Informed Consent, Price Transparency, and Disclosure

Abstract

In the American medical system, patients do not know the final price of treatment until long after the treatment is given, at which point it is too late to say 'no.' I argue that without price disclosure many, perhaps all, tokens of consent in clinical medicine fall below the standard of valid, informed consent. This is a sweeping and broad thesis. The reason for this thesis is surprisingly simple: medical services rarely have prices attached to them which are known to the patient prior to treatment. Yet, for many patients, knowledge of the price is relevant to whether they would give consent. If informed consent requires that patients know all information about their treatment that is relevant to their decision, then consent to a medical intervention in the absence of the price is not informed consent.

Keywords

Informed Consent; Price Transparency; Disclosure; Cost; Reasonable Person

Main Text

Early in the COVID-19 pandemic, Texas resident Travis Warner sought a PCR test to see if he had COVID due to possible exposure at work. He and his wife went to an ER 30 minutes from their home, where they were tested for COVID. The bill he eventually

received was for $56,384, of which he was responsible for $16,915.20.[1] Obviously, had he known what the price for this test would be, Warner would never have gone through with it. Sadly, Warner confronted the harsh reality that the American medical system is a 'menu without prices'.[2] In most cases, patients and doctors do not know the final price of treatment until long after the treatment is given, at which point it is too late to say 'no.'

Obviously, this lack of price transparency is bad for patients, who lose the ability to price shop and respond rationally to their options. My concern is not with this important, but familiar, claim. I endorse a much bolder thesis, namely that the lack of price transparency has the surprising effect of jeopardizing the informed consent of patients. I argue that without price disclosure many, perhaps all, tokens of consent in clinical medicine fall below the standard of valid, informed consent. This is a sweeping and broad thesis. The reason for this thesis is surprisingly simple: medical services rarely have prices attached to them which are known to the patient prior to treatment. Yet, for many patients, knowledge of the price is relevant to whether they would give consent. If informed consent requires that patients know all information about their treatment that is relevant to their decision, then consent to a medical intervention in the absence of the price is not informed consent.

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[1] A. Pattani, Aneri. 2021. The Bill for His COVID Test In Texas Was A Whopping $54,000. *NPR* 30 September. Available at: https://www.npr.org/sections/health-shots/2021/09/30/1039788368/covid-test-high-bill-er

[2] N. Henrikson & V. Shankaran. Improving Price Transparency in Cancer Care. *Journal of Oncology Practice* 2016; 12: 44-48, p. 44.

The upshot of my argument is substantial. Informed consent is the foundational value of modern medical ethics. If I'm correct, we cannot achieve informed consent without radically reforming the pricing of medical services to make prices known to consumers prior to treatment. That is my *negative thesis*, that consent is not informed without price transparency. My *positive thesis* is that we must, as a matter of justice, attach prices to all medical interventions. This could be achieved in several ways. Both fully socialized medicine (where the price is $0 for the patient) and fully market-based medicine (where the price is set by supply and demand) would allow for informed consent. I do not take a stance on which of these systems is correct. My focus is mainly the negative thesis.

In section I, briefly explain how widespread the price transparency crisis is. In section II, I canvas the dominant views of what patients are entitled to know for their consent to be sufficiently informed. In section III, I argue that knowledge of prices is required by all plausible views of what patients have a right to know. In section IV, I address objections.

I. THE CRISIS OF PRICE TRANSPARENCY

As I stated earlier, most patients don't know the price of medical services prior to receiving those medical services. In one study (which viscerally illustrates this), researchers randomly chose two hospitals in each of the fifty states and called each ('using a standardized script') to ask about the price of a hip replacement for their uninsured 62-year-old grandmother.[3] The researchers also called the US News and World Report top 20 orthopedic hospitals with the same question. The results were astounding.

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[3] J. Rosenthal, X. Lu & P. Cram. Availability of Consumer Prices From US Hospitals for a Common Surgical Procedure. *JAMA Internal Medicine* 2013; 173: 427-432, p. 427.

They were able to 'obtain a complete price from 12 (60%)' of the 20 top ranked hospitals and a complete price from '64 hospitals (63%)' of the 102 non-top-ranked hospitals they called.[4] But, only ten of those hospitals were able to give the full price ('hospital fee plus physician fee') in one call; 54 hospitals 'were able to give the complete price only after...[the researchers] contacted the hospital and physician practices separately.'[5] The other approximately 40% of hospitals were either only able to provide a partial price or no price at all.[6] Overall, 'only 16% of a randomly selected group of US hospitals were able to provide complete bundled price' for the procedure.[7] Across these hospitals, when the price could be given, it varied from $11,000 to $125,798 for the same procedure.[8] And, even when this information was available, getting it 'was difficult and frequently required multiple conversations with numerous staff members at each hospital as well as affiliated physicians offices'.[9] This is not an isolated example but, sadly, represents the broader reality of the American medical system.[10]

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[4] Ibid: 428.

[5] Ibid: 428.

[6] Ibid: 428.

[7] Ibid: 429-430.

[8] Ibid: 427.

[9] Ibid: 429-430.

[10] According to the National Conference of State Legislatures, 25 states have price transparency laws. But, a recent survey found that 'most U.S. hospitals are not complying with federal regulations requiring medical centers to post their prices online' (D. Diamond. 2021. Nearly all hospitals flout federal requirement to post prices, report finds. *The Washington Post* 16 July. Available at: https://www.washingtonpost.com/health/2021/07/16/hospital-cost-transparency/). The NCSL document is available here: National Council of State Legislatures. 2021. *Transparency and Disclosure of Health Care Prices*. NCSL. Available at:

II. WHEN IS CONSENT SUFFICIENT INFORMED?

Informed consent is not merely a 'yes' from the patient; it requires that the patient be informed of certain information. What information must be disclosed? Much ink has been spilt on this topic, and I won't resolve that issue here. Most bioethicists agree that informed consent does not require that patients have *full information* but instead think they must be *sufficiently informed*. In this section, I canvas the dominant views of what information must be disclosed to a patient for her consent to be sufficiently informed. All views of informed consent agree that patients have a right to know (although not all use rights language) all information that is *relevant* to their treatment; in the absence of relevant information disclosure, their consent is not sufficiently informed.[11] The question

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https://www.ncsl.org/research/health/transparency-and-disclosure-health-costs.aspx#:~:text=All%2DPayer%20Claims%20Databases,-All%2DPayer%20Claims&text=Currently%2025%20states%20have%20enacted,states%20have%20existing%20voluntary%20efforts.

[11] This is widely endorsed. The AMA's Code of Medical Ethics' Opinions on Informing Patients says, 'physicians should sensitively and respectfully disclose all relevant medical information to patients' (AMA Council on Ethical and Judicial Affairs. 2012. *AMA Code of Medical Ethics' Opinions on Informing Patients*. Available at: https://journalofethics.ama-assn.org/article/ama-code-medical-ethics-opinions-informing-patients/2012-07). As Savulescu and Momeyer say, 'Respect for autonomy finds expression in the doctrine of informed consent. According to that doctrine, no medical procedure may be performed upon a competent patient unless that patient has consented to have that procedure, after having been provided with the relevant facts' (J. Savulescu & R. Momeyer. Should informed consent be based on rational beliefs? *Journal of Medical Ethics* 1997; 23: 282-288, p. 282). Grisso and Appelbaum also hold that competence requires 'the ability

on which there is substantial disagreement is what information is *relevant* in the sense of being required for informed consent. According to Beauchamp and Childress, there are three main views: (1) the professional practice standard, (2) the reasonable person standard, and (3) the subjective standard.

According to the professional practice standard, the relevant information that doctors must disclose is determined by the 'professional community's customary practices,' meaning that 'professional custom establishes the amount and kinds of information to be disclosed'.[12] Thus, whatever it is common practice to disclose is what doctors are obligated to disclose.

According to the familiar reasonable person standard, 'we must determine the information to be disclosed by reference to a hypothetical reasonable person'.[13] If this reasonable person were to judge a piece of information to be relevant, then that information is relevant.[14] Conversely, if this reasonable person judges a piece of

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to understand information relevant to treatment decision making' (T. Grisso & P. Appelbaum. (1998). *Assessing Competence to Consent to Treatment: A Guide for Physicians and Other Health Professionals*. Oxford, UK: Oxford University Press, p. 31).

[12] T. Beauchamp & J. Childress. (2001). *Principles of Biomedical Ethics*. 5th Edition. Oxford, UK: Oxford University Press, p. 82.

[13] Ibid: 82.

[14] Millum and Bromwich have recently defended a modified reasonable person standard for disclosure (J. Millum & D. Bromwich. Informed Consent: What Must Be Disclosed and What Must be Understood? *American Journal of Bioethics* 2021; 21: 46-58), as has Sawicki (N.

information to not be relevant to their decision, then doctors are not obligated to disclose that information.

Lastly, the subjective standard 'judges adequacy of information by reference to the specific informational needs of the individual person, rather than the hypothetical 'reasonable person''.[15] In other words, whether a particular piece of information is relevant to a patient is determined by the patient's own desires. This view struggles with placing a reasonable limit on disclosure. It would not be feasible for doctors to canvas all possible things that might be material to patients prior to performing an intervention. Beauchamp and Childress suggest limiting the principle in the following way: 'the physician is obligated to disclose the information a particular patient needs to know, if the physician could reasonably be expected to know that patient's informational needs.'[16] In short, whether a piece of information is relevant to a patient is determined by the patient herself, but doctors are only obligated to disclose information that either the patient asks for or which the doctor could reasonably think is relevant for this specific patient.

All of these standards can be understood as stating a counterfactual requirement for valid consent, specifically a *dealbreaker* condition. Suppose X consents to Y doing action Z. A dealbreaker is some piece of information such that if X knew it, X would not have

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Sawicki. Modernizing Informed Consent: Expanding the Boundaries of Materiality. *University of Illinois Law Review* 2016; 821: 821-872).

[15] Beauchamp and Childress, op. cit. note 12, p. 83.

[16] Ibid: 83.

consented to Y doing Z.[17] According to the reasonable person standard, if a doctor withholds information that would cause a reasonable person to dissent if she knew it, and the patient consents, then this is not valid consent. According to the subjective standard, if the doctor withholds information that would cause this particular patient to dissent if she knew it, and the patient consents, this is not valid consent. Although they do not use the dealbreaker terminology, most accounts invoke the identical concept of materiality.[18] For example, consider this passage from Faden and Beauchamp:

> Substantial understanding [which is required for informed consent] demands apprehension of all the material or important descriptions-but not all the relevant (and certainly not all possible) descriptions....what distinguishes relatively important descriptions of R [an intervention] from relatively unimportant descriptions? Perhaps the most important general criterion is the extent to which the description is material to the person's decision to authorize R...a person must understand those propositions about R and about authorizing R that are germane

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[17] I borrow this terminology from Dougherty (T. Dougherty. Sex, Lies, and Consent. *Ethics* 2013; 123: 717-744.).

[18] As an anonymous referee helpfully pointed out to me, although these views may all reach the same result in this case, the mechanics differ. The failure to disclose relevant information could undermine consent for different reasons according to different theories. For example, in the passage below, Faden and Beauchamp say that consent is undermined in this case by patients not having substantial understanding. Millum and Bromwich, in contrast, suggest that the failure to disclose relevant information undermines consent by undermining the voluntariness of the patient's decision (Millum and Bromwich, op. cit. note 14, p. 6). Although the mechanics differ, my argument only relies on these views converging on the same conclusion.

to the person's evaluation of whether R is an intervention the person should authorize.[19]

For my purposes, I will use the terms 'dealbreaker,' 'material to consent,' and 'relevant to consent' interchangeably.[20]

At this juncture, one might object on the grounds that, historically, medical ethicists and legal scholars have understood relevant information to be restricted to only *medical information*, to the exclusion of non-medical information.[21] This means that the above standards of disclosure should be restricted to only medical information that a reasonable person, etc., would want to know. On this view, prices, as they are non-medical information, would not be included within the scope of disclosure. Although this has, in fact, been the common view, I believe that it is mistaken. To say that doctors only need to disclose relevant medical information, not relevant information simpliciter, seems like a very arbitrary principle that we would not apply in any other commercial contexts. For

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[19] R. Faden & T. Beauchamp. (1986). *A History and Theory of Informed Consent*. Oxford, UK: Oxford University Press, p. 302.

[20] The legal standard of medical informed consent also follows this: 'in defining the scope of the informed consent duty, courts uniformly concluded that physicians have a legal obligation to inform patients of material information about a proposed course of treatment' (Sawicki, op. cit. note14, p. 827).

[21] As Sawicki says, 'legal scholars interpreting the common law history of informed consent have concluded that, with very rare exceptions, the physician's duty only extends to disclosure of medically material facts------not other types of information that may nevertheless be relevant to a patient's choice' (Ibid: 833).

example, if I am buying a TV, it would be odd for the salesperson to think they had done their due diligence of disclosure if they neglected to tell me that buying the TV signed me up for a 5-year, expensive cable service. This information is clearly something relevant to the average consumer, and it's reasonable to think I wouldn't buy the TV if I knew this. It would not be reasonable for the salesperson to say that she withheld this on the grounds that only information narrowly about the product itself was owed.

The common justification for this view is that doctors are not financial counselors; they are tasked with healing to the best of their abilities. On this view, 'physicians should simply focus on what is best for their patients regardless of cost'.[22] Thus, to consider (and disclose) cost to patients would be to focus on something other than giving the best care possible. This is fair enough, and it may turn out that doctors themselves are not the ones best suited to give price information to patients. As I argue later, it is likely insurance providers who bear the bulk of this obligation. This, however, does not absolve the medical profession broadly of its obligation to inform patients of relevant information.

As a final response to this view, one can argue that cost information should be considered relevant medical information because comes with medical side effects. There is evidence that the burden of high costs can cause patients substantial distress, lowers adherence to treatment, and causes patients to delay care.[23] All of this makes the patient's health worse,

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[22] C. Alexander, M. Hall, & J. Lantos. Rethinking Professional Ethics in the Cost-Sharing Era. *The American Journal of Bioethics* 2006; 6: 17-22, p. 20.

[23] Shankaran and Ramsey say that 'high out-of-pocket spending on cancer treatment has been shown in recent studies to be associated with decreased treatment adherence and poorer quality of life' (V. Shankaran & S. Ramsey. Addressing the Financial Burden of Cancer Treatment: From

which clearly counts as a relevant *medical* outcome of a treatment. Thus, even if doctors must only disclose medical information, costs can be a relevant piece of medical information.

To recap, patients are owed the relevant/material information (according to whichever standard of disclosure is correct) about their treatment, and this information ought not be restricted just to narrowly medical information.

III: PRICE IS RELEVANT/REQUIRED INFORMTION ON EACH PLAUSIBLE STANDARD

Having set out the various standards for what information is relevant for informed consent, I now argue that, for most patients and most interventions, price is relevant. Price is a dealbreaker for almost everyone. If this is true, then doctors routinely perform interventions on patients without informing patients of relevant information which, if the

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Copay to Can't Pay. *JAMA Oncology* 2015; 1: 273-274, p. 273). As a further example, Ubel, Abernathy, and Zafar note that 'many insured patients burdened by high out-of-pocket costs from cancer treatment reduce their spending on food and clothing to make ends meet or reduce the frequency with which they take prescribed medications' (P. Ubel, A. Abernathy &Y Zafar. Full Disclosure-Out-of-Pocket Costs as Side Effects. *New England Journal of Medicine* 2013; 369: 1484-1486, p. 1485). Zafar notes that, in a sample from Washington state, 'having a cancer diagnosis was associated with a 2.65-times greater likelihood of declaring personal bankruptcy,' and other work has found that 'those cancer patients who declared bankruptcy had a 79% greater mortality risk than those who had not' (Y. Zafar. Financial Toxicity of Cancer Care: It's Time to Intervene. *Journal of the National Cancer Institute* 2016*;* 108: 1-4, p. 2). Hall (A. Hall. Financial Side Effects: Why Patients Should Be Informed of Costs. *Hastings Center Report* 2014; 44: 41-47, p. 43) also argues that cost has downstream side-effects.

patient if the patient knew it, may cause her to withdraw her consent. If this is true, then these patients' tokens of consent are not valid.

I argue that on each plausible standard of what information is relevant (and thus required for informed consent), price counts as relevant. I say each plausible standard, because the professional practice standard is obviously incorrect. It would entail that there was nothing objectionable about the common practice of not seeking patients' informed consent prior to the informed consent revolution in the 1970s, as that was the professional practice at the time.[24] On both the reasonable person and subjective standards, price is relevant.

Take the reasonable person standard; surely, a reasonable person would want to know the price of a service prior to agreeing to purchase it. Consider contexts outside of medicine. Suppose S is buying a car. It would be bizarre to suggest that it's reasonable that S would buy the car prior to hearing its price. Most reasonable people use price as a signal for how to rationally allocate their time and money. This is the chief function of prices in a market. I see no reason for thinking that standard, rational market behavior should be jettisoned once we enter the clinical setting. If the rational consumer wants to know prices, then the rational patient (who is a consumer of medical services) would want to

[24] For a concise summary of truly reprehensible and shocking consent practices prior to the 1970s, see T. Beauchamp. Informed Consent: Its History, Meaning, and Present Challenges. *Cambridge Quarterly of Healthcare Ethics* 2011; 20: 515-523.

know the price. Thus, on the reasonable person standard, price is a dealbreaker, meaning that if we are to secure consent, we must give prices.[25]

One might object here that only certain prices are dealbreakers to the reasonable person. For example, perhaps the reasonable person would not consider any prices below $50 to be relevant. In other words, with low-cost treatments, reasonable patients may not really care about the price, indicating that they would not consider it to be relevant information of which they must be informed for valid consent. While I feel the force of this objection, I still think it imposes an ad hoc conception of the reasonable consumer. For what other commercial domains would we say that a reasonable consumer wouldn't care about low prices?[26] And, even if this objection succeeds, this would only show that those treatments that have very low prices escape my argument. Sadly, that is not the majority of medical treatments.

Turning to the subjective standard, there is ample empirical evidence that patients want to know the price of care before receiving care. In a study of 220 patients, 81.4% 'either strongly agreed or agreed with preferring that their physician talk with them about their out-of-pocket costs before beginning treatment,' and 92% wanted 'to know their out-of-

[25] The preceding argument is very similar to Morgan (R. A. Morgan. Cost: An Important Question that Must Be Asked. *HEC Forum* 2022; (no issue assigned) :1-10, p. 5). He does not put his argument in terms of the reasonable person standard, but he does make the same point that we don't expect non-medical consumers to choose without prices.

[26] Morgan (Ibid: 5) makes a similar point.

pocket costs before beginning treatment'.[27] In a study with 96 cancer patients, 80% 'wanted cost information,' but 72% 'responded that no health care professional has ever discussed costs with them'.[28] Overall, the authors suggest that there is 'growing evidence...that people are comfortable with and want direct communication about their costs in the clinical setting'.[29] And, there is evidence that doctors themselves know that patients want price information.[30]

Overall, on the two plausible standards for what information must be disclosed for informed consent to be valid, price must be disclosed, meaning that in the absence of prices, consent is not sufficiently informed and thus not valid.

Versions of this argument have been advanced by a few other bioethicists, but mine is unique in several ways. Hall argues for a connection between informed consent and prices; she bases her argument on considerations of autonomy and the claim that 'what

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[27] N. Henrikson, et al. Communication with Physicians about Health Care Costs: Survey of an Insured Population. *Permanente Journal* 2017; 21: 16-070, p. 18.

[28] R. Kelly, et al. Patients and Physicians Can Discuss Costs of Cancer Treatment in the Clinic. *Journal of Oncology Practice* 2022; 11: 308-313, p. 308.

[29] Henrikson et al., op. cit. note 27, p. 21.

[30] As Sloan and Ubel note, 'One survey...reports that 86% to 95% of a representative sample of internists are aware of patients in their panel going without medical care because of cost' (C. Sloan & P. Ubel. The 7 Habits of Highly Effective Cost-of-Care Conversations. *Annals of Internal Medicine* 2019; 170: S33-S36, p. S33). The survey is found in S. L. Perez, et al. U.S. internists' perspectives on discussing cost of care with patients: structured interviews and a survey. *Annals of Internal Medicine* 2019; 170: S39-45.

counts as a benefit for a patient cannot be determined by the physician from an objective medical standpoint.'[31] My argument only overlaps with her first claim, but she defends it on different grounds by likening the right to know about side-effects with the right to know about financial risks. My argument agrees with this but casts a wider net across multiple theories of disclosure. Morgan makes a very similar argument to mine that 'cost conversations are essential to informed consent because patients have a right to information that they think is relevant'.[32] Although my argument is very much in agreement with Morgan, his argument is substantially shorter and less-developed than mine. Finally, Richman, Hall, and Schulman briefly develop an argument linking informed consent and price transparency based on the idea of an implied contract. On their view, a patient [is obligated] to pay whatever amount a prudent patient and provider would have agreed to, given appropriate time and information.'[33]

At this juncture, a crucial objection enters: what if it's true that patients are entitled to price information, but this information simply cannot be given to them prior to treatment? In some cases, patients aren't given the price because there is no price until the hospital submits the claim to the insurance company, and in some cases the price is just simply so hard to discover that it would consume all of a doctor's daily time. Because ought implies can, and because the price cannot be provided, medical providers are not blameworthy for not supplying prices to patients. And, because the price cannot be given, doctors are

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[31] Hall, op. cit. note 23, p. 42.

[32] Morgan, op. cit. note 25, p. 1. Morgan notes that this idea is present in both the Nuremberg Code and the 1981 Presidential Commission Report 'Making Health Care Decisions.'

[33] B. Richman, M. Hall &K. Schulman. Overbilling and Informed Financial Consent-A Contractual Solution. *New England Journal of Medicine* 2012; 367: 396-397, p. 397.

not obligated to give it.

Although this is a strong objection, I believe it fails. There are two versions of this objection, one in principle and one in practice. The in-principle objection says that doctors are not obligated to provide prices, because prices, in principle, cannot be given. They simply don't exist until after the procedure. The in-practice objection says that doctors are not obligated to provide prices, because it is so difficult to find prices that it would be infeasible and overly demanding to ask this of them. Both versions fail.

The in-principle objection clearly fails, because the price does exist prior to the treatment. There is nothing magical about the price of medical services that stops prices from being known ex-ante. And, clearly insurance firms have no issue with assessing prices when it comes time to bill patients. Thus, there are prices; they just simply aren't revealed to doctors or patients. The existence of retail clinics, which provide prices for all services, is enough to refute the in-principle version of the objection. Furthermore, if the price is an emergent property of the negotiation between providers and insurance, they could simply be mandated to carry out this negotiation in advance of providing the service. Overall, the in-principle version of the objection fails because it is clearly *possible* to provide prices to patients before they make treatment decisions.[34]

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[34] As Hall says, 'the impossibilities here are neither logical nor physical; they are entirely artificial. We have created (or allowed to develop) a system that is needlessly complex. Other countries manage, through a variety of means, to create health care systems where prices are clear and simple...Furthermore, it is possible to figure out the costs of treatment—otherwise, patients would never receive any bills. Hospitals, clinics, and other providers are clearly capable of working with

But, not all possible actions are obligatory. The in-practice objection enters here to say that, in the status quo, it is overly demanding (and thus not obligatory) of doctors to suggest that they need to provide patients with prices. I agree that, in many cases, doctors in the status quo are not obligated to provide prices if discerning that price would seriously impair their ability to serve patients. Indeed, finding the price is extremely complicated. Consider the following passages that illustrate this:

> The current reality is that it is very difficult, and often impossible, for the clinician to know the actual out-of-pocket costs for each patient, since costs vary by intervention, insurer, location of care, choice of pharmacy or radiology service, and so on.[35]

> It is often very difficult to know those costs in advance. For instance, while hospitals have a set list of costs for various procedures—the charge master—these lists often have little to do with what will ultimately be charged for any individual patient's care. Different payers, whether private insurers or government payers, often negotiate separate rates for the same procedure, and typically only those without insurance coverage are charged the price listed on the charge master...to disclose costs to patients, the practitioner would first need to know which plan each patient is covered by and what the negotiated rates are for that plan. Yet even this information is not enough. Individuals on the same

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insurance companies to figure out exactly what the patient will be billed. The difficulty is in the timing, which is not an insoluble problem' (Hall, op. cit. note 23, p. 45)

[35] Ubel, Abernathy & Zafar, op. cit. note 23, p. 1484.

> plan can end up with different out-of-pocket costs for the same procedures in the same facility, depending on how much they have paid out of pocket so far. In order to tell individual patients what their costs will be, the physician or other health care provider would also need to know the exact requirements of the patients' plans in terms of copayments, deductibles, out-of-pocket maximums, and any other types of coinsurance, as well as how much of those coinsurance requirements the particular patient has already met.[36]

All of this reveals the tragic nature of the American medical system; prices are necessary for informed consent, but it is so practically difficult to determine prices that it seems like asking too much to demand this of every doctor. Overall, patients' consent is invalid, but doctors are often powerless to render it valid. What of the status of the in-practice objection? If the goal of this objection is to narrowly show that doctors are off the hook for providing prices, then I think it succeeds. But, surely we should not just leave things there. All this proves is that the patient's consent is invalid but that it's not doctors' responsibility to mend the situation. We should strive for a state where consent can be sufficiently informed. The solution relies on a facilitative principle like the following:

> **Background Consent**: If background actors in a domain that requires the consent of a participant could (without undue burden) provide information that would render the participant's consent valid, these background actors are obligated to provide that information.

[36] Hall, op. cit. note 23, p. 44.

This principle is very plausible. Perhaps this principle ought not apply to all domains, but it seems clear that it applies in medicine, where informed, valid consent is the chief guiding principle. All people involved in healthcare, not just doctors, are serving the overall purpose of the healthcare system, which is to (within reasonable limits) make people healthier, consistent with ethical standards.[37] In practice, means that even though doctors may not be immediately responsible for informing patients of prices, certain background actors (insurance firms, hospitals, etc.) are responsible for this. This could take a variety of forms, i.e. hospitals providing financial counseling staff, insurance companies having a tool on their website that allows for inputting billing codes to determine prices, etc. Is this an undue burden? I think not, because, as Hall rightly notes, insurance firms have no issue assessing prices when it's time to bill patients.[38] This principle merely asks them to do their current workload earlier.

One might object that we consent all the time to actions that have an unknown future, which the consent receiver cannot anticipate. For example, suppose that I buy a car. The salesperson cannot guarantee that it will last for 100,000 miles. But, suppose that I would not consent if I knew the car would last less than 100,000 miles. It turns out that the car makes it to 95,000 miles. The salesperson did not inform me of something that was a dealbreaker for me. It seems that there is nothing defunct about this interaction. The salesperson simply is not obligated to disclose information that he has no way of

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[37] Beyond the initial plausibility of this principle, I believe a sustained argument for it can be given based on the role obligations of people involved in medicine. I lack sufficient space to develop that argument here. Thanks are due to an anonymous referee for suggesting an argument along these lines.

[38] Ibid: 45.

knowing, and my consent is not invalid if the car doesn't make it as far as I want. So, if doctors can't know the price, aren't they just like the salesperson who cannot tell us how long the car will last? I agree that consent is valid in the presence of dealbreakers that one party could never guarantee, but that is not the case for medicine. While car salespeople genuinely have no way of knowing how long the car will last in exact terms, the healthcare industry is only artificially unable to offer exact prices. With institutional changes, prices could be given. There is no such analogous change to the auto industry that would allow salespeople to know exactly how long a car will last.

I want to take a moment to note how sweeping my conclusion, if correct, is. If I am right that knowledge of the price is a necessary condition of informed consent, then this means that (because price is virtually never known in the US), most medical interventions in the US fail to meet the standard of informed consent! This means that we are routinely failing to live up to our own foundational principle.

IV: OBJECTIONS

I. What about life-saving care?

What about cases where the potential harm of not receiving the treatment is so bad that no price would be high enough to deter a patient? For example, if getting the treatment avoids death or incredible loss of quality of life, it seems like there is no price at which someone would say 'no' to this treatment, meaning that price is not a dealbreaker in such cases. While I find this plausible I still think that many people would want to know the price of the service even with a potentially lifesaving treatment. All interventions have a chance of not working. Suppose that A has cancer and is told that very expensive

treatment is the only sure way of saving her life, while chemotherapy has a 20% chance of saving her life. A has a family and wants to leave her children sufficient money to pay for college. If she did the better treatment, she would bankrupt herself. If A values the guarantee of her children's education over the higher chance of her surviving, then she would want to know the prices of each service. But, even if this objection succeeds, it would only negate my argument in cases of life or death medical care.

II. Will this make patients forgo necessary treatment?

One might worry that increased price transparency would cause price conscious patients to delay or not even seek care out of concern for the cost. Whereas, if they didn't know the price ex ante, they would have been likely to seek care. I think we can all see the paternalism lying behind this objection, in that it assumes that medical interests are the patient's only interests worth advancing.[39] Patients may reasonably seek to advance other interests, at the expense of their health, and this is their right.[40] To suggest that informing patients of the true cost would be bad on the grounds of how they might use this

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[39] The type of paternalism involved will depend on why the doctor doesn't want to tell the patient the price. If the doctor thinks that the patient is mistaken to value saving money over health, then this would be an instance of strong paternalism. If the doctor thinks that the patient in fact values health over saving money and is acting in a way that is practically irrational, then this would be weak paternalism. See Dworkin (G. Dworkin. 2020. *Paternalism*. The Stanford Encyclopedia of Philosophy (2020): Available at: https://plato.stanford.edu/entries/paternalism/) for a helpful entry on the varieties of paternalism, from which I draw these definitions.

[40] Hall (op. cit. note 23, p. 43) echoes this point. As an anonymous referee suggested to me, we could also inform patients of the fact that price transparency may cause them to delay care.

information is unduly paternalistic.

III. Will this justify low quality care for poor individuals?

A related objection is that if doctors are to be concerned with disclosing costs to patients, they might not tell poor patients about treatments that they know these patients cannot afford. As Fins asks, 'if some treatment options are out of a patient's 'price range,' will he or she be free to make voluntary choices about care? And if some items are too costly, will they be conveyed at all? Would providers simply exclude the more expensive options from the alternatives available to other customers with coverage or better insurance?'[41] I don't see at all how this follows. In the status quo, poor patients already cannot afford certain treatments. Simply informing them of options beyond their price range does nothing to change this. If anything, it allows poor individuals the option of choosing treatments they can afford, rather than incurring massive medical debt. But, we can also solve this problem by requiring doctors to show all treatment options, even those not within the patient's financial means. Ultimately, this is a problem with quality of insurance and cost of care, not price transparency.

CONCLUSION:

I've argued that for their consent to be valid and informed, patients must have the prices of medical services disclosed to them prior to choosing a treatment option. The upshot of my view is that informed consent requires price transparency. This conclusion is neutral between two different institutional types of healthcare. Both socialized medicine (where

[41] J. Fins. Fee Disclosure at a Cost. *Hastings Center Report* 2014; 44: 3, p. 3.

the price is $0) and a fully market-based system with price transparency would satisfy the requirements I've argued for in this paper.[42] I do not take a stance on which system is preferable.

If it's true that most medical interventions in the US lack valid, informed consent, what should we do? Should we cease all care? Obviously not. In non-ideal circumstances of injustice, we should do the action that is least unjust, which is to treat patients rather than not treat them. But, this is no reason to be content with non-ideal conditions.

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[42] Some HMO insurance plans will also pass this test. And, as an anonymous referee pointed out to me, insurance schemes with a flat or maximum co-payment would also pass this test.