taken place. Some hospitals were using newly affordable computer capacity to collect and analyze data on the outcomes of the care they delivered. Some state medical care regulators had instituted programs that require doctors and hospitals performing particular procedures to report on patients’ presenting conditions and treatment outcomes.\textsuperscript{34} A few businesses and governments engaged in purchasing health care for their employees were requiring the providers and prospective providers to collect and furnish outcome data.\textsuperscript{35}

Little of the data then collected was intended for publication.\textsuperscript{36} But key blocks of it, most notably the 1986 study of Medicare billing records\textsuperscript{37} and the 1989 New York survey of heart surgery outcomes,\textsuperscript{38} became available to the public through Freedom of Information Act (FOIA) requests by news media and others. These data releases were traumatic for some providers, because they showed risk-adjusted mortality rates for surgeons and

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\item \textsuperscript{32} See MILLENSON, supra note 18, at 174-76 (describing the study and its release).
\item \textsuperscript{33} See id.
\item \textsuperscript{34} See, e.g., Leslie Werstein Hann, Keeping Score, in BEST’S REVIEW—LIFE-HEALTH INSURANCE EDITION 31, 32 (1998) (listing New Jersey, Pennsylvania, New York, Maryland and Texas as “among the states publishing health-plan report cards on the Internet”).
\item \textsuperscript{35} See, e.g., MILLENSON, supra note 18, at 216-22 (describing Hershey Foods’ successful effort to require medical providers to furnish outcome data to Hershey).
\item \textsuperscript{36} See Schneider & Epstein, supra note 20, at 1638 (“Information on the quality of care provided by physicians, hospitals, and health plans has traditionally been collected for internal quality assurance and has almost always remained confidential.”).
\item \textsuperscript{37} See Joel Brinkley, U.S. Releasing Lists of Hospitals with Abnormal Mortality Rates, N.Y. TIMES, Mar. 12, 1986, at A1.
\item \textsuperscript{38} See Green, supra note 7, at 70-72 (describing the litigation).
\end{itemize}
hospitals by name.39 The releases were, however, well received by the media and the public. Both state and federal governments began routinely releasing such data and statistics and encouraging patients and referring physicians to use them to select the doctors, hospitals, or HMOs with the best outcomes.40 Responding to criticisms of the accuracy of the government’s adjustments, non-profit organizations and entrepreneurs used their own formulae to readjust the raw data, generate new statistics, and make those statistics available on websites.41

Outcome evaluation has been controversial. Risk adjustment is not perfect, and as a result, hospitals and doctors do not always receive the ratings they should.42 In an effort to improve their ratings, hospitals and doctors sometimes misreport the presenting conditions of their patients or refuse to treat patients for whom they think the risk adjustment may be inadequate.43 On the whole, however, outcome evaluation has been a tremendous success. Providers with the highest risk-adjusted mortality rates have been forced to improve or leave the market.44 Bad ratings, whether justified or not, have prompted reviews that have led to improvements.45 Risk-adjusted mortality rates for the kinds of procedures reported on have fallen.46 Controversy remains,47 but it is controversy over the methods for,

39 See MILLENSON, supra note 18, at 175 (stating that “news that comparative information [derived from the HCFA study] on clinical quality . . . would be . . . released to the public with real hospital names attached sent shock waves through the medical community”).

40 See, e.g., NEW YORK REPORT, supra note 5, at 1 (“We encourage doctors to discuss this information with their patients and colleagues as they develop treatment plans.”).


42 See Lisa I. Iezzoni, The Risks of Risk Adjustment, 278 JAMA 1600 (1997) (discussing empirical study and concluding that “[s]everity adjusted mortality rates alone are unlikely to isolate quality differences across hospitals”); see also Green, supra note 8 (arguing against the use of provider-specific outcome statistics as evidence in informed consent or malpractice litigation).

43 See infra notes 81-82 and accompanying text.

44 See, e.g., MILLENSON, supra note 18, at 202 (noting that the 27 low-volume surgeons who stopped performing CABG surgery in New York State from 1989 to 1992 had risk-adjusted death rates 2.3 to 5 times the statewide average); Lisa Priest, Where Patients Can Judge Surgeons: Pennsylvania’s Free Guide Is a Hit with Patients, and Death Rates for Bypass Operations Have Declined by 26%, TORONTO STAR, Sept. 20, 1997 (noting that Dr. Elliot Sendoroff, the heart surgeon with the highest risk-adjusted mortality rate according to the New York Report, no longer did heart surgery). See also Robert L. Lowes, Informed Consent Will Require More Informing, 74 MED. ECON. 93, 94 (1997) (noting that the defendant doctor in Johnson v. Kokemoor, Dr. Richard Kokemoor, no longer performs neurosurgery).

45 See MILLENSON, supra note 18, at 201 n.39 (citing news stories in which 6 of 31 hospitals performing CABG surgery in New York state “publicly admitted that the performance report prompted new quality improvement initiatives”).

46 See Cardiac Scorecard: N.Y. Bypass Mortality Hits 8-Year Low, HEALTH LINE, Nov. 13, 1998 (“Since New York began monitoring bypass surgery in 1989, the death rate associated with the procedure has dropped 30% to 1996s low of 2.44 deaths per 100 (1996 is the latest year for which data is available.”). But see Ghali et al., supra note 17 (finding mortality reductions in Massachusetts, which
and appropriate uses of, outcome evaluations, not over whether outcome evaluation should be done.

In early 1997, the Joint Commission on Accreditation of Healthcare Organizations announced that it would require hospitals seeking accreditation to integrate the use of outcome and other performance measures into their daily operations.\(^4\) Outcome evaluation, including publication of comparative provider statistics on hospitals, HMOs, and individual surgeons, is now an accepted feature of the medical landscape.\(^5\) As Michael Millenson concludes, “We have finally gone from a system that fiercely defended the idea that medical accountability must be defined by the opinions of doctors to a system that accepts the principle that doctors can be held accountable by outsiders using objective data.”\(^6\)

What this means for the purpose of the analysis presented in this Article is that the status quo and most realistic alternative to the system proposed by Twerski and Cohen is a system in which comparative provider statistics are generated, published, and made available to patients by government agencies, private publishers, and on the Internet. The difference between the systems compared here is whether the provider has a legal duty to make patients aware of available comparative provider statistics and to explain them.

II. THE SYSTEM THAT WOULD RESULT FROM TwerSKI AND COHEN’S PROPOSAL

A. Twerski and Cohen’s Proposal

As applied to CABG surgery, Twerski and Cohen’s proposal would place on the surgeon who performs the procedure, the hospital in which it is performed, and any medical care organization involved the duty to disclose relevant comparative provider statistics to the extent that, as the Kokemoor court put it, “a reasonable person in the patient’s position would need to know [them] in order to make an intelligent and informed decision.”\(^7\) Absent such disclosure, the patient would have an action against the provider for lack of informed consent. The plaintiff who proves that he or she would have switched to a less risky provider had one been disclosed would be entitled to recover the portion of damages that represent the plaintiff’s “lost chance.”\(^8\)

\(^{47}\) See, e.g., Ghali et al., supra note 17 (questioning whether publication of outcome statistics caused the reductions in risk-adjusted mortality that occurred in New York and northern New England).

\(^{48}\) See MILLENSON, supra note 18, at 362.

\(^{49}\) See id. (describing the solid foothold of outcome measurement in the medical profession).

\(^{50}\) Id. at 348.

\(^{51}\) Johnson v. Kokemoor, 545 N.W.2d 495, 504 (Wis. 1996).

\(^{52}\) See Comparing Medical Providers, supra note 1, at 21.
Twerski and Cohen would not require a provider to “analyze or process any raw data in its possession,” but would place on providers a duty to disclose if the provider “has risk information in a form from which comparative inferences can be drawn.” This distinction may not be tenable. As Kokemoor illustrates, the information necessary for the patient to make an intelligent and informed decision is not the average level of risk for a general class of procedures—in that case, basilar bifurcation aneurysm surgery—but rather the patient-specific level of risk for the particular procedure that the patient is to undergo—a 40-year-old diabetic undergoing surgery for a large basilar bifurcation aneurysm. In most cases, comparative provider statistics will not be available “off the rack” for the patient-specific risk associated with the particular procedure. If the available data are likely to yield information useful to the patient, however, then the reasonable provider might have to generate those statistics from that data.

As to the information that must be provided, Twerski and Cohen’s proposal creates no safe harbor and draws no bright lines. Providers would have to decide what information provides a reasonable basis for decisionmaking, disclose it to their patients, and then, if necessary, defend their choices of information in actions brought by their patients. Providers would not, however, be required to make disclosures that their patients did not want.

Finally, Twerski and Cohen’s proposed duty would have only a single formal means of implementation: courts granting money damages in cases brought against providers by patients who suffered adverse results. The duty may also be implemented by informal means: the development among providers of social norms requiring providers to disclose even when disclosure was not in their immediate economic interests.

B. Strategic Reaction to the Modified System

Participants in law-related systems often respond strategically to changes. That is, they respond with the kinds of behavior that the system rewards. For an untried system, the nature of that behavior may be difficult to predict, yet it has the potential to drastically transform some systems. Thus, the designer of a law-related system (usually referred to in the legal literature as a “policymaker”) must perform an additional step not required of the designer of a business information system: a strategic analysis. In a strategic analysis, the system designer “game-plays” the system from the perspectives of various participants. The focus is on how the various par-

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53 Second Revolution, supra note 3, at 38.
54 Id.
55 See Kokemoor, 545 N.W.2d at 499.
56 See Second Revolution, supra note 3; Peter H. Schuck, Rethinking Informed Consent, 103 YALE L.J. 899, 956-58 (1994) (arguing for freedom to contract regarding the necessity for and level of informed consent).
57 See LoPucki, supra note 15, at 507-09 (describing strategic analysis).
Participants are likely to alter their behavior in response to the new system, the system dynamic that is likely to result from the new behaviors, and, if that dynamic is not what the designers want, what they can do to change it. Such projections are always speculative, but analysts do them because they frequently generate ideas for system improvement.

Assuming for the purpose of analysis that the courts will impose the Twerski and Cohen duty, the threshold question is whether providers will make the disclosure and, if so, in what form or forms. As Professor Schuck put it, "Tort law is particularly impotent when it seeks to alter behavior in the kind of settings in which informed consent proper is supposed to occur." 58

In Kokemoor, the Supreme Court of Wisconsin found that a patient had not given informed consent because the physician had not disclosed comparative provider statistics. 59 The medical profession's lack of response to Kokemoor 60 suggests that providers have in fact chosen, at least initially, to ignore the duty. But Kokemoor can be interpreted to impose a duty far less extensive than that advocated by Twerski and Cohen. Kokemoor involved both a high-risk procedure and a provider whose projected performance was probably well below average for providers regularly performing the procedure. One can interpret the case as imposing a duty only on providers whose projected performance is so bad that they are not qualified, under current medical standards, to perform the procedure. Under this interpretation, the average providers of CABG surgery would not have to inform their patients of the existence of the best providers, even though the best providers had a risk-adjusted mortality rate less than half theirs. 61 This interpretation is buttressed by the Kokemoor court's conclusion that the decision would require few physicians to disclose comparative provider statistics. 62

Some providers may not be disclosing today because they do not think disclosure is required for any procedure they are qualified to perform under current medical standards. Other providers may believe that they have a broader duty under Kokemoor but ignore it on the theory that the loss of business resulting from disclosure would exceed the damages awarded for nondisclosure. Over ninety-five percent of CABG recipients survive the

58 Schuck, supra note 56, at 938.
59 See Kokemoor, 545 N.W.2d at 505, 510.
60 In the three years since the Kokemoor decision, there has been little comment in the legal, medical, or general literature. Searches in the Lexis files MEDLIN/RXMEGA, LAWREV/ALLREV/ and NEWS/CURNWS for "Kokemoor" yield a total of only about ten relevant citations. This lack of concern may in part result from the rejection of the holding in Kokemoor by a Washington Court of Appeals. See Whiteside v. Lukson, 947 P.2d 1263 (Wash. Ct. App. 1997). None of the comment that does exist suggests that providers are now divulging comparative provider statistics as part of the process for obtaining informed consent. Id.
61 The latest mortality statistics for CABG surgery released by the New York State Health Department show four hospitals with risk-adjusted mortality rates in excess of 4.0% and ten hospitals with risk-adjusted mortality rates of less than 2.0%. See NEW YORK REPORT, supra note 5, at 9.
62 See Kokemoor, 545 N.W.2d at 510.
ministrations of even relatively poor providers. Among the fewer than five percent who die in the hospital, only a small proportion of these estates are likely to sue. Informed consent cases are notoriously difficult to win. The large bulk of them will be dismissed or settled for amounts less than the projected award at trial. The damages awarded at trial under Twerski and Cohen’s formula will on average be only about half of what would be awarded to the same patient in a successful action for wrongful death. The amounts that would be awarded to CABG patients for wrongful death would be relatively small to begin with, because CABG patients have shorter-than-average life expectancies. In cases where the differences in provider statistics are small, decedents’ representatives may have difficulty finding attorneys who will take the cases on contingent fees. Considering all of these limits together, the rational provider with poor statistics may find it cost-effective to not disclose and accept the legal consequences instead.

If the imposition of the Twerski and Cohen duty does change provider behavior, it more likely will be because providers with good statistics embrace the duty. Some providers already use favorable comparative provider statistics in advertising. The Twerski and Cohen duty may provide a welcome excuse for repeating the favorable comparisons to those patients about to go under the knife. As such dutiful disclosures enter the public consciousness—through mass media treatment as well as personal experiences—the resulting social norms may make it difficult for those providers with bad statistics to continue to stand mute. Of course, such a change will take time.

Once providers decide to disclose, they will face the issue of what information to disclose and in what form. The practice with regard to informed consent generally suggests that disclosure will come in two stages.

63 See NEW YORK REPORT, supra note 5, at 9-10 (showing nearly all hospitals and surgeons in New York to have adjusted mortality rates of less than 5%).
64 See, e.g., PAUL C. WEILER, A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION 73 (1993) (estimating only a one in fifty chance that a patient who suffers a negligent medical injury will file a malpractice claim).
65 See, e.g., Schuck, supra note 56, at 935 (describing some of the difficulties).
66 The average CABG patient runs a mortality risk of about 2% to 3%. Switching to the best available provider would reduce that risk to between 1% and 2%, roughly halving it. Assuming the risk to be precisely halved, that is the proportion of damages Twerski and Cohen would allow. Comparing Medical Providers, supra note 1, at 29.
67 For example, Millenson notes:

In recent years the Society of Thoracic Surgeons has assembled detailed clinical information on outcomes of the procedure. However, the society prohibits public release of figures on individual surgeons or hospitals, or even comparisons among states or regions of the country. There is one exception: surgeons who want to disclose their personal results—even if just for marketing purposes—can do so. “This whole system was designed for the individual surgeon for his own use,” the head of the society’s data committee explained to the Chicago Tribune in 1993.

68 See Schuck, supra note 56, at 947 (arguing that the American Medical Association could have generated such norms when the informed consent doctrine was first gaining ground).
First, the doctor will explain the comparative provider statistics, perhaps in a two-way conversation. Then, the patient will be required to sign a form containing the essential information. If the patient later sues, the written form will be the most authoritative evidence of what was disclosed. But *Kokemoor* demonstrates that the patient may also put the provider's oral presentation in issue in the litigation.

Twerski and Cohen seem to assume that providers will disclose the comparative provider statistics published by their state's government. These may not, however, be the statistics a reasonable patient would want. Commentators have criticized the methods by which state governments have generated statistics, some analysts claim to have superior methods for risk adjustment, and the governments' risk categories will not be appropriate for some patients. Some providers may take advantage of the flexibility of the "reasonable patient" standard to report unofficial statistics that compare them more favorably—perhaps even statistics they themselves have generated. The limit on this escape, however, is that the statistics disclosed

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69 *See, e.g.,* Paula Walter, *The Doctrine of Informed Consent: To Inform or Not To Inform?* 71 St. John's L. Rev. 543, 547-48 (1997). ("The informed consent doctrine envisages a joint decision-making process in which the physician digests the technical information for the patient and transmits this information in a manner comprehensible by a layperson. The patient, in turn, asks questions, evaluates the information conveyed, and agrees to either proceed or not to proceed with the recommended treatment."). But see Schuck, *supra* note 56, at 933 (expressing doubt that much dialogue actually occurs); *id.* at 934 ("[A]necdotal and social science evidence alike demonstrate that informed consent law in action is often ritualistic, formalistic, and hollow.").

70 *See Schuck, supra* note 56, at 917 ("Increasingly, the disclosure is evidenced by a written form signed by the patient prior to treatment, which recites both the risks disclosed to her and her voluntary consent to treatment.").

71 The evidence that Dr. Kokemoor failed to obtain informed consent was entirely testimonial regarding the discussions between him and the plaintiff. *See Kokemoor,* 545 N.W.2d at 499-500 (recounting, as testimony, oral exchanges between defendant and plaintiff).

72 *See Second Revolution, supra* note 3.

73 *See Green, supra* note 7.

74 *See Kathy Robertson, Hospitals Having Palpitations over New Report Cards, SACRAMENTO BUS. J.,* Nov. 20, 1998, at 6 (reporting that the risk adjustment methods of Healthcare Report Cards are confidential).

75 For example, Dr. Kokemoor's defense was that he had disclosed accurate information for surgery to clip a basal aneurysm. *See Kokemoor,* 545 N.W.2d at 500. The plaintiff's attorney successfully argued, however, that the disclosure should have been for surgery by a physician with the defendant's relatively limited experience. *See id.* at 499.

76 Professor Jon Macy has proposed as the "iron rule" of law school ratings that regardless of methodology, ratings prepared by a person affiliated with a school will show that school more favorably than ratings prepared by others. Cf. Theodore Eisenberg & Martin T. Wells, *Ranking and Explaining the Scholarly Impact of Law Schools,* 27 J. LEGAL STUD. 373, 396 (1998) (showing the results of a study done by Cornell professors ranking Cornell Law School 6th in the United States on basis of citation, the results of a study done by a Chicago-Kent professor ranking Chicago-Kent 28th in the United States on basis of productivity, and the results of a study done by U.S. NEWS & WORLD REPORT, ranking Cornell 11th and Chicago-Kent 45th on the basis of scholarly reputation).
Twerski and Cohen’s Second Revolution

must be sufficiently grounded in fact so that the provider can defend them at trial. If they are not, the provider gains little or nothing by disclosing.

As they strategize about the contents of disclosure, providers will examine the available statistics, experiment with various interpretations, and consider generating new statistics. These exercises will not only enable them to present themselves to patients in the best possible light, but also cause providers to focus inevitably on their own shortcomings as indicated in the statistics. One way to get better statistics is to do a better job. Thus, the strategizing is not merely a cost to the system, but also a mechanism for improving the quality of care.

The flexibility that the system gives providers with regard to manner of presentation will moderate the harshest effects of the required comparisons. Nevertheless, under Twerski and Cohen’s proposal, substantial numbers of providers will be bound to disclose distinctly superior performance by their competitors. Some commentators predict that such disclosures will cause nearly all the recipients to switch providers. That is unlikely for several reasons. First, switching will be impractical for many patients, either because they are members of an HMO that will not pay for the alternative provider or because of the urgency of the patient’s medical condition. Second, some patients will opt for the higher-risk provider in order to have the procedure performed near home, friends, and family, or because they have personal or historical ties to the higher-risk provider. Third, the lower-risk providers may charge substantially more for their services or be committed to other patients for substantial periods into the future. Fourth, the disclosures will come late in the preparations for surgery when it will be psychologically difficult for patients to switch. Fifth, some patients will decline the disclosure because they prefer to have their cardiologist make the decision for them. Finally, some patients may be so disarmed by the candor of the higher-risk provider that they may choose to stick with him or her for that reason alone. It is certainly possible that when advised of the existence of even a substantially lower-risk provider, most patients will not switch.

Several commentators have expressed the belief that providers will respond to adverse rankings based on statistical data by cooking the statistics.

77 For example, Dan Tennenhouse, a longtime risk-management consultant to Kaiser Permanente, a large not-for-profit HMO based in Oakland, California, was quoted as saying: “When you explain to most any patient who’s facing surgery with potentially serious complications that you have a 12% risk factor, and then tell him that a doctor at a big tertiary-care center 90 miles away has a 10% risk factor, you can expect to lose the patient.” Robert L. Lowes, Are the Litigation Floodgates Going to Open Even Wider?, 74 MED. ECON. 104 (1997).

78 See, e.g., S. Silber et al., Waiting Times and Death on the Waiting List for Coronary Artery Bypass Operation, 21 HERZ 389 (1996) (reporting mean waiting times of 13 to 20 days and a risk of dying on the waiting list of 1.3% per month for CABG surgery).

79 See supra Part I. Given that informed consent is part of a decisionmaking process, courts should require that providers obtain it sufficiently early to facilitate that process. However logical such a change may be, it goes beyond the proposal that is the subject of this Article.
Providers can report patients as more severely ill than they are on presentation or as more well than they are after treatment (referred to as “upcoding”\textsuperscript{80}), or they can refuse to treat patients for whom they believe the government’s risk adjustment is inadequate.\textsuperscript{81} While the seriousness of these strategic responses should not be minimized, there is little reason to think they will be exacerbated significantly by Twerski and Cohen’s proposed duty. Providers are already evaluated on the basis of their comparative statistics—by their employers, their hospitals, their managed care plans, their large corporate purchasers, and their insurers. The incentives for upcoding or refusing treatment already exist.\textsuperscript{82} The duty to disclose comparative provider statistics to patients will add to those incentives, but only marginally.

III. COMPARATIVE EVALUATION OF THE CURRENT AND PROPOSED SYSTEMS

The costs of producing comparative provider statistics should not weigh heavily in evaluating Twerski and Cohen’s proposal. Governments and providers will incur the costs of producing the statistics and making them “available” to patients via the Internet or other channels of communication,\textsuperscript{83} whether or not the courts impose the duty to disclose them as part of obtaining informed consent.

At present, only about one percent of CABG patients make successful use of comparative provider statistics.\textsuperscript{84} Absent Twerski and Cohen’s proposal, that proportion can be expected to increase as the statistics improve in quality and more patients become aware of them, but even in the long run, most patients will require assistance to discover and make successful use of comparative provider statistics in the few days between decision and surgery. Possession and even understanding of risk-adjusted mortality statistics for the procedure recommended is not enough. The statistics must be interpreted by a loyal expert with reference to the patient’s own case. As two commentators put it:

\textsuperscript{80} See MILLENSON, supra note 18, at 23, 201 (reporting the practice and resulting corruption of data).

\textsuperscript{81} See id. at 197-201 (discussing and partly refuting charges that doctors and hospitals refused treatment to high-risk patients in response to publication of the New York CABG mortality rates); Schneider, supra note 19 (after commencement of state reporting of comparative provider statistics, “fifty-nine percent of [New York] cardiologists reported increased difficulty in finding surgeons willing to perform CABG surgery in severely ill patients who required it”). But see Eric D. Peterson et al., The Effects of New York’s Bypass Surgery Provider Profiling on Access to Care and Patient Outcomes In the Elderly, 32 J. AM. COLLEGE CARDIOLOGY 993 (1998) (finding “no evidence that [New York’s] provider profiling limited procedure access of New York’s elderly or increased out-of-state transfers” of patients).

\textsuperscript{82} MILLENSON, supra note 18, at 192-201.

\textsuperscript{83} See supra notes 47-50 and accompanying text.

\textsuperscript{84} A recently published study found that only 12% of Pennsylvania CABG recipients knew in advance that Pennsylvania published cardiac surgery mortality rates and that only one-third of them had seen the published rates. See Schneider & Epstein, supra note 20, at 1639. Only 1% reported discussing the ratings with a physician and only 1% reported that the Pennsylvania publication was a major or moderate influence in choice of surgeon or surgical group. See id. at 1639-40. Schneider and Epstein reported they “found formidable evidence that public reporting of mortality outcomes in Pennsylvania has had virtually no direct impact on patients’ selection of hospitals or surgeons.” Id. at 1642.
Standing alone, statistical probabilities of survival may indeed not be material for an individual patient. Statistical probabilities become material, however, if they indicate whether the particular patient is likely to survive, or predict that patient’s probable quality of life with and without treatment. The informed consent issue thus centers on disclosure of proposed treatment success rates concerning both survival prospects and quality of life for the specific individual.\(^{85}\)

Patients generally do not have the expertise either to determine which comparative provider statistics are relevant or to interpret these statistics once they have made the determination. For example, to find the comparative provider statistics relevant to her upcoming surgery, the plaintiff in \(Ko\-kemoor\) would have had to understand that she needed the statistics on large posterior circulation aneurysm surgery rather than the statistics on aneurysm surgery generally.

The provider initially selected by the patient is the ideal person to provide the necessary expertise.\(^{86}\) That provider is more familiar than any other system participant with the patient’s condition, the procedure to be performed, the alternative providers, and the relevant comparative provider statistics; that provider is also physically convenient to the patient. Twerski and Cohen’s duty would put that provider on notice that a court may later second-guess the provider’s judgment as to what the patient needed to know. By doing so, it would help to align the interests of the disclosing provider with those of the patient.

Absent the duty that Twerski and Cohen propose, providers and payors will continue to use comparative provider statistics to improve health care, but in doing so, they will pursue their own interests. Despite providers’ protestations that they are fiduciaries for patients and would not allow financial incentives to influence their judgment, history teaches us that their judgments do respond to financial incentives. Under the fee-for-service system of the 1960s and 1970s, providers were paid more if they provided more services. For those who could pay, that system delivered more services than were necessary. Under the fledgling managed care system of the 1980s and early 1990s, providers had financial incentives to deny care. As a result, that system tended to deliver fewer services than were necessary.\(^{87}\)

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\(^{86}\) See, e.g., Schneider & Epstein, *supra* note 20, at 1642 ("Providers may also play an important role. Without a tailored and intensive program for dissemination and patient education, efforts to aid patient decision making with performance reports are unlikely to succeed.").

\(^{87}\) See MILLENSON, *supra* note 18, at 285-305 (discussing the relationship between financial incentives of providers and the levels of medical care provided).
The interests of providers differ in important respects from those of their patients.88 Absent an effective system for delivering comparative provider statistics, power will remain with the payors and providers and the system will evolve in accord with their values. From the patients’ perspective, the process of selecting providers will continue to be reputation based rather than outcome based, with reputations only a dim, lagging reflection of outcomes.

In the short run, imposition of the Twerski and Cohen duty would increase the proportion of patients who actually receive and effectively use such statistics. In the long run, that proportion could become substantial. When most selections of providers are made by informed and well-advised patients, the interests of providers and payors will coincide with those of patients and the system will evolve accordingly.

For many readers, the most troubling aspect of Twerski and Cohen’s proposal will be the obligation on providers to make disclosures in conflict with their own financial interests. Such obligations currently exist in a variety of contexts, and there is substantial literature analyzing them.89 Although the commentators put forth a variety of justifications for non-disclosure in most circumstances, they generally admit an exception for fiduciary relationships90 such as that which exists between doctor and patient.91 As Christopher Wonnell notes, among the justifications for this duty to disclose is that it eliminates an expense the beneficiary would otherwise incur to discover facts already known to someone else.92 Anthony Kronman’s principal argument against a general duty to disclose—that those required to disclose would have insufficient incentives to gather the information in the first place93—is inapplicable, because providers already

90 See, e.g., Wonnell, supra note 89, at 331 (noting that “[n]ondisclosure by a fiduciary is generally prohibited”).
91 See, e.g., Moore v. Regents of the Univ. of Cal., 793 P.2d 479, 483 (Cal. 1990) (“[A] physician must disclose personal interests unrelated to the patient’s health, whether research or economic, that may affect the physician’s professional judgment ... and ... a physician’s failure to disclose such interests may give rise to a cause of action for performing medical procedures without informed consent or breach of fiduciary duty.”). See also Marjorie Maguire Shultz, From Informed Consent to Patient Choice: A New Protected Interest, 95 Yale L.J. 219, 259 (1985) (“A doctor’s specialized knowledge and powerful role make her a fiduciary to those who depend on her. Consequently, the doctor owes undivided loyalty to her patients.”).
92 See Wonnell, supra note 89, at 380-81.
93 See Kronman, supra note 89, at 26 (“It is doubtful whether the benefits of market information which are not eliminated by a disclosure requirement are sufficient by themselves to justify a deliberate investment in its production.”).
gather most of the necessary information for other purposes94 and Twerski and Cohen's proposal would require them to gather the rest.

Once the decision has been made that patients should have and use comparative provider statistics, the problem for systems analysis is how to supply it in usable form. Because the provider has so much of the necessary information and expertise already, it is difficult to imagine another mechanism that could rival the duty to disclose in efficiency.

American society is already deeply committed, ethically and legally, to placing the interests of the patient first.95 Providers have always recognized a duty to refer patients to other providers who could serve them better. But with no means of determining whose care was "better," that duty was largely illusory. Now, comparative provider statistics have, for the first time, made it possible for the public to collect on the medical profession's longstanding commitment. As Twerski and Cohen demonstrate in The Second Revolution in Informed Consent, the commitment is so pervasive in the language of informed consent that its revocation would be both a major break with precedent and an embarrassment to the system.

The costs of making the proposed disclosures would be minimal. Providers are already familiar with most of the necessary data. Their duty to search for more presumably would be limited to data that was cost effective from the patient's point of view. Providers already must meet with patients to obtain their informed consent; in the ordinary case the proposed disclosures would add only a minute or two. The benefits of the proposed disclosures—shifting patients from low-success providers to high-success providers—would be great.96

Two other arguments against the wide dissemination of comparative provider statistics are also worthy of consideration. The first is that most of the differences disclosed in them are not statistically significant.97 That is, they may result merely from chance. Those differences nevertheless can be expected to drive patient decisions and thereby inflict unwarranted harm on particular providers.

Even those who make this argument usually concede that patients should base decisions on differences that do not rise to the level of statisti-

94 See supra Part I.B.
95 See, e.g., Samuel Hellman & Deborah S. Hellman, Of Mice but Not Men: Problems of the Randomized Clinical Trial, in ETHICAL ISSUES IN MODERN MEDICINE (John D. Arras & Bonnie Steinbock eds., 4th ed. 1995) ("The physician, by entering into a relationship with an individual patient, assumes certain obligations, including the commitment to act in the patient's best interests."); Jacobi, supra note 88, at 720 ("Medical ethics has long regarded the patient's interests as the only proper basis for a physician's decisions.").
96 See Maerki, supra note 9 (estimating that regionalization of care could eliminate 60% of hospital deaths from certain procedures).
97 For example, in the latest statistics for CABG surgery in New York, only 4 of 32 hospitals had mortality rates significantly different from the statewide rate at the .05 level. See NEW YORK REPORT, supra note 5, at 9.
The unfairness to providers can be minimized by improvements in the statistics over time. In the meantime, providers—who will control both the form and content of the presentation of the statistics—can explain the limitations of the data. Ultimately, there is nothing unfair about using the best information available in decisionmaking. That is something every one of us does every day, often to the detriment of others.

Closely related to this argument is one that asks how new providers, who are likely to have worse statistics because they lack experience, are to get their start in a world where patients will know who they are and can avoid them. From a systems perspective, the answer is simple. When the demand for experienced providers exceeds the supply, some patients will have to opt for, or be assigned to, inexperienced providers. Until then, it would not make much sense to leave experienced, low-risk providers idle so that inexperienced, high-risk providers can gain experience. In a system that allocated medical services by forcing patients to choose providers without information about their levels of experience, precisely that could happen.

As a practical matter, this means that inexperienced providers will practice on those unable or unwilling to pay the higher prices that the most experienced and successful providers command. That is the deeply ingrained reality of the system as it currently operates. To deny patients who are able and willing to pay higher prices the information they need to get the quality for which they are paying may confuse the picture and thereby assuage some consciences. But it is not a desirable solution, because it reduces the incentives of providers to offer quality care.

The second argument against the wide dissemination of comparative provider statistics is that if all patients chose providers based on adequate information, all would choose essentially the same providers. Because the providers chosen could not serve all patients, some patients would be relegated to worse providers and be aware of that fact. Though the providers who treat them might be the same ones that they would have chosen in a world without information, these patients might not be as happy with the treatment and the outcomes objectively might not be as good.

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99 See, e.g., Lowes, supra note 44 (quoting neurosurgeon-lawyer W. Ben Blackett as saying, "The surgeon who's done the most spinal-cord surgeries, for instance, had to do his first one sometime .... But if a new doctor can't do his first, where will our future experts come from?").
100 For example, in Milwaukee, HMOs pay cardiac surgeons $3000 to $5000 for CABG surgery, while Medicaid—which serves the indigent—pays cardiac surgeons only $1500 for CABG surgery. This slighting of the poor is deliberate; Medicare—which serves the elderly—pays cardiac surgeons $2500 for CABG surgery. See Interview by Aaron Twerski with anonymous Milwaukee cardiac surgeon (Feb. 17, 1999). The corresponding figures obtained from a New York City hospital were $3500 on the private market, $3000 for Medicare, and $1200 for Medicaid.
101 See, e.g., P.J. Bush, The Placebo Effect, 14 J. AM. PHARMACEUTICAL ASSN. 671 (1974) (the demeanor of the physician in the context of a total therapeutic setting can achieve a placebo effect). This effect might be lost if the physician is required to reveal the physician's second-rate outcome statistics.
The opposite view is at least equally plausible. Patients today may be suffering from lack of faith in a system they know they do not understand, trust, or control. If one's doctor was assigned by the HMO or the hospital and one has no sound basis for thinking that the HMO or hospital is above average, then one has no sound reason to think that the doctor is above average. In fact, one has good reason to think that the doctor is below average. Some patients have good information about doctors, and it is reasonable to suppose that they chose the best available, leaving the worst for random assignment.

A system grounded in the ignorance of patients would be constantly in danger of erosion through the dissemination of information. In addition, a system in which substantial numbers of patients choose to remain ignorant of the quality of care provided to them would tend to misallocate its resources. Either effect might alone outweigh the benefits to be gained from ignorance.

IV. CONCLUSION

The imposition of a legal duty on medical providers to disclose comparative provider statistics as part of the process of obtaining informed consent may at first seem drastic. As the analysis in this Article has shown, however, it likely would be moderate in effect. Comparative provider statistics already are extensively collected, intensively used, and widely disseminated. Requiring providers to disclose them to patients would merely focus more patient and provider attention on them and expand their use in provider selection.

Requiring providers to make disclosures against their own economic interests may also seem harsh. Conscientious providers, however, already take comparative provider statistics into account in determining whether to refer patients. Here also, the change would be one of degree rather than a sharp break with the past.

Over the long run, imposition of the Twerski and Cohen duty probably would effect large economic changes in the system for medical care delivery. In the short run, the changes would be moderate. Providers' strategic activity and patients' inertia would allow relatively weak providers time to make themselves competitive. The worst providers probably would have difficulty retaining patients if they complied with the duty, but that is hardly cause for concern.

The most important difference in system function likely to result from imposition of the duty Twerski and Cohen propose is that the flow of outcome statistics will reach, and inform the decisions of, substantial numbers of patients. If that occurs, the medical care delivery system will evolve naturally toward the kinds of quality defined by patients' values and preferences. Power will shift from providers to patients, but that is as it should be.
