

# THE REASONABLE PATIENT AND THE HEALER

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## PART I: THE LAW AND THE PATIENT

One of the teaching tasks that lawyers probably do not undertake frequently enough is the reexamination of key legal concepts, especially those concepts the applications of which have changed over many years. The concept of the reasonable person is particularly important, and particularly elusive, in the law of negligence, and thus in the law of medical malpractice.<sup>1</sup> Most of all, the application of the reasonable person to informed consent poses a conceptual challenge that could have important implications for the physician-patient relationship.

### A. *The Reasonable Person in Negligence Law*

The reasonable person is a measure of liability for negligence that judges the actor's conduct according to a community standard<sup>2</sup> of minimally acceptable behavior.<sup>3</sup> What is most crucial and hard to understand about the reasonable person is the abstract quality of the concept. The reasonable person is not a particular person, nor should it be identified with any category or group of individuals, nor

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1. 57A AM. JUR. 2D *Negligence* § 133 (2004) (“The phrasing of the standard of care in negligence cases in terms of the ‘reasonable person’ is firmly implanted in the American law of negligence.”); *see also* Ford Motor Co. v. Burdeshaw, 661 So. 2d 236, 238 (Ala. 1995); Ky. Fried Chicken of Cal., Inc. v. Superior Court, 927 P.2d 1260, 1266 (Cal. 1997); United Blood Servs. v. Quintana, 827 P.2d 509, 519 (Colo. 1992); Doe Parents No. 1 v. Haw. Dep’t. of Educ., 58 P.3d 545, 583 (Haw. 2002); Dachlet v. State, 40 P.3d 110, 117 (Idaho 2002); Jones v. Chi. HMO Ltd. of Ill., 730 N.E.2d 1119, 1130 (Ill. 2000); Minneapolis Emps. Ret. Fund v. Allison-Williams Co., 519 N.W.2d 176, 182 (Minn. 1994); Donald v. Amoco Prod. Co., 735 So. 2d 161, 175 (Miss. 1999); Scott v. Henrich, 938 P.2d 1363, 1368 (Mont. 1997); Dixon *ex rel.* Estate of Mullis v. Monroe Oil Co., 505 S.E.2d 131, 137 (N.C. 1998); Mansfield v. Circle K. Corp., 877 P.2d 1130, 1132 (Okla. 1994); McCall v. Wilder, 913 S.W.2d 150, 155 (Tenn. 1995); Lamb v. B & B Amusements Corp., 869 P.2d 926, 930 (Utah 1993).

2. RESTATEMENT (SECOND) OF TORTS § 283 cmt. c (1965).

3. *See id.* at cmts. b–c.

is it meant to represent the average person.<sup>4</sup> The reason for this insistence on abstraction is to prevent the triers of fact (usually the jury) from judging the defendant according to how jurors would like to think they themselves would have acted.<sup>5</sup> This helps to ensure that the reasonable person standard remains a minimal but nonetheless substantive standard: the reasonably prudent person, not the person of perfect prudence. The reasonable person is both a representation of how individuals behave toward each other in society and a standard addressing how they are expected to behave in order to maintain basic safety and civil order.<sup>6</sup> That is, the reasonable person is a basic measure of both what human behavior is and what it ought to be.

Abstraction thus helps to reduce the risk that the standard will creep upward, but it also makes it difficult to grasp just what the standard entails.<sup>7</sup> That is, embodying the reasonable person in application to a particular set of facts always presents a challenge. The challenge arises in part because the cultural context of the reasonable person—originally “the man in the Clapham omnibus”<sup>8</sup> and later “the man who takes the magazines at home, and in the evening pushes the lawn mower in his shirt sleeves”<sup>9</sup>—is continually changing, both in general and in light of the particular facts of a given case. To give an obvious example, the reasonable *person* was originally the reasonable *man*.<sup>10</sup>

4. *Id.* at cmt. c (“The reasonable man is a fictitious person, who is never negligent, and whose conduct is always up to standard. He is not to be identified with any real person; and in particular he is not to be identified with the members of the jury, individually or collectively.”).

5. *Id.* (“It is . . . error to instruct the jury that the conduct of a reasonable man is to be determined by what they would themselves have done.”); see *Freeman v. Adams*, 218 P. 600, 601 (Cal. Dist. Ct. App. 1923); *Warrington v. N.Y. Powers & Light Corp.*, 300 N.Y.S. 154, 158 (App. Div. 1937); *Louisville & N.R. Co. v. Gower*, 3 S.W. 824, 827 (Tenn. 1887).

6. RESTATEMENT (SECOND) OF TORTS § 283 cmt. b.

7. See *id.* at cmt. c.

8. MARC A. FRANKLIN, ROBERT L. RABIN & MICHAEL D. GREEN, *TORT LAW AND ALTERNATIVES* 52 (9th ed. 2011) (quoting 3 FOWLER V. HARPER ET AL., HARPER, JAMES AND GRAY ON TORTS 433 (3d ed. 2007)).

9. S.I. STRONG & LIZ WILLIAMS, *COMPLETE TORT LAW: TEXT, CASES, & MATERIALS* 67 (2011) (quoting *Hall v. Brooklands Auto Racing Club*, (1932) 1 K.B. 205 at 224 (Eng.)).

10. See RESTATEMENT (SECOND) OF TORTS § 283 reporter’s note (1966) (noting *Vaughan v. Menlove*, (1837) 132 Eng. Rep. 490 (C.P.) 490, was the first case to mention the notion of the reasonable man); see also *Warrington*, 300 N.Y.S. at 158 (“typical prudent man”); *Drown v. New Eng. Tel. & Tel. Co.*, 70 A. 599, 605 (Vt. 1908) (“prudent man”); *Osborne v. Montgomery*, 234 N.W. 372, 376 (Wis. 1931) (“reasonably prudent and intelligent man”); *Blyth v. Birmingham Waterworks Co.*, (1856) 156 Eng. Rep. 1047, 1049 (“reasonable man”).

Prosser and Keeton describe this “hypothetical paragon of virtue”<sup>11</sup> as

“the embodiment of all those qualities which we demand of a good citizen. He . . . invariably looks where he is going, and is careful to examine the immediate foreground before he executes a leap or a bound; . . . [he] will inform himself of the history and habits of a dog before administering a caress; . . . [he] uses nothing except in moderation, and even while he flogs his child is meditating only on the golden mean.”<sup>12</sup>

Descriptions like this make it obvious that the reasonable person is not the same as the average or typical person; yet it is just as obvious that, without a clear understanding of the concept’s role, the standard embodied by the reasonable person could become quite stringent.

To maintain the abstract quality of this actor despite the vivid Babbitt-like portrait created by such descriptions, it has been deemed important to speak only of how *the* reasonable person, or *a* reasonable person, would behave under the circumstances. This is in full accord with the abstract nature of this hypothetical actor. Yet we also know from the common law that “reasonable minds may differ.”<sup>13</sup> In one sense, what is really meant by the reasonable person is a measure of how *all* people should behave. The plaintiff in a common law negligence case must show that the defendant did not behave as the reasonable person would, and therefore acted negligently under the circumstances—in other words, *no* reasonable person would act as the defendant acted.<sup>14</sup> If reasonable minds differ about the propriety of given actions under particular circumstances, the plaintiff has not met the burden of proof that the action taken by the defendant was unreasonable under the circumstances, and there can be no liability.<sup>15</sup> However, to appeal directly and explicitly to *all* reasonable people could unacceptably personalize the reasonable person by inviting an empirical or statistical analysis. And as we know in bioethics, what *is* is not at

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11. Randall R. Bovbjerg, *Problems and Solutions in Medical Malpractice: Comments on Chapters Six and Seven*, in *THE LIABILITY MAZE: THE IMPACT OF LIABILITY LAW ON SAFETY AND INNOVATION* 274, 278 (Peter W. Huber & Robert E. Litan eds., 1991).

12. W. PAGE KEETON ET AL., *PROSSER AND KEETON ON THE LAW OF TORTS* § 32, at 174 n.9 (5th ed. 1984) (quoting A.P. HERBERT, *MISLEADING CASES IN THE COMMON LAW* 12–16 (1930)).

13. See 57A AM. JUR. 2D, *supra* note 1, §§ 570, 1270.

14. See RESTATEMENT (SECOND) OF TORTS §§ 281, 328A (1965); see also *id.* § 328A cmt. d.

15. *Id.* § 328A.

all the same as what *ought* to be.<sup>16</sup> Thus, appealing to all reasonable people in a standard negligence case could threaten the meaning of this largely “ought”-based standard by introducing “is”-based data. I do not intend here to inquire into the philosophy of negligence law, however. Instead, we will follow the reasonable person into *medical* negligence.

### B. *Informed Consent: The Switch from Actor to Patient*

The move from general negligence law to medical negligence law has important implications for the reasonable person, and those implications become even more interesting when we move to the legal doctrine of informed consent. In negligence law, it is important to recognize that the *behavior* of the defendant actor is at issue.<sup>17</sup> Similarly, in professional negligence, which includes medical malpractice, it is the *actions* of the professional that come under scrutiny.<sup>18</sup> The standard against which the actor is judged is that of the relevant professional under the circumstances—measured by expert testimony, professional guidance, etc.<sup>19</sup> In short, the reasonable professional replaces the reasonable person.<sup>20</sup> This professional standard applies in medical malpractice, which is simply the name given to negligence in the medical profession.<sup>21</sup>

Informed consent law has an unusual history, though. Early case law treated the physician’s failure to obtain the patient’s consent as a battery—a deliberate and unconsented-to touching.<sup>22</sup>

16. See DAVID HUME, A TREATISE OF HUMAN NATURE 469–70 (L.A. Selby-Bigge ed., Oxford Univ. Press 1896) (1738).

17. RESTATEMENT (SECOND) OF TORTS § 281(b).

18. See 61 AM. JUR. 2D *Physicians, Surgeons, Etc.* § 187 (2012); see also *Finley v. United States*, 314 F. Supp. 905, 911 (N.D. Ohio 1970) (applying Ohio law); *Complete Family Care v. Sprinkle*, 638 So. 2d 774, 777 (Ala. 1994); *Barris v. Cnty. of L.A.*, 972 P.2d 966, 970 (Cal. 1999); *Berdyck v. Shinde*, 613 N.E.2d 1014, 1020 (Ohio 1993).

19. RESTATEMENT (SECOND) OF TORTS § 299A; see 61 AM. JUR. 2D, *supra* note 18; see also *Mitchell v. United States*, 141 F.3d 8, 13 (1st Cir. 1998) (applying Massachusetts law); *In re Sealed Case*, 67 F.3d 965, 969 (D.C. Cir. 1995) (applying D.C. law); *Gorab v. Zook*, 943 P.2d 423, 427 (Colo. 1997); *Fusilier v. Dauterive*, 764 So. 2d 74, 78 (La. 2000); *Marshall v. Klebanov*, 902 A.2d 873, 879 (N.J. 2006); *Sheeley v. Mem’l Hosp.*, 710 A.2d 161, 165 (R.I. 1998); *Melton v. Medtronic, Inc.*, 698 S.E.2d 886, 892 (S.C. Ct. App. 2010).

20. See RESTATEMENT (SECOND) OF TORTS §§ 289 cmt. m, 299A; see also 57A AM. JUR. 2D, *supra* note 1, § 177.

21. 61 AM. JUR. 2D, *supra* note 18; see also, e.g., *Morrison v. MacNamara*, 407 A.2d 555, 560–61 (D.C. 1979). See generally WILLIAM L. PROSSER, HANDBOOK OF THE LAW OF TORTS § 32, at 161–66 (4th ed. 1971).

22. See, e.g., *Canterbury v. Spence*, 464 F.2d 772, 783 (D.C. Cir. 1972) (“It is the settled rule that therapy not authorized by the patient may amount to a tort—a common law battery—by the physician.”); 61 AM. JUR. 2D, *supra* note 18, § 149; see also *Bonner v. Moran*, 126 F.2d 121, 122 (D.C. Cir. 1941) (holding that surgery is a technical battery unless there is consent by the patient); *Mims v. Boland*, 138 S.E.2d 902, 906 (Ga. Ct. App. 1964) (explaining that a physician

Medical battery was therefore no different from deliberately knocking someone down in the street, but definitely different from knocking the same person down negligently. This meant that failing to obtain consent before treating a patient was the legal equivalent of striking the patient. In one respect, that made perfect sense, but in other respects, this treatment seemed to be a profound failure of respect for the medical profession. Thus, the legal doctrine moved from consent to *informed* consent and from battery (unconsented-to touching) to negligence (professional failure to provide necessary information).<sup>23</sup> Labeling the failure to provide information and obtain consent as negligent rather than intentional seemed more in accord with respect for the medical profession.<sup>24</sup> This, too, seems appropriate, but the change has other implications.

The elements of the negligence cause of action are, generally speaking, straightforward: duty, breach, causation, and damages.<sup>25</sup> The negligent actor breaches a duty of behavior—that is, fails to live up to the reasonable person standard—and the breach causes injury measurable in money damages.<sup>26</sup> Making informed consent a matter of medical negligence complicates this somewhat. The essence of informed consent is the requirement of information disclosure by the physician.<sup>27</sup> That disclosure must be measured against a professional liability standard.<sup>28</sup> If “reasonable” disclosure means the information disclosed by a reasonable physician, then informed consent fits a standard negligence formula: the reasonable professional serves as a measure of the disclosing physician’s liability.

But how does the breach of duty cause damages when what is measured by the professional standard is not the physical encounter

is guilty of battery if he treats another without that person’s consent); *Bakewell v. Kahle*, 232 P.2d 127, 129 (Mont. 1951) (“[A]n unauthorized operation is . . . an assault and battery . . .” (quoting *Physicians’ & Dentists’ Bus. Bureau v. Dray*, 111 P.2d 568, 569 (Wash. 1941))); *Nolan v. Kechjian*, 64 A.2d 866, 868 (R.I. 1949) (“[A]n operation without consent . . . constitutes a . . . battery . . .”); *Physicians’ & Dentists’ Bus. Bureau v. Dray*, 111 P.2d 568, 569 (Wash. 1941) (explaining that an unauthorized operation is a battery).

23. *Spar v. Cha*, 907 N.E.2d 974, 979 (Ind. 2009) (“Lack of informed consent to a harmful touching in medical malpractice cases was traditionally viewed as a battery claim. More recently, unless there is a complete lack of consent, the theory is regarded as a specific form of negligence for breach of the required standard of professional conduct.”); *Van Sice v. Sentany*, 595 N.E.2d 264, 267 n.6 (Ind. Ct. App. 1992); *Revord v. Russell*, 401 N.E.2d 763, 766 (Ind. Ct. App. 1980); 61 AM. JUR. 2D, *supra* note 18, § 148; see *KEETON ET AL.*, *supra* note 12, at 190.

24. See RUTH R. FADEN & TOM L. BEAUCHAMP WITH NANCY M. P. KING, *A HISTORY AND THEORY OF INFORMED CONSENT* 29–30 (1986).

25. RESTATEMENT (SECOND) OF TORTS § 281.

26. *Id.* § 328A.

27. See FADEN & BEAUCHAMP, *supra* note 24, at 29.

28. See RESTATEMENT (SECOND) OF TORTS § 299A.

with the patient—not the touching itself? If a physician recommends or undertakes a course of action with the patient's consent, but leaves out information the patient considers crucial, then the course of action itself—the touching—may or may not have met professional standards.<sup>29</sup> The surgery might have been perfectly performed, and the drug prescribed might clearly be the right drug.<sup>30</sup> But when the negligence lies not in the touching but in the information disclosed about the touching, the causation requirement introduces a complication. It is not enough to say that information was withheld from a patient. There must be adverse consequences.<sup>31</sup> In the medical setting, if the adverse consequences do not arise from improper performance, then they must arise from an adverse event that accompanies proper performance. In medicine, as we know, there can be adverse consequences from good performance. Virtually all medical treatments have expected side effects, and the materialization of an expected but undisclosed adverse effect can cause injury. Moreover, the outcome of a properly performed treatment may be acceptable to some but undesirable under the circumstances to others; that is, there could be more than one reasonable choice, but lack of information could have prevented the plaintiff patient from choosing freely.<sup>32</sup> When the negligence claimed lies in the physician's failure to disclose information, the causation requirement means that the patient must be able to demonstrate to the satisfaction of the trier of fact that, if the missing information had been provided, he or she would have made a different decision and thus would have avoided the adverse outcome that engendered the claim.<sup>33</sup>

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29. *Wilkinson v. Vesey*, 295 A.2d 676, 685 (R.I. 1972) (“[T]he doctrine of informed consent imposes a duty upon a doctor which is completely separate and distinct from his responsibility to skillfully diagnose and treat the patient’s ills.” (footnote omitted)); *see Flanagan v. Wesselhoeft*, 712 A.2d 365, 370 (R.I. 1998); 61 AM. JUR. 2D, *supra* note 18, § 150.

30. *Shabinaw v. Brown*, 874 P.2d 516, 520 (Idaho 1994) (“A physician can be liable for failure to obtain informed consent before treatment without being negligent in the actual treatment of the patient.”); *see Sherwood v. Carter*, 805 P.2d 452, 457 (Idaho 1991), *abrogated on other grounds by Verska v. Saint Alphonsus Reg’l Med. Ctr.*, 265 P.3d 502 (Idaho 2011); *Wilkinson*, 295 A.2d at 685; 61 AM. JUR. 2D, *supra* note 18, § 150.

31. *See* RESTATEMENT (SECOND) OF TORTS § 328A.

32. *See Cobbs v. Grant*, 502 P.2d 1, 9–10 (Cal. 1972); *Bloskas v. Murray*, 646 P.2d 907, 913 (Colo. 1982); *Sherwood*, 805 P.2d at 459; *Wilkinson*, 295 A.2d at 688.

33. *Spar v. Cha*, 907 N.E.2d 974, 979–80 (Ind. 2009) (“To succeed on a lack of informed consent action, the plaintiff must prove [inter alia] ‘. . . cause in fact, which is to say that the plaintiff would have rejected the medical treatment if she had known the risk . . . .’” (quoting 1 DAN B. DOBBS, *THE LAW OF TORTS* § 250 (2001))); *Thompson v. Gerowitz*, 944 N.E.2d 1, 6 (Ind. Ct. App. 2011); 61 AM. JUR. 2D, *supra* note 18, § 151.

Thus, there are now two actors—the defendant and the plaintiff—in each informed consent case (even outside jurisdictions applying comparative negligence or “last clear chance”), each of whose actions is being judged. And those actions are not of the standard sort common to ordinary negligence. The issue is not whether the physical performance of the agreed-upon service meets professional standards or not.<sup>34</sup> Instead, there are two closely related issues. First, has the necessary information been provided by the physician? Second, would the reasonable patient have chosen differently if properly informed?

Whether the necessary information has been provided can be judged in two ways: by a professional standard of disclosure or by a patient-based standard.<sup>35</sup> In the professional standard, what is disclosed must match what is deemed appropriate by the profession (which can be called the reasonable physician disclosure standard).<sup>36</sup> But as the court reasoned in the landmark *Canterbury v. Spence*<sup>37</sup> decision, a professional standard fails to take account of the needs and interests of patients and can effectively preclude liability if the profession simply circles the wagons.<sup>38</sup> So an information disclosure standard based on what patients reasonably need and want to know is essential. This can be called the reasonable patient disclosure standard.<sup>39</sup> Among the states that have enacted legislation

34. *Pluger v. Physicians Ins. Co. of Wis.*, No. 95-1886, 1996 WL 207792, at \*2 (Wis. Ct. App. 1996) (“The doctrine of informed consent focuses upon the reasonableness of a physician’s disclosures to a patient rather than the reasonableness of a physician’s treatment of that patient.” (quoting *Johnson ex rel. Adler v. Kokemoor*, 545 N.W.2d 495, 501 n.16 (1996))); see 61 AM. JUR. 2D, *supra* note 18, § 150.

35. See 61 AM. JUR. 2D, *supra* note 18, § 170.

36. See *Willis v. Bender*, 596 F.3d 1244, 1254 (10th Cir. 2010); *Telles-Hernandez ex rel. Hernandez v. United States*, 665 F. Supp. 2d 1064, 1077 (N.D. Cal. 2009); *Giles v. Brookwood Health Servs., Inc.*, 5 So. 3d 533, 554 (Ala. 2008); *Brumley v. Naples*, 896 S.W.2d 860, 865 (Ark. 1995); *Wilson v. Merritt*, 48 Cal. Rptr. 3d 630, 637 (Ct. App. 2006); *Stauffer v. Karabin*, 492 P.2d 862, 865 (Colo. App. 1971); *Brown v. Wood*, 202 So. 2d 125, 130 (Fla. Dist. Ct. App. 1967); *Sherwood*, 805 P.2d at 458; *Culbertson v. Mernitz*, 602 N.E.2d 98, 100 (Ind. 1992); *Stovall v. Harms*, 522 P.2d 353, 358 (Kan. 1974); *Rojas v. Barker*, 195 P.3d 785, 789 (Kan. Ct. App. 2008); *Foster v. Oral Surgery Assocs.*, 940 A.2d 1102, 1106 (Me. 2008); *Roberts v. Young*, 119 N.W.2d 627, 630 (Mich. 1963); *Collins v. Itoh*, 503 P.2d 36, 40 (Mont. 1972); *Giese v. Stice*, 567 N.W.2d 156, 162 (Neb. 1997); *Karlin v. IVF Am., Inc.*, 712 N.E.2d 662, 666 (N.Y. 1999); *Melton v. Medtronic, Inc.*, 698 S.E.2d 886, 894 (S.C. Ct. App. 2010); *Rizzo v. Schiller*, 445 S.E.2d 153, 155 (Va. 1994); *Weber v. McCoy*, 950 P.2d 548, 552 (Wyo. 1997); 61 AM. JUR. 2D, *supra* note 18, § 171.

37. 464 F.2d 772 (D.C. Cir. 1972).

38. *Id.* at 786.

39. The following cases and authorities provide an explanation of the patient-oriented standard. See *Unthank v. United States*, 732 F.2d 1517, 1521 (10th Cir. 1984) (applying Utah Law); *Craig v. Borcicky*, 557 So. 2d 1253, 1258 (Ala. 1990); *Harrold v. Artwohl*, 132 P.3d 276, 280 (Alaska 2006); *Spann v. Irwin Mem’l Blood Ctrs.*, 40 Cal. Rptr. 2d 360, 367 (Ct. App. 1995); *Miller v.*

governing informed consent to medical treatment, North Carolina stands out with its statute requiring that both standards be met. As North Carolina General Statute 90-21.13 states:

No recovery shall be allowed against any health care provider upon the grounds that the health care treatment was rendered without the informed consent of the patient or other person authorized to give consent for the patient where:

(1) The action of the health care provider in obtaining the consent of the patient or other person authorized to give consent for the patient was in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities; and

(2) A reasonable person, from the information provided by the health care provider under the circumstances, would have a general understanding of the procedures or treatments and of the usual and most frequent risks and hazards inherent in the proposed procedures or treatments which are recognized and followed by other health care providers engaged in the same field of practice in the same or similar communities.<sup>40</sup>

It is important to recognize that the reasonable person standard should be understood to require information that *all* reasonable people need in order to make a decision. Thus, if reasonable minds may differ, the only information that need not be disclosed is information that *no* reasonable person would need. Equally important, though, is what *Canterbury* said about the quantum of disclosure—all information material to the decision.<sup>41</sup> Here, materiality means information that the reasonable patient deems it important to have, which is more information than might be reasonably construed as dispositive.<sup>42</sup> That is, patients need—and use—more information than the quantum of information that ultimately anchors the decision in one of the several available

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Van Newkirk, 628 P.2d 143, 147 (Colo. App. 1980); *Sherwood v. Danbury Hosp.*, 896 A.2d 777, 788 (Conn. 2006); *Carr v. Strode*, 904 P.2d 489, 498 (Haw. 1995); *Doe v. Johnston*, 476 N.W.2d 28, 31 (Iowa 1991); *Pertuit v. Tenant La. Health Sys.*, 49 So. 3d 932, 935–36 (La. Ct. App. 2010); *Norwood Hosp. v. Munoz*, 564 N.E.2d 1017, 1021 (Mass. 1991); *Dunn v. Yager*, 58 So. 3d 1171, 1200 (Miss. 2011); *Acuna v. Turkish*, 930 A.2d 416, 425 (N.J. 2007); *White v. Leimbach*, 959 N.E.2d 1033, 1039 (Ohio 2011); *Isaac v. Jameson Mem'l Hosp.*, 932 A.2d 924, 929 (Pa. Super. Ct. 2007); *State v. Breen*, 767 A.2d 50, 58 (R.I. 2001); *Shadrick v. Coker*, 963 S.W.2d 726, 731 (Tenn. 1998); *Small v. Gifford Mem'l Hosp.*, 349 A.2d 703, 706 (Vt. 1975); *Brown v. Dibbell*, 595 N.W.2d 358, 366 (Wis. 1999); 61 AM. JUR. 2D, *supra* note 18, § 172.

40. N.C. GEN. STAT. § 90-21.13 (2013).

41. *Canterbury*, 464 F.2d at 786–87.

42. *See id.* at 787; Jon R. Waltz & Thomas W. Scheuneman, *Informed Consent to Therapy*, 64 NW. U. L. REV. 628, 640 (1970).

options. A reasonable patient might value knowing a great deal about the surgical procedure recommended by his or her physician, although only one or two crucial facts ultimately drive the choice between physical therapy and surgery. The “general understanding” language of the North Carolina statute is therefore consistent with the materiality standard.

Most significantly, the *Canterbury* court also reasoned that patients who have been injured are susceptible to judgment by hindsight.<sup>43</sup> For that reason, the court definitively separated the duty to provide material information from the causation element.<sup>44</sup> Patients who have experienced an adverse outcome are certainly likely to say, and often in all good faith to believe, not only that they wanted the missing information, but also that had they been given it, they would of course have made a different decision and thus avoided injury.<sup>45</sup> The court questioned the fairness of subjective patient-centered standards of both disclosure and causation, and required that both the disclosure standard (all information material to the decision) and the causation standard (a different decision would have followed from provision of all material information) should be judged according to the standard of the reasonable person in the patient’s position.<sup>46</sup> As the North Carolina statute notes in a third clause, there can also be no recovery if “[a] reasonable person, under all the surrounding circumstances, would have undergone such treatment or procedure had he been advised by the health care provider.”<sup>47</sup>

Now it should be clear that the informed consent doctrine views the physician-patient relationship as a meeting of reasonable minds. The first actor, the physician, may be judged according to whether his or her actions meet a professional standard, and also according to whether his or her disclosures meet a professional or a reasonable patient standard measuring the information deemed material to the choice.<sup>48</sup> But it is now also plain that the second actor—the patient—is being judged both according to the reasonableness of his or her decisions (to adhere to the physician’s recommendations or not) and according to the reasonableness of his or her needs and desires for information. In order to protect the physician from the patient’s hindsight, only the information that a reasonable person in the patient’s position would want or need has to be disclosed, and only if a reasonable person would have made a different decision if

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43. *Canterbury*, 464 F.2d at 790–91.

44. *Id.* at 790–92.

45. *Id.* at 790.

46. *Id.* at 787, 791.

47. N.C. GEN. STAT. § 90-21.13(a)(3) (2013).

48. See 61 AM. JUR. 2D, *supra* note 18, §§ 171–172.

properly informed can the patient claim that his or her injury was caused by the physician's failure to disclose.<sup>49</sup>

To reiterate, the problem here is saying *the* reasonable patient, or *a* reasonable patient. We know that reasonable minds may differ. We also know that the cultural realities of patient care are such that reasonable differences can be considerable. And finally, we know that the powerful influence of the physician in the physician-patient relationship can all too easily obscure to physicians the differences between their own views and the views of their patients about information and decision making. Even the most cursory examination of the literature addressing how physicians and nonphysician surrogates view the patient's best interests demonstrates this clearly.<sup>50</sup> Physicians tend to focus on the patient's best *medical* interests, and patients and their families nearly always consider medical interests in a much broader context: the patient as a person with a life, a history, preferences, and values that encompass far more than the medically best choice. Moreover, physicians often identify "rational" decision making as the ideal.<sup>51</sup> Some physicians may genuinely believe that no nonrational considerations enter into their own decisions, which they view as entirely driven by data. And some dismiss emotional and other nonmedical decision-making factors as simply irrational and therefore out of place.

It is critical to recognize that "reasonable" and "rational" are not synonyms. The quality of "rationality" artificially separates facts and emotions. In contrast, the quality of "reasonableness" includes consideration of the broad range of ordinary and appropriate factors that inform the choices of patients and their families, including their full complement of life experiences, preferences, values, and goals. Medical decisions are meant to serve the patient's goals, not to drive them.

For these reasons, it is absolutely essential to refer instead to *all* reasonable people in the position of the patient in order to properly understand the reasonable person standard in disclosure and, especially, in causation. Recall that the North Carolina statute states: "No recovery shall be allowed against any health care provider upon the grounds that the health care treatment was

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49. See *id.* §§ 151, 172.

50. See David S. Brody, *The Patient's Role in Clinical Decision-Making*, 93 ANNALS INTERNAL MED. 718, 718 (1980); Michelle Edwards et al., *What Are the External Influences on Information Exchange and Shared Decision-Making in Healthcare Consultations: A Meta-Synthesis of the Literature*, 75 PATIENT EDUC. & COUNSELING 37, 37, 50 (2009); Timothy E. Quill & Howard Brody, *Physician Recommendations and Patient Autonomy: Finding a Balance Between Physician Power and Patient Choice*, 125 ANNALS INTERNAL MED. 763, 763-64 (1996).

51. See Donald R. Woolever, *The Art and Science of Clinical Decision Making*, FAM. PRAC. MGMT., May 2008, at 31, 32-35 (explaining the kind of information physicians use to make decisions).

rendered without the informed consent of the patient”<sup>52</sup> if “a reasonable person, under all the surrounding circumstances, would have undergone such treatment or procedure”<sup>53</sup> if properly informed.

If the causation question is asked this way, it should be obvious that *a* reasonable person must be read as *all* reasonable people. Otherwise, the fact that some patients might reasonably make one choice and other patients might reasonably make a different choice would protect the physician from liability. Juries need to distinguish between one person who persuasively says, “I needed certain information that I was not given,” and a rule of thumb that would require physicians to provide all patients with certain information. But juries also need to acknowledge that the information provided by physicians needs to be sufficient to equip *all* reasonable patients to make a decision (while still excluding unreasonable information needs, about which the physician should not be expected to guess). At the same time, it is essential to recognize that the following semantic formulation of the question—“Would a reasonable person in the patient’s position have made the same decision with more information?”—can all too readily be answered in the affirmative. The trier of fact must understand that the defendant physician cannot be held liable if and only if *all* reasonable people would have made the same decision with additional information as surely as they would have without it. This is the only standard that protects the reasonable people who would have made different decisions.

To give a simplistic example, suppose that the information withheld is about a relatively low likelihood of a life-threatening complication from a potentially beneficial intervention. (This pretty much reflects the factual situation in *Canterbury*.<sup>54</sup>) There are plenty of people who could reasonably make either choice: to agree to undergo the intervention, or to avoid it in order to avoid any risk of complications. Unless the trier of fact is reminded that reasonable minds may differ, the mere fact that many reasonable people would choose the intervention regardless could prevent other reasonable people from having the opportunity to make a different choice.

This example also reminds us that what is most important about informed consent as a *legal* doctrine is its effect on the *ethics* and the *practice* of informing patients. Both the case law and statutes addressing informed consent address hindsight because informed consent cases always arise in hindsight.<sup>55</sup> The patient

52. N.C. GEN. STAT. § 90-21.13(a).

53. *Id.* § 90-21.13(a)(3).

54. *Canterbury v. Spence*, 464 F.2d 772, 776–78 (D.C. Cir. 1972).

55. *See, e.g., id.* at 791; *see also* Joan H. Krause, *Reconceptualizing Informed Consent in an Era of Health Care Cost Containment*, 85 IOWA L. REV. 261, 318 (1999) (noting that many states have adopted an objective test as a

from whom information is withheld simply will not know that any information was withheld unless and until something goes wrong. But in the real world of medical practice, in real physician-patient relationships, doctors need to learn how to inform their patients for a decision. Thus, the hindsight-oriented doctrine of informed consent gets turned around and taught to physicians in training as prescriptive: “Here’s what you should tell patients in order to help them decide.” The reasonable relationship changes from an after-the-fact test to a standard used to build that relationship from the beginning.

I use the term “reasonable” advisedly, knowing that it might be mistakenly treated as synonymous with “rational.” I use it because reasonable discussion—talking together—is essential to the physician-patient relationship. Long before any informed consent claim might be entertained, the physician has the duty to support and promote autonomous decision making by talking with patients about the choices they face.<sup>56</sup> Aware of the risk that reasonable could mean rational, Larry Churchill argued in the Symposium at which this Essay was presented that there are *no* reasonable patients.<sup>57</sup> I disagree, preferring to argue that *all* patients are reasonable, because all people are capable of engaging in meaningful discussion and decision making in a physician-patient relationship that is governed by the physician’s duty to inform, guide, and learn from patients.

Recognizing that the informed consent doctrine and its unique application of the reasonable person standard should apply prospectively to the building of decision-making relationships between physicians and patients, and putting that recognition into practice, are key factors that distinguish healers from physicians. And that’s how we get to something completely different: Alice Trillin’s story.

## PART II: THE STORY AND THE HEALER

In 1976, Alice Trillin was diagnosed with lung cancer. She wrote about her experience in a justifiably famous essay *Of Dragons and Garden Peas*, which was published in the *New England Journal of Medicine*.<sup>58</sup> In 1990, she was afraid it had returned. So were her

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means of overcoming hindsight bias); Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899, 919 (1994).

56. See FADEN & BEAUCHAMP, *supra* note 24, at 138.

57. See Larry R. Churchill, Joseph B. Fanning & David Schenck, *Five Threats to Patient-Centered Care*, 50 WAKE FOREST L. REV. 251 (2015); see also Larry R. Churchill, *The Place of the Ideal Observer in Medical Ethics*, 17 SOC. SCI. & MED. 897, 898 (1983).

58. Alice Stewart Trillin, *Of Dragons and Garden Peas: A Cancer Patient Talks to Doctors*, 304 NEW ENG. J. MED. 699, 699–701 (1981).

doctors. Her 2001 essay in the *New Yorker*, *Betting Your Life*,<sup>59</sup> is probably not quite as famous, but it should be. In it, she describes a series of decision-making relationships and decisions.

#### A. *The Reasonable Patient*

A combination of a cough, pleural effusions, back pain, and five lytic “lights”—apparent lesions—on a bone scan led several prominent specialists to conclude that Alice’s lung cancer, which had appeared cured after so many years, had metastasized to her spine. Each specialist recommended that Alice undergo immediate, drastic surgery to stabilize her spine. With the advice and guidance of one oncologist who had followed her since her treatment, and whom she trusted, Alice went to see yet another specialist.<sup>60</sup> “The first thing [he] did . . . was to give me a thorough examination. This was the first physical I’d had since this drama began; everyone else had just looked at the X-rays and scans.”<sup>61</sup>

Two exceedingly important things happened next. First, her physician told her: “If you had widely metastasized cancer, as the M.R.I. and scans seem to suggest, you shouldn’t feel this well, or look this well, either. . . . [M]y advice is that you give this some time, if you can stand it, and see how this develops.”<sup>62</sup> Many physicians have heard this adage: “Don’t just do something—stand there.”<sup>63</sup> For reasonable patients, a recommendation of “watchful waiting” may come as a relief—or it may be extremely difficult to bear. The controversy that has long surrounded prognosis for and treatment of prostate cancer stems in part from the knowledge that many men die *with* prostate cancer, but far fewer die *from* prostate cancer.<sup>64</sup> A type of breast cancer known as ductal carcinoma in situ is currently causing similar controversy for women.<sup>65</sup> We are

59. Alice Stewart Trillin, *Betting Your Life*, *NEW YORKER*, Jan. 29, 2001, at 38, 38–42.

60. *Id.* at 38–41.

61. *Id.* at 41.

62. *Id.*

63. *See id.* at 38.

64. *See* Michael J. Barry, *Screening for Prostate Cancer—The Controversy That Refuses to Die*, 360 *NEW ENG. J. MED.* 1351, 1351–52 (2009); Ruth Etzioni et al., *Overdiagnosis Due to Prostate-Specific Antigen Screening: Lessons from U.S. Prostate Cancer Incidence Trends*, 94 *J. NAT’L CANCER INST.* 981, 988–89 (2002); Eric J. Feuer et al., *Cancer Surveillance Series: Interpreting Trends in Prostate Cancer—Part II: Cause of Death Misclassification and the Recent Rise and Fall in Prostate Cancer Mortality*, 91 *J. NAT’L CANCER INST.* 1025, 1025, 1030 (1999); R.A. Stephenson, *Prostate Cancer Trends in the Era of Prostate-Specific Antigen: An Update of Incidence, Mortality, and Clinical Factors from the SEER Database*, 29 *UROLOGIC CLINICS N. AM.* 173, 173–81 (2002).

65. *See* Devon Bush et al., *The Non-Breast-Cancer Death Rate Among Breast Cancer Patients*, 127 *BREAST CANCER RES. & TREATMENT* 243, 243 (2011); Virginia L. Ernster et al., *Mortality Among Women with Ductal Carcinoma in*

conditioned, in matters of medicine, to act swiftly and decisively, but we also know all too well that watching and waiting is an important choice. The evidence is clear that both choices are usually dictated, at least in part, by personality and experience—and that both choices are often reasonable.

Next, Alice Trillin asked this physician, “What if it is cancer?”<sup>66</sup> He said this: “If it is, you will come back to me and I will tell you what we can do. I will also tell you what I think you should do, and then you can make up your mind.”<sup>67</sup> And that was when she knew she could—and would—trust him. With this answer, he provided her with more information than the other specialists had given her when recommending immediate surgery. He also acknowledged that there was more than one potentially reasonable choice and ensured that she understood the choice was hers. But that is just from the perspective of the legal doctrine. From the standpoint of the physician-patient relationship, he did much more. He acted as a healer.

As it turned out, Alice did not have a recurrence of cancer. Instead, what was showing on her scans was radiation necrosis, treatable in the same way that osteoporosis is treated.<sup>68</sup> But before they knew this, she and her husband, Calvin, discussed why they believed this physician and did not believe the physicians who had come to a different conclusion. After all, the facts—the test results, the measurable calculations, the alarming scans—had not changed.<sup>69</sup> Alice reflected that yes, she liked the advice from this most recent specialist better, so it was possible she believed him for that reason. In addition, however, she was inclined to believe him because she trusted him, and she trusted him because her intuitions about her own body accorded with his advice. And that, she speculated, was because he was able to place the facts and calculations into a broader context: the context of her own life and circumstances. In other words, the facts and calculations *had* changed after all. This healer had allowed her life, her circumstances, her sense of self, her intuitions about her body, and his intuitions about her to become part of his reasoning and judgment.<sup>70</sup> Those facts and contextual features, though not reducible to “hard” numbers, test results, or measurable things, clearly belong in the decision-making calculus.

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*Situ of the Breast in the Population-Based Surveillance, Epidemiology and End Results Program*, 160 ARCHIVES INTERNAL MED. 953, 953 (2000).

66. Trillin, *supra* note 59, at 41.

67. *Id.*

68. *Id.* at 42.

69. *Id.*

70. *See id.*

### B. *The Healing Relationship*

Now I will try to make a connection between my view of informed consent and the healing relationships that Larry Churchill and his colleagues write about,<sup>71</sup> and that Alice Trillin, other patients, and their physicians are fortunate enough to engage in. The connection lies in the difference between the legalistic reductionism of a fear-of-liability consent process and what Alice's doctor said to her: "I'll tell you what we can do and what I think you should do, and then you can decide."<sup>72</sup>

As I have already noted, the legal doctrine of informed consent is, essentially, backward facing. It is designed not to help physicians talk with their patients but to protect physicians from liability if their patients sue them after the fact. That is not useful in practice, of course. Physicians and medical students need to apply informed consent doctrine prospectively, which necessarily broadens its focus. Physicians must determine what information is material to the patient's decision even if it is not necessarily dispositive; they must understand the patient's circumstances fully; and they must encourage patients to ask questions and acquire additional information that could be material to them but that the physician might not have thought to disclose.

In addition, the reasonable person in negligence law generally reflects both the realities of social relations and a fundamental social morality—both the *is* and the *ought*. Thus, there is an important way in which the law often takes on a teaching role. The interesting tensions between the *is* and the *ought* in health care—between what medical information laypersons want to have and what information health care providers ought to give them, and between what patients choose and what their physicians recommend—are of ongoing concern in medical care. Lively controversy exists in specialized areas, such as the return of results and incidental findings in genomics. These controversies are based on differences between what geneticists and researchers consider important information and what patients, families, research subjects, and bioethics scholars think are reasonable expectations.<sup>73</sup>

71. See generally LARRY R. CHURCHILL, JOSEPH B. FANNING & DAVID SCHENCK, *WHAT PATIENTS TEACH: THE EVERYDAY ETHICS OF HEALTH CARE* (2013) (discussing healthcare ethics by analyzing interviews with patients about their relationships with healthcare providers); DAVID SCHENCK & LARRY R. CHURCHILL, *HEALERS: EXTRAORDINARY CLINICIANS AT WORK* (2012) (examining healing relationships through interviews with physicians).

72. Trillin, *supra* note 59, at 41.

73. See generally ACMG Bd. of Dirs., *Points to Consider in the Clinical Application of Genomic Sequencing*, 14 *GENETICS MED.* 759 (2012) (medical geneticists); Laura M. Beskow & Wylie Burke, *Offering Individual Genetic Research Results: Context Matters*, *SCI. TRANSLATIONAL MED.*, June 30, 2010, at 38cm20, 38cm20 (bioethics scholars discussing preferences of research subjects); Stephanie M. Fullerton et al., *Return of Individual Research Results from*

And that is just one controversy. The new and still developing perspective of patient-centered care is itself a testament to the ongoing challenge of melding the physician's and patient's perspectives. Turning informed consent from a mere shield into a teaching tool helps keep it from being limited to a provision of information about which there can be no disagreement. A narrow "just the facts, ma'am" posture is an obvious potential consequence of the rote application of the reasonable person standard to disclosure, and a position that devalues both the social context of medical care and the experiences and values of patients, while enshrining a narrow, "medico-centric" view of what information is necessary and proper.

In the history of medicine, two things are true about the physician-patient relationship: doctors and patients have been trying to come together for as long as the medical profession has existed, and at the same time, society really has not been doing this very long. The mere fact that, in North Carolina, physicians are legally required to meet both a professional standard of disclosure and a patient-centered standard is a testament to the complexity of an ostensibly simple relationship.<sup>74</sup> The similarities and differences in the physician-patient relationship across time, culture, and circumstances reinforce my main point: the tensions and balancing acts here are inherent and interesting, and they cannot be ignored.

What the healer said to Alice reflects perfectly both the way informed consent is a teacher and the way healers recognize two important distinctions: the difference between what can be done and what should be done, and the difference between the physician's medical recommendation and patient's best interests-based choice. With a simple statement, he showed her that he understood medicine's limits, and that he would never throw information at her without putting it into context. In this way, he distinguished himself clearly from the other specialists she had seen, who said only, "You should immediately do what I recommend." But he also distinguished himself from the many physicians who mistakenly believe that the only way to avoid that brand of parentalism is to

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*Genome-Wide Association Studies: Experience of the Electronic Medical Records and Genomics (eMERGE) Network*, 14 GENETICS MED. 424 (2012) (researchers); Robert C. Green et al., *ACMG Recommendations for Reporting of Incidental Findings in Clinical Exome and Genome Sequencing*, 15 GENETICS MED. 565 (2013) (medical geneticists and other health care providers); Christian M. Simon et al., *Informed Consent and Genomic Incidental Findings: IRB Chair Perspectives*, 6 J. EMPIRICAL RES. ON HUM. RES. ETHICS 53 (2011) (chairs of institutional review boards); Brian Van Ness, *Genomic Research and Incidental Findings*, 36 J.L. MED. & ETHICS 292 (2008) (researchers); Susan M. Wolf et al., *Managing Incidental Findings and Research Results in Genomic Research Involving Biobanks and Archived Data Sets*, 14 GENETICS MED. 361 (2012) (researchers).

74. See N.C. GEN. STAT. § 90-21.13 (2013).

provide a raft of information at arms' length—"it's your choice"—because they are afraid that they may unduly influence the patient's decision simply by making a recommendation.<sup>75</sup>

A physician who is a healer knows that a recommendation is an essential component of a patient's decision, but that it is only one component. Recommendations help patients make sense of the information. When communicated thoughtfully, recommendations also help model for patients how to combine their own experiences, preferences, and values with the perspectives of medicine to come to their own determinations of what is best.<sup>76</sup> The physician says, "Here is what you need to know." The patient responds, "Yes, and here is what I want to know." The physician then says, "Here is what I think you should do." And the patient is then able to put it all together and say, "Here is what I need to do." Perhaps most importantly, this understanding of the role of the physician's recommendation in the patient's decision-making process has a coda that is unspoken but unmistakable: "I will never abandon you."

#### CONCLUSION: HOW CAN HEALERS AND REASONABLE PATIENTS FIND EACH OTHER?

As Alice Trillin's conversation with her healer demonstrates, healers and reasonable patients do not find each other so much as they create each other. The conversation they share in the first meeting of a healing relationship permits the potential that is already present to come fully into being. What we need is a system that increases the opportunities for this creation.

As long as the ethics, law, and practice of informed consent encourage sensitive and frank discussion, not only about indisputable facts but also about what is uncertain and unknown, those opportunities are present. As long as we teach "physicians in training" to support and promote patients' decision-making capacities, and encourage patients to engage in active partnerships with their physicians, those opportunities are present. And whenever we remind ourselves that although health care is filled with uncertainty, physicians and patients can face uncertainty together, we help to create relationships in which both healers and patients can learn and grow.

Unfortunately, it is very easy to acknowledge these things. It is much more challenging to find and develop the requisite opportunities, because our health care "non-system" continues to grow ever more complicated, rigid, and driven by data without regard to context. The flourishing of healing relationships takes time—both from one encounter to the next, and also within each

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75. See CHURCHILL ET AL., *supra* note 71, at 138.

76. See *id.*

encounter.<sup>77</sup> It requires folding important, not-quite-measurable factors into the facts. It requires listening, looking, touching, and paying attention.<sup>78</sup> It requires good teachers, who can remind physicians in training to find the things that matter in the conversation.<sup>79</sup>

*Healers: Extraordinary Clinicians at Work* lists a set of eight practitioner skills that promote a healing relationship:

Do the little things (greet and introduce yourself to everyone present; smile, make eye contact, sit down; be human; give your undivided attention)

Take time

Listen

Be open and find a connection with the patient

Note power differentials and remove barriers

Let the patient tell the story

Share authority

Be committed and trustworthy.<sup>80</sup>

These practices can be lined up next to the components of the informed-consent doctrine: (1) disclose to the patient the nature and consequences of the recommended course of action, the risks of harm, and the available alternatives; and (2) support and promote the patient in making a decision that is informed and voluntary and that reflects substantial understanding of the information provided.<sup>81</sup> When they are examined together, it is quite clear that these two lists of critical factors are both complementary and synergistic. Both lists provide guidance for conducting individual encounters, shaping particular decisions, and building good relationships.

*What Patients Teach: The Everyday Ethics of Health Care* focuses on the meaning of being a patient, which involves:

Having a relationship with a clinician;

sharing with that clinician the intention to care for the health of the patient;

the threat of illness, or its reality;

the threat or reality of significant pain and/or suffering;

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77. See SCHENCK & CHURCHILL, *supra* note 71, at 152.

78. *Id.* at 23–24 tbl.1.2.

79. *Id.* at 185–89.

80. *Id.* at 23–24 tbl.1.2.

81. See FADEN & BEAUCHAMP, *supra* note 24, at 30–34.

and the horizon of death (whether near or far).<sup>82</sup>

Implicitly or explicitly, all patients are affected by, and all physician-patient relationships are governed by, those existential threats. That is exactly what Alice Trillin and the healer confronted in their informed consent discussion: “What if . . . ?”<sup>83</sup> she asked. And he, because he was watching and listening, knew what she was asking, made himself trustworthy, and promised her that they would face those threats together,<sup>84</sup> with what Churchill and his colleagues call “doubled agency”:<sup>85</sup> “I will tell you what we can do. I will also tell you what I think you should do, and then you can make up your mind.”<sup>86</sup>

Doing all this is much harder in modern medical care than it should be. Yet it is obvious how rewarding it can be for clinicians to open themselves to fully sharing patients’ goals and facing threats together in relationships that grow over time.<sup>87</sup> Nonetheless, out of all these meaning-making skills and practices, only the doctrine of informed consent is generally regarded as essential, because of its legal roots. My goal, then, is to show that the rest of this flourishing tree can grow from those roots.

Maybe the best way to demonstrate this is to remind ourselves, and each other, that acknowledgment matters; talking together matters; the stories we tell matter.<sup>88</sup> And most importantly, all the things that doctors and patients share in healing relationships are context, all are data, and, finally, all must ultimately affect the health care system, no matter how in love it is with statistics and deliverables. We simply have to ensure that the system we have is a system in which healing relationships can be created and can flourish. If we keep working to protect and promote healing relationships, they might even take hold and help recreate the system itself, from the roots up. That is, at least, a goal worth striving for.

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82. CHURCHILL ET AL., *supra* note 71, at 72 tbl.4.1.

83. *See* Trillin, *supra* note 59, at 41.

84. *Id.*

85. CHURCHILL ET AL., *supra* note 71, at 115.

86. Trillin, *supra* note 59, at 41.

87. *See* SCHENCK & CHURCHILL, *supra* note 71, at 204–10.

88. *See id.* at 12–13.