FOREWORD

TOWARD RELATIONSHIP-CENTERED HEALTH LAW

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INTRODUCTION

A. This Symposium

This Symposium culminates a decade of work, based at Wake Forest University and involving leading national and international scholars, addressing the fundamental aims and orientation of health care law and ethics. In 2005, the *Wake Forest Law Review* hosted an academic workshop among leading health law scholars to explore the theme "Rethinking Health Law."[1] This first workshop, co-organized with Carl Schneider from the University of Michigan and Lois Shepherd from the University of Virginia, was motivated by the premise that the dominant paradigms of market theory and patient autonomy had largely run their intellectual courses. Instead, this group articulated the need for health law and ethics to be more "patient-centered"—a theme that was developed in the second event, in 2010, co-hosted by the *Wake Forest Law Review* and the University's new Center for Bioethics, Health, and Society.[2]

Building on this intellectual foundation, the *Wake Forest Law Review* and the Center for Bioethics, Health, and Society, along with my colleagues Chris Coughlin and Nancy King, planned a third major symposium to explore and develop the theme of "relationship-centered" health law and ethics. Our premise was that, while making law and ethics more patient centered is a move in the right direction, a one-directional focus on the patient could be too myopic. A relational perspective directs attention to the multi-directional

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1. *See* Symposium, *Rethinking Health Law*, 41 WAKE FOREST L. REV. 341 (2006); *see also* Mark A. Hall, Carl E. Schneider & Lois Shepherd, *Rethinking Health Law: Introduction*, 41 WAKE FOREST L. REV. 341, 342 (2006).

2. *See* Symposium, *Patient-Centered Health Law and Ethics*, 45 WAKE FOREST L. REV. 1429 (2010); *see also* Lois Shepherd & Mark A. Hall, *Patient-Centered Health Law and Ethics*, 45 WAKE FOREST L. REV. 1429, 1435–36 (2010).

pathways among patients/families, providers, and institutions over spans of time—rather than the simplifying idea of a professional delivering a discrete service.

Formulating the relational theme was inspired by two important books that were recently published by bioethics scholars at Vanderbilt: *Healers: Extraordinary Clinicians at Work*,[3] published by David Schenck and Larry Churchill in 2012, and *What Patients Teach: The Everyday Ethics of Health Care*,[4] published by Larry R. Churchill, Joseph B. Fanning, and David Schenck in 2013. The first book presents the results of fifty interviews with practitioners identified by their peers as "healers," describing the specific ways they improve their relationships with patients.[5] Using philosophical, anthropological, and psychological perspectives, the authors analyze the ritual structure and spiritual meaning of these healing skills, as well as their scientific basis. The second book, based on fifty-five interviews with patients, addresses two basic questions: "What do patients see as the core elements in forming therapeutic relationships with their healthcare providers?" and "[W]hat are the lessons for medical ethics and bioethics?"[6] The authors employ vignettes and stories to show why trust, arising from a reciprocity of vulnerability and clinical responsiveness, is central to the patient-physician relationship.[7] Using this distinctive blend of humanistic empiricism, the authors direct our attention to the "doubled agency" between doctors and patients, which gives rise to a set of mutual responsibilities focusing on patients' vulnerability.[8]

This Symposium invited a group of distinguished scholars to explore and develop these and other aspects of relationship-centered health law and ethics—either by responding to one or more particular aspects of these two Vanderbilt books, or by presenting their own thoughts connected to the conference's relationship-centered theme. Larry Churchill and colleagues begin by posing five challenges that a relationship-centered approach to care poses for health law. Although the essays that follow fall short of fully meeting this challenge, they take important strides.

Lois Shepherd and Margaret Mohrmann analyze how care providers can fulfill their ethical responsibility to be welcoming when dealing with ill-behaved patients. Elizabeth Pendo addresses how to meet the particular challenges posed by patients with

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3. DAVID SCHENCK & LARRY R. CHURCHILL, HEALERS: EXTRAORDINARY CLINICIANS AT WORK (2012).

4. LARRY R. CHURCHILL, JOSEPH B. FANNING & DAVID SCHENCK, WHAT PATIENTS TEACH: THE EVERYDAY ETHICS OF HEALTH CARE (2013).

5. SCHENCK & CHURCHILL, *supra* note 3, at xv, 23–24 tbl.1.2.

6. CHURCHILL, FANNING & SCHENCK, *supra* note 4, at xiii, xvii–xviii.

7. *See id.* at 9–10.

8. *See id.* at 9, 12.

disabilities. Rebecca Dresser shifts the focus to the research setting, where she examines classic issues of research ethics from the surprisingly overlooked perspective of research participants themselves. Nancy King explores and elucidates the key legal concept of "the reasonable patient" in the law of medical malpractice and informed consent. Christopher Robertson takes up the increasing challenge that physicians face to consider costs to patients in making treatment decisions. And, Christine Coughlin closes the Symposium by tackling another modern challenge—whether informed consent can be appropriately obtained through electronic media.

B. Relational vs. Transactional Perspectives

In this Foreword, I aim to further the movement toward a more relationship-centered body of law by briefly reviewing ways in which some major health law judicial decisions include, or fail to include, relational aspects of health care.[9] Patients exist, and medical care is delivered, within a web of critical relationships that patients and family members have with health care providers and institutions, and that providers and institutions have with each other. Real patients not only live in a web of relationships with their friends, families, and physicians that affect the way they act as rights holders and as consumers, but patients and physicians also have web-like relationships with various medical institutions. Doctors organize into practice groups and refer patients to specialists and clinics. Furthermore, patients have increasingly elaborate financial and medical relationships with health insurers, and important decisions about insurance are frequently made through employers.

A thoroughgoing, relationship-centered approach analyzes law from a more phenomenological perspective, focusing on patients' actual experiences in their interactions with physicians, hospitals and other facilities, insurers and health plans, employers, and various government agencies. This relational approach contrasts with the more transactional perspective that predominates elsewhere in the law. "A transactional perspective takes the atomistic view that each medical encounter is a discrete event rather than part of an on-going web of relationships."[10] On the other hand, "[a] relational web perspective . . . views medical encounters more holistically, as part of a larger context formed by the parties' interactions with each other and their relationships with other individuals and institutions."[11] Viewing the architecture of

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9. The relational theme was first articulated in Mark A. Hall & Carl E. Schneider, *Where Is the "There" in Health Law? Can It Become a Coherent Field?*, 14 HEALTH MATRIX 101 (2004). Parts of the following text draw from that article.

10. *Id.* at 103.

11. *Id.*

health care delivery and finance as relational rather than transactional forces us to think in a more complex, but realistic, way about the psychological and sociological dimensions of these interactions.

A transactional perspective treats medicine as a business—virtually like any other—and draws its doctrines from the many fields of law that govern ordinary commercial affairs, rather than answering basic legal questions by developing a set of doctrines specific to its subject. This generic doctrinal approach is "disinclined to search out the particular aspects of [health care] that might make it different from other businesses and relies instead on generalizations about how all business works and should work."[12] Plucking individual transactions from the web of life and treating them as discrete events encourages analyzing events in isolation from their context, which risks assigning inappropriate legal consequences to them. Real patients live their lives embedded in a web of relationships and personal histories that shape their thoughts and behaviors in ways not easily incorporated by a transactional model. This Foreword's review of case law will demonstrate that courts oftentimes consider the ways medical relationships pose special problems for the law, but other times they do not. The difficulty is that courts rarely reflect on which approach is preferable or how best to develop a relational approach. Nevertheless, particular case law examples are instructive, because they reveal the law's potential to develop a more systematic and thoroughgoing relational perspective.

I. CASE LAW EXAMPLES

A. Forming Treatment Relationships

Courts regard treatment relationships in both transactional and relational terms. The seminal decision from over a century ago—*Hurley v. Eddingfield*[13]—which is still printed in leading casebooks,[14] takes a starkly transactional stance. *Hurley* held that a physician had no duty to care for a patient's distress during childbirth that resulted in death, even though the husband tendered the physician's fee, the doctor had served as the family's physician prior to that point, and the doctor had no particular professional reason for his refusal to care for the patient (such as attending to another patient).[15] The court viewed this simply as the physician's "refusal to enter into a contract of employment," which of course the

12. *Id.*

13. 59 N.E. 1058 (Ind. 1901).

14. *E.g.*, MARK A. HALL, MARY ANNE BOBINSKI & DAVID ORENTLICHER, HEALTH CARE LAW AND ETHICS 104 (8th ed. 2013); SARA ROSENBAUM & DAVID M. FRANKFORD, LAW AND THE AMERICAN HEALTH CARE SYSTEM 19 (2d ed. 2012).

15. *Hurley*, 59 N.E. at 1058.

law does not require.[16] The court attached no significance to the patient's prior relationship with the physician.[17]

We learn from other cases, however, that courts are attuned to the ongoing nature of patient-physician relationships, tailoring the legal contours of these interactions according to spells of illness.[18] During a spell of illness, courts require physicians who undertake care to continue treating, even if they might want to withdraw, unless they are able to give patients adequate notice and opportunity to find an alternative source of care.[19] Otherwise, physicians are regarded as having abandoned their patients during treatment.[20] For instance, in *Ricks v. Budge*[21] the court held that a physician was liable for patient abandonment when he refused to proceed with an operation he had committed to perform, unless the patient first paid an outstanding bill.[22] The court explained:

> We believe the law is well settled that a physician or surgeon, upon undertaking an operation or other case, is under the duty, in the absence of an agreement limiting the service, of continuing his attention, after the first operation or first treatment, so long as the case requires attention. The 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 so as to enable the patient to secure other medical attention. A physician has the right to withdraw from a case, but if the case is such as to still require further medical or surgical attention, he must, before withdrawing from the case, give the patient sufficient notice so the patient can procure other medical attention if he desires.[23]

Relational factors also influence when courts will determine that treatment duties have been initiated—that is, when exactly doctors are held to have undertaken a patient's care. Lawyers commonly meet with clients to discuss the clients' situations prior to taking on their cases; lawyers are thus free to refuse representation until an explicit engagement has been stated.[24] In contrast, courts

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16. *Id.*
17. *Id.*
18. *See, e.g.*, Castillo v. Emergency Med. Assocs. P.A., 372 F.3d 643, 648 (4th Cir. 2004).
19. *See* Ricks v. Budge, 64 P.2d 208, 211–12 (Utah 1937).
20. *Id.* at 212.
21. 64 P.2d 208 (Utah 1937).
22. *Id.* at 210, 212–13.
23. *Id.* at 211–12.
24. RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 14 cmt. b (2000); *see also* Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643, 681 (2008). *But see* Togstad v. Vesely, 291 N.W.2d 686 (Minn. 1980) (finding

find that physicians have initiated a treatment relationship simply by talking to a patient, or even by scheduling an appointment, without any careful search for a meeting of the minds or the exchange of consideration.[25] This "hair trigger" stance is clearly informed by the differing expectations and reliance that patients, versus legal clients, bring to their potential professional relationships. For instance, in *Adams v. Via Christi Regional Medical Center*,[26] the court found that a treatment relationship was created when an anxious mother called the family physician about her daughter's distress during pregnancy, which caused her death.[27] Even though the doctor no longer practiced obstetrics, he told the mother that stomach pain was normal and advised her daughter to see a doctor the next day, which ended up being too late.[28] On the question of whether the doctor was subject to suit for negligent advice, the court explained:

> When Mrs. Adams spoke to him by telephone . . . and told him that [her daughter] was 5–8 weeks pregnant and experiencing abdominal pain, [the doctor] did not say that he did not consider [the daughter] to be his patient. He did not say that he no longer provided obstetrical care. Rather than suggesting to Mrs. Adams that she contact another doctor at that time, he listened to what Mrs. Adams told him about [her daughter] and gave her his medical opinion in response. [The doctor's] undertaking to render medical advice as to [the daughter's] condition gave rise to a physician-patient relationship. Thus, even if the earlier physician-patient relationship between [the doctor and the daughter] had lapsed or been extinguished, it was renewed.[29]

Other courts, however, have been reluctant to find a treatment relationship when a doctor's consultation is not with a patient, but rather with another physician.[30] Then, even though the professional may render equally important advice, the absence of direct contact with the patient tends to make courts more concerned about the relationship among professionals than with patients. Thus, in *Reynolds v. Decatur Memorial Hospital*,[31] where a young boy became quadriplegic due to a misdiagnosed spinal cord injury, the court held that:

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that a lawyer-client relationship was created implicitly by an initial consultation, without a formal agreement).

25. Hall & Schneider, *supra* note 24, at 681.

26. 19 P.3d 132 (Kan. 2001).

27. *Id.* at 134–35, 140.

28. *Id.* at 134–35.

29. *Id.* at 140–41.

30. *E.g.*, Oliver v. Brock, 342 So. 2d 1, 4 (Ala. 1976); Corbet v. McKinney, 980 S.W.2d 166, 171 (Mo. Ct. App. 1998).

31. 660 N.E.2d 235 (Ill. App. Ct. 1996).

> A doctor who gives an informal opinion at the request of a treating physician does not owe a duty of care to the patient whose case was discussed.
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> . . . .
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> . . . The consequence of such a rule would be significant. It would have a chilling effect upon practice of medicine. It would stifle communication, education[,] and professional association, all to the detriment of the patient. The likely effect in adopting plaintiff's argument also would be that such informal conferences would no longer occur.[32]

Relational aspects of a different sort inform hospitals' common law duties to treat patients. As with physicians, courts hold that hospitals do not have to give any particular reasons for declining to accept patients, except in emergency situations.[33] Then, courts reason that patients have reasonable expectations of service based on hospitals' custom of rendering emergency treatment regardless of ability to pay.[34] In the seminal case, *Wilmington General Hospital v. Manlove*,[35] yet another child died, this time because an emergency room nurse failed to recognize the seriousness of his fever and sent the child and the parents home for the night.[36] The court returned the case for trial under a newly announced theory, subsequently embraced by many other courts, which it explained as follows:

> It may be conceded that a private hospital is under no legal obligation to the public to maintain an emergency ward, or, for that matter, a public clinic.
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> But the maintenance of such a ward to render first-aid to injured persons has become a well-established adjunct to the main business of a hospital. If a person, seriously hurt, applies for such aid at an emergency ward, relying on the established custom to render it, is it still the right of the hospital to turn him away without any reason? In such a case, it seems to us, such a refusal might well result in worsening the condition of the injured person, because of the time lost in a useless attempt to obtain medical aid.
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> Such a set of circumstances is analogous to the case of the negligent termination of gratuitous services, which creates a tort liability.[37]

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32. *Id.* at 239–40.

33. Karen H. Rothenberg, *Who Cares?: The Evolution of the Legal Duty to Provide Emergency Care*, 26 HOUS. L. REV. 21, 22–24 (1989).

34. *Id.* at 24, 53–54.

35. 174 A.2d 135 (Del. 1961).

36. *Id.* at 136.

37. *Id.* at 139 (internal citations omitted).

In short, hospitals with emergency rooms have a relationship with the general public that obligates them to at least screen patients experiencing possible emergencies in order to determine the seriousness of the patients' conditions. Having screened the patient, a treatment relationship is then created.[38] If the condition cannot wait until a regular appointment, abandonment principles dictate that immediate treatment must be given, regardless of ability to pay, unless it is possible to transfer the patient to another provider without worsening the patient's condition.[39] These interrelated principles all derive from common law doctrine that is informed by the relational aspects of how doctors, hospitals, and patients interact. These same principles (with respect to hospitals) have now been codified in federal law as part of the Emergency Medical Treatment and Active Labor Act.[40]

B. Content of Treatment Relationships

1. Fiduciary Characterizations

"Fiduciary" is the term judges often use to characterize special relationships in various business contexts. For medicine, courts are somewhat ambivalent about whether physicians constitute full-scale legal fiduciaries to their patients. Some courts hold back from full-throated application of the "f" term (fiduciary), declaring instead that physicians have a special or "confidential" relationship with patients that sets their duties on a higher plane than ordinary, arm's-length commercial dealings.[41] Other courts, however, are not so bashful. They declare that "[t]he relationship of patient and physician is a fiduciary one of the highest degree. It involves every element of trust, confidence[,] and good faith."[42]

2. Confidentiality

Preserving the confidentiality of medical information and privileging it from discovery or testimony in court is perhaps the duty that rests most squarely on concerns about supporting the treatment relationship. The rule's sole and explicit purpose is to encourage patients to be candid with their physicians. In *Jaffee v. Redmond*,[43] the Supreme Court of the United States stressed that this purpose is especially strong in the context of psychiatric treatment:

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38. *See id.*
39. *See* Ricks v. Budge, 64 P.2d 208, 210–12 (Utah 1937).
40. 42 U.S.C. § 1395dd (2012).
41. *See, e.g.*, RESTATEMENT (THIRD) OF TRUSTS § 2 cmt. b(1) (2003); AUSTIN WAKEMAN SCOTT & WILLIAM FRANKLIN FRATCHER, THE LAW OF TRUSTS § 2.5, at 43 (4th ed. 1987).
42. Lockett v. Goodill, 430 P.2d 589, 591 (Wash. 1967).
43. 518 U.S. 1 (1996).

> Effective psychotherapy . . . depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears. Because of the sensitive nature of the problems for which individuals consult psychotherapists, disclosure of confidential communications made during counseling sessions may cause embarrassment or disgrace. For this reason, the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment.[44]

Courts have also relied on the "unique nature of the physician-patient relationship" to ban defense lawyers from communicating informally with the non-client physicians of patients who sue for medical malpractice.[45]

3. Informed Consent

Informed consent is the body of law where courts have given relational considerations the most attention. The seminal decision, *Canterbury v. Spence*,[46] stressed that "[t]he patient's reliance upon the physician is a trust of the kind which traditionally has exacted obligations beyond those associated with arms-length [sic] transactions. His dependence upon the physician for information affecting his well-being, in terms of contemplated treatment, is well-nigh abject"[47]—sentiments repeated many times since then. In crafting the content of informed consent disclosure requirements, courts take account of relational aspects in many different ways. For instance, they require physicians to do more than simply respond to patients' questions, recognizing that "[t]he patient may be ignorant, confused, overawed by the physician or frightened by the hospital, or even ashamed to inquire."[48]

Moving in the other direction, courts decline to require that physicians disclose any more information than the risks and benefits relating to the treatment being offered; they do not require disclosure, for instance, of "numerical life expectancy information . . . so that [the patient] and his wife might take timely measures to minimize or avoid the risks of financial loss resulting from his death."[49] Concerned about "intrud[ing] further . . . on the

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44. *Id.* at 10.

45. *See, e.g.*, Duquette v. Superior Court, 778 P.2d 634, 639 (Ariz. Ct. App. 1989). Although such suits waive patients' privilege of confidentiality, these courts are concerned that communications outside the formal discovery process might reveal confidential information that is not related to the litigation. *See, e.g.*, *id.* at 637.

46. 464 F.2d 772 (D.C. Cir. 1972).

47. *Id.* at 782.

48. *Id.* at 783 n.36.

49. Arato v. Avedon, 858 P.2d 598, 604, 607 (Cal. 1993) (rejecting the lower court's holding that such information must be disclosed).

subtleties of the physician-patient relationship," the leading decision explained:

> The contexts and clinical settings in which physician and patient interact and exchange information material to therapeutic decisions are so multifarious, the informational needs and degree of dependency of individual patients so various, and the professional relationship itself such an intimate and irreducibly judgment-laden one, that we believe it is unwise to require *as a matter of law* that a particular species of information be disclosed.[50]

Also, the law's "therapeutic exception" suspends the obligation to disclose treatment risks where this would "foreclose a rational decision" or "pose psychological damage to the patient."[51]

4. Liability Rules

Relational features also factor explicitly into various rules governing physician or hospital liability for medical negligence. First is the consensus position that health care providers may not enforce waivers of liability that patients sign at the point of treatment.[52] The leading decision, *Tunkl v. Regents of the University of California*,[53] offers the obvious justification:

> The would-be patient is in no position to reject the proffered [waiver] agreement, to bargain with the hospital, or in lieu of agreement to find another hospital. The admission room of a hospital contains no bargaining table where, as in a private business transaction, the parties can debate the terms of their contract.[54]

On the other hand, in order to give physicians sufficient leeway to reassure anxious patients, courts are reluctant to find that physicians have guaranteed good outcomes from treatment.[55] A leading case explains:

> Statements of opinion by the physician with some optimistic coloring are a different thing, and may indeed have therapeutic value. But patients may transform such statements into firm promises in their own minds, especially

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50. *Id.* at 606–07.

51. Kathleen M. Boozang, *The Therapeutic Placebo: The Case for Patient Deception*, 54 FLA. L. REV. 687, 731 n.260 (2002) (quoting *Canterbury*, 464 F.2d at 788) (internal citations omitted).

52. *See, e.g.*, Tunkl v. Regents of the Univ. of Cal., 383 P.2d 441, 446–47 (Cal. 1963) (discussing the unequal bargaining positions of hospitals and patients).

53. *Id.*

54. *Id.* at 447.

55. *See, e.g.*, Sullivan v. O'Connor, 296 N.E.2d 183, 186 (Mass. 1973).

> when they have been disappointed in the event . . . . If actions for breach of promise can be readily maintained, doctors, so it is said, will be frightened into practising "defensive medicine."[56]

Even doctrine as mundane as the statute of limitations has relational aspects in the medical arena. Courts have adopted a "continuing treatment" rule that tolls the running of the statute while an injured patient is still under the care of the defendant physician, since it is unrealistic for such a patient to begin pursuing a lawsuit while he or she remains so dependent on the treating physician's good will.[57] The rationale is well stated in *Watkins v. Fromm*:[58]

> It would be absurd to require a wronged patient to interrupt corrective efforts by serving a summons on the physician or hospital superintendent. . . . [T]he trust and confidence that marks the physician-patient relationship puts the patient at a disadvantage to question the doctor's techniques and gives the patient the right to rely upon the doctor's professional skill without the necessity of interrupting a continuing course of treatment by instituting suit. The exception not only provides the patient with the opportunity to seek corrective treatment from the doctor, but also gives the physician a reasonable chance to identify and correct errors made at an earlier stage of treatment.[59]

Institutional, rather than merely patient, relationships inform judicial decisions on the extent to which surgeons are vicariously liable for the negligence of nurses or anesthesiologists.[60] If one of the latter commits a mistake for which the surgeon is not directly responsible, earlier courts once held the surgeon automatically liable as "captain of the ship" and absolved the employing hospital from any liability.[61] Justice Cardozo, for instance, absolved a hospital from any alleged negligence by a nurse in failing to heed a patient's explicit instructions, reasoning in relational terms that strike us now as both archaic and sexist:

> [N]urses are employed to carry out the orders of the physicians, to whose authority they are subject.

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56. *Id.*

57. Watkins v. Fromm, 488 N.Y.S.2d 768, 772 (App. Div. 1985).

58. *Id.*

59. *Id.* at 772 (citations omitted) (quoting Borgia v. City of New York, 187 N.E.2d 777, 778 (N.Y. 1962)) (internal quotation marks omitted); Barrella v. Richmond Mem'l Hosp., 453 N.Y.S.2d 444, 447 (App. Div. 1982)).

60. *See* Stephen H. Price, *The Sinking of the "Captain of the Ship": Reexamining the Vicarious Liability of an Operating Surgeon for the Negligence of Assisting Hospital Personnel*, 10 J. LEGAL MED. 323, 340 (1989).

61. *Id.* at 323.

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> If, however, it could be assumed that a nurse is a servant of the hospital, . . . [w]as she to infer from the plaintiff's words that a distinguished surgeon intended to mutilate the plaintiff's body in defiance of the plaintiff's orders? Was it her duty, as a result of this talk, to report to the superintendent of the hospital that the ward was about to be utilized for the commission of an assault? I think that no such interpretation of the facts would have suggested itself to any reasonable mind. . . . The hour was midnight, and the plaintiff was nervous and excited. . . . There may be cases where a patient ought not to be advised of a contemplated operation until shortly before the appointed hour. To discuss such a subject at midnight might cause needless and even harmful agitation. About such matters a nurse is not qualified to judge. She is drilled to habits of strict obedience. She is accustomed to rely unquestioningly upon the judgment of her superiors. No woman occupying such a position would reasonably infer from the plaintiff's words that it was the purpose of the surgeons to operate whether the plaintiff, forbade it or not. I conclude, therefore, that the plaintiff's statements to the nurse on the night before the operation are insufficient to charge the hospital with notice of a contemplated wrong.[62]

More modern courts, however, have rejected automatic vicarious liability of surgeons, reasoning that "[t]he trend toward specialization in medicine has created situations where surgeons do not always have the right to control all personnel within the operating room. An assignment of liability based on a theory of actual control more realistically reflects the actual relationship which exists in a modern operating room."[63]

C. Corporate and Financial Law

1. Corporate Law

Relational aspects also inform courts' analyses of corporate and financial legal issues in the medical arena. For instance, courts give special scrutiny to covenants not to compete in employment contracts with physicians, out of concern that the public interest in freedom of contract "must be balanced against the public interest in upholding the highly personal relationship between the physician and his or her patient."[64] One court went so far as to prohibit restrictive covenants by physicians altogether, because:

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62. Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 94–95 (N.Y. 1914), *abrogated by* Bing v. Thunig, 143 N.E.2d 3 (N.Y. 1957).

63. Thomas v. Raleigh Gen. Hosp., 358 S.E.2d 222, 225 (W. Va. 1987) (citation omitted).

64. Intermountain Eye & Laser Ctrs., P.L.L.C. v. Miller, 127 P.3d 121, 132 (Idaho 2005).

> The right of a person to choose the physician that he or she believes is best able to provide treatment is so fundamental that we cannot allow it to be denied because of an employer's restrictive covenant. Were we to hold otherwise, many of [the doctor's] patients would be denied the opportunity to choose whether or not they wanted to continue being treated by him. These patients, who have entrusted confidential information to [the doctor] by virtue of their highly fiduciary relationship with him, should not have that relationship involuntarily terminated.[65]

Most explicitly, the prohibition of the corporate practice of medicine is designed to protect treatment relationships from interference by corporate and financial interests.[66] An early decision reasoned at length:

> Because of the rights with which the law invests a stockholder in a corporation for profit, recognition of such a means of conducting a professional business involves yielding the right of participation in control of its policies and in its earnings to lay persons. . . . The object of such a company would be to produce an earning on its fixed capital. Its trade commodity would be the professional services of its employees. Constant pressure would be exerted by the investor to promote such a volume of sales of that commodity as would produce an ever increasing return on his investment. To promote such sales it is to be presumed that the layman would apply the methods and practices in which he had been schooled in the market place. The end result seems inevitable to us, viz., undue emphasis on mere money making, and commercial exploitation of professional services. To universalize the use of this method of organizing the professions, or to permit such a use to become general, would ultimately wipe out or blight those characteristics which distinguish the business practices of the professions from those of the market place. Such an ethical, trustworthy[,] and unselfish professionalism as the community needs and wants cannot survive in a purely commercial atmosphere.[67]

The sanctity of patient-physician relationships was central to a groundbreaking decision that gave physicians a private right of action to challenge, on general grounds of fairness, a private hospital's refusal to admit them to the medical staff.[68] This extraordinary ruling restricts hospitals' normal freedom of contract based in part on the fact that:

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65. Murfreesboro Med. Clinic, P.A. v. Udom, 166 S.W.3d 674, 683 (Tenn. 2005).

66. Bartron v. Codington Cnty., 2 N.W.2d 337, 345 (S.D. 1942).

67. *Id.* at 346.

68. *See* Greisman v. Newcomb Hosp., 192 A.2d 817, 825 (N.J. 1963).

> Doctors need hospital facilities and a physician practicing in the metropolitan . . . area will understandably seek them at the [only or desired] [h]ospital. Furthermore, every patient of his will want the [h]ospital facilities to be readily available. It hardly suffices to say that the patient could enter the hospital under the care of a member of the existing staff, for his personal physician would have no opportunity of participating in his treatment . . . .[69]

2. Antitrust Law

Courts have had occasion in antitrust cases to consider whether relational factors affect the economic analysis of medical markets. In *California Dental Ass'n v. FTC*,[70] the Supreme Court held that advertising restrictions on dentists should not be considered a per se antitrust violation, in part because:

> Patients' attachments to particular professionals, the rationality of which is difficult to assess, complicate the picture even further. The existence of such significant challenges to informed decisionmaking [sic] by the customer for professional services immediately suggests that advertising restrictions arguably protecting patients from misleading or irrelevant advertising call for more than cursory [legal analysis].[71]

In the context of hospital mergers, Judge Posner rejected the argument that a hospital market can extend for hundreds of miles, in part based on patients' relationships with family and their doctors' relationships with local medical staffs that keep them close to home:

> For highly exotic or highly elective hospital treatment, patients will sometimes travel long distances, of course. But

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69. *Id.* at 824.

70. 526 U.S. 756 (1999).

71. *Id.* at 772–73 (citation omitted). In a similar vein, a non-antitrust state court decision stressed the uniquely powerful influence that doctors have over the medical goods that patients consume, and upheld legislative authority to prohibit physicians from owning pharmacies:

> The doctor dictates what brand [of drugs] the patient is to buy . . . [and] orders the amount of drugs and prescribes the quantity to be consumed. In other words, the patient is a captive consumer. There is no other profession or business where a member thereof can dictate to a consumer what brand he must buy, what amount he must buy, and how fast he must consume it and how much he must pay with the further condition to the consumer that any failure to fully comply must be at the risk of his own health. . . . [T]he patient then becomes a totally captive consumer and the doctor has a complete monopoly.

Magan Med. Clinic v. Cal. State Bd. of Med. Exam'rs, 57 Cal. Rptr. 256, 263 (Ct. App. 1967).

> for the most part hospital services are local. People want to be hospitalized near their families and homes, in hospitals in which their own—local—doctors have hospital privileges. . . .
>
> It is always possible to take pot shots at a market definition (we have just taken one), and the defendants do so with vigor and panache. Their own proposal, however, is ridiculous—a ten-county area in which it is assumed (without any evidence and contrary to common sense) that Rockford residents, or third-party payors, will be searching out small, obscure hospitals in remote rural areas if the prices charged by the hospitals in Rockford rise above competitive levels.[72]

In a later case, however, the Eighth Circuit considered these quaint ideas to be outmoded, due to the ways in which managed-care insurance has changed patients' relationships with providers:

> The district court also relied on the seemingly outdated assumption of doctor-patient loyalty that is not supported by the record. The evidence shows, and the district court acknowledged, that the issue of access to a provider through an insurance plan is determinative of patient choice. Essentially, the evidence shows that patients will choose whatever doctors or hospitals are covered by their health plan. Undeniably, although many patients might prefer to be loyal to their doctors, it is, unfortunately, a luxury they can no longer afford. . . . As much as many patients long for the days of old-fashioned and local, if expensive and inefficient, healthcare, recent trends in healthcare management have made the old healthcare model obsolete.[73]

3. Payment and Coverage Disputes

Disputes over payment for medical care provide a final arena illustrating how courts consider relational factors in health law. In determining whether treatment is medically necessary for purposes of receiving insurance reimbursement, courts have tended to give treating physicians' recommendations much heavier weight than the judgment of insurance company medical directors, based on the patients' dependency on their physicians.[74] One court expressed this sentiment with special rhetorical flourish, by referring to characters in a popular soap opera of the day (*General Hospital*):

> Only the treating physician can determine what the appropriate treatment should be for any given condition. Any other standard would involve intolerable second-guessing, with every case calling for a crotchety Doctor Gillespie to peer

72. United States v. Rockford Mem'l Corp., 898 F.2d 1278, 1284–85 (7th Cir. 1990).

73. FTC v. Tenet Health Care Corp., 186 F.3d 1045, 1055 (8th Cir. 1999).

74. Mount Sinai Hosp. v. Zorek, 271 N.Y.S.2d 1012, 1016 (Civ. Ct. 1966).

> over the shoulders of a supposedly unseasoned Doctor Kildare. The diagnosis and treatment of a patient are matters peculiarly within the competence of the treating physician. The diagnosis may be insightful and brilliant, or it may be wide of the mark, but right or wrong, the patient under his doctor's guidance proceeds upon his theories and sustains expenses therefor. Can a hospitalization insurer rightfully decline to pay for the expenses incurred on the theory that subsequent events may have proved the diagnosis or the recommended treatment to have been wrong?
>
> . . . .
>
> . . . Who can say with certainty which course of treatment is correct?[75]

In another payment context, however, courts have been somewhat oblivious to patients' vulnerability and dependency. When patients seek care outside the network of providers that have negotiated discounts with their health insurer, patients are subject to providers' full charges, as detailed in their lengthy and indecipherable price lists.[76] Typically, these full charges are several times the amounts that providers agree to accept in arm's-length negotiations with insurers, leading to allegations that the marked-up amounts are unconscionably high.[77] Most courts have rejected this challenge. As explained by one recent decision, courts excuse the apparently adhesive nature of patients' agreements to pay whatever the provider's unstated charges might be, by noting that, for hospital care, it is not feasible to specify an exact price in advance:

> As the Third Circuit has recognized, omitting a specific dollar figure is "the only practical way in which the obligations of the patient to pay can be set forth, given the fact that nobody yet knows just what condition the patient has, and what treatments will be necessary to remedy what ails him or her."
>
> . . . .
>
> We align ourselves with those courts that have recognized the uniqueness of the market for health care services delivered by hospitals . . . .[78]

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75. *Id.*

76. *See* Allen v. Clarian Health Partners, 980 N.E.2d 306, 308 & n.1 (Ind. 2012).

77. *See, e.g.*, *id.*

78. *Id.* at 310–11 (citations omitted) (quoting DiCarlo v. St. Mary Hosp., 530 F.3d 255, 264 (3d Cir. 2008)).

CONCLUSION

Both the Symposium participants and the many judges surveyed above recognize the need for health care law to be attuned to the unique relational features of the medical arena, rather than mechanically applying generic or abstract legal principles derived largely from commercial law or the law of individual rights. Such an approach would purposefully accommodate the psychological reality of treatment encounters and the complex structure of relationships among patients, physicians, facilities, insurers, employers, and many others.

We see from this brief survey of case law that judges are already well attuned to the psychological and structural realities of treatment relationships. Merely listing these examples does little, however, to establishing a relational framework for health law. Courts recognize relational factors in a somewhat inconsistent and haphazard manner. When judges take a relational viewpoint, they sometimes view medical relationships as bilateral and one-dimensional, rather than as part of a complex web of connections. Also, many relational insights are based simply on conventional wisdom, rather than on empirical evidence. And, relational insights are deployed unpredictably. When courts operate at too high a level of abstraction or from armchair empiricism, they can ignore a good deal about the actual circumstances and behavior of medical personnel and institutions.

Nevertheless, this survey of case law, along with other essays in this Symposium, provide some basis for a tentative synthesis of relational perspectives in health law. First, this perspective understands health care interactions in their longitudinal dimension, as part of a patient's life experience and ongoing interactions with a care provider, rather than as discrete and isolated transactions. Second, a relational perspective considers that treatment relationships are embedded in a web of other relationships that patients and doctors have with hospitals, insurers, other care providers, and family members. Third, relational health law incorporates key psychological and emotional aspects of medical care, most importantly, patients' inherent vulnerability and their innate need to rely on and trust care providers. Finally, relational health law recognizes the special importance that patients and society attach to treatment relationships—both for the instrumental value of improving health and reducing suffering, but also for the intrinsic value that attaches to all deeply meaningful human relationships. These are the elements that point the way towards a more coherent, systematic, and thoroughgoing approach to developing a truly relational body of health law doctrine.