Controversy

Informed consent in a different key: physicians' practice profiles and the patient's right to know

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In 1997 the State of Massachusetts enacted legislation that makes the practice profiles of its physicians available to the public. These profiles include such information as the physicians' education, the honours and awards they have received, their hospital affiliations and the insurance plans with which they are affiliated. They also report whether successful malpractice suits have been brought against the physicians, whether they have received any criminal convictions and whether they have been the subject of disciplinary actions by hospitals or medical officials within the last 10 years. The profiles do not list malpractice awards under appeal or complaints that have never resulted in legal or disciplinary actions. These practice profiles can be requested from a central clearing house and are then faxed on demand. They are also available electronically on the Internet (www.docboard.org/ma/df/masearch.htm). The law that allows the dissemination of this information is a trimmed-down version of a proposal that would have required the disclosure of *all* complaints and *all* malpractice claims, whether proven or not. Massachusetts is not alone in having such a law. Several other US states have similar legislation, including Arizona, California, Iowa, Ohio, Texas and Vermont.

Massachusetts is not Canada, and the physician–patient relationship here is not quite what it is in the United States. However, the Massachusetts initiative raises an interesting question for this country. Should Canadian provinces follow the lead of Massachusetts and adopt similar legislation?

The arguments in favour of doing so are powerful. They are based on 2 concepts central to Canadian medical practice: informed consent and public accountability.

The informed-consent argument goes something like this: Informed consent relates not only to a procedure or an intervention being offered to a patient but also to the person offering it. Traditionally, informed consent has been construed as having applicability beyond a specific procedure or intervention. The Canadian Medical Association itself has stated on many occasions, the last time being in 1990,[1] that patients have a moral right to seek out the physicians of their choice. However, patients cannot make an informed choice if they know nothing about a prospective physician beyond the fact that this person completed a medical degree at this or that university or that he or she has acquired further specialist training.

Of course, patients could be guided by word of mouth. In fact, earlier versions of the CMA *Code of Ethics* stated that word of mouth should be the physician's only means of advertising. This approach may have been effective when people lived in small communities and knew each other. In those circumstances, it might well have yielded an accurate picture of the abilities and practice patterns of a physician and might have been sufficient to allow patients to make an informed choice about which physician to see. However, in the modern urban environment word of mouth is an unrealistic means of obtaining such information, because few people know each other well enough to feel comfortable about sharing such sensitive information. Furthermore, in our society both patients and physicians are highly mobile, and word of mouth does not travel well from one city to another. Physicians who have been disciplined or who have lost a malpractice suit in one locale need merely move and set up shop in another to escape the effects of a bad reputation. Public disclosure of practice records, as in Massachusetts and many other US states, would address this problem.

Physicians cannot argue that, because no other profession is required to disclose the practice profiles of its practitioners, the disclosure of such information about physicians would be unfair and unjust. As a matter of logic, the fact that the members of other professions do not have to disclose their practice records does not establish that physicians should not disclose theirs. At best, it demonstrates that other professions share Canadian medicine's perspective on professional secrecy. The fact that people agree on something demonstrates only that they agree. The *correctness* of the subject of their agreement must be demonstrated on independent grounds.

On the subject of accountability, the other basis for arguments in favour of public disclosure of practice profiles, it is relevant that medicine is a service-provider monopoly, which puts it in a very special position. Society confers monopolies not for the sake of the holders of those monopolies but because it believes that only by restricting services in this fashion will the interests of society be properly served. Therefore, the primary consideration that should guide the relationship between the medical profession and the rest of society is not the welfare of the individual practitioner but the welfare of health care consumers and of soci-

ety as a whole. In this situation, physicians should reject the disclosure of practice profiles only if such disclosure would make it impossible for physicians in general to carry out their professional duties. The example of Massachusetts and other US states makes clear that this is not the case. Disclosure may make physicians practise more carefully, and it may even make it impossible for *certain* practitioners to earn a living, yet that happens even now when the provincial licensing bodies fulfil their mandate.

Then why not leave the issue up to the licensing bodies, given that they are society's duly constituted watchdogs over the practice patterns of the medical profession? Isn't it their role to make certain that the welfare of patients is not threatened by incompetent physicians or by physicians who have shown criminal or otherwise inappropriate tendencies? In other words, isn't the public interest well served by the existing quality assurance mechanisms?

To paraphrase a legal saying, proficiency and quality must not only exist but must also be seen to exist. Canadian medical-licensing bodies are staffed mainly by physicians. By and large, their operations are poorly understood by the public. They may even function behind closed doors. All of this fosters the perception that the licensing bodies tend to favour physicians.[2] This perception can be countered only by making all disciplinary proceedings open to the public, by making sure the majority of members on disciplinary bodies are non-physicians — or by making practice records publicly available, as in Massachusetts.

Finally, there is the matter of trust. Physicians operate within a fiduciary relationship with their patients. This entails more than a requirement that they do the best they can for their patients. It also means that physicians and patients should come together in an atmosphere of openness and mutual trust. It may reasonably be asked whether such trust is possible when significant information is withheld by *either* side. Physicians justifiably object when patients withhold or falsify relevant medical information about their lifestyle or habits and then expect to receive appropriate medical care. By the same token, the practice profiles of physicians — their experiences, their background and the like — reflect how they practise medicine and the quality of care they provide. Therefore, this information is relevant for health care consumers.

In *Reibl* v. *Hughes*,[3] the Supreme Court of Canada stated that a physician has a duty to disclose, unasked, what the objective reasonable person in the patient's position would want to know before agreeing (or refusing) a particular medical intervention. *Reibl* v. *Hughes* did not deal with the disclosure of practice profiles because that was not at issue. However, would the objective reasonable person in the patient's position not want to know whether her or his physician had been disciplined for inappropriate or incompetent behaviour or had lost a malpractice suit? If the practice profiles of physicians reflect their proficiency as practitioners, does the logic of *Reibl* v. *Hughes* not support the disclosure of such information? And, to take a more positive view, would a prospective patient not want to be able to select a physician on the basis of past training and qualifications, instead of mere word of mouth?

[Editor's note: The On_the_Net column (page 1353) provides addresses for 9 Web sites in Canada and the US that provide information about individual physicians.]

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