

REFUSING TO TREAT NONCOMPLIANT PATIENTS IS BAD MEDICINE

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Government health programs and private payors have adopted various reforms that fundamentally transform the physician-patient relationship. Public reporting on how well physicians perform on various quality and cost metrics, as well as payment reforms that link physicians' reimbursements to their performance on these metrics, incentivize physicians to improve the quality and efficiency of care they provide to patients. Less appreciated, however, is that these reforms also create strong incentives for physicians to reject patients who do not abide by their physician's medical opinion, including recommendations that the patient adopt healthier behaviors. These noncompliant patients increasingly will find themselves rejected by physicians, as current legal and ethical standards generally grant physicians full autonomy in deciding which patients to treat. This Article evaluates whether the law and standards of professional conduct should afford physicians broad discretion in deciding whether to treat noncompliant patients. It concludes that they should not and calls upon lawmakers and professional associations to place legal and ethical restraints on physicians' ability to reject noncompliant patients.

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INTRODUCTION

Every physician has encountered the noncompliant patient—the diabetic patient who fails to consistently take her prescribed medications, self-monitor her blood glucose, and abide by dietary restrictions; the patient with chronic obstructive pulmonary disease (COPD) who continues smoking, does not exercise regularly, and quits pulmonary rehabilitation; the orthopedic surgical patient who ignores postoperative weight-bearing instructions and misses follow-up

appointments. In all such cases, the patient's behavior fails to coincide with their physician's medical advice and recommendations for health.¹

Patient noncompliance presents "a major obstacle" to the effective and efficient delivery of health care.² Studies consistently find that a large number of patients fail to take their medications as prescribed, with as many as fifty percent of patients on long-term medication therapies failing to do so.³ Compliance with physician-recommended lifestyle changes (e.g., diet modification, smoking cessation) is even lower, with only twenty to thirty percent of patients changing their behavior.⁴ Not surprisingly, patients' noncompliance leads to poorer treatment outcomes and higher costs, including higher rates of mortality and morbidity and excess urgent care visits and hospitalizations.⁵

Many physicians express frustration with their noncompliant patients.⁶ Some physicians even terminate the physician-patient relationship in egregious cases of noncompliance. Most, though, continue treating their noncompliant patients, doing their best to educate patients about the importance of adhering to recommended treatments and healthy lifestyles. However, physicians' tolerance for

¹ Patients' behavior may diverge from their physicians' recommendations for two reasons—rejecting physicians' advice or nonadherence. In the first scenario the patient affirmatively refuses to follow the physician's recommendations. For example, a patient may reject a recommended medical intervention because she fears its risks or side effects or a patient may decide she simply does not want to change her diet, quit smoking, or otherwise modify her behavior. In contrast, the scenario of the nonadherent patient entails a patient who accepts the physician's advice but "fails to adhere to the regimens needed to implement it." David B. Resnik, *The Patient's Duty to Adhere to Prescribed Treatment: An Ethical Analysis*, 30 J. MED. & PHIL. 167, 168–69 (2005). For example, a patient may fill her prescription but fail to take the medication as prescribed, or she may attempt to lose weight or quit smoking but fail in her attempts to do so. See generally WORLD HEALTH ORG., ADHERENCE TO LONG-TERM THERAPIES: EVIDENCE FOR ACTION 3–11 (2003) (defining nonadherence as "the extent to which a person's behavior—taking medication, following a diet, and/or executing lifestyle changes—corresponds with agreed upon recommendations from a health care provider"). For purposes of this Article, I refer to both types of scenarios as "noncompliance."

² Nadia Sciberras et al., *Ethics in Practice: The Ethical and Practical Challenges of Patient Noncompliance in Orthopedic Surgery*, 61 J. BONE & JOINT SURGERY e61(1) (2013).

³ See Jing Jin et al., *Factors Affecting Therapeutic Compliance: A Review from the Patient's Perspective*, 4 THERAPEUTICS & CLINICAL RISK MGMT. 269, 269 (2008); Leigh Page, *Why Should Your Noncompliance Harm My Income?*, MEDSCAPE (Oct. 9, 2014), <http://www.medscape.com/features/content/6006314>.

⁴ See Jin et al., *supra* note 3, at 269.

⁵ See *id.* at 270–71 (explaining that noncompliance is directly associated with poor treatment outcomes in patients with a range of chronic conditions and poses financial burdens to society due to excess urgent care visits, hospitalizations, and higher treatment costs); see also WORLD HEALTH ORG., *supra* note 1, at 11–14 (describing the health and economic costs of nonadherence among patients with COPD, asthma, diabetes and other chronic conditions); Neil Chesanow, *The Noncompliance Epidemic: Why Are So Many Patients Noncompliant?*, MEDSCAPE (Jan. 16, 2014) <http://www.medscape.com/viewarticle/818850> ("Poor medication compliance is implicated in over 125,000 US deaths per year.").

⁶ See Bruce G. Bender, *Motivating Patient Adherence to Allergic Rhinitis Treatments*, 15 CURRENT ALLERGY ASTHMA REP. 10, 12 (2015) ("Health-care providers frequently report frustration over the nonadherence of their patients.").

their most noncompliant patients will wane as emerging health policy reforms give physicians a new reason to avoid noncompliant patients—profitability.

New payment models that tie physicians' reimbursements to their patients' health status and treatment costs mean noncompliant patients will reduce physicians' income.⁷ In addition, physicians may fear that their noncompliant patients, with their poorer health outcomes, will harm the physicians' performance on publicly available "report cards," thereby damaging their reputation and limiting their contract opportunities with private payors.⁸ As treating noncompliant patients increasingly becomes a financial burden for physicians, noncompliant patients may find themselves fired by their physicians.⁹ In addition, physicians may refuse to treat prospective patients who are likely (or perceived as likely) to be noncompliant.¹⁰ With limited exceptions, both the law and standards of professional conduct permit physicians to refuse to treat noncompliant patients.¹¹

The prospect of widespread avoidance of noncompliant patients by physicians raises the question of whether the law and standards of professional conduct should afford physicians this discretion. Most basically, should the physician-patient relationship be treated like any other consumer transaction, with either party free to terminate the relationship at will? Or do moral and policy considerations justify a departure from traditional principles of freedom-of-contract in the case of the noncompliant patient? Scholars and policymakers have largely neglected this important issue.¹² This Article fills in this gap by exploring the arguments for and against granting physicians broad discretion on whether to treat noncompliant patients. It concludes that on balance the arguments favor limiting physicians' ability to reject noncompliant patients and calls upon regulators and professional associations to place legal and ethical restraints on physicians' ability to

⁷ See *infra* Section I.A.

⁸ See *infra* Section I.B.

⁹ See *infra* Part I.

¹⁰ See Bender, *supra* note 6, at 12. The practice of favoring healthier, more compliant patients over less healthy, less compliant patients is sometimes referred to as "cherry-picking." See, e.g., Amar A. Desai et al., *Is There "Cherry Picking" in the ESRD Program? Perceptions from a Dialysis Provider Survey*, 4 CLINICAL J. AM. SOC'Y NEPHROLOGY 772 (2009) (defining "cherry picking" in the health care context as insurers and providers protecting themselves economically by avoiding sicker patients or preferentially attracting healthier patients); Judith H. Hibbard et al., *Does Compensating Primary Care Providers to Produce Higher Quality Make Them More or Less Patient Centric?*, 72 MED. CARE RES. & REV. 481, 482 (2015) (describing the practice of selecting healthier and more compliant patients as "cherry-picking").

¹¹ See *infra* Part II.

¹² Two commentators have discussed whether physicians should be permitted to reject noncompliant patients. See David Orentlicher, *Denying Treatment to the Noncompliant Patient*, 265 JAMA 1579, 1581 (1991) (arguing that ethical rules governing physicians generally should not reject patients for noncompliance); Mark Wicclair, *Dismissing Patients for Health-Based Reasons*, 22 CAMBRIDGE Q. HEALTHCARE ETHICS 308 (2013) (same).

do so.

Part I describes how recent policy reforms create strong incentives for physicians to reject patients who engage in unhealthy behaviors and fail to follow their physician's medical advice. Part II summarizes current legal and ethical standards governing the physician-patient relationship and explains that they permit physicians to refuse to treat noncompliant patients.

Part III calls upon Congress and state legislatures to enact legislation prohibiting physicians from firing or otherwise refusing to treat noncompliant patients and urges professional organizations and medical boards to revise their ethical standards to do the same. Imposing on physicians an obligation to treat noncompliant patients would serve important policy goals. First, it would strengthen the incentives recent policy reforms give providers to tackle the social, environmental, and behavioral health barriers to good health. Second, when physicians reject noncompliant patients, they experience discontinuity in care, a loss of trust in physicians, and stigma and shame. Requiring physicians to treat noncompliant patients eliminates these harms, thereby reinforcing physicians' ethical commitment to serving their patients' best interest. Third, prohibiting physicians from rejecting noncompliant patients protects the autonomy of patients who might feel pressured to agree to treatment recommendations, even if inconsistent with their personal preferences, in order to avoid termination of the physician-patient relationship. Finally, members of vulnerable groups are more likely to be rejected by physicians seeking to avoid noncompliant patients, leading to greater disparities in health. Prohibiting physicians from refusing to care for noncompliant patients would guard against this inequitable outcome.

Part IV considers justifications for affording physicians the discretion to fire or otherwise refuse to treat noncompliant patients: (1) physicians are justified in terminating the physician-patient relationship because noncompliant patients should be held accountable for failing to exercise self-care; (2) physicians should not be forced to assume financial liability for poor patient outcomes that stem from patients' lifestyle choices and nonadherence; (3) requiring physicians to treat noncompliant patients unduly compromises physicians' personal autonomy and freedom of association rights; and (4) firing noncompliant patients serves the patients' best interest by motivating the patient to improve their treatment adherence or, alternatively, allowing the patient to find another physician better suited to treat the patient. While these rationales are not without merit, ultimately they do not justify rules that permit physicians to reject noncompliant patients given competing policy considerations, societal norms of fairness and compassion, and professional norms of benevolence.

Finally, in recognition of the challenges faced by physicians caring

for noncompliant patients, Part V outlines policy reforms that would support physicians' efforts to improve patients' health-related behaviors and adherence to medical advice.

I. AVOIDING THE NONCOMPLIANT PATIENT

Physicians have long dealt with patients who fail to follow treatment recommendations. Sometimes physicians elect to terminate their most noncompliant patients out of frustration¹³ or a belief that these patients waste physicians' time and medical resources.¹⁴ Other physicians may hope that firing or threatening to fire a patient will compel the patient to modify his or her behavior.¹⁵ And some physicians may avoid noncompliant patients because they fear that they will face more lawsuits given noncompliant patients' higher-risk of morbidity and mortality.¹⁶ But physicians' increasingly have a new reason to avoid noncompliant patients—their bottom-line.

Emerging payment models link physicians' reimbursements to patient outcomes and aggregate health care costs. Consequently, noncompliant patients who are at higher-risk of poor health and require more costly services threaten to lower a physician's income. Physicians also may fear that noncompliant patients will drag down the physicians' scores on various patient outcome and efficiency metrics, causing harm to the physicians' reputation and limiting their professional opportunities. I refer to these reforms collectively as "performance incentive programs." As noncompliant patients become a pressing financial concern for physicians under performance incentive programs, physicians will increasingly resort to firing their noncompliant patients and will refuse to take on prospective patients likely (or perceived as likely) to be noncompliant.

¹³ See Resnik, *supra* note 1, at 170–71 ("When a patient fails to adhere to a prescription, a doctor may feel betrayed or exploited because the patient is not upholding his or her end of the bargain. . . . Non-adherence eventually takes its toll. At some point, many doctors decide that they would rather not treat non-adherent patients."); Wicclair, *supra* note 12, at 312 (explaining that a physician may fire a patient in response to "feelings of frustration and moral distress").

¹⁴ See Resnik, *supra* note 1, at 170–71 ("[I]f the pattern of nonadherence continues despite the doctor's concerted efforts to help the patient implement the treatment, the doctor may feel that he or she is wasting time and society's resources."); Wicclair, *supra* note 12, at 311 (stating that one motivation for firing a patient is a desire on the part of the provider to "prevent . . . wasting time and medical resources").

¹⁵ See Wicclair, *supra* note 12, at 314 ("When persistent efforts at persuasion have failed [to change a patient's behavior], firing or threatening to fire adult patients may be perceived as a last resort to get them to make better choices and modify their behavior.").

¹⁶ See Page, *supra* note 3, at 4 ("Physicians are also concerned about malpractice. Even though noncompliant patients are often responsible for bad outcomes, [one physician stated that he] is concerned they still might sue him if something went wrong . . .").

A. *Physicians' Incentives Under Value-Based Purchasing*

Traditionally, Medicare, Medicaid, and private insurers paid for their enrollees' health care on a fee-for-service basis, with health care providers receiving a separate payment for each unit of service provided to their Medicare patients.¹⁷ Fee-for-service thus rewarded physicians who provided patients a higher volume of care and favored high-tech, more intensive treatments that garnered higher payment rates.¹⁸ These incentives fueled a health care inflation rate that for the past fifty years has almost always exceeded general inflation, sometimes by as much as five percentage points.¹⁹ Fee-for-service also did not promote patients receiving high quality care, as physicians were compensated based on what they did and not on whether their patients' health improved.²⁰

Concerned with both the cost and quality of care, payors have shifted away from fee-for-service in favor of new payment models that reward providers for improving health outcomes and lowering costs.²¹ Collectively known as value-based purchasing (VBP), these payment strategies link providers' compensation to their success in raising the quality and lowering the cost of care. Under the first category of VBP programs, pay-for-performance,²² providers are rewarded with higher payment rates or bonuses if they perform well on selected measures of quality and/or efficiency, such as reducing the rate of post-operative complications, lowering diabetic patients blood glucose (or A1c) levels,²³ decreasing the rate of hospital admissions and readmissions, or lowering average treatment costs. Pay-for-performance initiatives also

¹⁷ See Harold D. Miller, *From Volume to Value: Better Ways to Pay for Health Care*, 28 HEALTH AFF. 1418, 1419 (2009), <http://content.healthaffairs.org/content/28/5/1418.full.pdf+html> (defining fee-for-service as paying providers a predetermined amount for each discrete service provided).

¹⁸ See generally Jessica Mantel, *Accountable Care Organizations: Can We Have Our Cake and Eat It Too?*, 42 SETON HALL L. REV. 1392, 1405 (2012) (describing how fee-for-service encourages "the provision of care of marginal or uncertain benefits, as doing so increases providers' incomes and satisfies patient demands that providers do everything possible to improve a patient's health," and "skews the system toward more costly interventions").

¹⁹ See Jim Dolmas, *Health Care Services Depress Recent PCE Inflation Readings*, 11 DALLAS FED 1, 2 (2016) (using data from the Bureau of Economic Analysis).

²⁰ See Steven A. Schroeder & William Frist, *Phasing Out Fee-for-Service Payment*, 368 NEW ENG. J. MED. 2029 (2013).

²¹ See *infra* text accompanying notes 28–30.

²² See CHERYL L. DAMBERG ET AL., RAND CORP., MEASURING SUCCESS IN HEALTH CARE VALUE-BASED PURCHASING PROGRAMS xi (2014); NAT'L ACADS. OF SCIENCES ENGINEERING MED., ACCOUNTING FOR SOCIAL RISK FACTORS IN MEDICARE PAYMENT 25–26 (Leslie Y. Kwan, Kathleen Stratton & Donald M. Steinwachs et al. eds., 2017) [hereinafter Kwan & Steinwachs] (describing VBP payment models that include financial or quality incentives).

²³ An A1c test measures a patient's average blood glucose during the previous two to three months. Lower A1c values signal better diabetes control and reduce a patient's risk of developing complications such as eye, heart, and kidney disease. See *Effects of the Medicare Modernization Act on Clinicians Involved in Diabetes Care*, AM. DIABETES ASS'N: CLINICAL DIABETES (Jan. 2006), <http://clinical.diabetesjournals.org/content/24/1/12>.

may penalize providers with lower payment if they perform poorly.²⁴ For example, under Medicare's Physician Value-Based Payment Modifier, higher performing physicians receive an upward adjustment to their rates under Medicare's physician fee schedule while poorer performing physicians receive lower payments.²⁵

The second category of VBP payment models include risk-based alternative payment models that hold providers accountable for the quality and cost of care by shifting financial risk to providers.²⁶ One of the more prominent examples of risk-based alternative payment models is shared savings for accountable care organizations (ACOs). ACOs are local organizations comprised of primary care physicians and other providers that agree to be jointly accountable for the cost and quality of care delivered to a patient population.²⁷ For example, under Medicare's Shared Savings Program, providers participating in ACOs that successfully lower the aggregate annual cost of caring for their Medicare patients receive a percentage of the savings, provided that the ACO also satisfies certain quality metrics.²⁸

²⁴ See DAMBERG ET AL., *supra* note 22, at ix, xiv.

²⁵ Patient Protection and Affordable Care Act, 42 U.S.C. § 1395w-4(p) (2012). Physicians classified as low cost/high quality, low cost/average quality, and average cost/higher quality receive an upward adjustment in their payment rates; physicians classified as low cost/low quality, average cost/average quality, or high cost/high quality receive no adjustment in their payment rates; and physicians classified as average cost/low quality, high cost/average quality, and high cost/low quality receive a downward adjustment in their payment rates. See CTRS. FOR MEDICARE & MEDICAID SERVS., SUMMARY OF 2015 PHYSICIAN VALUE-BASED PAYMENT MODIFIER POLICIES 15, table 4 (2016), <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/CY2015ValueModifierPolicies.pdf>. Implemented in January of 2015, the Physician VBP Modifier initially applied only to physicians and "eligible professionals" in groups of one hundred or more professionals but applies to all physicians in 2017. See Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, 42 C.F.R. §§ 410, 414, 415, 423, 425, 486, 495 (2012). The Medicare statute defines an "eligible professional" to include physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, clinical social workers, clinical psychologists, registered dietitians, nutrition professionals, audiologists, and physical, occupational, and qualified speech-language therapists. 42 U.S.C. § 1395w-4(k)(3)(B) (2012).

²⁶ See Kwan & Steinwachs, *supra* note 22, at I-2.

²⁷ Patient Protection and Affordable Care Act, 42 U.S.C. § 1395jjj (2012).

²⁸ Under the shared savings payment model, the ACO continues to receive fee-for-service based payments, but Medicare also rewards an ACO that meets or exceeds its targeted cost savings with a bonus equal to a percentage of the savings. See Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,927 (Nov. 2, 2011) (to be codified at 42 C.F.R. pt. 425). The Medicare Shared Savings Program also includes economic incentives for ACOs to improve quality by tying a portion of an ACO's reimbursement to its performance on quality benchmarks. For example, an ACO that performs poorly on the relevant quality measures may be ineligible for any bonus payment under the shared savings or shared savings and risk payment models, even if the ACO lowers the cost of care. See 42 C.F.R. § 425.100(b) (2012) (stating that ACOs participating in the Medicare Shared Savings Program are eligible for shared savings only if they meet the minimum quality performance standards, among other requirements). After completing their initial term in the program, providers participating in an ACO will continue to receive a percentage of any Medicare savings but also will be penalized with a downward adjustment in their Medicare

Experimentation with the VBP payment models began among private payors and state Medicaid programs in the mid-1990s, with the Medicare program joining the trend over ten years ago.²⁹ Today, payors have fully embraced VBP payment models. In 2015, the U.S. Department of Health and Human Services (HHS) set the ambitious goal of shifting ninety percent of traditional Medicare payments to these new payment models by 2018.³⁰ State Medicaid programs and private payors similarly are adopting VBP payment models.³¹

As payors continue the shift to VBP payment models, physicians will see a growing percentage of their compensation tied to performance metrics. For example, physicians participating in Medicare's forthcoming Merit-Based Incentive Payment System (MIPS) will see the portion of their fees linked to performance measures increase from four percent in 2019 to nine percent in 2022.³² Private payors also are

reimbursement rates if the ACO does not meet targeted cost savings. See 42 C.F.R. § 425.600(b) (providing that for subsequent agreement periods, an ACO may not operate under the one-sided model described at 42 C.F.R. § 425.604, leaving available only the two-sided model described at 42 C.F.R. § 425.606). ACOs also may elect to enroll in the shared savings and risk model during their initial term. See 42 C.F.R. § 425.600(a) (providing that during its initial agreement period, an ACO may elect to operate under either the one-sided model or two-sided model). A second example of alternative risk-based payment models is bundled payments, where the payor makes a single payment for an episode of care that then is allocated among multiple providers treating the patient. Bundled payment arrangements typically include payment adjustments based on the providers' collective performance on quality and efficiency measures. See DAMBERG ET AL., *supra* note 22, at xi.

²⁹ See DAMBERG ET AL., *supra* note 22, at 1 (describing the history of value-based purchasing).

³⁰ See Press Release, U.S. Dep't of Health & Human Servs., Better, Smarter, Healthier: In Historic Announcement, HHS Sets Clear Goals and Timeline for Shifting Medicare Reimbursements from Volume to Value (Jan. 26, 2015), <https://wayback.archive-it.org/3926/20170127185400/https://www.hhs.gov/about/news/2015/01/26/better-smarter-healthier-in-historic-announcement-hhs-sets-clear-goals-and-timeline-for-shifting-medicare-reimbursements-from-volume-to-value.html>.

³¹ See CTR. FOR HEALTH CARE STRATEGIES, INC., MEDICAID ACCOUNTABLE CARE ORGANIZATIONS: STATE UPDATE 1 (2015), <https://www.chcs.org/media/ACO-Fact-Sheet-06-13-17.pdf> ("Many states have begun to implement Medicaid accountable care organizations (ACOs) . . ."); DAMBERG ET AL., *supra* note 22, at ix; VERNON K. SMITH ET AL., MEDICAID REFORMS TO EXPAND COVERAGE, CONTROL COSTS AND IMPROVE CARE 35-38 (2015), <http://www.kff.org/report-section/medicaid-reforms-to-expand-coverage-control-costs-and-improve-care-introduction> (reporting that thirty-seven state Medicaid programs in either fiscal year 2015 or fiscal year 2016 are adopting or expanding their initiatives to reward quality and encourage integrated care, including patient-centered medical homes, health homes, and ACOs, with some states also implementing episode of care (e.g., bundled payment) initiatives and/or value-based purchasing initiatives); David Muhlestein, *Growth and Dispersion of Accountable Care Organizations in 2015*, HEALTH AFF. BLOG (Mar. 31, 2015), <http://healthaffairs.org/blog/2015/03/31/growth-and-dispersion-of-accountable-care-organizations-in-2015-2> (reporting that Medicaid ACOs have grown significantly since 2014, and that the growth in people included in accountable care arrangements since 2014 is primarily from the commercial and Medicaid sectors).

³² Under the Medicare Access and CHIP Reauthorization Act ("MACRA") of 2016, Medicare physicians must choose between two tracks beginning in 2019. The first track, MIPS, combines three existing Medicare performance incentives programs—the Physician Quality Reporting Program, the Physician Value-Based Modifier, and the Electronic Health Records

expected to increase the portion of physicians' compensation tied to performance measures.³³

Many physicians have responded to these financial incentives by restructuring their practices in ways that advance their patients' health at lower costs. They have improved coordination of patient care across different providers and clinical settings, ensured that patients receive clinically-based preventive care, and avoided providing medical care of limited value.³⁴ Unfortunately, linking physicians' payments to the overall health of their patient populations invites a less welcome development—physicians avoiding noncompliant patients.

Physicians will achieve financial success under VBP payment models only if they improve patient outcomes and lower costs. These goals cannot be realized simply by physicians improving the quality and efficiency of clinical care, but they also depend on patients adopting healthier lifestyles and adhering to physicians' recommendations. For example, lowering diabetic patients' A1c levels requires that the diabetic patient eat a healthier diet, lose weight, and exercise more.³⁵ Greater patient adherence to medication regimens lowers the risk of complications, thereby avoiding costly emergency care, hospitalizations, or other treatments.³⁶ And patients who adhere to post-surgical

Incentive Program. The second track pays an annual incentive payment equal to five percent of Medicare base payments to those physicians participating in alternative payment models (payment models that require the physicians to bear financial risk, link payments to various quality measures and satisfy other requirements specified by CMS). See Medicare Access and CHIP Reauthorization Act of 2016, Pub. L. No. 114-10, §§ 101(c), (e), 129 Stat 87 (2015).

³³ Cf. Dave Barkholz, *Changing How Doctors Get Paid*, MOD. HEALTHCARE (Mar. 11, 2017), <http://www.modernhealthcare.com/article/20170311/magazine/303119983> (quoting various health care executives who note that a higher percentage of their organizations' payor contracts will be based on cost and quality outcomes, with some organizations responding by linking a higher share of their physicians' compensation to performance metrics).

³⁴ See MAIA CRAWFORD ET AL., POPULATION HEALTH IN MEDICAID DELIVERY SYSTEM REFORMS 3–4 (2015), http://www.milbank.org/uploads/documents/papers/CHCS_PopulationHealth_IssueBrief.pdf (discussing the types of health services that improve population health, such as immunizations, screening for disease, and counseling for tobacco use, obesity, and other risky behaviors); John V. Jacobi, *Multiple Medicaid Missions: Targeting, Universalism, or Both?*, 15 YALE J. HEALTH POL'Y L. & ETHICS 89, 90 (2015) (explaining how ACOs reduce fragmentation among providers); Lauris Christopher Kaldjian, *Patient Care and Population Health: Goals, Roles and Costs*, 3 J. PUB. HEALTH RES. 81, 81 (2014) ("Much of the current emphasis on cost control is appropriately directed at avoiding tests and treatments that do not improve health.").

³⁵ See generally *Standards of Medicare Care in Diabetes—2017*, 40 J. CLINICAL & APPLIED RES. & EDUC. 51 (2017) (recommending various drug therapies, nutritional counseling, and physical activities to help diabetic patients control their condition).

³⁶ See Leslie R. Martin et al., *The Challenge of Patient Adherence*, 1 THERAPEUTICS & CLINICAL RISK MGMT. 189, 189 (2005) (explaining that medication nonadherence is a risk factor for a variety of subsequent health outcomes, including hospitalizations and even death); Meghan E. McGrady & Kevin A. Hommel, *Medication Adherence and Health Care Utilization in Pediatric Chronic Illness: A Systematic Review*, 132 PEDIATRICS 730, 730, 737 (2013) (reporting that a systematic review found that nine of ten studies demonstrated a relationship between medication nonadherence and increased health care use among children and adolescents with chronic medical conditions); Michael C. Sokol et al., *Impact of Medication*

instructions and rehabilitation have higher functional outcomes and lower morbidity.³⁷ Accordingly, a provider with a high percentage of noncompliant patients may have difficulty performing well on quality and cost metrics, resulting in the provider receiving lower payments under VBP payment models.³⁸ Patients who fail to follow treatment recommendations therefore threaten physicians' profitability.³⁹ Given the challenges physicians face in coaxing patients into sustained lifestyle changes,⁴⁰ refusing to treat the noncompliant patient offers physicians an easy way to protect their bottom-line.

Although there is little empirical evidence documenting the extent to which VBP payment models lead physicians to reject noncompliant patients, several physician surveys suggest a real risk of physicians doing so. In a 2015 survey of primary care physicians who had forty percent of their compensation linked to quality metrics, fifteen percent reported "that the compensation model increased the frequency that they suggested to noncompliant patients that they see a different [primary care physician]."⁴¹ In a 2006 survey of physicians, not only did eighty-

Adherence on Hospitalization Risk and Healthcare Cost, 43 MED. CARE 521, 521 (2005) (finding that for patients with diabetes and hypercholesterolemia, a high level of medication adherence was associated with lower disease-related medical costs, including lower hospitalization rates).

³⁷ See Sciberras et al., *supra* note 2, at e61(1) ("The functional outcome and morbidity after many orthopaedic surgical procedures are closely dependent on patient compliance with postoperative instructions and rehabilitation.").

³⁸ See Page, *supra* note 3, at 1 ("As payers begin to shift to outcomes-based reimbursements, physicians with high percentages of nonadherent patients stand to potentially see payments fall.").

Providers who treat patients who are sicker on average could perform worse on quality and cost metrics due to patient factors that are not under the provider's control (e.g., age, severity of illness), rather than due to lower quality care. See CTBS. FOR MEDICARE & MEDICAID SERVS., FACT SHEET: RISK ADJUSTMENT 1 (2015), <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/Risk-Adjustment-Fact-Sheet.pdf>.

Payors therefore use risk adjustment to adjust scores on quality measures and ensure that comparisons are fair across providers. See *id.*; ERIC SCHONE & RANDALL S. BROWN, ROBERT WOOD JOHNSON FOUND., RISK ADJUSTMENT: WHAT IS THE CURRENT STATE OF THE ART, AND HOW CAN IT BE IMPROVED? 1 (2013), <http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf407046>. Risk adjustment, when done properly, thereby deters providers from avoiding sicker patients. Risk adjustment, however, does not account for differences in the extent to which a provider's patients comply with medical advice or adopt healthier behaviors. See, e.g., CTBS. FOR MEDICARE & MEDICAID SERVS., *supra* note 38 (describing the factors CMS takes into account when performing risk adjustment under the Physician Value-Based Payment Modifier program). Consequently, risk adjustment does not account for the impact of patient noncompliance on providers' quality and cost metric scores.

³⁹ See Page, *supra* note 3, at 1 ("Physicians have always had to deal with patients who refuse to follow treatment recommendations, but this age-old quality and patient-care issue is about to become a pressing financial concern for doctors.").

⁴⁰ See Rhonda Dailey et al., *Challenges in Making Therapeutic Lifestyle Changes Among Hypercholesterolemic African-American Patients and Their Physicians*, 98 J. NAT'L MED. ASS'N 1895, 1895 (2006) (physicians participating in focus groups reported that barriers to therapeutic lifestyle changes among their African-American patients with hypercholesterolemia include lack of patient readiness and responsibility for change, as well as physicians' lack of time for and inadequate knowledge about patient counseling).

⁴¹ Hibbard et al., *supra* note 10, at 482-83.

two percent respond that quality measures could lead to physicians avoiding high-risk patients, but in written comments many stated that poorly compliant patients also would be avoided.⁴² For example, one physician commented that “If my pay depended on A1c values [of my diabetic patients], I have 10–15 patients whom I would have to fire.”⁴³ And in a 2008 survey of California physicians participating in pay-for-performance programs, some physicians reported that they had “forced disenrollment of noncompliant patients.”⁴⁴ Moreover, among the four physician organizations surveyed, physicians affiliated with the organization with the largest financial rewards (thirty percent of physician remuneration) expressed greater resentment toward noncompliant patients and were more likely to have disenrolled patients who did not change their behavior.⁴⁵ This finding suggests that the risk of physicians firing noncompliant patients likely will increase over time as a larger percentage of physicians’ incomes are linked to quality and efficiency metrics.⁴⁶

B. *Reputational Concerns*

Various changes in the health care marketplace also incentivize physicians to avoid noncompliant patients. In an effort to support patients making informed decisions when choosing among physicians, government agencies and payors have made available to the public data comparing physicians’ performance on various quality and cost measures.⁴⁷ For example, Medicare’s Physician Compare website allows patients to compare physician groups’ performance on various performance measures.⁴⁸ About half of states also have implemented

⁴² See Lawrence P. Casalino et al., *General Internists’ Views on Pay-for-Performance and Public Reporting of Quality Scores: A National Survey*, 26 HEALTH AFF. 492, 495 (2007).

⁴³ *Id.*

⁴⁴ Ruth McDonald & Martin Roland, *Pay for Performance in Primary Care in England and California: Comparison of Unintended Consequences*, 7 ANNALS FAM. MED. 121, 121 (2009).

⁴⁵ See *id.* at 122–23.

⁴⁶ Experts similarly believe that under VBP payment models some physicians will resort to firing patients who fail to follow proffered treatment advice. See Nellie Bristol, *Patient Engagement, Physician Performance Measures Could Be at Odds, Experts Say*, CONG. Q. HEALTHBEAT, Nov. 4, 2011, at 1 (reporting that participants in an Agency for Healthcare Research and Quality National Advisory Council forum speculated that “[p]hysicians could resort to ‘firing’ their patients to avoid missing quality-performance measures as patients become more assertive about making their own health care decisions . . .”).

⁴⁷ See JULIA JAMES, HEALTH POLICY BRIEF: PUBLIC REPORTING ON QUALITY AND COSTS: DO REPORT CARDS AND OTHER MEASURES OF PROVIDERS’ PERFORMANCE LEAD TO IMPROVED CARE AND BETTER CHOICES BY CONSUMERS? 1 (Mar. 8, 2012), http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_65.pdf.

⁴⁸ See U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., *Find Physicians & Other Clinicians, MEDICARE*, <https://www.medicare.gov/physiciancompare/search.html> (last visited Aug. 3, 2017).

public reporting programs, some of which profile physicians,⁴⁹ and some payors highlight on their websites physicians identified as providing high quality and cost-effective care.⁵⁰ Physicians who perform poorly on publicly reported data may fear that they will lose patients to competitors if they develop a reputation for providing low quality, costly care.⁵¹

Low-scoring physicians also may find themselves at a competitive disadvantage when contracting with private payors. Health insurers increasingly are adopting narrow networks comprised of higher quality, lower cost providers, with enrollees receiving care from “out of network” providers paying significantly higher cost-sharing or footing their bill entirely.⁵² In addition, health insurers are making greater use of tiered provider networks, with plan enrollees paying lower cost-sharing when they select efficient, high-value providers and higher cost-sharing when treated by less efficient providers.⁵³ Consequently, physicians with a poor track record for patient outcomes or efficiency risk exclusion

⁴⁹ See JAMES, *supra* note 47, at 2.

⁵⁰ For example, United Healthcare’s premium designation program collects data on its network physicians’ performance on quality and efficiency measures, with higher scoring physicians receiving a premium designation that is displayed publicly on United Healthcare’s consumer and physician web sites. See *UnitedHealth Premium Designation Program*, UNITEDHEALTHCARE, https://www.myuhc.com/content/myuhc/Member/Assets/Pdfs/Geoaccess/UnitedHealth_Premium_Overview.pdf (last visited Sept. 11, 2017).

⁵¹ Although the difficulties faced by patients in evaluating the care they receive may limit their ability to make informed choices among physicians, some physicians nevertheless are motivated to provide high quality care in order to protect their reputations. See FED. TRADE COMM’N & DEP’T OF JUSTICE, *IMPROVING HEALTH CARE: A DOSE OF COMPETITION* 17 (2004), <https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf> (stating that although there exists informational and payment barriers to effective competition, competition can play an important role in enhancing quality of care); see also Anne Frölich et al., *A Behavioral Model of Clinician Responses to Incentives to Improve Quality*, 80 HEALTH POL’Y 179, 187 (2007) (discussing a study of Wisconsin hospitals finding that public reporting of quality performance made hospitals more likely to adopt quality improvement programs); David Hyman, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 90 CORNELL L. REV. 893, 957 n.364 (2005) (stating that one motive of providers for improving quality may be concern for their reputation).

⁵² See Joseph Burns, *Narrow Networks Found to Yield Substantial Savings*, MANAGED CARE (Feb. 2012), <https://www.managedcaremag.com/archives/2012/2/narrow-networks-found-yield-substantial-savings> (summarizing comments from health insurance executives, who described adopting narrow networks built around cost-effective, high-quality providers); Merrill Goozner, *Building Narrow Networks That Work*, MOD. HEALTHCARE (Dec. 21, 2013), <http://www.modernhealthcare.com/article/20131221/magazine/312219986>. (same); see also AM.’S HEALTH INS. PLANS, *ISSUE BRIEF: HIGH-VALUE PROVIDER NETWORKS* 3 (2013), <https://www.ahip.org/wp-content/uploads/2016/04/High-Value-Provider-Networks-AHIP-Issue-Brief.pdf> (describing trends of insurers adopting smaller provider networks comprised of providers with a track record of providing high-quality, cost-efficient care).

⁵³ See PAUL FRONSTIN, EMP. BENEFIT RESEARCH INST., *TIERED NETWORKS FOR HOSPITAL AND PHYSICIANS HEALTH CARE SERVICES* 3 (2003), <http://www.ebri.org/pdf/briefspdf/0803ib.pdf> (explaining that payors with tiered networks may assign providers to tiers based on their quality and efficiency of care). Providers also may be assigned to tiers based on their charges. See *id.*

from plans' networks or preferred tiers.⁵⁴ In an effort to avoid these competitive disadvantages, physicians may reject noncompliant patients in order to raise their performance on quality and cost measures.⁵⁵

II. PHYSICIANS' LEGAL AND ETHICAL OBLIGATIONS

The law generally treats physicians and patients no differently than other sellers and buyers in the marketplace for goods and services—free agents who can choose with whom they wish to do business. Courts have long afforded physicians the freedom to select their patients.⁵⁶ The common law therefore permits a physician to refuse to enter into a physician-patient relationship with a prospective patient for virtually *any* reason. Although federal statutes have carved out exceptions to the common law rules, these exceptions have been narrowly drawn. Most notably, anti-discrimination laws generally prohibit physicians and other health care providers from refusing to treat patients on the basis of the patient's race, gender, religion, national origin, age, disability, and sexual orientation.⁵⁷ The Emergency Medical Treatment and Active Labor Act (EMTALA) also requires physicians to screen and stabilize any individual with an emergency condition accessing a hospital's emergency department.⁵⁸ Beyond these limited exceptions, however, physicians have no duty to treat any individual with whom they do not have a physician-patient relationship. Accordingly, a physician can decline to accept as a new patient any individual the physician believes will be noncompliant.

Once the physician and patient have entered into a treatment

⁵⁴ See AM. HOSP. ASS'N, HOSPITALS IN PURSUIT OF EXCELLENCE: A COMPENDIUM OF ACTION GUIDES 27 (2013), http://www.hpoe.org/Reports-HPOE/2013_HPOE_Compendium.pdf (explaining that less efficient, lower quality providers may “be excluded from the narrow and tiered networks that are being formed nationwide”); see also Bryan A. Liang, *Deselection Under Harper v. Healthsource: A Blow for Maintaining Patient-Physician Relationships in the Era of Managed Care?*, 72 NOTRE DAME L. REV. 799, 799–803 (1997) (explaining that deselection is driven by managed care plan's desire to minimize costs); Suzanne Delbanco, *The Payment Reform Landscape: Benefit and Network Design Strategies to Complement Payment Reform*, HEALTH AFF. BLOG (Nov. 4, 2014), <http://healthaffairs.org/blog/2014/11/04/the-payment-reform-landscape-benefit-and-network-design-strategies-to-complement-payment-reform> (stating that higher cost, lower quality providers “do not make it into the preferred tiers”).

⁵⁵ See generally *supra* notes 37–38 and accompanying text (explaining how noncompliant patients can hurt a provider's performance on quality and cost measures).

⁵⁶ See *Findlay v. Bd. of Supervisors*, 230 P.2d 526, 531 (Ariz. 1951) (stating that a physician is under “no obligation to engage in practice or to accept professional employment . . .”); *Hurley v. Eddingfield*, 59 N.E. 1058 (Ind. 1901) (discussing the discretion given to physicians in choosing the terms on which they practice medicine); *Rice v. Ronaldo*, 119 N.E.2d 657, 659 (Ohio Ct. App. 1951) (explaining that a physician is under no legal obligation to render services to everyone who seeks to engage him); *Limbaugh v. Watson*, 12 Ohio Law Abs. 150, 151 (Ohio Ct. App. 1932) (stating that physicians have a right to select their patients).

⁵⁷ See *infra* notes 289–92 and accompanying text.

⁵⁸ See *infra* note 288 and accompanying text.

relationship, the physician can terminate the physician-patient relationship at any time subject only to the prohibitions under the aforementioned anti-discrimination laws and the common law rules on patient abandonment. The law of patient abandonment requires a physician to provide her patient with all necessary care until termination of the physician-patient relationship.⁵⁹ The doctrine further provides that physicians can unilaterally terminate the physician-patient relationship only after giving the patient sufficient notice so as to afford the patient a reasonable opportunity to find another physician.⁶⁰ Thus, the patient abandonment doctrine only imposes a *procedural* restraint on a physician's ability to terminate the treatment relationship; it does not limit the *substantive* reasons for a physician's doing so.⁶¹ As long as a physician provides proper notice, she is free to fire a noncompliant patient.

Ethical guidelines issued by professional physician associations, including the American Medical Association (AMA) and American College of Physicians (ACP), echo these legal standards. Consistent with the common law rule granting physicians discretion on whom to accept as patients, the AMA's Principles of Medical Ethics state that "[a]

⁵⁹ See *Groce v. Myers*, 29 S.E.2d 553, 557 (N.C. 1944) ("[The physician-patient relationship] cannot be terminated at the mere will of the physician, but must last until the treatment is no longer required, or until it is dissolved by the consent of the parties, or until reasonable notice is given in order that the patient may have an opportunity to engage the services of another."); *Ricks v. Budge*, 64 P.2d 208, 211-12 (Utah 1937) ("The [physician's] obligation of continuing attention can be terminated only by the cessation of the necessity which gave rise to the relationship, or by the discharge of the physician by the patient, or by the withdrawal from the case by the physician after giving the patient reasonable notice to enable the patient to secure other medical attention."); *Gray v. Davidson*, 130 P.2d 341, 345 (Wash. 1942) ("[W]hen a physician undertakes to treat a patient, it is his duty to continue to devote his best attention to the case either until medical attention is no longer needed, he is discharged by the patient, or he has given the patient reasonable notice of his intention to cease to treat the patient, so that another physician may be obtained.").

⁶⁰ See *Hammonds v. Aetna Cas. & Sur. Co.*, 237 F. Supp. 96 (N.D. Ohio 1965) (discussing the need for reasonable notice so that another physician may be procured); *Scripps Clinic v. Superior Court*, 134 Cal. Rptr. 2d 101, 109 (Cal. Ct. App. 2003) (explaining that a physician can abandon a patient only after due notice and the opportunity to secure other medical personnel); *Lyons v. Grether*, 239 S.E.2d 103, 106 (Va. 1977) (explaining that a physician has the right to withdraw but needs to afford the patient a reasonable opportunity to find another physician). Some courts also allow the physician to terminate the physician-patient relationship if she arranges for another physician to care for the patient. See *Norton v. Hamilton*, 89 S.E.2d 809, 812 (Ga. Ct. App. 1955) (holding that prior to termination a physician must provide either notice or a replacement physician). In communities where the physician is the only physician available to treat the patient, some courts may not allow the physician to terminate the physician patient relationship even with notice to the patient. See Angela R. Holder, *Physician's Abandonment of Patient*, in 3 AMERICAN JURISPRUDENCE PROOF OF FACTS 117, § 3 (2017) ("If, of course, as is true in many communities in this country, the physician is the only one available, it is probable that regardless of the provocation given him by the patient he is not free to withdraw.").

⁶¹ See MARK A. HALL ET AL., *HEALTH CARE LAW AND ETHICS IN A NUTSHELL* 112 (3d ed. 1999) ("The only explicit restraint on a doctor's (or hospital's) freedom to abandon a patient is the *procedural* one of notice. As classically conceived, there is no real *substantive* content to abandonment law because the law does not scrutinize the *reasons* for abandonment . . .").

physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve . . .”⁶² Similarly, the ACP Ethics Manual provides that a physician-patient relationship arises only upon the “mutual agreement” of both the physician and patient, and that “[i]n the absence of a preexisting relationship, the physician is not ethically obliged to provide care to an individual” absent an emergency or the unavailability of another physician.⁶³ The AMA’s Code of Medical Ethics and the ACP Ethics Manual also permit physicians to terminate the physician-patient relationship with proper notice⁶⁴; although, the latter states that physicians should do so only “[u]nder rare circumstances” and only if “adequate care is available elsewhere and the patient’s health is not jeopardized” by the dismissal.⁶⁵ With limited exceptions, then, the medical profession’s standards of professional conduct thus permit physicians to refuse to treat noncompliant patients.

III. JUSTIFICATIONS FOR PROHIBITING PHYSICIANS FROM DISCRIMINATING AGAINST NONCOMPLIANT PATIENTS

The prospect of widespread avoidance of noncompliant patients by physicians raises fundamental questions regarding whether to afford physicians this discretion. This Part examines this important issue and concludes that both policy and moral considerations support legal and ethical prohibitions against physicians dismissing noncompliant patients or rejecting prospective patients that a physician believes will be noncompliant.

A. *Reinforcing the Policy Goals Behind Performance Incentive Programs*

In rewarding improved patient outcomes, performance incentive programs push physicians and their affiliated organizations⁶⁶ toward

⁶² See AM. MED. ASS’N, CODE OF MEDICAL ETHICS 1 (2016), <https://www.ama-assn.org/sites/default/files/media-browser/code-of-medical-ethics-chapter-1.pdf> [hereinafter CODE OF MEDICAL ETHICS].

⁶³ Lois Snyder, *American College of Physicians Ethics Manual: Sixth Edition*, 156 ANNALS INTERNAL MED. 73, 75 (2012).

⁶⁴ The AMA’s Code of Medical Ethics provides as follows: “Physicians’ fiduciary responsibility to patients entails an obligation to support continuity of care for their patients. . . . When considering withdrawing from a case, physicians must: [n]otify the patient (or authorized decision maker) long enough in advance to permit the patient to secure another physician” CODE OF MEDICAL ETHICS, *supra* note 62, at 12.

⁶⁵ Snyder, *supra* note 63, at 76.

⁶⁶ While some physicians own their own practices, physicians increasingly are employed by or otherwise affiliated with larger organizations. See, e.g., Stephen L. Isaacs et al., *The Independent Physician—Going, Going . . .*, 360 NEW ENG. J. MED. 655, 655–57 (2009) (stating that the percentage of physicians who own their own practices has been declining at a rate of

better management of patients' care.⁶⁷ In particular, performance incentive programs encourage physicians and their affiliated organizations to provide more preventive care, follow evidence-based guidelines, and improve the coordination of care across providers and clinical settings.⁶⁸ Performance incentives also motivate physicians and their affiliated organizations to address the barriers to patients adopting healthier behaviors, including social, environmental, and behavioral health factors, low health literacy, and poor physician-patient communications. Legal and ethical standards that allow physicians to reject noncompliant patients weaken these incentives and thereby frustrate the goals underlying performance incentive programs.

1. Lowering Barriers to Patient Compliance and Healthy Behaviors

Social and environmental factors play a significant role in shaping individuals' health.⁶⁹ Behavioral health issues, health literacy, and the quality of physician-patient communications also impact health, including whether patients comply with their physicians' recommendations and adopt healthy behaviors.⁷⁰ In rewarding providers for improved patient outcomes, performance incentive programs encourage physicians and their affiliated organizations to address these barriers to patient compliance.

The social determinants of health include "the circumstances in which people are born, grow up, live, work and age . . ."⁷¹ They include

approximately two percent for the past twenty-five years, and that the percentage of physicians in small practices (i.e., practices with ten or fewer physicians) decreased by nearly fifteen percent between 1996 and 2004). The types of organizations physicians are joining vary but include integrated delivery systems, multispecialty group practices, and accountable care organizations. Many physicians also are becoming employees of hospitals. See SUZANNE M. KIRCHHOFF, CONG. RESEARCH SERV., R42880, PHYSICIAN PRACTICES: BACKGROUND, ORGANIZATION, AND MARKET CONSOLIDATION (2013), <https://fas.org/sgp/crs/misc/R42880.pdf>.

⁶⁷ See KIRCHHOFF, *supra* note 66; *supra* text accompanying note 34.

⁶⁸ See *supra* text accompanying note 34; see also Aparna Higgins et al., *Provider Performance Measures in Private and Public Programs: Achieving Meaningful Alignment with Flexibility to Innovate*, 32 HEALTH AFF. 1453, 1456 (2013) (listing the performance measurement domains and subdomains commonly used by health plans as including care coordination, patient safety, and preventives services and screenings).

⁶⁹ See David A. Asch & Kevin G. Volpp, *What Business Are We in? The Emergence of Health as the Business of Health Care*, 367 NEW ENG. J. MED. 888, 888 (2012) ("An enormous body of literature supports the view that differences in health are determined as much by the social circumstances that underlie them as by the biologic processes that mediate them."); Jacobi, *supra* note 34, at 97 ("[Nonmedical factors] can be more powerfully determinative of the health of a population than the delivery of traditional health services.").

⁷⁰ See Geoffrey R. Swain et al., *Health Care Professionals: Opportunities to Address Social Determinants of Health*, 113 WIS. MED. J. 218, 218, 221–22 (2014) (describing the different types of social determinants affecting health).

⁷¹ *Social Determinants of Health: Key Concepts*, WORLD HEALTH ORG., <http://www.who.int/>

various financial and nonfinancial factors that influence whether individuals receive appropriate medical care in a timely manner, including whether they adhere to recommended medication regimens and obtain follow-up care. For example, financial considerations such as the inability to pay cost-sharing obligations lead some individuals to delay or forego needed medical care.⁷² Transportation challenges,⁷³ lack of paid sick leave,⁷⁴ and an inability to arrange for child care during appointment times may lead patients to forego follow-up care.⁷⁵ Living and working conditions also contribute to unhealthy lifestyles. Many individuals consume less healthy foods because they cannot afford or lack access to healthier options, increasing their risk for obesity or malnutrition.⁷⁶ Similarly, lack of green space or safe neighborhoods

social_determinants/thecommission/finalreport/key_concepts/en (last visited Sept. 15, 2016).

⁷² See Jeffrey T. Kullgren et al., *Nonfinancial Barriers and Access to Care for U.S. Adults*, 47 HEALTH SERVICES RES. 462, 467 (2007) (reporting the results of a survey finding that “barriers in the affordability dimension were the most common reasons for unmet need or delayed care” (emphasis omitted)). While the insurance reforms and subsidies put in place by the Affordable Care Act (ACA) lower these barriers, they do not completely eliminate them. See Benjamin D. Sommers, *Health Care Reform’s Unfinished Work—Remaining Barriers to Coverage and Access*, 373 NEW ENG. J. MED. 2395, 2395–96 (2015) (stating that for people with higher incomes who do not qualify for subsidies under the ACA, cost remains a significant barrier to obtaining health insurance, and even among insured individuals high cost-sharing can limit access to timely and affordable care). For example, a survey of 10,000 patients found that seventeen percent identified cost issues as a reason for their not taking their medications as directed by their physicians. See FROST & SULLIVAN, PATIENT NONADHERENCE: TOOLS FOR COMBATING PERSISTENCE AND COMPLIANCE ISSUES 4, <http://www.frost.com/prod/servlet/cpo/115071625.pdf>.

⁷³ See Kullgren et al., *supra* note 72, at 470 (identifying transportation problems as a reason for unmet need or delayed care); Richard Wallace et al., *Access to Health Care and Nonemergency Medical Transportation: Two Missing Links*, 1924 J. TRANSP. RES. BOARD 76, 76 (2005) (reporting that approximately 3.6 million Americans do not obtain medical care in a given year because of lack of transportation).

⁷⁴ See KEVIN MILLER, CLAUDIA WILLIAMS & YOUNGMIN YI, INST. FOR WOMEN’S POLICY RESEARCH, PAID SICK DAYS AND HEALTH: COST SAVINGS FROM REDUCED EMERGENCY DEPARTMENT VISITS iii, 7–8 (2011), <https://iwpr.org/wp-content/uploads/wpallimport/files/iwpr-export/publications/B301-PSD&ED.pdf> (finding that workers with paid sick days are less likely to delay seeking care for themselves and their families). For example, the percentage of workers who underwent mammograms, Pap tests, and endoscopies at recommended intervals, who had seen a doctor during the previous twelve months, or who had at least one visit to a health care provider during the previous twelve months was significantly lower among those lacking paid sick leave as compared to those with sick leave (even after controlling for sociodemographic and health care-related factors). See Lucy A. Peipins et al., *The Lack of Paid Sick Leave as a Barrier to Cancer Screening and Medical Care-Seeking: Results from the National Health Interview Survey*, 12 BMC PUB. HEALTH 520, 520, 523–24 (2012).

⁷⁵ See Jason R. Woloski et al., *Childcare Responsibilities and Women’s Medical Care*, J. WOMEN’S HEALTH ISSUES & CARE, Jan. 2014, at 4–5 (linking patients foregoing and delaying care to logistical challenges associated with childcare responsibilities).

⁷⁶ See Patti Neighmond, *People with Low Incomes Say They Pay a Price in Poor Health*, NPR: SHOTS (Mar. 2, 2015, 4:05 AM), <http://www.npr.org/sections/health-shots/2015/03/02/389347123/people-with-low-incomes-say-they-pay-a-price-in-poor-health> (profiling the story of Anna Beer, who after losing her job could no longer afford fresh fruits, vegetables, and poultry and instead purchased less expensive canned and frozen foods with more salt and preservatives, which she believed had contributed to her deteriorating health); Michele Ver Ploeg, *Access to Affordable, Nutritious Food is Limited in “Food Deserts,”* U.S. DEP’T AGRIC.

limit opportunities for exercise.⁷⁷

Behavioral health issues also influence patient compliance. Patients who cope with the psychological stress of their disease through denial or otherwise exhibit a negative attitude toward therapy are more likely to reject their physicians' recommendations.⁷⁸ In addition, patients with substance abuse problems and mental illness such as depression may have less capacity for self-management of their disease.⁷⁹

Studies also link patient compliance to health literacy,⁸⁰ defined by the National Institutes of Health as the "degree to which individuals

(Mar. 1, 2010), <https://www.ers.usda.gov/amber-waves/2010/march/access-to-affordable-nutritious-food-is-limited-in-food-deserts> (explaining that "food deserts" are neighborhoods where residents do not live near supermarkets or other food retailers that carry affordable and nutritious food, and where residents instead rely on smaller stores that often do not carry healthy foods and/or charge higher prices). These problems can be especially problematic for self-management of chronic conditions such as diabetes and hypertension. For example, hospitals have observed a spike in admissions for hypoglycemia among low-income diabetics during the last week of the month when Supplemental Nutrition Assistance Program (SNAP) allocations are exhausted. See Hilary K. Seligman et al., *Exhaustion of Food Budgets at Month's End and Hospital Admissions for Hypoglycemia*, 33 HEALTH AFF. 116 (2014).

⁷⁷ See Gary G. Bennett et al., *Safe to Walk? Neighborhood Safety and Physical Activity Among Public Housing Residents*, 4 PLOS MED. 1599 (2007) (discussing the connection between neighborhood safety and physician activity); Ross C. Brownson et al., *Environmental and Policy Determinants of Physical Activity in the United States*, 12 AM. J. PUB. HEALTH 1995 (2001) (finding that neighborhood characteristics such as sidewalks, enjoyable scenery, and heavy traffic were positively associated with physical activity).

⁷⁸ See Jin et al., *supra* note 3, at 277 ("Fifteen studies showed an association between patients' negative attitude toward therapy (e.[g]., depression, anxiety, fears of anger about their illness) and their compliance."); Orentlicher, *supra* note 12, at 1580 ("Dialysis patients typically respond to the psychological stresses of their disease and its treatment with the coping mechanisms of denial. Too much denial by a patient of his or her condition may cause rejection of therapeutic recommendations . . .").

⁷⁹ See Elizabeth H.B. Lin et al., *Relationship of Depression and Diabetes Self-Care, Medication Adherence, and Preventive Care*, 27 DIABETES CARE 214 (2004) (finding that among diabetics, patients with major depression had poorer self-care for patient-initiated behaviors that are difficult to maintain, including exercise, diet, and medication adherence); Randy A. Sansone & Lori A. Sansone, *Alcohol/Substance Misuse and Treatment Nonadherence: Fatal Attraction*, 5 PSYCHIATRY 19, 43 (2008) (summarizing studies finding that alcohol and substance abuse reduces patient adherence). Numerous studies have found an association between patient's compliance and their mental health and substance abuse problems. For example, a meta-analysis of studies examining medication adherence found that chronically ill patients who suffered from depression were seventy-six percent less likely than non-depressed patients to adhere to their medication regimen. See Jerry L. Grenard et al., *Depression and Medication Adherence in the Treatment of Chronic Diseases in the United States: A Meta-Analysis*, 26 J. GEN. INTERNAL MED. 1175, 1177-78 (2011). Similarly, studies show that depression in elderly patients with coronary artery disease "affected compliance markedly," Jin et al., *supra* note 3, at 277; and mental illness and substance abuse impacts the extent to which surgical patients comply with postoperative instructions. See Sciberras et al., *supra* note 2, at 3.

⁸⁰ See generally Aleda M.H. Chen et al., *Health Literacy and Self-Care of Patients with Health Failure*, 26 J. CARDIOVASCULAR NURSING 447, 448-49 (2011) (finding that health literacy was positively related to self-care maintenance among patients with heart failure symptoms); Jin et al., *supra* note 3, at 277 (summarizing the results of empirical studies examining the association between health literacy and compliance); Voncella McCleary-Jones, *Health Literacy and Its Association with Diabetes Knowledge, Self-Efficacy and Disease Self-Management Among African Americans with Diabetes Mellitus*, 22 ABNF J. 30 (2011) (reporting that among African Americans with diabetes mellitus, health literacy was positively

have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.”⁸¹ Nearly half of all adults in the United States have poor health literacy.⁸² Patients with lower health literacy often do not understand the health education materials provided by physicians or pharmacists and may have greater difficulty monitoring their symptoms.⁸³ They also may fear that they will become dependent on long-term medications and have mistaken beliefs regarding the effectiveness of medications over time.⁸⁴

Finally, poor physician-patient communication contributes to patients lacking full knowledge about their disease and the role that recommended therapies and behavior changes play in improving their health. Too often physicians fail to give their patients sufficient and clear information.⁸⁵ Nor do all physicians take the time to explore a patient’s beliefs, concerns, or preferences,⁸⁶ and rarely do physicians evaluate their patients’ comprehension.⁸⁷ The problem of poor physician-patient communication is particularly acute among patients with poor health literacy, as the combination of physicians’ use of

associated with diabetes knowledge, and that those with lower levels of diabetes knowledge had lower levels of dietary self-care activities); Chandra Y. Osborn et al., *Health Literacy Explains Racial Disparities in Diabetes Medication Adherence*, 16 J. HEALTH COMM. 268 (2011) (summarizing research finding an association between health literacy and medication adherence).

⁸¹ CATHERINE SELDEN ET AL., NAT’L INSTS. OF HEALTH, HEALTH LITERACY vi (2000), <https://www.nlm.nih.gov/archive/20061214/pubs/cbm/hliteracy.pdf>.

⁸² See MARK KUTNER ET AL., AM. INSTS. FOR RESEARCH, THE HEALTH LITERACY OF AMERICA’S ADULTS v (2006), <https://nces.ed.gov/pubs2006/2006483.pdf> (reporting rates of health literacy in the United States).

⁸³ See Michael K. Paasche-Orlow & Michael S. Wolf, *The Causal Pathways Linking Health Literacy to Health Outcomes*, 31 AM. J. HEALTH BEHAV. S1, S19, S23 (2007) (discussing the ways in which health literacy impacts patient compliance).

⁸⁴ See Jin et al., *supra* note 3, at 276–77 (describing patient attitudes and beliefs associated with lower medication compliance). Patients’ knowledge (or lack thereof) about their disease and treatment significantly impacts patients’ compliance. For example, patients who believe their medications are necessary and benefit their health have higher rates of adherence than those lacking a clear understanding of why their physician prescribed a medication or the consequences of not taking the medication. See Bender, *supra* note 6, at 4 (stating that various studies show that patients are less likely to adhere to their treatment regimens if they lack a clear understanding of both their illness and the treatment regimen recommended by their physician, or are confused or have doubts about the prescribed medication regimen); Harry Chummun & David Bolan, *How Patient Beliefs Affect Adherence to Prescribed Medication Regimens*, 22 BRITISH J. NURSING 270, 273 (2013).

⁸⁵ See R.C. Chaurasia, *Compliance—The Root of Therapy*, 109 J. INDIAN MED. ASS’N 339, 339 (2011) (“A doctor may be responsible for poor compliance in many ways like by giving little or insufficient information, poor or less explanation . . .”).

⁸⁶ See Chesnow, *supra* note 5, at 4 (“[Physicians] are often unable to understand differences in patient preferences regarding information and participation during consultations. They often fail to listen to patients and explore their views on their disease and medication.”).

⁸⁷ See Paasche-Orlow & Wolf, *supra* note 83, at S22 (“Oftentimes, a great amount of information is relayed to patients, but providers seldom evaluate patient comprehension in any meaningful manner.”).

medical terms and these patients' limited health vocabulary leads to limited patient understanding of the information conveyed.⁸⁸ As a result, a significant number of patients, from forty to sixty percent, cannot correctly report what their physicians expect of them, such as the physician's directions for prescribed medications.⁸⁹ Not surprisingly, studies evaluating the link between patient adherence and physician communication repeatedly find higher rates of nonadherence when the communication between physicians and patients is poor.⁹⁰

Performance incentive programs push physicians and their affiliated organizations to address the social, environmental, and behavioral health conditions that impact patients' health behaviors. Many providers assist their patients with income and food insecurity needs by helping them enroll in public assistance programs that address their income and food insecurity needs, such as the Supplemental Nutrition Assistance Program (SNAP) (formerly known as food stamps), the Women, Infants, and Children (WIC) program, or the Social Security Disability Insurance program.⁹¹ Providers also can arrange transportation for patients needing transport to and from their medical appointments.⁹² Several providers have launched initiatives

⁸⁸ See Mark V. Williams et al., *The Role of Health Literacy in Patient-Physician Communication*, 34 FAM. MED. 383, 384 (2002) (discussing the challenges of patients' understanding physician's vocabulary); see also Osborn et al., *supra* note 80, at 273 (finding that patients with lower health literacy "report inadequate provider communication across domains critical to successful chronic disease care and self-management"). For example, diabetic patients with poor health literacy are more likely than those with adequate health literacy to rate their physician's communication as low in the domains of general clarity, explanation of the patient's condition, and explanation of processes of care. See Dean Schillinger et al., *Functional Health Literacy and the Quality of Physician-Patient Communication Among Diabetes Patients*, 52 PATIENT EDUC. & COUNSELING 315 (2004).

⁸⁹ See Beena Jimmy & Jimmy Jose, *Patient Medication Adherence: Measures in Daily Practice*, 26 OMAN MED. J. 155, 156 (2011).

⁹⁰ See Lut Berben et al., *An Ecological Perspective on Medication Adherence*, 34 WESTERN J. NURSING RES. 635, 639–40 (2012) (reporting that a meta-analysis on patient adherence to treatment recommendations "found that the risk for nonadherence was 19% higher when there was poor communication with the physician").

⁹¹ See STUART BUTLER, JONATHAN GRABINSKY & DOMITILLA MASI, BROOKINGS INST., *HOSPITALS AS HUBS TO CREATE HEALTH COMMUNITIES: LESSONS FROM WASHINGTON ADVENTIST HOSPITAL* 7 (2015), <https://www.brookings.edu/research/hospitals-as-hubs-to-create-healthy-communities-lessons-from-washington-adventist-hospital> (describing a hospital's program to help patients enroll in "social services and benefits for which they are eligible"); Christopher J. Gearon, *Treating Hunger as a Health Issue*, U.S. NEWS & WORLD REP. (Feb. 13, 2014, 10:28 AM), <http://health.usnews.com/health-news/hospital-of-tomorrow/articles/2014/02/13/treating-hunger-as-a-health-issue> (stating in response to "payment carrots and sticks" under the ACA that reward "keeping people well and preventing disease," some hospitals are going beyond care-delivery transformations and "teaming up with local stakeholders... in hopes of moving the needle on social determinants of health in communities").

⁹² See, e.g., BUTLER, GRABINSKY & MASI, *supra* note 91, at 6, 9–10 (describing the efforts of Washington Adventist Hospital to coordinate transportation to and from appointments); Imran Cronk, *The Transportation Barrier*, ATLANTIC (Aug. 9, 2015), <http://www.theatlantic.com/health/archive/2015/08/the-transportation-barrier/399728> (noting that some health care providers employ community health workers to coordinate transportation for

designed to address patients' food insecurity issues, providing meals to at-risk individuals and pushing for produce-filled grocery stores in urban food deserts.⁹³ Recent years also have seen growth in provider-sponsored medical-legal partnerships⁹⁴ that assist patients with legal problems that contribute to poor health.⁹⁵

Performance incentive programs also encourage physicians, particularly primary care providers, to more effectively identify and address their patients' behavioral health problems. Primary care and behavioral health care largely operate separately from one another.⁹⁶ This has contributed to far too many patients receiving little or no treatment for their behavioral health conditions, as medical providers often do not recognize their patients' behavioral health needs or do little to help patients obtain effective behavioral health treatment.⁹⁷ Greater coordination and integration between primary care and behavioral health providers, however, can improve treatment of behavioral health conditions,⁹⁸ which in turn can increase patient compliance.⁹⁹ Specifically, primary care providers can utilize evidence-based screening tools to help identify patients with behavioral health needs; establish stronger referral relationships with behavioral health providers or co-

patients to and from appointments).

⁹³ See Gearon, *supra* note 91.

⁹⁴ Whereas there were few medical-legal partnerships five to ten years ago, today approximately 300 hospitals and health centers have medical-legal partnerships. See NAT'L CTR. FOR MED. LEGAL PARTNERSHIP, <http://medical-legalpartnership.org/partnerships> (last visited Jan. 14, 2016) (presenting statistics on the current number of medical-legal partnerships); Tina Rosenberg, *When Poverty Makes You Sick, a Lawyer Can Be the Cure*, N.Y. TIMES: OPINIONATOR (July 17, 2014, 9:30 PM), http://opinionator.blogs.nytimes.com/2014/07/17/when-poverty-makes-you-sick-a-lawyer-can-be-the-cure/?_r=0 ("There were few medical-legal partnerships until about five or 10 years ago . . .").

⁹⁵ Medical-legal partnership (MLP) embeds lawyers and paralegals alongside health care teams to detect, address, and prevent health-harming social conditions for people and communities. See *The MLP Response*, NAT'L CTR. FOR MED. LEGAL PARTNERSHIP, <http://medical-legalpartnership.org/mlp-response> (last visited Feb. 5, 2016); KATE MARPLE ET AL., NAT'L CTR. FOR MED. LEGAL PARTNERSHIP, FRAMING LEGAL CARE AS HEALTH CARE: A GUIDE TO HELP CIVIL LEGAL AID PRACTITIONERS MESSAGE THEIR WORK TO HEALTH CARE AUDIENCES 3 (2015), <http://medical-legalpartnership.org/wp-content/uploads/2015/01/Framing-Legal-Care-as-Health-Care-Messaging-Guide.pdf>. For example, MLPs may assist patients with housing issues, such as preventing evictions or suing landlords for noncompliance with local housing standards, helping victims of domestic violence obtain restraining orders, or assisting with appeals of public benefit denials. See *id.*

⁹⁶ See Sarah Klein & Martha Hostetter, *In Focus: Integrating Behavioral Health and Primary Care*, COMMONWEALTH FUND, <http://www.commonwealthfund.org/publications/newsletters/quality-matters/2014/august-september/in-focus> (last visited Sept. 15, 2017).

⁹⁷ See *id.* (stating that as many as sixty to seventy percent of patients with behavioral health problems leave medical settings without receiving treatment for their behavioral health conditions).

⁹⁸ See CHRIS COLLINS ET AL., MILBANK MEMORIAL FUND, EVOLVING MODELS OF BEHAVIORAL HEALTH INTEGRATION IN PRIMARY CARE 3–4 (2010), <https://www.milbank.org/wp-content/uploads/2016/04/EvolvingCare.pdf> (making the case for greater coordination and integration among primary care and behavioral health providers).

⁹⁹ See *supra* notes 80–81 and accompanying text (discussing the association between behavioral health problems and patient compliance).

locate behavioral health care in the primary care setting; and regularly consult with behavioral health providers and jointly develop a treatment plan that includes both medical and behavioral elements.¹⁰⁰

Performance incentive programs also reward those physicians who increase patient compliance by improving their communication style, particularly among those patients with poor health literacy.¹⁰¹ Most obviously, physicians can provide simple and clear information and instructions¹⁰² and take the time to address patient's concerns about risks and side effects.¹⁰³ In addition, physicians can improve compliance by supplementing oral communications with written information and directions, information leaflets, pictures, and medication charts, all of which have been shown to improve patient understanding.¹⁰⁴ Physicians also can improve patient compliance by replacing a didactic approach to communicating health information with shared decision-making, a collaborative approach where patients and providers jointly identify therapeutic goals and treatment options.¹⁰⁵

Physicians and their affiliated organizations also can improve patient compliance by implementing intensive patient education interventions that target risky behaviors among high-need patients. For example, participants in a comprehensive diabetes education initiative reduced their A1c levels and increased their physical activity.¹⁰⁶

¹⁰⁰ See COLLINS, *supra* note 98, at 12–13 (identifying approaches to increasing coordination and integration among primary care and behavioral health providers); Klein & Hostetter, *supra* note 96 (same).

¹⁰¹ More effective patient-provider communication can lead to improved patient compliance. For example, a study of diabetic patients found that effective patient-provider communication (both general communication processes and diabetes-specific communications) led to better self-care among patients, even when controlling for patients' sociodemographic characteristics, health status, and other characteristics of the health care context. See John O. Piette et al., *Dimensions of Patient-Provider Communication and Diabetes Self-Care in an Ethnically Diverse Population*, 18 J. GEN. INTERNAL MED. 624, 632 (2003). As noted previously, increased patient compliance improves physicians' performance under performance incentive programs. See *supra* Section III.A.

¹⁰² See Felicity C. Blackstock et al., *Why Don't Our Patients with Chronic Obstructive Pulmonary Disease Listen to Us?: The Enigma of Nonadherence*, 13 ANNALS AM. THORACIC SOC'Y 317, 320 (2016) (stating that potential strategies for improving medication adherence include "providing simple and clear instructions"); Chaurasia, *supra* note 85, at 340 ("Give precise and clear instructions to the patient.").

¹⁰³ See Jimmy & Jose, *supra* note 89, at 157 ("Patients' fears and concerns about adverse drug reactions can be alleviated by educating patients regarding common side effects of the drugs which they are taking, how to prevent an adverse drug reaction, if possible, and also convincing the patient of the need for treatment.").

¹⁰⁴ See generally Jimmy & Jose, *supra* note 89, at 156–57; Jin et al., *supra* note 3, at 277; Paasche-Orlow & Wolf, *supra* note 83, at S22.

¹⁰⁵ See Piette et al., *supra* note 101, at 624 (stating that diabetic patients have higher rates of compliance when given a central role in setting self-care goals); Sandra R. Wilson et al., *Shared Treatment Decision Making Improves Adherence and Outcomes in Poorly Controlled Asthma*, 181 AM. J. RESPIRATORY & CRITICAL CARE MED. 566 (2010) (finding that patients of providers who received training in shared decision-making demonstrated dramatically higher adherence than patients of other providers).

¹⁰⁶ See Michael S. Spencer et al., *Effectiveness of a Community Health Worker Intervention*

Intensive smoking cessation interventions also have been shown to improve long-term smoking cessation rates, which in turn reduces hospitalizations and mortality rates.¹⁰⁷

Finally, performance incentive programs promote physicians and their affiliated organizations to improve patient compliance by developing less complex treatment regimens, particularly in the area of prescribed medications. Studies show that medication adherence rates fall as the medication regimen becomes more complex and involve numerous medications with varying dosages and schedules.¹⁰⁸ Medication adherence also declines if the cost of the prescribed therapy is a financial burden for a patient.¹⁰⁹ Physicians and their affiliated organizations therefore can improve medication adherence by simplifying medication regimens and prescribing lower cost therapies when available. In addition, prescribing a longer supply (e.g., twelve months rather than three months) improves compliance given the inconvenience of obtaining refills.¹¹⁰ Studies also show that sending automated reminders to patients who have not refilled their prescriptions, such as telephone calls, emails, text messages, and letters, improves patients' medication adherence.¹¹¹

Among African American and Latino Adults with Type 2 Diabetes: A Randomized Controlled Trial, 101 AM. J. PUB. HEALTH 2253–60 (2011) (reporting the results of the REACH Detroit Partnership, which used community health workers to conduct diabetes education class and two home visits).

¹⁰⁷ See Syed M. Mohiuddin et al., *Intensive Smoking Cessation Intervention Reduces Mortality in High-Risk Smokers with Cardiovascular Disease*, 131 CHEST 446 (2007). The authors reported that thirty-three percent of smokers with acute cardiovascular disease who received twelve weeks of behavior modification counseling and individualized pharmacotherapy after a hospitalization had continuous smoking cessation rates at twenty-four months, as compared to only nine percent of those who had received printed educational materials and counseling prior to discharge. Moreover, during the two-year follow-up period, those receiving the intensive smoking cessation interventions were less likely to have been hospitalized and had a lower mortality rate than those who only had received printed educational materials and pre-discharge counseling. *See id.*

¹⁰⁸ See Jimmy & Jose, *supra* note 89, at 156 (“Barriers to the effective use of medicines specifically include . . . complex regimens that require numerous medications with varying dosing schedules.”); Jin et al., *supra* note 3, at 278 (citing studies that found a correlation between medication compliance and the number of dosing times per day). For example, for patients prescribed a single medication to be taken once daily, the average compliance rates is approximately eighty percent, whereas the average compliance rate drops to fifty percent for medications that must be taken four times per day. *See Chesanow, supra* note 5, at 5.

¹⁰⁹ See Patricia Anne O’Malley, *Medication Adherence and Patient Outcomes Part 1: Why Patients Fail to Take Prescribed Medications*, 27 CLINICAL NURSE SPECIALIST 227, 228 (2013) (recommending that physicians prescribe “affordable medications to minimize interrupted supply or nonfilling of prescriptions due to financial burden”).

¹¹⁰ See John F. Steiner, *Rethinking Adherence*, 157 ANNALS INTERNAL MED. 580, 583 (2012) (reporting that women who were prescribed a twelve month supply of oral contraceptives had a thirty percent decrease in the risk for unintended pregnancies and a forty-six percent decrease in the risk of abortion as compared to those prescribed a three month supply).

¹¹¹ For example, among parents identified as not refilling their asthmatic children’s inhaled corticosteroid medication, those who received computer-generated calls were 25.4% more adherent than those who did not. *See Bruce G. Bender et al., Pragmatic Trial of Health Care Technologies to Improve Adherence to Pediatric Asthma Treatment: A Randomized Clinical*

2. Preserving Incentives for Physicians to Lower Barriers to Compliance and Healthy Behaviors

As the above discussion illustrates, for many patients simply giving them competent medical advice and treatments will do little to improve their health if providers then send these patients back to the same living conditions that made them unhealthy.¹¹² Similarly, physicians will have limited success in improving patients' health if they fail to address patients' behavioral health issues or poor health literacy. Performance incentives change this dynamic by rewarding physicians who, together with their affiliated organizations, improve patients' health knowledge and tackle the social, environmental, and behavioral health factors that contribute to unhealthy behavior and noncompliance.¹¹³ In fact, many physicians and their affiliated organizations have responded to performance incentives by implementing various programs that address obstacles to their patients living healthier lives and adhering to medical advice.¹¹⁴

Legal standards and standards of professional conduct that allow physicians to reject noncompliant patients, however, weaken the incentives for providers to tackle the barriers to patient compliance. Specifically, current legal and ethical standards give physicians an

Trial, 169 JAMA PEDIATRICS 317 (2015). Another study found that among patients receiving treatment for allergic rhinitis, those receiving text message reminders reported adherence rates at double of those not receiving text messages. See Kuiji Wang et al., *A Randomized Controlled Trial to Assess Adherence to Allergic Rhinitis Treatment Following a Daily Short Message Service (SMS) via the Mobile Phone*, 163 INT'L ARCHIVES ALLERGY & IMMUNOLOGY 51 (2014). And a group of Kaiser Permanente patients who received automated telephone call reminders followed by a reminder letter were 1.6 times more likely to refill their statin prescriptions. See Bender, *supra* note 6, at 12–13.

¹¹² See Steven Ross Johnson, *Getting to the Root of the Problem: Systems Tackle Social Conditions to Improve Outcomes Despite the Financial Risks*, MOD. HEALTHCARE (Feb. 1, 2014), <http://www.modernhealthcare.com/article/20140201/magazine/302019986> (quoting David Williams, a professor of public health at Harvard University).

¹¹³ See CRAWFORD ET AL., *supra* note 34, at 2–4, 11 (“[T]here are a growing number of examples of population health services that extend literally and/or figuratively beyond the traditional walls of the a clinical setting, . . . [including initiatives] promoting community or public health services.”); Gearon, *supra* note 91 (stating in response to “payment carrots and sticks” under the ACA that reward “keeping people well and preventing disease,” some hospitals are going beyond care-delivery transformations and “teaming up with local stakeholders . . . in hopes of moving the needle on social determinants of health in communities”); Johnson, *supra* note 112 (“[A] growing number of health systems across the country . . . have begun tackling the social, economic and environmental conditions in the communities they serve as part of their programs to reduce hospital readmissions and improve outcomes.”); see also Jennifer DeCubellis & Leon Evans, *Investing in the Social Safety Net: Health Care’s Next Frontier*, HEALTH AFF. BLOG (July 7, 2014), <http://healthaffairs.org/blog/2014/07/07/investing-in-the-social-safety-net-health-cares-next-frontier> (“Across the country, a growing number of innovators in the health care sector are designing care coordination programs to better serve low-income, high-need populations and begin to address the relevant social issues.”). See generally Jessica Mantel, *Taking Aim at the Social Determinants of Health: A Central Role for Providers*, 33 GA. ST. U. L. REV. 217, 239–42 (2017).

¹¹⁴ See Mantel, *supra* note 113, at 246–49.

escape hatch from the penalties performance incentive programs impose on providers who do not improve their patients' health behaviors. Rather than simplify the medication regimen or provide automated refill reminders to a patient having trouble with medication adherence, the physician can simply dismiss the patient. Rather than arrange transportation for the patient who otherwise will not obtain regular follow-up care, the physician can terminate the physician-patient relationship. Rather than provide an intensive education program for the diabetic patient with continuously high A1c levels, the physician can refuse to treat the patient.

Physicians can and should do more to promote their patients leading healthier lives. Indeed, policymakers adopted performance incentive programs for the very purpose of motivating physicians and other providers to improve their patients' health. Legal and professional standards that allow physicians to reject noncompliant patients thwart this vitally important policy. Accordingly, if policymakers and professional associations are serious about health promotion, they must constrain physicians' ability to avoid noncompliant patients.

B. *Honoring Professional Norms of Beneficence and Nonmaleficence*

The medical ethics literature underscores the special nature of the physician-patient relationship, a relationship characterized by patients who depend on physicians using their skills and knowledge to promote their patients' well-being.¹¹⁵ The professional norms governing physicians therefore require that physicians show fidelity to their patients. Specifically, the norm of beneficence requires that "[t]he physician's primary commitment must always be to the patient's welfare and best interests . . . [regardless of] patient characteristics, such as decision-making capacity, behavior, or social status."¹¹⁶ The corollary norm of nonmaleficence requires that the physician refrain from any action that would unnecessarily harm a patient.¹¹⁷

Firing or otherwise avoiding noncompliant patients, however, flouts the norms of beneficence and nonmaleficence. As described below, dismissing noncompliant patients results in discontinuity in care,

¹¹⁵ See Marc A. Rodwin, *Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System*, 21 AM. J.L. & MED. 241, 245, 247 (1995) (characterizing the physician-patient relationship as one where physicians have specialized knowledge and expertise and patients are dependent on physicians given their illness and anxiety, and therefore "[c]ontemporary literature in medicine and medical ethics assumes that physicians are indeed fiduciaries . . .").

¹¹⁶ Snyder, *supra* note 63, at 75.

¹¹⁷ See ELIZABETH MARTIN, *Nonmaleficence*, CONCISE MEDICAL DICTIONARY (8th ed. 2010) (defining nonmaleficence as the principle that "doctors should avoid causing harm to patients").

and this in turn leads to poorer health among noncompliant patients and higher medical spending. The rejection of noncompliant patients also lowers these patients' trust in physicians and can leave patients feeling stigmatized and ashamed. A prohibition against physicians rejecting noncompliant patients would curtail these harms, thereby ensuring that physicians honor their professional norms of beneficence and nonmaleficence.

1. Eliminating the Adverse Consequences from Discontinuity in Care

Experts have long-recognized the importance of continuity of care, defined as “a sustained partnership between patient and clinician.”¹¹⁸ Noncompliant patients rejected by physicians, particularly those fired by their current provider, experience discontinuity in care. In particular, these patients may incur an extended interruption in their care, as physicians may be reluctant to accept as a new patient an individual dismissed by their prior physician for noncompliance.¹¹⁹ As explained below, the discontinuity in care experienced by these noncompliant patients leads to poorer health and higher health costs. Prohibiting physicians from avoiding noncompliant patients would eliminate these problems.

An interruption in care can lead to unmet medical needs or a delay in care. During the time a patient has no usual source of care,¹²⁰ prescriptions may go un-refilled, diagnostics tests and medical procedures may be delayed, and medical counseling may be foregone. For example, one survey found that respondents who experienced a change in their usual source of care¹²¹ during the prior twelve months were more likely than those with a usual source of care to report unmet medical needs (12.5% versus 6.6%) and postponement of needed medical care (32.8% versus 22%).¹²² Similarly, a 2005 study found that

¹¹⁸ Dong Wook Shin, *Impact of Continuity of Care on Mortality and Health Care Costs: A Nationwide Cohort Study in Korea*, 12 ANNALS FAM. MED. 534, 534 (2014).

¹¹⁹ Cf. Wicclair, *supra* note 12, at 316 (discussing a Sun-Sentinel article describing the phenomenon of ob-gyns refusing to treat overweight women who are or may become pregnant given their increased risk of morbidity and mortality).

¹²⁰ “Usual source of care” means “the particular medical professional, doctor’s office, clinic, health center, or other place where a person would usually go if sick or in need of advice about his or her health.” *MEPS Topics: Usual Source of Care*, AGENCY FOR HEALTHCARE RES. & QUALITY, https://meps.ahrq.gov/data_stats/MEPS_topics.jsp?topicid=44Z-1 (last visited Sept. 12, 2017).

¹²¹ In addition to being dismissed by a provider, individuals may change their usual source of care due to changes in health insurance, changing medical needs, quality concerns, geographic moves, or personal preference. See Maureen A. Smith & Jessica M. Bartell, *Changes in Usual Source of Care and Perceptions of Health Care Access, Quality, and Use*, 42 MED. CARE 975, 975 (2004).

¹²² See *id.* at 977.

relative to those with a stable usual source of care, low-income children in Oregon who changed their usual source of care reported higher rates of unmet medical need (25.5% versus 10.6%), unmet prescription need (32.1% versus 17.3%), problems getting immediate care (23.5% versus 16.7%), problems getting specialty care (38.6% versus 21.8%), unmet dental need (34.1% versus 19.9%), and unmet counseling need (37.3% versus 13.9%).¹²³

Although many noncompliant patients eventually find a new source of care, the discontinuity in their care nevertheless may adversely impact the quality of care received from their new provider. As explained by one commentator, “[w]hen patients concentrate their care with a single physician, these physicians are more likely to develop an accumulated knowledge about their patients’ medical conditions,” including “a finer understanding of the severity of each medical problem and how multiple medical problems interact.”¹²⁴ In addition, patients who have continuity with the same physician are more likely to receive ongoing preventive care.¹²⁵ Patients with a sustained relationship with a physician also may develop greater trust in their physician’s expertise and judgment and thus may be more likely to seek out and abide by their physician’s opinion.¹²⁶ In contrast, when a patient fired for noncompliance switches physicians, the physician-patient bond of trust and understanding “must laboriously be re-created.”¹²⁷ In the interim, the quality of care received by the patient may suffer.

Studies confirm that continuity of care promotes higher quality care and enhanced patient-adherence and self-management, while discontinuity in care results in poorer health outcomes and higher utilization and costs. For example, a 2014 study found that among Medicare patients with congestive heart failure, chronic obstructive pulmonary disease, and type 2 diabetes, those with higher levels of continuity of care were less likely to be hospitalized, require emergency room visits, or experience complications; they also had lower episode of care costs.¹²⁸ Similarly, a study of HMO¹²⁹ patients with arthritis,

¹²³ See Jennifer E. DeVoe et al., *A Medical Home Versus Temporary Housing: The Importance of a Stable Usual Source of Care Among Low-Income Children*, 124 PEDIATRICS 1363, 1369 (2009).

¹²⁴ James M. Gill et al., *The Effect of Continuity of Care on Emergency Department Use*, 9 ARCHIVES FAM. MED. 333, 336–37 (2000).

¹²⁵ See Shin, *supra* note 118, at 539 (“In addition to cardiovascular mechanisms, patients [with cardiovascular conditions] who have a sustained relationship with a physician may receive other preventive services . . .”).

¹²⁶ See Gill et al., *supra* note 124, at 337 (“When patients have a continuity relationship with their physician, it is likely that they will develop a sense of trust in the physician’s knowledge and medical judgment.”). See generally *infra* notes 137–41 and accompanying text (discussing the association between patient trust and adherence).

¹²⁷ Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643, 653 (2008).

¹²⁸ See Peter S. Hussey et al., *Continuity and the Costs of Care for Chronic Disease*, 174 JAMA 742 (2014).

asthma, epigastric pain/peptic ulcer disease, hypertension, and otitis media found that patients with greater continuity of care used fewer health care resources.¹³⁰ Other studies find similar results.¹³¹

These studies indicate that when physicians refuse to treat noncompliant patients, the resulting discontinuity in care leads to poorer health for these individuals, as well as higher costs for the health insurers and government health programs that pay for their care. Such actions hardly demonstrate a commitment to patients' best interests. A prohibition against physicians rejecting noncompliant patients, however, would promote greater continuity of care, thereby ensuring that physicians' honor the professional norms of beneficence and nonmaleficence.

2. Protecting Patients' Trust in Physicians

The beneficence norm, with its requirement that a physician act in her patient's best interests, preserves patient trust in physicians.¹³² Patient trust is the cornerstone of successful physician-patient relationships. Patient trust promotes patients sharing with their physicians sensitive and confidential information that may be crucial to the effective diagnosis and treatment of a patient's ailments.¹³³ In addition, with trust patients are more willing to seek care from a physician and follow her medical advice.¹³⁴ Physicians therefore must

¹²⁹ HMO is the commonly used abbreviation of "health maintenance organization."

¹³⁰ See Michele Raddish et al., *Continuity of Care: Is It Cost Effective?*, 5 AM. J. MANAGED CARE 727 (1999) (finding that increasing the number of primary care or specialty care providers a patient saw was significantly associated with increased prescriptions and prescription costs, more outpatient visits, and increased hospital admissions).

¹³¹ See, e.g., Gill et al., *supra* note 124, at 336–37 (finding that Medicaid patients with high provider continuity make fewer emergency department visits). International studies also have found that patients with greater continuity of care have better health incomes and lower utilization of expensive care. See Shin, *supra* note 118, at 535–38 (examining Korean National Health Insurance enrollees with new diagnosed cardiovascular risk factors and finding that those with continuity of care scores above the median had increased risk of mortality, incident myocardial infarction, and incident ischemic stroke, fewer inpatient and outpatient days, and lower inpatient and outpatient costs relative to those with continuity of care scores below the median); Jan M. De Maeseneer et al., *Provider Continuity in Family Medicine: Does it Make a Difference for Total Health Care Costs?*, 1 ANNALS FAM. MED. 144 (2003) (finding that Belgian patients who visited the same family physicians during the measured time period had higher functional status and lower total health care costs than those who visited multiple physicians).

¹³² See Jessica Mantel, *A Defense of Physicians' Gatekeeping Role: Balancing Patients' Needs with Society's Interests*, 42 PEPP. L. REV. 633, 648 (2015) ("Demanding that physicians act as the patient's fiduciary . . . reinforc[es] patients' trust in their physicians.").

¹³³ See Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 498–500 (2002); David Orentlicher, *Health Care Reform and the Patient-Physician Relationship*, 5 HEALTH MATRIX 141, 147–48 (1995).

¹³⁴ See Hall, *supra* note 133, at 478 (describing the instrumental value of trust in medical relationships); Orentlicher, *supra* note 133, at 147 ("The willingness of patients to turn to physicians for care, to speak openly about intimate and potentially embarrassing information,

take care to promote a culture of patient trust. Physicians' rejection of noncompliant patients, however, threatens to do the opposite.

Noncompliant patients, fearful of being fired, may withhold important information from their physicians.¹³⁵ In particular, patients may minimize their self-care failures and exaggerate their self-care successes when communicating with their physician. For example, a previously fired diabetic patient may not reveal to her new physician that she has not adhered to the prescribed medication regimen, continues to eat unhealthy foods, and/or fails to regularly monitor her glucose levels. Although no studies have examined whether noncompliant patients do in fact withhold important information from physicians, both physicians and patients report that patients who fear being judged by their physicians are reluctant to discuss their true self-care behaviors.¹³⁶ Presumably noncompliant patients' fear of rejection by physicians would similarly chill physician-patient communications given the parallels between feeling judged and fears of being rejected by one's physician.

Patients fired for noncompliance also may lose trust in the medical profession generally, leading to even lower levels of treatment adherence and reduced use of future medical services. When patients do not trust their physician to act in their best interest, they have less confidence in the physician's treatment recommendations.¹³⁷ Indeed, numerous studies have found a positive association between treatment adherence and the degree to which a patient trusts her physician.¹³⁸ Moreover,

and to rely on their physicians' recommendations depends in large part on the ability of patients to trust that physicians are acting primarily to advance the interests of their patients.”).

¹³⁵ See Lois Shepherd, *HIV, the ADA, and the Duty to Treat*, 37 HOUS. L. REV. 1055, 1097 (2000) (arguing that physicians should have a duty to treat, as patients “[s]ecure in the knowledge that they cannot be legally denied medical care” will then “reveal those aspects about themselves that doctors need to know”).

¹³⁶ See Marilyn D. Ritholz et al., *Barriers and Facilitators to Self-Care Communication During Medical Appointments in Adults with Type 2 Diabetes*, 10 CHRONIC ILLNESS 303 (2014).

¹³⁷ See Sannisha K. Dale et al., *Medical Mistrust Is Related to Lower Longitudinal Medication Adherence Among African-American Males with HIV*, 21 J. HEALTH PSYCHOL. 1311, 1312 (2014) (“[M]edical mistrust may result in suspicions about physicians’ recommendations . . . and consequently lead to lower medication adherence.”); Arch G. Mainous III et al., *Continuity of Care and Trust in One’s Physician: Evidence from Primary Care in the United States and the United Kingdom*, 33 FAM. MED. 22, 22–23, 26 (2001) (“The trust that patients have in their physician to act in their best interest may also contribute to the effectiveness in medical care . . . [whereas a] lack of trust by patients may lead to conflict between the patient and the physician about the cause of the patient’s medical program or appropriate methods of treatment. Such conflict may, in turn, lead to a lack of patient adherence”); Hayley S. Thompson et al., *The Group-Based Medical Mistrust Scale: Psychometric Properties and Association with Breast Cancer Screening*, 38 PREVENTIVE MED. 209, 210 (2004) (stating that individuals with greater distrust in the health care system are expected to have more doubts about the benefits and effectiveness of recommended treatments, including cancer screening).

¹³⁸ See Berben et al., *supra* note 90, at 640 (“In our recent systematic review, we . . . found that the degree of trust the patient has in the health care professional was one of the factors most consistently related to medication adherence.”); Leonard L. Berry et al., *Patients’*

patients with low levels of trust frequently delay or forego appropriate preventive or follow-up care, such as routine check-ups, cancer screenings, and cholesterol screenings.¹³⁹ These findings hold not only when patients mistrust their treating physician, but also when patients mistrust the health care system generally.¹⁴⁰ Patients rejected for noncompliance therefore may develop a general mistrust of providers and approach their new physician with wariness, resulting in diminished treatment adherence and reduced use of needed care.¹⁴¹

When physicians refuse treatment to noncompliant patients, they undermine these patients' trust in physicians. With diminished trust, noncompliant patients may experience poorer health, as they may be less forthcoming with their physicians and less willing to seek out and abide by physicians' guidance. This state of affairs clearly contravenes the medical profession's commitment to promote patients' well-being and do no harm. Accordingly, the law and standards of professional conduct should prohibit physicians from undermining patient trust through the rejection of noncompliant patients.

3. Avoiding the Stigmatization and Shaming of Patients

Being fired by your physician can be deeply distressing and stigmatizing. Patients in the United Kingdom who were removed from their general practitioner's patient list found removal "profoundly

Commitment to Their Primary Physician and Why It Matters, 6 ANNALS FAM. MED. 6–13 (2008) (finding that patient trust was positively associated with adherence); Kimberly A. Gudzone et al., *Patients Who Feel Judged About Their Weight Have Lower Trust in Their Primary Care Providers*, 97 PATIENT EDUC. COUNSELING 128, 129 (2014) (summarizing prior studies that found that patients who trust their primary care providers were more committed to the primary care relationship and more likely to adhere to medical advice).

¹³⁹ See Wizdom Powell Hammond et al., *Masculinity, Medical Mistrust, and Preventive Health Services Delays Among Community-Dwelling African-American Men*, 25 J. GEN. INTERNAL MED. 1300 (2010) (finding that Black men with higher medical mistrust were significantly more likely to delay routine check-ups and cholesterol screenings); Maria C. Katapodi et al., *Distrust, Predisposition to Use Health Services and Breast Cancer Screening: Results from Multicultural Community-Based Survey*, 47 INT'L J. NURSING STUD. 975 (2010) (finding that distrust of the health care system was associated with lower frequency of mammograms and provider-given clinical breast exams); Thomas A. LaVeist et al., *Mistrust of Health Care Organizations Is Associated with Underutilization of Health Services*, 44 HEALTH SERVICES RES. 2093 (2009) (finding that patient mistrust of health care organizations is associated not only with lower adherence, but also with lower health services utilization).

¹⁴⁰ See sources cited *supra* note 139; see also Dale et al., *supra* note 137, at 1311 (finding that general medical mistrust among African American males predicted lower continuous medication adherence over time).

¹⁴¹ See LaVeist et al., *supra* note 139, at 2012 ("[I]t may be that mistrust emanating from patient experiences in one aspect of the health care system would lead to general mistrust of health care."). For example, patients in the United Kingdom who reported that their prior general practitioner was "untrustworthy" were more skeptical of their new general practitioner. See Carolyn Tarrant et al., *Continuity and Trust in Primary Care: A Qualitative Study Informed by Game Theory*, 8 ANNALS FAM. MED. 440, 442–43 (2010).

stigmati[z]ing,” “threatening,” and “an attack on their right to be a [National Health Service] patient.”¹⁴² These patients also feared that their removal would negatively affect other physicians’ view of them and result in their receiving care that differed from what others receive.¹⁴³ Patients rejected for noncompliance may be particularly prone to these feelings, as they often feel unfairly judged for their poor health behaviors given the social, environmental, and behavioral health challenges they face.¹⁴⁴

These feelings of stigma can have psychological consequences and trigger health-harming stress and maladaptive behaviors. Several studies demonstrate that feelings of stigma cause stress,¹⁴⁵ which in turn can damage immune defenses, vital organs, and physiological systems.¹⁴⁶ Stigma also increases individuals’ risk for behavioral health issues and poor coping behaviors. For example, studies have found that individuals who experience weight stigma are at higher risk for depression, anxiety, substance abuse, and suicide.¹⁴⁷ These individuals also engage in binge-eating and disordered eating patterns and have lower motivation for health-promoting activities such as exercise.¹⁴⁸ To the extent noncompliant patients fired by their physicians are at risk for similar problems, they will experience even poorer health and higher medical costs.

Patients who suffer stigma in the clinical setting also have less trust in their physicians,¹⁴⁹ which as noted above can adversely impact

¹⁴² Tim Stokes et al., *Patients’ Accounts of Being Removed from Their General Practitioner’s List: Qualitative Study*, 326 BRITISH MED. J. 1316 (2003).

¹⁴³ The authors of these studies reported that

The dominant form of stigma reported by patients was “felt” stigma (a feeling of shame and fear of discrimination), particularly a fear that their future health care would be adversely affected by the “spoiling” of their identity as “good” patients. Participants feared that their notes had been flagged so that they would receive different treatment from other [general practitioners] . . .

See *id.* at 1317.

¹⁴⁴ See Jay A. Jacobson, *The Effect of Patients’ Noncompliance on Their Surgeons’ Obligations*, 87 SURGICAL CLINICS NORTH AM. 937, 944 (2007) (commenting that patients may feel unfairly blamed for what they do not feel responsible for when their nonadherence results from challenging circumstances, such as difficult paying for drugs or an addiction relapse). See generally *infra* Section IV.A.1 (explaining why noncompliant patients are not necessarily blameworthy for their nonadherence and unhealthy behaviors).

¹⁴⁵ Mark L. Hatzenbuehler, *How Does Sexual Minority Stigma “Get Under the Skin”? A Psychological Mediation Framework*, 135 PSYCHOL. BULL. 707 (2009); Bruce G. Link & Jo C. Phelan, *Stigma and Its Public Health Implications*, 367 LANCET 528 (2006).

¹⁴⁶ See Paula Braveman, Susan Egerter & David R. Williams, *The Social Determinants of Health: Coming of Age*, 32 ANN. REV. PUB. HEALTH 381, 385, 388 (2010) (noting the impact of stress on health).

¹⁴⁷ See Rebecca M. Puhl et al., *Overcoming Weight Bias in the Management of Patients with Diabetes and Obesity*, 34 CLINICAL DIABETES 44 (2016).

¹⁴⁸ See *id.*

¹⁴⁹ See Jacobson, *supra* note 144, at 944 (explaining that patients who feel unfairly blamed for their nonadherence “are likely to lose respect and trust in their physician”).

physician-patient communications and lower patient-adherence.¹⁵⁰ For example, some obese patients who experience a lack of empathy from providers or who feel blamed for their weight are “reluctant to discuss their weight concerns in light of previous negative experiences.”¹⁵¹ Similarly, researchers found that Black patients who previously experienced racial discrimination in the health care setting had lower rates of medication adherence and that this resulted in part from their diminished trust in their physicians.¹⁵² Patients who feel stigmatized also frequently avoid follow-up care, care that is crucial for managing ongoing medical issues or early detection of emerging health problems.¹⁵³

In sum, when physicians fire or otherwise refuse to treat noncompliant patients, they inflict great harm on these patients. These patients experience discontinuity in care, a loss of trust in physicians, and stigma and shame, all of which contribute to poorer health. Laws and standards of professional conduct that allow physicians to reject noncompliant patients thus countenance actions that are harmful to these patients. In other words, current laws and professional standards subvert the medical profession’s commitment to the norms of beneficence and nonmaleficence. Rather than uphold current rules that rest on dubious ethical grounds, lawmakers and professional associations should prohibit physicians from rejecting patients for noncompliance. In doing so, they will reinforce physicians’ moral commitment to their patients’ welfare and best interests.

C. *Honoring Patient Autonomy*

The paternalism that characterized the past practice of medicine, where physicians were presumed to know what is best for patients, has been replaced with respect for patient autonomy.¹⁵⁴ No longer are patients expected to obediently follow their physicians’ recommendations. Rather, current codes of medical ethics and the laws of informed patient consent grant patients the right to make medical decisions consistent with their own values and preferences, decisions

¹⁵⁰ See *supra* notes 137–41 and accompanying text.

¹⁵¹ Puhl et al., *supra* note 147, at 45.

¹⁵² See Yendelela L. Cuffee et al., *Reported Racial Discrimination, Trust in Physicians, and Medication Adherence Among Inner-City African Americans with Hypertension*, 103 AM. J. PUB. HEALTH e55 (2013).

¹⁵³ See Puhl et al., *supra* note 147, at 46 (noting that one of the long-term effects of stigmatization in health care is avoidance of follow-up care).

¹⁵⁴ See Jacobson, *supra* note 144, at 939 (“The long tradition of medical paternalism, doctor knows best, and following doctor’s ‘orders’ is no longer widely accepted by the American public or supported by laws related to patient decision making.”); Resnick, *supra* note 1, at 171 (discussing the demise of medical paternalism).

that may run counter to physicians' recommendations.¹⁵⁵ Physicians' conditioning continued treatment on a patient's adherence to medical advice, however, threatens to undermine this fundamental patient right.

Some patients' nonadherence may be involuntary—they desire to follow their physicians' recommendations and live healthier lives, but they face significant obstacles to doing so or simply lack the willpower. For many patients, however, their noncompliance is a fully autonomous choice, a conscious refusal to comply with a physician's advice after weighing the relevant benefits and costs for themselves.¹⁵⁶ For example, medications may have deleterious side-effects that some patients wish to avoid, such as drowsiness that interferes with operating a vehicle or working.¹⁵⁷ Other patients may conclude that dietary restrictions, giving up smoking, or painful treatments make life less enjoyable.¹⁵⁸ Although some may disagree with a patient's decision to elevate competing goals or values above health, the principle of self-determination nevertheless demands that we respect the patient's choice.¹⁵⁹

When physicians fire or threaten to fire their noncompliant patients, the physicians' actions jeopardize patients' autonomy. Patients who fear termination of the physician-patient relationship may feel they have little choice but to follow their physicians' recommendations, even if those recommendations are inconsistent with the patient's preferences and values.¹⁶⁰ As explained by one commentator, “[i]f a physician could respond to a patient's refusal of some treatment recommendations by denying treatment altogether, then patients would have little choice in

¹⁵⁵ See Jacobson, *supra* note 144, at 939 (noting that the current American Medical Association Code of Ethics “reflects the larger changes in American society that have diminished the unquestioned authority of leaders and professionals and elevated the autonomy and rights of individuals and classes of persons, including patients”); Resnik, *supra* note 1, at 171 (“Medical ethics opinions, codes, and articles written in the last three decades have emphasized patient's rights, such as the right to refuse treatment, the right to make medical decisions, the right to be informed, and so on.”).

¹⁵⁶ See Sciberras et al., *supra* note 2, at e61(2) (“Noncompliance may be considered as a form of autonomy.”).

¹⁵⁷ See Resnik, *supra* note 1, at 179 (explaining why some patients may have good reasons for their medication nonadherence).

¹⁵⁸ Cf. Orentlicher, *supra* note 12, at 1581 (listing examples of when patients may “trade length of life for quality of life”).

¹⁵⁹ See Mike W. Martin, *Responsibility for Health and Blaming Victims*, 22 J. MED. HUMAN. 95, 102 (2001) (“If we disagree with [the patient's] judgment, we should nevertheless avoid the self-righteous assumption that there is only one reasonable view of what self-respect requires.”).

¹⁶⁰ Orentlicher, *supra* note 12, at 1581–82. The possibility of physicians engaging in coercive behavior toward their noncompliant patients is not merely academic conjecture, as some physicians subject to performance incentives have reported cajoling their patients into compliance, “scolding them” or acting as the “nagging parent.” See Hibbard et al., *supra* note 10, at 488 (quoting comments from physicians describing how quality improvement incentives changed the nature of the physician-patient relationship); McDonald & Roland, *supra* note 44, at 123 (stating that U.S. physicians subject to performance incentives tied to patient outcomes “appeared to increase pressure to cajole and persuade their patients to secure their compliance”). Firing or threatening to fire noncompliant patients simply takes such behavior to the next level.

their care. They could accept all of their physician's treatment regimen or none of it."

The practice of physicians refusing to treat noncompliant patients thereby threatens to render patients' rights to self-determination meaningless. To guard against the United States returning to an era of medical paternalism, lawmakers and professional associations should prohibit physicians from dismissing noncompliant patients or rejecting prospective patients perceived as noncompliant.

D. *Reducing Disparities in Health*

Numerous studies have found that the burdens of poor health—illness, premature death, disability—disproportionately affect vulnerable populations.¹⁶¹ Racial minorities and individuals with lower levels of family income and education have higher rates of mortality and morbidity.¹⁶² The prevalence of chronic conditions such as asthma, diabetes, and hypertension also varies by race and ethnicity, educational attainment, and family income.¹⁶³ The federal government has identified the elimination of disparities in health¹⁶⁴ as a national priority, reflecting a desire to achieve health equity among all Americans.¹⁶⁵

¹⁶¹ See CTRS. FOR DISEASE CONTROL & PREVENTION, MORBIDITY AND MORTALITY WEEKLY REPORT 3 (2013), https://www.cdc.gov/mmwr/preview/ind2013_su.html#HealthDisparities2013 [hereinafter CDC Health Disparities and Inequalities Report 2013].

¹⁶² See *id.* at 15 (reporting association between mortality and morbidity rates and income and education levels); The Henry J. Kaiser Family Foundation, *State Health Facts: Minority Health*, KAISER FAMILY FOUNDATION, <http://kff.org/state-category/minority-health> (last visited Sept. 12, 2017) (reporting higher deaths in 2014 for Blacks as compared to Whites, and higher rates of cancer (2013), heart disease (2014), asthma (2015), and diabetes (2013) for Blacks as compared to Whites).

¹⁶³ See CDC Health Disparities and Inequalities Report 2013, *supra* note 161, at 93, 100, 146. According to the CDC, asthma prevalence was 7.9% among Whites, 10.5% among Blacks, 10.8% among American Indians/Alaska Natives, 5.0% among Asians, 14.4% among multi-race/other-race persons, 15.9% among Puerto Ricans, and 5.4% among Mexicans. See *id.* at 93. The prevalence rate for diabetes among adults in 2010 was 4.5 percentage points higher among Blacks and 4.7% higher among Hispanics than non-Hispanic Whites; 5.8% higher among those who did not graduate high school than among those with a college degree; and 4.6% higher among those considered poor as compared to those with high income. See *id.* at 100. The prevalence of hypertension among adults from 2007–2010 was 41.3% for Blacks as compared to 28.6% for non-Hispanic Whites, 36.9% for those with less than high school as compared to 28% for those with a college degree, and 32.8% for those with incomes below the federal poverty line as compared to 27.6% those with incomes above 500% of the federal poverty line. See *id.* at 146.

¹⁶⁴ The Centers for Disease Control and Prevention defines disparities in health as observed differences in health outcomes or health determinants between populations. See *id.* at 3.

¹⁶⁵ See *Disparities: Healthy People 2020*, OFF. DISEASE PREVENTION & HEALTH PROMOTION, <https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities> (last updated Aug. 5, 2017) ("During the past 2 decades, one of Healthy People's overarching goals has focused on disparities In Healthy People 2020, that goal was expanded even further: to achieve health equity, eliminate disparities, and improve the health of all groups."). "Healthy People 2020 defines health equity as the attainment of the highest level of health for all people.

The emerging trend of physicians rejecting patients for noncompliance, however, threatens to worsen disparities in health. As explained below, members of vulnerable populations disproportionately face social and environmental circumstances that hinder their adopting healthier lifestyles and adhering to their physicians' medical advice. Lower rates of health literacy among vulnerable populations also negatively impact these patients' compliance with medical advice. Consequently, members of vulnerable groups have higher rates of noncompliance and therefore are more likely to be rejected by physicians seeking to avoid noncompliant patients. Moreover, physicians' tendency to subconsciously apply stereotypes to patients with certain socio-demographics both negatively influences physicians' assessments of these patients' levels of compliance and contributes to actual differences in patient compliance. Eliminating disparities in health therefore necessitates a prohibition against physicians refusing to treat patients for reasons of noncompliance.

1. The Disproportionate Impact of Social and Environmental Factors

As explained in Section II.A, a range of social and environmental factors adversely impact individuals' health behaviors, including their adherence to medical advice. These factors disproportionately impact members of vulnerable groups. For example, lower average family income and lack of paid sick leave contribute to individuals from vulnerable groups delaying or foregoing needed care.¹⁶⁶ Lower income families also have difficulty affording healthier foods that support improved weight management and general health, as they generally are more expensive than less healthy foods.¹⁶⁷ In addition, lower-income communities, as well as rural and predominately minority communities, often have few if any healthier food retailers¹⁶⁸ and existing food outlets

Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities." *See id.*

¹⁶⁶ *See supra* notes 72, 74 and accompanying text (explaining the association between income and sick leave and individuals' health). Racial and ethnic minorities are more likely than Whites to have annual incomes below the federal poverty level. *See* CDC Health Disparities and Inequalities Report 2013, *supra* note 161, at 16 (reporting that in 2011, 16.4% of non-Hispanic Blacks and 16% of Hispanics had incomes below the federal poverty level, as compared to 12.4% of non-Hispanic Whites). Only 46% of Hispanic workers have paid sick days, as compared to 63% of White workers, and only one in three workers earning less than \$15,000 annually have paid sick days while nearly nine in ten workers earning above \$65,000 have paid sick days. *See* INST. FOR WOMEN'S POLICY RESEARCH, PAID SICK DAYS ACCESS AND USAGE RATES VARY BY RACE/ETHNICITY, OCCUPATION, AND EARNINGS 2, 5 (2016), <https://iwpr.org/wp-content/uploads/wpallimport/files/iwpr-export/publications/B356.pdf>.

¹⁶⁷ *See supra* note 76 and accompanying text.

¹⁶⁸ *See* CDC Health Disparities and Inequalities Report 2013, *supra* note 161, at 20–23.

in these communities typically charge higher prices.¹⁶⁹ Financial problems, safety concerns, racism, and other challenges that disproportionately affect certain groups can lead to chronic stress, with this stress then adversely impacting adherence to medical advice and prescribed medications.¹⁷⁰

Given these disparities in the social determinants of health, not surprisingly numerous studies have found that vulnerable populations have greater noncompliance than other groups. For example, lower-income adults have greater difficulty controlling their asthma.¹⁷¹ Among patients with hypertension, racial and ethnic minorities, individuals with lower levels of family income, and individuals with lower educational attainment have poorer blood pressure control.¹⁷² Studies also have found that racial and ethnic minorities are less likely than non-Hispanic Whites to adhere to prescribed medications,¹⁷³ and that those with lower levels of family income and educational attainment

Specifically, the CDC reported that individuals residing in rural census tracts were approximately four times as likely to lack access to a healthier food retailer as those residing in urban tracts. *See id.* at 22. In addition, individuals residing in census tracts with less than 64% non-Hispanic Whites were half as likely to lack access to a healthier food retailer as tracts with a higher percentage of non-Hispanic tracts, while persons in census tracts with average income of below \$27,269 were 1.2 times as likely to lack access to a healthier food retailer than census tracts with higher income. *See id.* Finally, individuals residing in census tracts where fewer than 27% of the population had a college education were significantly more likely to lack access to a healthier food retailer (33.3% versus 25.8%). *See id.* at 22–23.

¹⁶⁹ *See* Renee E. Walker et al., *Disparities and Access to Healthy Food in the United States: A Review of Food Deserts Literature*, 16 HEALTH & PLACE 876, 880 (2010) (listing studies that found that residents living in areas without a supermarket pay more for their food).

¹⁷⁰ *See infra* notes 223–24 and accompanying text. *Cf.* Megan C. Roberts et al., *Racial/Ethnic and Socioeconomic Disparities in Endocrine Therapy Adherence in Breast Cancer: A Systematic Review*, 105 AM J. PUB. HEALTH e4, e4 (2015) (stating that individuals who have high levels of social stressors, such as minority women, have “competing social and economic demands [that] may take priority over medication adherence, leading to suboptimal medication use”).

¹⁷¹ *See* CDC Health Disparities and Inequalities Report 2013, *supra* note 161, at 94 (reporting that among adults surveyed between 2006–2010, those with incomes below 100% of the federal poverty level were 53.9% likely to report having an asthma attack in the past year, while those with incomes above 450% of the federal poverty level were 48.9% likely to have reported having had an attack).

¹⁷² *See id.* at 146. Among adults surveyed from 2007–2010, 42.5%, 34.4%, and 30.3% of Blacks, Hispanics, and Mexican American adults respectively successfully controlled their blood pressure, as compared to 52.6% of non-Hispanic Whites. Only 41.8% of those with less than high school controlled their blood pressure, as compared to 52.6% of those with a college degree, and 46.2% of those with incomes below the federal poverty line did so as compared to 51.4% of those with incomes at or above 500% of the federal poverty line. *See id.*

¹⁷³ *See* Jessica Forsyth et al., *Perceived Discrimination and Medication Adherence in Black Hypertensive Patients: The Role of Stress and Depression*, 76 PSYCHOSOMATIC MED. 229, 229 (2014) (noting research finding that Blacks are significantly less likely than Whites to adhere to antihypertensive medication); Walid F. Gellad et al., *Race/Ethnicity and Nonadherence to Prescription Medications Among Seniors: Results from a National Study*, 22 J. GEN. MED. 1572, 1574 (2007) (finding racial disparities in medication adherence among seniors, with 45.3% of Blacks and 48.8% of Hispanics reporting nonadherence as compared to 41.1% of Whites); Connie M. Trinacty et al., *Racial Differences in Long-Term Adherence to Oral Antidiabetic Drug Therapy: A Longitudinal Cohort Study*, 9 BMC HEALTH SERVICES RES. 24 (2009) (finding that Black diabetics are have lower medication adherence than White diabetics).

also may have lower medication adherence.¹⁷⁴

Disparities in social and environmental conditions also may explain disparities in lifestyle behaviors. Vulnerable populations face more challenging living and working conditions, which in turn can cause chronic stress. Stressed individuals frequently engage in harmful behaviors—such as smoking—in an effort to self-soothe,¹⁷⁵ may lack the physical and emotional energy to exercise, and may have greater difficulty sleeping.¹⁷⁶ Studies of lifestyle behaviors in fact do find disparities among various groups. Smoking, for example, is much more prevalent among those with lower levels of educational attainment and family incomes.¹⁷⁷ Government statistics also show that racial and ethnic minorities and individuals with lower levels of educational attainment and family income are less likely to meet recommended guidelines for aerobic physical activity, muscle-strengthening,¹⁷⁸ and hours of sleep each night.¹⁷⁹

¹⁷⁴ See Jin et al., *supra* note 3, at 275 (summarizing studies that found an association between educational level and non-compliance, but noting that some studies did not find an association); Sharon J. Rolnick et al., *Patient Characteristics Associated with Medication Adherence*, 11 CLINICAL MED. & RES. 54 (2013) (finding that medication adherence among patients with depression, hypertension, diabetes, asthma, chronic obstructive pulmonary disease, multiple sclerosis, cancer, or osteoporosis was lower among those living in areas with lower income and educational rates).

¹⁷⁵ See *infra* note 223.

¹⁷⁶ See Torbjörn Åkerstedt, *Psychosocial Stress and Impaired Sleep*, 32 SCANDINAVIAN J. WORK ENV'T & HEALTH 493 (2006) (cross-sectional studies show that stress is associated with shortened sleep, fragmentation, and possibly a reduction in sleep stages 3 and 4); Linda M. Delahanty et al., *Psychological Predictors of Physical Activity in the Diabetes Prevention Program*, 106 J. AM. DIETETIC ASS'N 698 (2006) (finding that among diabetic patients participating in a diabetes prevention program, those with lower levels of perceived stress had higher physical activity levels); J. Firth et al., *Motivating Factors and Barriers Toward Exercise in Severe Mental Illness: A Systematic Review and Meta-Analysis*, 46 PSYCHOL. MED. 2869 (2016) (reporting that various studies found that low mood and stress were the most prevalent barrier to exercise (61% of patients)).

¹⁷⁷ In a 2009–2010 survey, 34.6% of those who did not graduate from high school self-identified as smokers as compared with 13.2% of those with college degrees. See CDC Health Disparities and Inequalities Report 2013, *supra* note 161, at 82. In addition, adults with family incomes below the poverty level are more than twice as likely to smoke than those in the highest family income group (29.2% versus 13.9%). See CHARLOTTE A. SCHOENBORN ET AL., U.S. DEP'T HEALTH & HUMAN SERVS. & CTRS. FOR DISEASE CONTROL & PREVENTION, HEALTH BEHAVIOR ADULTS: UNITED STATES, 2008–2010, 24 (2013), https://www.cdc.gov/nchs/data/series/sr_10/sr10_257.pdf.

¹⁷⁸ See SCHOENBORN ET AL., *supra* note 177, at 44–46. In 2008–2010, 50.1% of non-Hispanic White adults met the 2008 national guidelines for aerobic physical activity and 21.6% met both the aerobic and muscle-strengthening guidelines. In contrast, only 37% of Blacks and 35.9% of Hispanic adults met the aerobic guidelines and only 16.7% of Blacks and 12.9% of Hispanics met both guidelines. Adults with a graduate-level degree were more than twice as likely as those with less than a high school diploma to have met the guidelines for aerobic physical activity (63.6% versus 28.9%), and almost three times as likely to have met the muscle-strengthening guidelines (35.1% versus 11.9%). Finally, adults with incomes above 400% of the federal poverty level were nearly twice as likely to have met the aerobic guidelines than those with incomes below the poverty level (57.8% versus 32.4%), and about twice as likely to have met the muscle-strengthening guidelines (31.4% versus 15.1%). See *id.* at 44–46.

¹⁷⁹ According to the Centers for Disease Control, insufficient sleep increases the risk of a

Disparities in health literacy rates also may lead to lower rates of compliance among certain vulnerable groups. Racial and ethnic minorities, those with lower levels of educational attainment, and those living in poverty have lower rates of health literacy.¹⁸⁰ Consequently, patients from these groups often have greater difficulty understanding and following the health information given to them by physicians and others.¹⁸¹ This in turn contributes to lower rates of adherence and poorer self-care maintenance¹⁸² among members of these groups as compared to other patients.¹⁸³

To summarize, vulnerable populations' disparate exposure to social and environmental conditions and lower health literacy contributes to disparities in compliance and unhealthy lifestyle behaviors. Given these higher rates of noncompliance, patients from vulnerable populations are more likely to be fired or rejected by physicians seeking to avoid noncompliant patients.

2. Physicians' Implicit Bias

Physicians' implicit biases also may result in their rejecting patients from certain groups more frequently than other patients. To simplify the processing of complex information, people subconsciously apply

range of health conditions, including diabetes, high blood pressure, cardiovascular disease, obesity, depression, cognitive dysfunction, and injury. *See* SCHOENBORN ET AL., *supra* note 177, at 68. Whereas 72.9% of White adults met the federal government's Healthy People 2020 objective of adequate sleep (7-8 hours/night), only 64.3% of Black adults did so. 68.8% of adults with a bachelor's degree, 72.3% of those with an advanced degree, and 74.1% of those with family incomes at or above 400% of the poverty level had adequate sleep, as compared to 54.2% of adults with a GED and 68.6% of those with family incomes below the poverty level. *See id.* at 69-70.

¹⁸⁰ *See* KUTNER ET AL., *supra* note 82, at v, 9-14 (reporting lower rates of health literacy among Black, Hispanic, American Indian/Alaska Native, and multiracial adults; that average health literacy increases with each higher level of educational attainment; and that adults living below the poverty level had lower average health literacy than adults living above the poverty threshold); RIMA RUDD ET AL., EDUC. TESTING SERV., LITERACY AND HEALTH IN AMERICA 3-4 (2004), <https://www.ets.org/media/research/pdf/picheath.pdf> (reporting that health literacy is strongly related to educational attainment, that White adults have significant higher health literacy than Black, Hispanic and other adults, and that working adults with additional assets have higher health literacy).

¹⁸¹ *See supra* notes 83-84 and accompanying text; *see also* Chen, *supra* note 80, at 447 ("Inadequate health literacy can cause difficulties in understanding and following directions given within the healthcare system.").

¹⁸² For additional discussion of the association between health literacy and adherence and self-care, *see generally* Jin et al., *supra* note 3, at 277 (2008) (summarizing the results of empirical studies examining the association between health literacy and compliance); Osborn et al., *supra* note 80, at 268-69 (summarizing research finding an association between health literacy and medication adherence); *see also supra* note 90.

¹⁸³ *See* RUDD ET AL., *supra* note 180, at 43 (stating that disparities in health literacy "may well increase already existing disparities in health care"); Osborn et al., *supra* note 80, at 270-71 (concluding that racial and ethnic disparities in health literacy explains in part racial and ethnic disparities in medication adherence).

generalized beliefs about a group to its individual members.¹⁸⁴ As explained by Michelle Van Ryn and Jane Burke, this strategy “can lead to stereotype usage: the generation of a widely held image of a group of people through which specific individuals are perceived.”¹⁸⁵ The automatic activation of subconscious stereotypes biases the person’s judgment about the group’s individual members, often in ways that conflict with the person’s explicit beliefs.¹⁸⁶ For example, a person who sincerely holds the explicit belief that men and women are equally competent nevertheless may subconsciously apply negative stereotypes of women’s competence, resulting in the person judging a female job applicant as less qualified than a male applicant with a similar resume.¹⁸⁷

Numerous studies show that physicians are not immune to subconscious stereotype usage, and that their implicit biases impact their professional judgment. Studies directly measuring subconscious bias¹⁸⁸ find that the vast majority of health care professionals have low to moderate levels of implicit racial and ethnic bias even though most physicians report no such explicit bias.¹⁸⁹ Although less studied than

¹⁸⁴ See Michelle Van Ryn & Jane Burke, *The Effect of Patient Race and Socio-Economic Status on Physicians’ Perceptions of Patients*, 50 SOC. SCI. & MED. 813, 814 (2000) (“In order to make the social world more manageable, people often make judgements [sic] about categories or groups of people and generalize these judgements [sic] to all individuals mentally assigned to that category or group.”).

¹⁸⁵ *Id.* (citations omitted).

¹⁸⁶ See Elizabeth N. Chapman et al., *Physicians and Implicit Bias: How Doctors May Unwittingly Perpetuate Health Care Disparities*, 28 J. GEN. MED. 1504, 1505 (2013) (explaining that implicit bias from the automatic activation of racial, ethnic, gender, and age stereotypes influences judgment of and behavior toward individuals from the stereotyped groups, and that this unconscious implicit bias can starkly differ from explicit beliefs).

¹⁸⁷ See Corinne A. Moss-Racusin et al., *Science Faculty’s Subtle Gender Biases Favor Male Students*, 109 PROCEEDINGS NAT’L ACAD. SCI. 16474 (2012) (reporting the results of a study where participants rated the résumés of male applicants for a laboratory manager position as significantly more competent and hireable than identical female applicants).

¹⁸⁸ Researchers measure subconscious bias using the computer-based Implicit Association Test (IAT). This test measures subconscious bias as follows:

The IAT measures the time it takes subjects to match representatives of social groups (e.g., age, gender, and race) to particular attributes (e.g., *good*, *bad*, *cooperative*, and *stubborn*). The IAT operationalizes unconscious bias by hypothesizing that subjects will match a group representative to an attribute more quickly if they connect these factors in their minds, regardless of their awareness of this connection. For instance, the more strongly subjects associate pictures of *white persons* with *good* concepts and pictures of *black persons* with *bad* concepts, the more quickly they will match them, and vice versa. The computerized IAT measures the aggregate time required for these matching tasks under two conditions (pairings). A difference in average matching speed for opposite pairings (e.g., *black+bad/white+good* vs *black+good/white+bad*) determines the IAT score.

Alexander R. Green et al., *Implicit Bias Among Physicians and its Prediction of Thrombolysis Decisions for Black and White Patients*, 22 J. GEN. INTERNAL MED. 1231, 1231 (2007).

¹⁸⁹ See William J. Hall et al., *Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review*, 105 AM. J. PUB. HEALTH e60, e60 (2015) (summarizing studies applying the Implicit Association Test to health care professionals, all of which but one found evidence of implicit racial and ethnic bias).

racial and ethnic bias, evidence suggests that physicians also are not immune to implicit gender bias,¹⁹⁰ and at least one study has found that heterosexual health care providers have implicit preferences for heterosexual patients over lesbian and gay patients.¹⁹¹

Studies also demonstrate that physicians' implicit biases lead them to unintentionally discriminate against patients from certain socio-demographic groups despite their genuine desire to provide equitable care.¹⁹² In one study physicians with moderate to high implicit racial bias scores were less likely to recommend thrombolysis to Black patients than to White patients.¹⁹³ Similarly, studies that compare treatment recommendations for patients identical in all respects except for social category (e.g., race, gender) also find disparate treatment recommendations. For example, physicians asked to evaluate hypothetical patient vignettes were more likely to recommend male patients for arthroplasty than female patients, while White patients seen in emergency departments are more likely to receive pain management interventions than Black and Hispanic patients.¹⁹⁴

In addition to impacting treatment recommendations, physicians' implicit bias may cause them to unfairly judge patients from certain groups as less compliant than other patients. Several studies have documented that implicit racial, ethnic, and socioeconomic bias negatively affect physicians' views of their minority and lower income patients' intelligence, cooperativeness, likelihood of being non-adherent, and proclivity to engage in risky behavior.¹⁹⁵ For example, in a study that presented physicians with vignettes depicting HIV-positive patients, physicians predicted that Black men would be less likely than White men to adhere to prescribed medication regimens.¹⁹⁶ Another

¹⁹⁰ See Chapman et al., *supra* note 186, at 1508 (summarizing studies of implicit gender bias).

¹⁹¹ See Janice A. Sabin et al., *Health Care Providers' Implicit and Explicit Attitudes Toward Lesbian Women and Gay Men*, 105 AM. J. PUB. HEALTH 1831 (2015).

¹⁹² See DAYNA BOWEN MATTHEW, JUST MEDICINE: A CURE FOR RACIAL INEQUALITY IN AMERICAN HEALTH CARE 39 (2015) ("Physicians' implicit biases lead to unintentional and in some cases, even unconscious discrimination. The resulting biased behavior may directly contradict the physician's sincerely held, explicit beliefs and intentions to provide excellent care to all patients regardless of their race or ethnicity."); Hall et al., *supra* note 189, at e61, e71 ("[E]ven if [providers'] explicit attitudes demonstrate a desire to provide equitable care, health care providers may unintentionally interact with patients of color less effectively than with White patients, which may contribute to health disparities.").

¹⁹³ See Hall et al., *supra* note 189, at e72.

¹⁹⁴ See Chapman et al., *supra* note 186, at 1507 (summarizing studies examining implicit bias).

¹⁹⁵ See generally MATTHEW, *supra* note 192, at 57, 79–91 (explaining how providers' implicit beliefs can negatively impact their views of racial and ethnic minority patients and discussing studies demonstrating this dynamic); Hall et al., *supra* note 189, at e66–70 (summarizing studies that found an association between patients' race and physicians' implicit and explicit judgments regarding medical compliance).

¹⁹⁶ See Laura M. Bogart et al., *Factors Influencing Physicians' Judgments of Adherence and Treatment Decisions for Patients with HIV Disease*, 21 DECISION PSYCHOL. & RISK PERCEPTIONS

study found that physicians perceived Black coronary patients as having a higher risk of both noncompliance with cardiac rehabilitation and substance abuse relative to White patients, and perceived coronary patients with lower socioeconomic status as less likely to comply with cardiac rehabilitation and more likely to be irrational and lacking self-control.¹⁹⁷ These findings suggest a real risk that physicians will attribute higher levels of noncompliance to patients with certain socio-demographics as compared to other patients, regardless of whether the facts support such judgments. This in turn may lead to physicians firing patients from certain socio-demographic groups more frequently than other patients.

Implicit bias also impacts physicians' verbal and nonverbal communication in ways that impact patient compliance. Numerous studies document that physicians' implicit racial biases influence the quality of the physician-patient interaction. Differences include "the length of time doctors spend with minority patients as compared to Whites; the level of verbal exchange and shared decision-making in which they engage; their body language; verbal tone, and eye contact; and their willingness to credit and respond to information provided."¹⁹⁸ Similar communication differences arise in physicians' interactions with Hispanic patients.¹⁹⁹ Physicians' implicit racial and ethnic bias also may impact the content of physician-patient communications, with minority patients receiving less information about their health status and health care options than White patients.²⁰⁰

These differences in communication style adversely impact patients' judgments about their physicians. For example, studies have found that physicians' scores on a test measuring implicit racial bias were negatively correlated with Black patients' perceptions of the quality of the physician-patient communication, a physician's contextual knowledge of the patient, patient-centeredness, and physician warmth

28 (2001).

¹⁹⁷ See Van Ryn & Burke, *supra* note 184.

¹⁹⁸ MATTHEW, *supra* note 192, at 108.

¹⁹⁹ See *id.* at 109-10 (discussing research comparing physicians' interviewing skills with Anglo-American and Spanish-American patients).

²⁰⁰ As Dayna Matthew explains:

Beyond experiencing different styles of communication, minority patients also routinely receive less information from their providers about their health and health choices than white patients. These disparities in the content of the messages that physicians provide to minorities also appear to be related to unconsciously biased perceptions of the racial and ethnic groups to which these patients belong, rather than to individualized judgments about the knowledge and circumstances that dictate what is appropriate to share with each patient. Some physicians filter the information they communicate based on their biased expectation that minority patients cannot afford to pay for excellent health care or will not understand complex treatment regimens.

Id. at 111.

and friendliness.²⁰¹ Higher physician implicit racial bias scores also were negatively correlated with whether Black patients felt respected by the providers, liked the provider, and would recommend their provider to others.²⁰² Importantly, minority patients' perceptions of bias can result in their being less engaged in the physician-patient encounter and disclosing less information about their health,²⁰³ resulting in a "viciously reciprocal cycle of miscommunication between doctors and patients"²⁰⁴

Moreover, the evidence suggests that minority patients respond to physicians' implicit bias by reducing both their compliance with medical advice and future use of medical services.²⁰⁵ Positive physician-patient interactions promote better patient understanding of medical advice and greater patient trust, which in turn encourages higher levels of patient compliance.²⁰⁶ Conversely, patients less satisfied with their physician-patient interaction are less compliant. Not surprisingly, then, studies show that physicians' disparate communication styles are associated with poorer adherence among racial and ethnic minorities relative to White patients.²⁰⁷ For example, one study found that although Black and White patients had similar levels of trust prior to their initial visits for medical care, their post-visit levels of trust diverged as a result of disparate physician communication styles; furthermore, these differences were associated with lower patient adherence among Black patients relative to White patients.²⁰⁸ Patients who are mistrustful of or who anticipate prejudicial attitudes from health care providers also are more likely to avoid future encounters with the health care system.²⁰⁹ This dynamic reveals itself in studies showing that minority patients'

²⁰¹ See Hall et al., *supra* note 189, at e72 (summarizing results from studies measuring association between physicians IAT scores and various domains of patient care).

²⁰² See *id.*

²⁰³ See MATTHEW, *supra* note 192, at 141 ("[C]onsistent with studies showing [generally] that when patients perceive that their physicians like, care about, and are interested in them, they are more likely to volunteer information and actively participate in the clinical encounter," studies involving African American patients show that "these patients respond to their white providers by asking fewer questions, seeking less clarification of information provided by physicians, and exhibiting a less positive emotional tone in their visits with physicians"); Van Ryn & Burke, *supra* note 184, at 823 ("When patients perceive that physicians like them, care about them and are interested in them as a person, they are more likely to volunteer information and be more active in the encounter.").

²⁰⁴ MATTHEW, *supra* note 192, at 4.

²⁰⁵ See *generally id.* at 146 (summarizing studies showing an association between physicians' implicit racial and ethnic bias and minority patients' poorer adherence and health care outcomes); Hall et al., *supra* note 189, at e71–72 (same).

²⁰⁶ See MATTHEW, *supra* note 192, at 117 ("[When] providers more often create a successful clinical encounter, and indeed a collaborative partnership, that encourages these patients to trust their provider and comply with recommendations and instructions.").

²⁰⁷ See *id.* at 117–18 (describing studies finding an association between physician-patient communication styles and disparate adherence rates among White and minority patients).

²⁰⁸ See *id.* at 118 (summarizing a study conducted by Dr. Howard Gordon of Black and White lung cancer patients).

²⁰⁹ See *supra* notes 139–41 and accompanying text.

perceived levels of physician bias are associated with fewer follow-up visits and reduced use of medical services.²¹⁰

In sum, the research suggests that implicit bias not only distorts physicians' *perceptions* of a patient's level of compliance based on the patient's socio-demographics, but also contributes to *actual* differences in the level of compliance among socio-demographic groups. Consequently, patients from vulnerable populations are more likely to be fired or rejected for noncompliance by physicians seeking to avoid noncompliant patients. This in turn reinforces, if not increases, existing disparities in health between populations. The United States therefore cannot achieve greater health equity if laws and standards of professional conduct permit physicians to reject patients for noncompliance. Lawmakers and professional associations accordingly should prohibit physicians from doing so.

In sum, current legal rules and ethical standards that permit physicians to reject noncompliant patients frustrates fundamental values and policy goals—preserving life and health, protecting patients' trust in medical professionals, promoting equality, and respecting human dignity. Society therefore should prohibit physicians from rejecting noncompliant patients when a physician can offer the noncompliant patient medically appropriate treatment. Specifically, Congress and/or state legislatures should adopt laws that protect noncompliant patients from discrimination in the health care context. Professional organizations such as the AMA and ACP also should revise their codes of professional conduct to impose on physicians an obligation to care for noncompliant patients, with state medical licensing boards doing the same.

To clarify, physicians' obligation to treat noncompliant patients would not be absolute. Physicians should not provide medically inappropriate care to a noncompliant patient, even if demanded by the patient. Indeed, if a patient's noncompliance compromises her ability to benefit from a particular treatment, providing such care would be unethical. Moreover, if the physician cannot offer the physician any medically appropriate treatment, the physician would have no obligation to enter into or continue the physician-patient relationship.²¹¹ For example, if a surgeon reasonably determines that a

²¹⁰ See MATTHEW, *supra* note 192, at 118 (describing the findings of the Gordon study); Hammond et al., *supra* note 139, at 1306 (finding that medical mistrust rooted in expectations of racially biased treatment was associated with Black men delaying routine check-ups and cholesterol screening). See generally Chapman et al., *supra* note 186, at 1507 (stating that minority patients' negative perceptions of the physician-patient interaction could reduce patients return for follow-up care).

²¹¹ See Orentlicher, *supra* note 12, at 1582 (“The obligation to treat noncompliant patients should not be an absolute one,” and “does not imply that patients can demand irrational medical care Similarly, when a patient persistently rejects a physician's proposals for therapy and the physician has nothing left to offer the patient, the physician is not obligated to continue the patient-physician relationship.”).

noncompliant patient is not a good candidate for surgery, the surgeon would have no duty to treat the patient. Finally, physicians remain free to refuse treatment to noncompliant patients for other legitimate reasons, such as nonpayment or belligerent behavior on the patient's part.

IV. JUSTIFICATIONS FOR THE STATUS QUO

Defenders of legal and ethical standards that afford physicians discretion in deciding whether to treat noncompliant patients offer several justifications for the current rules: (1) physicians are justified in terminating the physician-patient relationship because noncompliant patients should be held accountable for failing to exercise self-care; (2) physicians should not be forced to assume financial liability for poor patient outcomes that stem from patients' lifestyle choices and nonadherence; (3) requiring physicians to treat noncompliant patients unduly compromises physicians' personal autonomy and freedom of association rights; and (4) firing noncompliant patients serves the patients' best interest by motivating the patient to improve their treatment adherence or, alternatively, allowing the patient to find another physician better suited to treat the patient. This Part evaluates these rationales. While not without merit, ultimately these rationales do not justify a status quo that undermines patients' health and compromises fundamental principles of fairness, equality, and beneficence.

A. *The Personal Responsibility Rationale*

Many in society hold negative views of those who smoke, are overweight, unfit, or otherwise engage in unhealthy behaviors.²¹² This disdain stems from the underlying assumption that unhealthy behaviors are the product of faulty character traits such as laziness, weakness, or ignorance.²¹³ Even some physicians describe their noncompliant patients in judgmental terms, labelling them as lazy or lacking self-

²¹² See NAT'L INSTS. OF HEALTH, CLINICAL GUIDELINES ON THE IDENTIFICATION, EVALUATION, AND TREATMENT OF OVERWEIGHT AND OBESITY IN ADULTS: THE EVIDENCE REPORT 20 (1998); Bryan Gibson, *Psychological Aspects of Smoker-Nonsmoker Interactions: Implications for Public Policy*, 49 AM. PSYCHOLOGIST 1081, 1081 (1994); Lydia Saad, *One in Four Americans Have Less Respect for Smokers*, GALLUP (Aug. 5, 2011), <http://www.gallup.com/poll/148850/one-four-americans-less-respect-smokers.aspx>.

²¹³ See Gibson, *supra* note 212 (summarizing studies finding that nonsmokers perceive smokers less favorably on an array of personal characteristics, including self-discipline, morality, intelligence, and insecurity); Sophie Lewis et al., *How Do Obese Individuals Perceive and Respond to the Different Types of Obesity Stigma That They Encounter in Their Daily Lives? A Qualitative Study*, 73 SOC. SCI. & MED. 1349, 1350 (2011).

control and willpower.²¹⁴ Some commentators have argued that those who fail to care for themselves should be held accountable for the consequences of their unhealthy choices.²¹⁵ Denying treatment to noncompliant patients is consistent with this personal responsibility ethos.²¹⁶

Two distinct principles underlie the personal responsibility rationale: First, a patient's noncompliance justifies ascribing to the patient a judgment of wrongdoing, which Gerald Dworkin refers to as a finding of "culpability" or "establish[ing] fault and assign[ing] blame."²¹⁷ Second, termination of the physician-patient relationship "ought to flow from this first judgment," which Dworkin refers to as "liability" or "demands on the person to do something or on others to act toward him in certain ways."²¹⁸ This Section assesses both the fairness of judging noncompliant patients as morally culpable and whether physicians' rejection of noncompliant patients is an appropriate form of liability. It concludes that a patient's moral responsibility for her noncompliance often is open to doubt given the significant impact of social, environmental, and mental health factors on individuals' behavior. Moreover, physicians are not the appropriate judges for determining an individual patient's culpability for their noncompliance. Finally, even if noncompliant patients fairly can be characterized as morally culpable, penalizing them with termination of the physician-patient relationship goes against the compassion society generally affords the sick and the health profession's norms of beneficence and nonmaleficence.

²¹⁴ See Resnik, *supra* note 1, at 170 ("[T]he doctor may view non-adherent patients as a moral problem. This is the main reason why doctors often describe non-adherent patients in morally loaded terms, such as 'lazy,' 'difficult,' 'defiant', 'non-compliant', or 'crazy.'"); Puhl et al., *supra* note 147, at 44 (describing the negative biases of primary care providers, "including attitudes that patients with obesity are lazy, lack self-control and willpower, [and are] personally to blame for their weight . . .").

²¹⁵ See Amy Darby, *The Individual, Health Hazardous Lifestyles, Disease and Liability*, 2 DEPAUL J. HEALTH CARE L. 787, 788, 792-98 (1999) (highlighting various proposals for holding individuals responsible for their unhealthy behaviors); Meredith Minkler, *Personal Responsibility for Health? A Review of the Arguments and the Evidence at Century's End*, 26 HEALTH EDUC. & BEHAV. 121, 124-26 (1999) (summarizing the arguments for personal responsibility for health).

²¹⁶ See Orentlicher, *supra* note 12, at 1581 ("Denials of treatment are ethically permissible in response to patient noncompliance on account of the principle that individuals must assume responsibility for their actions."). Orentlicher nevertheless concludes that competing ethical considerations favor physicians refraining from firing their noncompliant patients. *See id.*

²¹⁷ Gerald Dworkin, *Voluntary Health Risks and Public Policy: Taking Risks, Assessing Responsibility*, 11 HASTINGS CTR. REP. 26, 28 (1981).

²¹⁸ *Id.* Mike Martin similarly speaks of judgment blame, which he defines as "the simple ascription of wrongdoing to a person who is morally accountable," liability blame, which involves "assigning liabilities (costs, penalties, punishment) for harmful consequences," and censure blame, which are acts of public criticism, including shunning. Martin, *supra* note 159, at 96.

1. Noncompliant Patients' Moral Culpability

Health experts increasingly embrace what Lindsay Wiley calls the ecological model of health.²¹⁹ The ecological model “places supposedly private, individual choices and risks into their social context and emphasizes structural explanations for health behaviors and outcomes.”²²⁰ It therefore requires that judgments regarding noncompliant patients' moral culpability consider the broader social context that influences individual behavior.

As described in Section III.A, social, environmental, and behavioral health factors play a significant role in shaping individuals' behaviors. In particular, they influence patients' compliance with their physicians' recommendations by supporting or constraining an individual's capacity to access and pay for recommended medical care, adopt healthy behaviors, and adhere to physicians' medical advice. Financial considerations, transportation and childcare challenges, and lack of sick leave impact whether individuals obtain timely follow-up care or adhere to medication regimens.²²¹ Adverse economic and environmental factors contribute to poor diet and insufficient physical activity.²²² Financial problems, unstable housing, and safety concerns cause stress, and stress in turn can lead individuals to engage in harmful behaviors such as smoking and substance abuse in an effort to self-soothe.²²³ Moreover, stressed individuals often lack the physical or emotional energy or time to carefully follow prescribed medication regimes, monitor their symptoms, or otherwise self-manage their disease.²²⁴ Studies also link patient compliance to health literacy²²⁵ and behavioral health issues, such as depression and anxiety.²²⁶ Characterizing unhealthy behaviors as largely personal failures ignores the significant influence these factors have on individuals' conduct.

In highlighting the impact of social, environmental, and mental

²¹⁹ See Lindsay F. Wiley, *Health Law As Social Justice*, 24 CORNELL J.L. & PUB. POL'Y 47, 96–98 (2014) (describing the shift among public health experts away from the behavioral model of health, which emphasizes individual behavior choices, to the ecological model of health).

²²⁰ *Id.* at 97.

²²¹ See *supra* notes 73–75 and accompanying text.

²²² See *supra* notes 76–77 and accompanying text.

²²³ See Sue A. Kaplan et al., *The Perception of Stress and Its Impact on Health in Poor Communities*, 38 J. COMMUNITY HEALTH 142, 142, 146–47 (2013) (reporting the results of focus groups examining how low income individuals perceive stress and its relationship to health); Fred C. Pampel et al., *Socioeconomic Disparities in Health Behaviors*, 36 ANN. REV. SOC. 349, 353 (2010) (explaining that those deprived economically and living in disadvantaged neighborhoods face a variety of chronic stress, and that this may lead to smoking and other unhealthy behaviors in an attempt to cope or self-medicate).

²²⁴ Cf. Chesnow, *supra* note 5, at 2 (“After a divorce, job loss, or any traumatic event, depression may set in; taking medication as directed may then be the last thing on the patient's mind.”).

²²⁵ See sources cited *supra* note 80.

²²⁶ See sources cited *supra* notes 78–79.

health factors on individual's health behavior, I do not mean to suggest that all patient noncompliance is involuntary or outside individual control. Clearly individuals exercise some degree of free will when choosing a course of action contrary to their physicians' advice.²²⁷ Indeed, some individuals who face challenging social and environmental circumstances manage to quit unhealthy lifestyles and adhere to recommended treatment regimes.²²⁸ But construing patient noncompliance as *solely* a matter of individual choice and personal responsibility ignores the fact that health behaviors result from a multi-dimensional interplay of *both* personal and external factors.

Judgments regarding the moral culpability of noncompliant patients therefore cannot be made without giving consideration to the broader social context shaping individuals' health behaviors. Doing so raises fundamental questions regarding the extent of noncompliant patients' culpability. Can society fairly cast blame on a diabetic patient for her noncompliance when she has limited financial means and resides in a food desert with few opportunities for safe exercise? Can society fairly cast blame on the COPD patient who continues smoking when he struggles with depression and stressful life events? Can society fairly cast blame on the surgical patient who fails to follow postoperative instructions and obtain follow-up care when she has low health literacy and cannot delay her return to work? As these cases illustrate, when we view a patient's noncompliance within the broader social context, for many patients society rightly softens its moral judgments of their culpability, even eliminating culpability for patients facing insurmountable obstacles to healthy behaviors. Accordingly, in many (perhaps most) cases of patient noncompliance, ascribing wrongdoing to the patient is unwarranted.²²⁹

Moreover, even if some noncompliant patients fairly may be

²²⁷ See Minkler, *supra* note 215, at 126 ("Few . . . would argue that individuals lack any responsibility for health-related decisions and actions . . .").

²²⁸ See *id.* at 130 ("[M]any individuals, despite highly adverse environmental circumstances and constraints, do manage to quit smoking, dramatically change their diet and exercise patterns, and in other ways act effectively to improve their health.").

²²⁹ See generally Dworkin, *supra* note 217, at 31 (arguing that holding individuals accountable for their unhealthy behaviors on the grounds that they caused their poor health becomes dubious given "the mixed character of the voluntariness of many behaviors" and "[t]he difficulty in determining the relative causal role of voluntary vs. nonvoluntary factors in the genesis of illness"); Martin, *supra* note 159, at 102–05 (noting that individual responsibility for illness is open to question given the obstacles many individuals face, and that the "enormous complexity of causal relationships" for poor health favors compassion rather than blame); Minkler, *supra* note 215, at 126 (criticizing the emphasis on personal responsibility because it ignores "the social context in which the individual decision making and health-related action take place," particularly in the case of the poor); Wicclair, *supra* note 12, at 313 (rejecting the argument that firing noncompliant patients is justified on the grounds of holding patients accountable for their irresponsible behavior and choices, arguing that there is "considerable controversy about the extent to which patients are responsible for illnesses" associated with unhealthy behavior, and that the individual's responsibility is therefore "open to question").

judged as morally culpable, physicians are not the appropriate decision makers for this determination. Many physicians do not fully understand the complex ways in which social, environmental, and mental health factors impact their patients' health-related behaviors.²³⁰ Furthermore, determinations regarding a noncompliant patient's culpability ultimately involve value judgments, and there is no reason to think physicians are uniquely qualified to make these judgments. In fact, physicians may be uniquely *unqualified* to make these judgments, as self-interest may bias them against their noncompliant patients. Specifically, because firing the noncompliant patient allows physicians to perform better under performance incentive programs, physicians may be subconsciously motivated to deem their noncompliant patients morally culpable and thus deserving of dismissal.²³¹

In sum, the task of assessing a noncompliant patient's culpability is both complex and morally ambiguous. Physicians do not possess any special expertise to make this determination, and casting them as the moral judges of patients' noncompliance risks introducing unfair bias into the process. In practice, then, many noncompliant patients may be unfairly designated as wrongdoers. This in turn raises fundamental questions about whether the personal responsibility rationale can justify physicians' rejection of their noncompliant patients.

2. Holding Noncompliant Patients Accountable

Even if physicians could fairly judge a noncompliant patient's moral culpability, a second question remains—is it just to hold patients accountable for their noncompliance through the denial of care? I argue below that the answer to this question is no. Punishing the noncompliant patient by refusing to enter into or continue the physician-patient relationship runs counter to both the health profession's commitment to benevolence and the compassion society shows the sick. Accordingly, even if penalizing noncompliant patients in

²³⁰ Cf. Nancy P. Chin et al., *Social Determinants of (Un)Healthy Behaviors*, 13 EDUC. FOR HEALTH 317, 321 (2000) (noting that a medical education that focuses on the biopsychosocial model of health produces health providers with insufficient awareness of the social causes of diseases); Melissa D. Klein et al., *Training in Social Determinants of Health in Primary Care: Does It Change Resident Behavior?*, 11 ACAD. PEDIATRICS 387, 387–88 (2011) (advocating for training primary care physicians to identify and address the social determinants of health, as many physician residents may not know how to do so and may lack an understanding of these issues).

²³¹ As I have explained elsewhere, cognitive psychologists have found that when people have a vested interest in a decision's outcome, they have an unconscious tendency to form judgments that suit their desired ends or goals. See generally Jessica Mantel, *The Myth of the Independent Physician: Implications for Health Law, Policy and Ethics*, 64 CASE W. RES. L. REV. 455, 498 (2013). Physicians' judgments regarding their noncompliant patients therefore may be subconsciously affected by physicians' financial incentives under various performance incentive programs. See *id.* at 504–05.

some form would be justified, terminating the physician-patient relationship is not an appropriate means of doing so.

Commentators have forcefully called for society to show compassion for the sick “regardless of the cause of the sickness or the culpability of the afflicted person.”²³² This norm of compassion, however, is more than aspirational rhetoric; it finds expression in the insurance reforms adopted under the Affordable Care Act (ACA). Prior to enactment of the ACA,²³³ private insurers employed a range of practices that penalized individuals at high-risk of poor health, including those leading unhealthy lifestyles. Under experience rating practices, insurers charged higher premiums to those considered at high-risk, taking into account factors such as whether the individual was overweight, used tobacco, or engaged in other unhealthy behaviors.²³⁴ Insurers also considered an individual’s past and current medical history, including chronic conditions or other illnesses resulting in part from poor health habits.²³⁵ For individuals considered extremely high-risk, insurers would reject their application for insurance altogether or refuse to re-insure them at the end of a plan year.²³⁶ Finally, many insurers also excluded from coverage pre-existing health conditions, meaning they would not pay for any future medical expenses associated with previously diagnosed illnesses that resulted from unhealthy behaviors.²³⁷ Without access to affordable, comprehensive health insurance, many individuals with poor health behaviors found themselves unable to access needed care.

The ACA eliminated these practices. Insurers no longer can deny enrollment or re-enrollment to individuals on the basis of their health²³⁸ or deny coverage of pre-existing conditions.²³⁹ Nor can they charge higher-risk individuals steeper premiums (a prohibition known as

²³² DANIEL CALLAHAN, FALSE HOPES: OVERCOMING THE OBSTACLES TO A SUSTAINABLE, AFFORDABLE MEDICINE 199 (1998).

²³³ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

²³⁴ See THE HENRY J. KAISER FAMILY FOUND., HEALTH INSURANCE MARKET REFORMS: RATE RESTRICTIONS 1 (June 2012), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8328.pdf> (describing health status rating).

²³⁵ See Gary Claxton et al., *Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA*, HENRY J. KAISER FAM. FOUND. (Dec. 12, 2016), <http://kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca> (stating that prior to enactment of the ACA, most individual market insurance policies included general pre-existing condition exclusion provisions).

²³⁶ See *id.* (explaining medical underwriting); BERNADETTE FERNANDEZ, CONG. RESEARCH SERV., RL 32237, HEALTH INSURANCE: A PRIMER (2004) (same).

²³⁷ See Claxton et al., *supra* note 235 (explaining exclusion riders, or the practice of insurers excluding from coverage medical conditions disclosed by an applicant).

²³⁸ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2705, 124 Stat. 156 (2010) (codified at 42 U.S.C. § 300gg-4 (2012)).

²³⁹ See Pub. L. No. 111-148, § 2704, 124 Stat. 154 (2010) (codified at 42 U.S.C. § 300gg-3 (2012)).

“community rating”),²⁴⁰ with the exception of a surcharge on tobacco users of up to fifty percent.²⁴¹ Insurers also cannot impose higher cost-sharing on high-risk individuals.²⁴² Together, these reforms ensure that health insurance, and in turn medical care, are generally available to all individuals regardless of lifestyle choices.

Although Republicans in Congress favor repeal and replacement of the ACA, Republican leaders have voiced support for prohibiting insurers from denying enrollment or re-enrollment to individuals on the basis of their health or denying coverage of pre-existing conditions.²⁴³ Moreover, most of the leading conservative health reform proposals would continue the ACA’s community rating requirement for those individuals who maintain continuous health care coverage.²⁴⁴

While these insurance reforms specifically address the market for private health insurance, they more broadly signal society’s reluctance to punish those with poor health habits by denying them access to health care (with the glaring exception of higher premiums for tobacco users). In other words, with the ACA, the United States has rejected an attitude of blame toward those who fail to exercise self-care in favor of compassion. Perhaps the public’s compassion reflects an acknowledgment of and willingness to forgive human imperfection, or a belief that “[c]ompassion rather than contempt” is more appropriate when the ill “are the primary victims of their own weakness.”²⁴⁵ Allowing physicians to punish their noncompliant patients by denying them care, however, violates this norm of compassion for the sick.

Allowing physicians to punish their noncompliant patients also violates the long-standing professional norms of beneficence and nonmaleficence. As described above, the beneficence norm requires that the physician dedicate herself to her patients’ welfare and best interests, while the corollary norm of nonmaleficence obligates the physician to refrain from any action that would unnecessarily harm a patient.²⁴⁶ As argued in Section III.B, firing or otherwise avoiding the noncompliant patient “hardly demonstrates the[se] commitments.”²⁴⁷

²⁴⁰ See Pub. L. No. 111-148, § 2701, 124 Stat. 155 (2010) (codified at 42 U.S.C. § 300gg (2012)).

²⁴¹ See *id.*

²⁴² See Pub. L. No. 111-148, § 1302, 124 Stat. 165 (2010) (codified at 42 U.S.C. § 18022(b)(4)(B) (2012)).

²⁴³ See Alex Ruoff, *Rand Paul Plan Would OK Denying Coverage for Pre-Existing Conditions*, BLOOMBERG BNA (Jan. 10, 2017), <https://www.bna.com/rand-paul-plan-n73014449588>; Gene B. Sperling & Michael Shapiro, *How the Senate’s Health-Care Bill Would Cause Financial Ruin for People With Preexisting Conditions*, ATLANTIC (June 23, 2017), <https://www.theatlantic.com/business/archive/2017/06/ahca-senate-bill-preexisting-conditions/531375>.

²⁴⁴ See, e.g., American Health Care Act of 2017, H.R. 1628, 115th Cong. (2017); Better Care Reconciliation Act, S. 270, 115th Cong. (2017).

²⁴⁵ Martin, *supra* note 159, at 105.

²⁴⁶ See *supra* notes 116–17 and accompanying text.

²⁴⁷ Wicclair, *supra* note 12, at 310. As summarized by one commentator, physicians who fire

In sum, imposing liability on the noncompliant patient through termination of the physician-patient relationship contravenes the compassion and benevolence generally afforded the sick. When coupled with concerns that noncompliant patients may be unfairly judged as wrongdoers, physicians' rejection of noncompliant patients can only be described as unjust and excessive. For these reasons, the personal responsibility rationale does not provide a defensible justification for current laws and ethical standards that afford physicians discretion on whether to treat noncompliant patients.

B. *The Fairness and Autonomy Rationales*

As explained in Part I, physicians will find limited success under performance incentive programs if they simply improve the clinical care they give patients; rather, their patients also must adopt healthier lifestyles and adhere to physicians' treatment recommendations. Physicians, however, contend that they can do little to influence their patients' health-related behavior, and that holding physicians accountable for what they cannot control thus unfairly punishes them.²⁴⁸ As explained by one physician,

When I hear my colleagues talk, it's the same sort of thing—I'm being punished for things I can't control. Patient behavior. You can't make people come in [for doctor appointments]. You can't make them eat healthy, stop smoking, take their medication. But you can be punished as a physician if your numbers don't look good.²⁴⁹

In other words, physicians object to the imposition of financial liability for an outcome they did not cause and, in their view, are powerless to change. Avoiding noncompliant patients gives physicians an escape from this perceived injustice. Consequently, a rule infringing on physicians' ability to do so may be criticized as unjust.

Relatedly, physicians may argue that rules that obligate them to treat noncompliant patients compromise their individual autonomy.²⁵⁰

noncompliant patients "add to the plight of patients who already experience feelings of confusion, shame and guilt that work against recovery from acute illness and management of chronic illness." Martin, *supra* note 159, at 111.

²⁴⁸ See Hibbard et al., *supra* note 10, at 490 (reporting that in a 2013 survey of primary care physicians subject to pay-for-performance, "patients unwillingness to change their behavior" was listed by respondents as the top obstacle to improving their quality metrics, and more than a third said that what they found most frustrating about the compensation model was "the fact that patients' lifestyle behaviors influenced their salaries"); McDonald & Roland, *supra* note 44, at 124 (reporting that California physicians subject to pay-for-performance "believed they were being held accountable for things beyond their control").

²⁴⁹ Hibbard et al., *supra* note 10, at 491; *see also* Page, *supra* note 3, at 4 ("[P]atients should be penalized, not the doctors.").

²⁵⁰ Cf. Jacobson, *supra* note 144, at 937-38 (stating that none of his medical students believed they had an obligation to serve any particular patient or patient population, that they

Specifically, they may argue that such a rule violates a time-honored American norm—the freedom to associate with persons of one’s own choosing. As previously discussed, current legal and ethical standards governing the physician-patient relationship reflect this principle, granting physicians as sellers of medical care the right to reject a prospective patient or fire an existing patient for virtually any reason.²⁵¹

This Section evaluates this fairness and autonomy rationales and concludes that they do not justify legal and ethical rules that permit physicians to fire their noncompliant patients. Importantly, the fairness and autonomy rationales ignore the fiduciary nature of the physician-patient relationship. Like other fiduciaries, physicians have an ethical obligation to compromise their personal autonomy and financial interests in favor of the noncompliant patient’s welfare. In addition, imposing on physicians a duty to treat noncompliant patients would be consistent with laws that have imposed similar duties on common carriers, public utilities, and other industries serving important needs.

1. Physicians’ Ethical Obligations Limit Their Autonomy

The traditional freedom of contract found in the marketplace for goods and services “is predicated on a paradigm of arms-length bargaining.”²⁵² The relationship between a physician and patient, however, is not an arms-length relationship but a fiduciary one of special trust and confidence.²⁵³ As such, physicians, like lawyers, are subject to higher standards of behavior and responsibility than individuals engaged in ordinary commercial transactions.

The fiduciary norms that govern both the medical and legal professions find expression in the standards of professional conduct that govern ongoing relations with patients/clients. Yet only the legal profession has adopted ethical rules that constrain their members’ ability to unilaterally terminate the client relationship.²⁵⁴ The medical profession should follow the legal profession’s lead and adopt ethical rules that limit physicians’ ability to fire their noncompliant patients.

As fiduciaries, physicians generally must give primacy to their patients’ welfare and best interests.²⁵⁵ This commitment requires physicians to place their patients’ welfare above their own, including

“resented the idea that others expected or asserted” that they should have such a duty, and that physicians “[would] not welcome the idea of being told what to do or being obliged to do it” given that they “value their freedom, autonomy and authority”).

²⁵¹ See *supra* Part II.

²⁵² Timothy S. Hall, *Third-Party Payor Conflicts of Interest in Managed Care: A Proposal for Regulation Based on the Model Rules of Professional Conduct*, 29 SETON HALL L. REV. 95, 139 (1998).

²⁵³ See *id.*; Rodwin, *supra* note 115.

²⁵⁴ See *infra* notes 265–66 and accompanying text.

²⁵⁵ See *supra* notes 115–16 and accompanying text (discussing the beneficence principle).

above their personal financial interests. As stated in the AMA's Code of Medical Ethics, "[t]he primary objective of the medical profession is to render service to humanity; reward of financial gain is a subordinate consideration. Under no circumstances may physicians place their own financial interests above the welfare of their patients."²⁵⁶ Consequently, once the physician accepts an individual as a patient, any conflict between the physician's economic interests and the patient's welfare must be resolved in favor of the latter.²⁵⁷

Nevertheless, current ethical standards that obligate physicians to place their patients' welfare above their own interests apply only for as long as the physician agrees to care for the patient.²⁵⁸ As explained in Part II, physicians are free to terminate the physician-patient relationship for virtually any reason, including when doing so serves the physician's financial interest. In other words, with respect to termination of the physician-patient relationship, the beneficence norm yields to physicians' interests in protecting their personal autonomy and financial interests. This professional tenet stands in stark contrast to the ethical rules governing the attorney-client relationship that restrict when lawyers may withdraw their representation.

The American Bar Association (ABA) Model Rules of Professional Conduct, which have been adopted by all fifty states and the District of Columbia (with modifications),²⁵⁹ set forth model ethical rules for lawyers. Rule 1.16 of the ABA Model Rules of Professional Conduct regulates the termination of the attorney-client relationship.²⁶⁰ Rule 1.16(b)(1) generally prohibits lawyers from withdrawing from representing a client if doing so cannot be accomplished "without material adverse effect on the interests of the client."²⁶¹ In focusing on "the impact the withdrawal will have on the client's interests, and not

²⁵⁶ CODE OF MEDICAL ETHICS, *supra* note 62, at 188.

²⁵⁷ See Nathan A. Bostick et al., AM. MED. ASS'N COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, *Report of the Council on Ethical and Judicial Affairs: Physician Pay-for-Performance Programs*, 3 IND. HEALTH L. REV. 429, 437 ("Practicing physicians who participate in [pay-for-performance] programs while providing medical services to patient should maintain primary responsibility to their patients and provide competent medical care, regardless of financial incentives . . ."); Hall, *supra* note 252, at 130 ("[M]edical ethics recognizes that a physician's first duty is to her patient, and that the physician's personal or financial interest must be subordinated to the interest of the patient."); Nancy J. Moore, *What Doctors Can Learn from Lawyers About Conflicts of Interest*, 81 B.U. L. REV. 445, 450 (2001) (stating that when conflicts arise between physicians' financial interest and the interests of their patients, "it is the ethical duty of the physicians . . . to resist temptation").

²⁵⁸ See Thomas H. Boyd, *Cost Containment and the Physician's Fiduciary Duty to the Patient*, 39 DEPAUL L. REV. 131, 137 (1989).

²⁵⁹ See *State Adoption of the ABA Model Rules of Professional Conduct*, AM. BAR ASS'N, http://www.americanbar.org/groups/professional_responsibility/publications/model_rules_of_professional_conduct/alpha_list_state_adopting_model_rules.html (last visited Aug. 7, 2017).

²⁶⁰ See CTR. FOR PROF'L RESPONSIBILITY, AM. BAR ASS'N, ANNOTATED MODEL RULES OF PROFESSIONAL CONDUCT (8th ed. 2015).

²⁶¹ MODEL CODE OF PROF'L CONDUCT r. 1.16(b)(1) (AM. BAR ASS'N 2015).

the attorney's reasons for withdrawing,"²⁶² this rule recognizes the lawyer's fiduciary obligation to place the client's interests over the lawyer's personal interests. Lawyers who violate Rule 1.16 may be subject to disciplinary action in the state where licensed.²⁶³

Given the similarities between the legal and medical professions, the ethical rules governing lawyers' withdrawals from representation are instructive for the medical profession. The success of both the attorney-client and physician-patient relationship depends on the client/patient's willingness to trust and confide in their lawyer/physician.²⁶⁴ The ethical rules governing both professions aim to preserve this trust by imposing fiduciary obligations on its members.²⁶⁵ Yet only the legal profession has recognized that preserving trust in the profession necessitates a general prohibition on lawyers withdrawing from representation when doing so materially harms a client's interest, particularly when the matter is in ongoing litigation. Physicians similarly should be prohibited from firing their noncompliant patients, as such action can undermine patient trust in the profession,²⁶⁶ compromise patients' autonomy,²⁶⁷ and harm patients' well-being by causing discontinuity in care and feelings of stigma and shame.²⁶⁸

Physicians may counter that the ethical rules governing lawyers permit lawyers to withdraw their representation for good cause, even if detrimental to the client, and that this principle similarly supports physicians firing their noncompliant patients for good cause. The ABA Model Rules of Professional Conduct permit the lawyer to withdraw from representation when the client has engaged in culpable conduct, such as fraud or insisting on an immoral or unethical course of action.²⁶⁹

²⁶² *In re* Petition for Distribution of Attorney's Fees, 870 N.W.2d 755 (Minn. 2015).

²⁶³ See MODEL CODE OF PROF'L CONDUCT preamble (2015) (explaining that a lawyer's violation of mandatory rules of professional conduct may be the basis of a professional disciplinary action by a state).

²⁶⁴ See Hall, *supra* note 252, at 134 ("[T]he physician-patient relationship and the lawyer-client relationship are both grounded on similar principles of trust and similar ethical duties."); Moore, *supra* note 257, at 447 ("Both doctors and lawyers believe that trust is essential to the success of the professional relationship.").

²⁶⁵ See Edward D. Re, *The Profession of the Law*, 5 J. CIV. RTS. & ECON. DEV. 109, 111 (2000) (explaining that the elements that comprise the privileges and responsibilities of the legal profession include "that the client's trust presupposes that the practitioner's self-interest is overbalanced by devotion to serving both the client's interest as well as the public good"); *supra* notes 256-57, 260-62 and accompanying text.

²⁶⁶ See *supra* Section III.B.2.

²⁶⁷ See *supra* Section III.C.

²⁶⁸ See *supra* Sections III.B.1 and III.B.3.

²⁶⁹ See MODEL CODE OF PROF'L CONDUCT r. 1.16(b)(2)-(7) (AM. BAR. ASS'N 2015) (withdrawing representation permitted if "[t]he client persists in a course of action involving the lawyer's services that the lawyer reasonably believes is criminal or fraudulent; the client has used the lawyer's services to perpetrate a crime or fraud; the client insists upon taking action that the lawyer considers repugnant or with which the lawyer has a fundamental disagreement; the client fails substantially to fulfill an obligation to the lawyer regarding the lawyer's services and has been given reasonable warning that the lawyer will withdraw unless the obligation is

Physicians may argue that they too have good cause to fire their noncompliant patients in light of these patients' failure to adhere to medical advice and adopt healthy behaviors.²⁷⁰ This argument echoes the personal responsibility rationale discussed in Section IV.A. As explained above, however, ascribing moral culpability to noncompliant patients is seldom warranted given the obstacles to healthy behaviors faced by many patients. Accordingly, a patient's noncompliance should not be considered good cause that would justify a physician's termination of the physician-patient relationship.

Physicians also may note that Rule 1.16(b)(6) the ABA's Model Rules of Professional Conduct permit a lawyer to withdraw if continued representation of a client "will result in an unreasonable financial burden on the lawyer."²⁷¹ Physicians may argue that they too should be allowed to terminate the physician-patient relationship when continued treatment imposes an unreasonable financial hardship, and that the financial consequences of treating noncompliant patients satisfy this condition. In applying Rule 1.16(b)(6), however, courts set a high bar for unreasonableness and are unwilling to approve a lawyer's request to withdraw from representation simply because representation will prove unprofitable.²⁷² As explained by one court,

An attorney has certain obligations and duties to a client once representation is undertaken. These obligations do not evaporate because the case becomes more complicated or the work more arduous or the retainer not as profitable as first contemplated or imagined. Attorneys must never lose sight of the fact that the profession is a branch of the administration of justice and not a mere money-getting trade.²⁷³

Consequently, courts only approve lawyers' requests to withdraw when the lawyer is unlikely to recover fees²⁷⁴ or any recovery would be

fulfilled; the representation . . . has been rendered unreasonably difficult by the client, or other good cause for withdrawal exists.").

²⁷⁰ Cf. Resnik, *supra* note 1, at 170, 176–77 (explaining that a patient makes a variety of implicit or explicit promises to the doctor to adhere to their treatment plan or modify poor health habits, and that when they fail to do so "the patient is not upholding his or her end of the bargain").

²⁷¹ MODEL CODE OF PROF'L CONDUCT r. 1.16(b)(6) (AM. BAR ASS'N 2015).

²⁷² See Eric W. Macaux, *Limiting Representation in the Age of Private Law: Exploring the Ethics of Limited-Forum Retainer Agreements*, 19 GEO. J. LEGAL ETHICS 795 (2006) (explaining that jurisdictions that have applied the financial hardship justification for withdrawing representation "have set the reasonableness bar high"); Sylvia Stevens, *When a Client Repudiates a Settlement: What Can You Do?*, 68 OR. ST. BAR BULL. 9 (2008) (stating that courts do not look favorable on withdrawal for reasons of financial burden unless the burden is "unanticipated and significant," and that "[c]ourts are loathe to allow a lawyer to withdraw from a case merely because it appears less profitable than originally anticipated").

²⁷³ Haines v. Liggett Grp., 814 F. Supp. 414, 424 (D.N.J. 1993) (citations omitted).

²⁷⁴ See, e.g., *City of Joliet v. Mid-City Nat'l Bank of Chi.*, 998 F. Supp. 2d 689 (N.D. Ill., 2014) (withdrawal permitted when client unable to pay outstanding fee of \$5 million); *In re Franke*, 55 A.3d 713 (Md. Ct. Spec. App. 2012) (withdrawal permitted when client had not paid

“substantially less” than the value of the lawyer’s work.²⁷⁵ The medical profession similarly should reinforce physicians’ fiduciary obligation to give primacy to the patient’s welfare over profits.²⁷⁶ Although caring for noncompliant patients may reduce physicians’ profits under performance incentive programs, this falls far short of imposing a significant financial hardship on physicians that would justify dismissal of the noncompliant patient.

2. Policy Justifications for Limiting Physicians’ Right to Refuse Treatment to Noncompliant Patients

As argued above, a rule that prohibits physicians from firing their noncompliant patients reinforces a physician’s fiduciary commitment to place a patients’ welfare above her own interests. Yet physicians’ fiduciary obligations are triggered only upon entering into the physician-patient relationship; a physician owes no fiduciary duty to individuals who are not her patients.²⁷⁷ Arguably, then, physicians should remain free to reject any prospective patient the physician believes will be noncompliant. Compelling policy interests, however, justify restrictions on physicians’ ability to reject both current and prospective patients.

Although laws regulating the marketplace for goods and services generally treat sellers and buyers as free agents with broad discretion to decide with whom they will do business, freedom of association in the marketplace is not absolute. The law regularly overrides autonomy in the marketplace in favor of competing values such as equality, human dignity, and preserving life and health. As described below, imposing on physicians a duty to treat noncompliant patients would be consistent with this legal tradition.

Regulators frequently curb the economic independence of actors that serve important public needs. This so-called public utility regulation traces back to common law doctrines that imposed on

outstanding fees of \$120,000); *In re* Withdrawal of Attorney, 594 N.W.2d 514 (Mich. Ct. App. 1999) (law firm permitted to withdraw when plaintiff had “virtually no likelihood of recovering an award of money damages or attorney fees from defendant” and case would require an additional 1000 or more hours or work).

²⁷⁵ *Smith v. R.J. Reynolds Tobacco Co.*, 630 A.2d 820 (N.J. Super. Ct. App. Div. 1993) (stating that trial courts should allow lawyers to withdraw if they submitted expert proofs that any recovery would be substantially less than the value of the work required).

²⁷⁶ *Cf. Bostick et al.*, *supra* note 257, at 431, 437 (stating that physicians who participate in performance incentives programs such as pay-for-performance must maintain primary responsibility to their patients regardless of financial incentives and therefore should “avoid selectively treating healthier patients for the purpose of bolstering their individual or group performance outcomes”).

²⁷⁷ *See Boyd*, *supra* note 258, at 137 (explaining that physicians’ fiduciary obligations, including the duty to put a patient’s interests above the physician’s interests, “attach at the time the physician undertakes to treat the patient”).

common carriers and innkeepers an obligation to be reasonable in their dealings with the public, including a duty to serve all-comers on a nondiscriminatory basis.²⁷⁸ These principles continue today through comprehensive regulation of a wide array of industries affected with a public interest and the power to exploit consumers,²⁷⁹ including the transportation, communication, banking, and insurance industries.²⁸⁰ Regulation of these industries has been defended on the grounds that “they wield . . . undue market power over goods or services upon which the public had grown dependent.”²⁸¹ Medicine too has acquired these hallmarks.

The twentieth century witnessed tremendous advances in medicine, with the practice of medicine evolving into a sophisticated, highly professional endeavor. As Nicholas Bagley has argued, with these changes the practice of medicine acquired the same attributes that have justified public utility regulation of other industries: “the power to abuse its control over a necessity.”²⁸² Specifically, health care has become indispensable to individuals’ well-being as medicine has come to play an ever larger role in relieving suffering and preventing premature death. Patients, however, cannot self-prescribe or administer medical tests or treatments, but instead must rely on the physicians and other health providers who both control access to health care and possess the necessary knowledge and expertise.²⁸³ These features—health care as an

²⁷⁸ See Nicholas Bagley, *Medicine As a Public Calling*, 114 MICH. L. REV. 57, 58–59, 72 (2015) (discussing the common law duties of innkeepers and common carriers, including the duty that all must be served on a nondiscriminatory basis); Shepherd, *supra* note 135, at 1090 (stating that under the common carrier doctrine, innkeepers and carriers “had an obligation not to turn away customers without reasonable justification”). Courts also required that “adequate facilities must be provided, reasonable rates must be charged, and no discrimination must be made.” BRUCE WYMAN, *THE SPECIAL LAW GOVERNING PUBLIC SERVICE CORPORATIONS AND ALL OTHERS ENGAGED IN PUBLIC EMPLOYMENT* xi (1911).

²⁷⁹ See Bagley, *supra* note 278, at 59 (explaining that the public utility concept recognized that the law must constrain the behavior of “[a]ny industry that served an important human need and had the market power to exploit consumers”); Shepherd, *supra* note 135, at 1090 (“Today, the concept behind common carrier obligations is retained, less through common law application, and more through the comprehensive regulation of certain industries affected with a public interest . . .”).

²⁸⁰ See Bagley, *supra* note 278, at 73.

²⁸¹ *Id.* at 71.

²⁸² *Id.* at 84.

²⁸³ See Shepherd, *supra* note 135, at 1089–90 (arguing that one justification for requiring physicians not to discriminate on unfair grounds is society, through the licensing process, has granted physicians a self-regulated monopoly over access to health care). Contrary to public perceptions, public utility regulation was not limited to natural monopolies. As Professor Bagley explains:

[A] business need not be monopolistic in a strict sense. An extraordinary range of market features—the costs of shopping around, bargaining inequalities, informational disadvantage, rampant fraud, collusive pricing, emergency conditions, and more—could all frustrate competition and so give rise to “virtual” or “practical” monopolies that would warrant state intervention. By no means was the regulation of

important human need and providers' control over access—leave patients vulnerable to exploitation and consumer disadvantage.²⁸⁴ This vulnerability in turn justifies state intervention that protects patients.

Health law includes several examples where courts and regulators have recognized patients' vulnerability and adopted laws that promote patients' access to health care on a reasonable and nondiscriminatory basis. As described in Part II, the common law doctrine of patient abandonment promotes patients' access to continuous care by imposing constraints on physicians' autonomy. Specifically, the doctrine prohibits physicians from terminating the physician-patient relationship for those patients needing continuing medical attention without first providing adequate notice.²⁸⁵ In adopting the patient abandonment doctrine, courts not only emphasize the fiduciary nature of the physician's duties, but also the public nature of the physicians' calling.²⁸⁶

Several federal laws also bear the trademarks of public utility regulation. Enacted in 1946, the Hill-Burton Act requires all hospitals and other facilities that received federal subsidies for construction and modernization to make their services available on a nondiscriminatory basis.²⁸⁷ EMTALA similarly imposes on hospitals and its affiliated physicians a duty to serve certain patients. Aimed at preventing “patient dumping”—the practice of hospitals refusing to treat or transferring indigent, uninsured patients requiring emergency care—EMTALA requires hospital emergency rooms that participate in Medicare (i.e., most hospitals) to stabilize any person with an emergency condition or in active labor.²⁸⁸ Title VI of the Civil Rights Act of 1965 prohibits any health care provider receiving federal financial assistance, including Medicare and Medicaid payments, from discriminating against patients on the basis of race, color, or national origin,²⁸⁹ while the Age Discrimination Act of 1975 and Title IX of the Education Amendments of 1972 prohibit discrimination on the basis of age and sex

public callings confined to the natural monopolies that today are thought to be its proper targets.

Bagley, *supra* note 278, at 77–78.

²⁸⁴ See *id.* at 84–85 (discussing the potential for consumer exploitation in the health care market).

²⁸⁵ See *supra* text accompanying note 59.

²⁸⁶ See *Norton v. Hamilton*, 89 S.E.2d 809, 812 (Ga. Ct. App. 1955) (“[P]ublic considerations which are inseparable from the nature and exercise of [the physician’s] calling” justify imposing a duty to provide continuing care); *Ballou v. Prescott*, 64 Me. 305, 313 (1874) (stating that courts “impose specific duties in connection with and growing out of special undertakings,” especially when as in the case of the physician-patient relationship the relationship is “public in nature”).

²⁸⁷ See James F. Blumstein, *Court Action, Agency Reaction: The Hill-Burton Act As a Case Study*, 69 IOWA L. REV. 1227, 1228–29 (1984).

²⁸⁸ 42 U.S.C. § 1395dd(a)–(b) (2012).

²⁸⁹ Civil Rights Act of 1964, Pub. L. No. 88-352, 78 Stat. 241, 252–53 (codified as amended at 42 U.S.C. §§ 2000d–d-4 (2012)).

respectively.²⁹⁰ The American Disabilities Act of 1990 affords similar protections to persons with disabilities, explicitly including hospitals and physicians' offices within its scope.²⁹¹ Section 1557 of the ACA echoes these earlier laws, prohibiting discrimination in the health care setting on the basis of race, color, national origin, sex, and age.²⁹²

Although these laws do not impose on the health care industry a fully developed service obligation to treat all patients, they nevertheless reflect the public utility tradition of curbing the economic independence of actors serving an important human need.²⁹³ Specifically, they protect the vulnerability of certain patients in the marketplace for health care who might otherwise be denied equal access to care. Prohibiting physicians from rejecting noncompliant patients represents a logical extension of these protections.²⁹⁴ Nevertheless, the question remains whether compelling policy interests justify doing so.

For the reasons discussed in Part III, I believe important policy objectives outweigh physicians' autonomy interests. Laws and rules of professional conduct that allow physicians to avoid noncompliant patients frustrate an important objective of performance incentive programs: motivating physicians and their affiliated organizations to improve their patients' health behaviors. Physicians' contention that they can do little to influence their patients' behaviors, and that holding them financially accountable for their patients' noncompliance therefore unfairly punishes them, is overstated. Providers who implement the activities described in Section III.A.1 can make real inroads in increasing patient compliance and, ultimately, in improving patients' health. Providers can improve their physician-patient communications, adopt intensive patient education interventions, and implement programs that address the social, environmental, and behavioral health obstacles to patient compliance.²⁹⁵ Allowing physicians to fire their noncompliant patients would significantly weaken physicians' incentives to perform these actions.

Rejection of noncompliant patients frustrates other important policy goals. As explained previously, patients fired for noncompliance

²⁹⁰ 20 U.S.C. § 6101 (age); 20 U.S.C. § 1681 (sex).

²⁹¹ 42 U.S.C. § 12181 (2012).

²⁹² Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1557, 124 Stat. 119 (2010) (codified at 42 U.S.C. § 18116 (2012)).

²⁹³ See Bagley, *supra* note 278, at 94 (“[T]aken as a whole, the network of laws regulating access to medical services reflects the impulse that private actors serving important needs owe a legal duty to serve the public.”).

²⁹⁴ See Shepherd, *supra* note 135, at 1090–91 (arguing that requiring “physicians to treat all those who seek their care (unless there is a good reason to refuse) . . . is consonant with the centuries old theory of ‘common carrier’ obligations” and more recent “of certain industries affected with a public interest . . .”). See generally Bagley, *supra* note 278 (arguing that the regulation of medicine, including regulating the duties of hospitals and physicians to fairly serve the public, is consistent with public utility regulation).

²⁹⁵ See *supra* notes 91–111 and accompanying text.

experience discontinuity in care, and this in turn leads to poorer health among noncompliant patients and higher medical spending for those who insure these individuals.²⁹⁶ Rejection of noncompliant patients also lowers these patients' trust in physicians and can leave patients feeling stigmatized and ashamed.²⁹⁷ Importantly, allowing physicians to refuse treatment to noncompliant patients undermines patient autonomy, as patients fearful of being rejected by their physician may feel pressured into agreeing to treatment recommendations that go against their personal preferences.²⁹⁸ Finally, the emerging trend of physicians avoiding noncompliant patients will exacerbate existing disparities in health.²⁹⁹

So while physicians' fairness and autonomy interests should not be dismissed lightly, in the case of noncompliant patients they are outweighed by other fundamental values—preserving life and health, promoting equality, and respecting human dignity. Regulators and professional associations therefore should prohibit physicians from rejecting noncompliant patients despite such rule's infringement on physicians' autonomy.

C. *The Beneficence Rationale*

Finally, physicians may argue that professional norms of beneficence obligate them to reject their noncompliant patients. The beneficence principle demands that physicians act in a patient's best interest.³⁰⁰ In some circumstances a physician may conclude that her rejection of the noncompliant patient does in fact serve the patient's best interests. Specifically, the physician may believe that firing (or threatening to fire) the patient will spur the patient to improve her treatment adherence and make better lifestyle choices. I refer to this justification as the paternalistic rationale. Alternatively, a physician may determine that she no longer can provide effective care to a noncompliant patient due to a breakdown in the physician-patient relationship, and that another physician would be better suited to treat the patient. I refer to this justification as the alternative physician rationale. This Section discusses these two beneficence rationales and argues that both are problematic.

²⁹⁶ See *supra* Section III.B.1.

²⁹⁷ See *supra* Sections III.B.2 and III.B.3.

²⁹⁸ See *supra* Section III.C.

²⁹⁹ See *supra* Section III.D.

³⁰⁰ See Martin, *supra* note 159 (defining beneficence as “[t]he obligation to act in patients’ best interests at all times”).

1. The Paternalistic Rationale

When persistent counseling fails to change a patient's behavior, the physician may view actual or threatened termination of the physician-patient relationship as a "last resort" to induce compliance with medical advice.³⁰¹ In other words, a physician may believe that her rejection of the patient serves as the means for promoting a desired outcome—improvement in the patient's self-care.³⁰² The physician's actions therefore are consistent with the beneficence principle, grounded in a paternalistic impulse that can be summed up as "tough love."

It is doubtful, however, that this paternalistic justification for physicians' rejection of noncompliant patients could be defended empirically.³⁰³ The assumption that physicians threatening patients with dismissal will successfully motivate patients to change their health-related behaviors conflicts with practical experience. Despite widespread awareness of the significant health risks associated with smoking, poor diets, and lack of exercise, many people's sincere attempts to change these behaviors are met with failure. The suggestion that pending rejection by one's physicians is the carrot (or stick) that prompts lasting behavior changes simply stretches credulity, particularly for those patients facing social, environmental, and behavioral health barriers to healthier behaviors.

2. The Alternative Physician Rationale

A physician also may argue that the beneficence norm supports dismissal of a noncompliant patient when the relationship has deteriorated to the point that the physician can no longer provide competent care. A physician frustrated with her noncompliant patient may "become emotionally exhausted" or develop "strong negative emotions" toward the patient.³⁰⁴ These feelings can compromise the patient's care, as they may impede effective physician-patient communication, bias the physician's decision-making, or diminish patient trust if the patient senses the physician's negative attitude.³⁰⁵

³⁰¹ Wicclair, *supra* note 12, at 314.

³⁰² *See id.* at 314 ("Health-based firing is a means to promote desirable changes in [the patient's] choices and behavior.").

³⁰³ *See id.* ("This justification is based on a questionable empirically assumption. It is doubtful that available evidence supports a claim that either threatening to fire or actually firing patients is an effective last resort rather than counter-productive act of frustration or desperation.").

³⁰⁴ *See* Tim Stokes et al., *Ending the Doctor-Patient Relationship in General Practice: A Proposed Model*, 21 FAM. PRAC. 507, 510 (2004).

³⁰⁵ *See* Wicclair, *supra* note 12, at 316 (discussing how a breakdown in the physician-patient relationship "can impede communication, decision-making, and mutual respect and trust").

Relatedly, the physician who is unable to secure the patient's compliance may conclude that another physician will have better success in doing so given differences in the physicians' temperament or treatment style.³⁰⁶ For example, another physician may be more effective at communicating relevant medical information or have a more encouraging bedside manner that supports patients changing their health behaviors.³⁰⁷ In such cases, severing the physician-patient relationship arguably promotes the patient's best interest by prompting the patient to find a new physician better able to meet her needs. Nevertheless, terminating these patients is the wrong mechanism to achieve this end.

If the law and standards of professional ethics permit physicians to reject noncompliant patients for the reasons described above, physicians may invoke the alternative physician rationale to mask more self-interested motivations. Caring for difficult, noncompliant patients can be "hard," "thankless," and "frustrating."³⁰⁸ Firing noncompliant patients allows physicians to escape these negative feelings. Ethically, however, physicians must strive to put aside their bias against a patient in favor of compassion and fidelity.³⁰⁹ As explained by one commentator, physicians must "care for their patients without letting moral judgment or personal bias cloud their compassion for the suffering human being in front of them."³¹⁰ Accordingly, a physician should not be permitted to place her own desire to avoid the challenges inherent in caring for noncompliant patients above her ethical responsibilities to do so.

Rejecting noncompliant patients can also serve physicians' financial and reputational interests under performance incentive programs, as described in Part I. Physicians primarily concerned about their success under performance incentive programs may use the

³⁰⁶ See *id.* (stating that termination may be appropriate if "the physician has good reason to believe that another doctor would be able establish a more effective relationship that will more successfully promote the patient's health").

³⁰⁷ Cf. Martin, *supra* note 159, at 111 ("Good clinical judgment usually finds a suitable combination of sympathy and firmness. It remains focused on providing support in the form of education, reassurance, helpful suggestions, and encouragement to change bad habits . . ."). Another physician also may be better suited to care for a patient because they possess more relevant *clinical* expertise, such as an ob-gyn with expertise in caring for pregnant women who are obese, smoke, or are otherwise high-risk. When the treating physician does not have the clinical expertise to provide the noncompliant patient medically appropriate care, transferring the patient's care to a physician with the relevant skill set would be appropriate. Indeed, a physician may be exposing herself to medical liability if she continues to provide care to a patient whose clinical needs extend beyond the physician's expertise.

³⁰⁸ Ramy Sedhorn, *Taking Our Oath Seriously: Compassion for Patients*, 18 AMA J. ETHICS 69, 70 (2016).

³⁰⁹ See Michael Hawking, *Courage and Compassion: Virtues for So-Called "Difficult" Patients*, 19 AMA J. ETHICS 357 (2017) (calling for physicians to treat their patients with compassion).

³¹⁰ Micah Johnson, *Do Physicians Have an Ethical Duty to Repair Relationships with So-Called "Difficult" Patients?*, 19 AMA J. ETHICS 323, 326 (2017).

“patient’s best interest” argument as a benevolent justification for terminating their noncompliant patients. In particular, physicians may exaggerate the extent to which there has been a breakdown in the physician-patient relationship or inflate the alternative physician’s competence. Simultaneously they may downplay the detrimental impact that dismissal can have on noncompliant patients.³¹¹

Among physicians with a genuine fidelity to their patients’ interests over the physician’s own financial interests, they nevertheless may be subconsciously motivated to conclude that they cannot adequately care for a noncompliant patient. Psychologists studying cognitive motivation have found that individuals have a subconscious tendency to form initial judgments that promote their own self-interest.³¹² More conscious deliberations then perform the secondary role of rationalizing the self-serving conclusion.³¹³ Accordingly, physicians subject to performance incentive programs may, consistent with their self-interest, be subconsciously biased to conclude that dismissing the noncompliant patient is “the right thing to do.”³¹⁴ Specifically, a physician may be biased toward finding an irrevocable breakdown in her relationship with a noncompliant patient or concluding that another physician will provide better care to the patient.

In raising these concerns, I do not mean to characterize the alternative physician rationale as illegitimate. When a physician’s negative feelings toward a patient threaten the quality of care provided, continuing the physician-patient relationship may prove harmful to the patient. Moreover, if another physician truly could provide more

³¹¹ See generally *supra* Section IV.B.

³¹² See Dan M. Kahan, *Foreword: Neutral Principles, Motivated Cognition, and Some Problems for Constitutional Law*, 125 HARV. L. REV. 1, 19 (2011) (describing “the unconscious tendency of individuals to process information in a manner that suits some end or goal”). For example, studies have found that individuals have faster reaction times when generating and endorsing memories and beliefs consistent with conclusions that promote an individual’s self-interest or desired ends. See Ziva Kunda, *The Case for Motivated Reasoning*, 108 PSYCH. BULL. 480, 483–85 (1990) (summarizing studies on biased memory search).

³¹³ See Milton C. Regan, *Moral Institutions and Organizational Culture*, 51 ST. LOUIS U. L.J. 941, 959–60 (2007) (“[W]e typically engage in moral reasoning after our judgments have been formed, and . . . we engage in that exercise in order to justify, rather than arrive at, those judgments.”). See generally DANIEL KAHNEMAN, *THINKING, FAST AND SLOW* 105 (2011) (explaining that deliberative processes merely endorse individuals’ initial impressions by providing justifications for them). This does not mean deliberative reasoning cannot override our initial impressions—it can—but doing so requires mobilizing substantial mental focus, something individuals do infrequently, particularly when their mental capacity is otherwise taxed by the complexity of the situation or performing other tasks. See Don A. Moore & George Loewenstein, *Self-Interest, Automaticity, and the Psychology of Conflict of Interest*, 17 SOC. JUST. RES. 189, 193 (2004) (stating that although “[c]ontrolled processes can override automatic processes,” studies have found “that when mental capacity is constrained because people are under cognitive load, it is harder for them to engage in reflection and correction of automatic judgments”). See generally KAHNEMAN, *supra* note 313, at 81 (describing the “laziness” of System 2 deliberative cognitive processes).

³¹⁴ See Mantel, *supra* note 231, at 498–505 (explaining how physicians’ self-interest subconsciously biases physicians to make clinical decisions consistent with their self-interest).

effective care the patient's interests may be better served by switching physicians. Rather, my point is that physicians may be too quick in concluding that termination serves the patient's best interests. When a physician genuinely believes that insurmountable obstacles threaten the physician-patient relationship or that another physician would be better suited for the patient, she should discuss her concerns with the patient. However, if the patient insists on continuing the physician-patient relationship, the physician should not be permitted to fire the patient. This approach would allow physicians to honor the beneficence principle without undermining the wide-ranging policies and values served by a prohibition against physicians rejecting noncompliant patients.

V. SUPPORTING PROVIDERS' EFFORTS TO IMPROVE PATIENT COMPLIANCE

Parts III and IV argued that legal and ethical standards should prohibit physicians from rejecting noncompliant patients. Adopting rules that bar physicians from discriminating against noncompliant patients, however, is only one side of the equation. Changing patients' health-related behaviors is no small task. As described above, complex social, environmental, and behavioral health factors impact individuals' capacity to adhere to physicians' medical advice.³¹⁵ Identifying and addressing these underlying causes of nonadherence requires time, skill, and organizational resources that many physicians currently lack. Counseling patients on overcoming their personal barriers to compliance can involve many hours,³¹⁶ yet declining payment rates have caused physicians to reduce the amount of time they spend with each patient.³¹⁷ In addition, many physicians lack the skills to communicate effectively with patients about barriers to adherence or lack knowledge about strategies for improving patients' health behaviors.³¹⁸ And while

³¹⁵ See *supra* Section III.A.1.

³¹⁶ For example, clinical studies of one effective counseling technique, known as motivational interviewing, found that the technique typically involves one to five hours of counseling. See Bender, *supra* note 6, at 4 (describing the time commitment involved for motivational counseling to bring about behavior changes).

³¹⁷ See Page, *supra* note 3, at 4 (explaining that lack of time is a problem for physicians treating nonadherent patients, as declining payment rates push physicians to keep patients moving in order to maintain their income by increasing their volume). See generally Bender, *supra* note 6, at 4 (noting that the time needed to provide effective counseling to noncompliant patients is "not feasible in most clinical settings"); Chesnow, *supra* note 5, at 4-5 (stating that busy physicians do not have the time to "sit down with a patient and tease out his or her unique personal barriers to compliance," and "[t]he more patients you are forced to see to pay the bills, the less time you have to explore and address patient barriers to compliance").

³¹⁸ See Hibbard et al., *supra* note 10, at 493 (stating that the findings from the authors' physician survey and interviews shows that physicians "may need help with skill development and help in learning about evidence-based strategies for supporting patient self-management");

accountable care organizations and other large health care providers may have the personnel and other resources to support interventions that address barriers to compliance,³¹⁹ small and medium-sized physician practices often do not.³²⁰ A prohibition against physicians rejecting noncompliant patients therefore should be balanced with policies and infrastructure that support physicians and their affiliated organizations' efforts to improve patient compliance.

While a detailed discussion of how policymakers can support efforts to improve patient compliance is beyond the scope of this Article, I highlight here some matters for policymakers' consideration. First, government programs and private payors should ensure that their payment policies do not hinder providers' efforts to improve patient compliance. Time spent by physicians or other health professionals counseling noncompliant patients must be adequately compensated. For example, Medicare covers medication management therapy—comprehensive services provided by pharmacists that include medication review, care coordination, and follow-up services.³²¹ Payors also should adequately compensate providers for intensive interventions designed to improve patients' health-related behaviors, such as the diabetes self-management and smoking cessation initiatives described in Section III.A. Any increase in payors costs for these services potentially will be offset by a decrease in costly emergency care, hospitalizations, or other treatments,³²² although more research is needed to identify the most cost-effective interventions.³²³

Mantel, *supra* note 113, at 268–69 (noting that many health professionals lack the skills to assess and develop strategies for addressing the social determinants of health); Page, *supra* note 3, at 8 (noting that a consultant who works with health providers and plans on improving patient communication believed that “most physicians have ineffective skills in identifying patients who will potentially ignore treatment recommendations, and working with them to become more motivated to engage in their treatment”).

³¹⁹ See generally Mantel, *supra* note 113, at 269–71 (explaining that larger health care organizations may have the capacity to address the social determinants that adversely impact health).

³²⁰ See Steiner, *supra* note 110, at 583–84 (explaining that improvements in adherence may best be accomplished by organization-based interventions that require substantial time, an investment in information systems, staff training, and adoption of a medical home model, something small practices may not be able to do on their own). See generally Mantel, *supra* note 113, at 269–71 (stating that small and medium-sized physician practices may be poorly equipped to address the social determinants of health on their own).

³²¹ *Medication Therapy Management*, CENTERS FOR MEDICARE & MEDICAID SERVICES, <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/MTM.html> (last updated Aug. 1, 2017, 12:38 PM); CTRS. FOR MEDICARE & MEDICAID SERVS., 2015 MEDICARE PART D MEDICATION THERAPY MANAGEMENT (MTM) PROGRAMS: FACT SHEET SUMMARY OF 2015 MTM PROGRAMS 25–26 (Aug. 21, 2015), <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/CY2015-MTM-Fact-Sheet.pdf>.

³²² See sources cited *supra* note 35 and accompanying text.

³²³ See Leah L. Zullig et al., *A Renewed Medication Adherence Alliance Call to Action: Harnessing Momentum to Address Medication Nonadherence in the United States*, 10 PATIENT PREFERENCE & ADHERENCE 1189 (2016) (“[I]t is widely believed that improving medication

Second, mindful of physicians' perception that they can do little to improve patients' health-related behaviors,³²⁴ policymakers should fund research and training on how providers can best address patients' noncompliance. Physicians and their affiliated organizations would benefit greatly from research on the most effective and efficient ways to improve patients' adherence and health-related behaviors. The National Institutes of Health (NIH) provides some support for research on interventions designed to improve adherence³²⁵ and health-related behaviors,³²⁶ but additional research is needed.³²⁷ In addition to funding additional research in this domain, government agencies could develop training programs that support providers in improving their patients' adherence, as they have done in the areas of patient safety,³²⁸ meaningful use of electronic health records,³²⁹ health care compliance,³³⁰ and public

adherence will result in improved individual- and population-level health and reduced health care spending," but that more research is needed on the efficacy of various interventions); see also sources cited *supra* note 36 and accompanying text.

³²⁴ See *supra* notes 248–49 and accompanying text.

³²⁵ See PA-17-060 *Oral Anticancer Agents: Utilization, Adherence, and Health Care Delivery*, NAT'L INST. HEALTH, <https://grants.nih.gov/grants/guide/pa-files/PA-17-060.html> (last visited Sept. 12, 2017); PA-14-334 *Advancing Interventions to Improve Medication Adherence*, NAT'L INST. HEALTH, <https://grants.nih.gov/grants/guide/pa-files/PA-14-334.html> (last visited Sept. 12, 2017); *Department of Health and Human Services*, NAT'L INST. HEALTH, <https://grants.nih.gov/grants/guide/pa-files/PA-14-181.html> (last visited Sept. 12, 2017). The Adherence Network is a working group with representatives from various NIH Institutes, Centers, and Offices working to "provide leadership and vision for adherence research at NIH." *National Institutes of Health Adherence Network*, FACEBOOK, https://www.facebook.com/pg/NIHAdherenceNetwork/about/?ref=page_internal (last visited Sept. 12, 2017). The National Institutes of Health Adherence Network also sponsors a distinguished speaker series on adherence issues. *Id.*

³²⁶ See, e.g., PAR-17-087, *Tobacco Use and HIV in Low and Middle Income Countries*, NAT'L INST. HEALTH, <https://grants.nih.gov/grants/guide/pa-files/PAR-17-087.html> (last visited Sept. 12, 2017); PA-14-114, *Behavioral Interventions to Address Multiple Chronic Health Conditions in Primary Care*, NAT'L INST. HEALTH, <https://grants.nih.gov/grants/guide/pa-files/PA-14-114.html> (last visited Sept. 12, 2017); PA-14-15, *Self-Management for Health in Chronic Conditions*, NAT'L INST. HEALTH, <https://grants.nih.gov/grants/guide/pa-files/PA-14-345.html> (last visited Sept. 12, 2017); PA-14-315, *Testing Interventions for Health-Enhancing Physical Activity*, NAT'L INST. HEALTH, <https://grants.nih.gov/grants/guide/pa-files/PAR-14-315.html> (last visited Sept. 12, 2017).

³²⁷ See Hayden B. Bosworth et al., *Medication Adherence: A Call for Action*, 162 AM. HEART J. 412 (2011) (reporting that participants in a think tank meeting on the current status of medication adherence concluded that as "compared with the many thousands of trials for the efficacy of individual drugs," research on effective medication adherence interventions is more limited, and that "prospective research is required to fully understand the effects of various interventions on adherence").

³²⁸ See *Patient Safety Network Training Catalog*, AGENCY FOR HEALTHCARE RES. & QUALITY, <https://psnet.ahrq.gov/pset?qs=compliance> (last visited Sept. 12, 2017) (listing patient safety training programs offered by the Agency for Healthcare Research and Quality).

³²⁹ See *National Learning Consortium*, HEALTHIT.GOV, <https://www.healthit.gov/providers-professionals-national-learning-consortium> (last updated July 11, 2014) (listing resources, training, and tools developed by HHS that support providers working towards the implementation, adoption, and meaningful use of electronic health systems).

³³⁰ See *HEAT Provider Compliance Training Videos*, OFF. INSPECTOR GEN.: U.S. DEP'T HEALTH & HUMAN SERVICES, https://oig.hhs.gov/newsroom/video/2011/heat_modules.asp (last

health.³³¹ Medical schools and other graduate programs for health care professionals also should incorporate into their curriculums training on interventions that enhance patient adherence,³³² including better communication between physicians and patients.³³³

Third, policymakers can help physician practices acquire the organizational resources necessary for improving patient adherence and health-related behaviors. For example, efforts to enhance patient compliance are most effective when delivered by an interdisciplinary team of health professionals, social workers, and other professionals.³³⁴ To help smaller physician practices transition to this model of care, some states are funding interdisciplinary community health teams that support multiple physician practices, thereby relieving small practices from having to each establish and fund their own interdisciplinary team.³³⁵ Alternatively, a few states are providing start-up funding to physician practices transitioning to the interdisciplinary team model.³³⁶ Other states should follow suit and provide similar support to smaller physician practices.

CONCLUSION

Caring for patients who fail to follow medical advice or adopt healthy behaviors has long frustrated physicians. Now, caring for these patients also may harm a physician's reputation and reduce her income.

visited Sept. 12, 2017); *MLN Web-Based Training*, CENTERS FOR MEDICARE & MEDICAID SERVICES, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html> (last updated Apr. 13, 2017) (listing provider compliance courses offered by the Centers for Medicare & Medicaid Services).

³³¹ See *CDC Learning Connection*, CENTERS FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/learning> (last updated Aug. 1, 2017).

³³² See Berben et al., *supra* note 90, at 644 (“Health care curricula need to be revised to include competencies in adherence-enhancing interventions.”); Piette et al., *supra* note 101, at 632 (stating that their research findings, showing an association between patients’ self-care and providers’ communication processes, provides “further support for including provider training in communication as a legitimate and important component of medical education”).

³³³ See generally Section III.A (discussing how poor physician-patient communications contributes to poor patient adherence, particularly among patients with low health literacy).

³³⁴ See Berry et al., *supra* note 138, at 11 (stating that coaching and other interventions that encourage patients to make positive lifestyle changes “are most effective when physicians are part of a larger team of allied health professionals”).

³³⁵ See Mary Takach & Jason Buxbaum, *Care Management for Medicaid Enrollees Through Community Health Teams*, COMMONWEALTH FUND 9 (MAY 2013), http://www.commonwealthfund.org/~media/files/publications/fund-report/2013/may/1690_takach_care_mgmt_medicaid_enrollees_community_hlt_teams_520.pdf (describing the functions of community health teams). States supporting community health teams include Alabama, Maine, Minnesota, New York, North Carolina, Oklahoma, and Vermont.

³³⁶ Start-up funds can be used to hire new staff (e.g., case managers) and pay for other structural changes. See Kelly Devers et al., *Innovative Medicaid Initiatives to Improve Service Delivery and Quality of Care: A Look at Five State Initiatives*, HENRY J. KAISER FAM. FOUND. 8 (Sept. 2011), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8224.pdf>.

Because noncompliant patients are likely to get sicker and consume more health care, the physicians who treat these patients may have poorer grades on publicly available report cards and lower reimbursements under payment models that link providers' payments to patient outcomes. Physicians can escape this predicament, however, by firing or otherwise refusing to treat noncompliant patients. Current legal and ethical standards support physicians doing so, as they grant physicians broad discretion in deciding whom to treat.

As detailed in this Article, denying treatment to patients for reasons of noncompliance raises significant policy and ethical concerns. When physicians fire or refuse to treat noncompliant patients, their actions are detrimental to these patients' health and well-being, undermine patients' trust in the medical profession, risk compromising patient autonomy, and increase disparities in health. These harmful consequences clearly run counter to the medical profession's professed fidelity to patients' best interests and their ethical obligation to put a patient's welfare above the physician's own financial interests. Nor can the status quo be defended by invoking the ethos of personal responsibility given the influence social, environmental, and behavioral health factors have on individuals' conduct. The laws and standards of professional conduct that govern the physician-patient relationship therefore should be revised to prohibit physicians from refusing to treat noncompliant patients.