

The Legal and Historical Foundations of Patients as Medical Consumers

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INTRODUCTION

As Ted Ruger explains in his masterful intellectual history¹ there are multiple competing views of health care law. Under one view, which I term “essentialism,”² health care law is a distinctive academic field because the particular attributes of medicine and treatment relationships matter fundamentally, not just incidentally, to how law governs this field. According to this view, the core of health care law “consists of those aspects of law for which the unique features of medicine are central to the analysis or inquiry, rather than medicine simply being an incident of generic law’s subject matter.”³ The competing conceptualization, which has been denigrated as the “law of the horse” or the “law and a

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1. Theodore W. Ruger, *Health Law’s Coherence Anxiety*, 96 GEO. L.J. 625 (2008)

2. Mark A. Hall, *The History and Future of Health Care Law: An Essentialist View*, 41 WAKE FOREST L. REV. 347 (2006).

3. *Id.* at 361.

banana” view,⁴ is that much of health care law consists of nothing more than conventional rules from other legal fields as they apply to the services, actors, and institutions that happen to populate the medical arena.

The essentialist position is easiest to defend for the special rules that arise directly from the fiduciary attributes of the doctor-patient relationship, such as the laws of medical confidentiality, informed consent, and professional liability.⁵ One can reasonably question, however, whether the essentialist view is accurate throughout much of what commonly is taught, practiced, or thought of as health care law. Do the special attributes of medical relationships matter fundamentally, or even importantly, for contract, corporate, tax, or antitrust law? Determining which view of health care law is more correct would require a sweeping examination of the entire field that far exceeds the scope of any single article.⁶ For instance, one could start from the inner core of health care law and move outward, systematically measuring how strongly the special attributes of health, medicine, and the doctor-patient relationship radiate in diminishing levels of influence through the outer reaches of the field.

To avoid such exhaustive work, this Essay approaches from another direction. It considers the most mundane legal aspect of medical care—the patient’s obligation to pay for service. The simple payment obligation is where one would most expect the generic features of commercial law to predominate. Therefore, if we find that any of the special features of medical relationships influence this corner of health law, the claim that the deeply contextualized features of health care law permeate the field will have greater plausibility—much like an astronomer who finds evidence of the Big Bang in the outermost galaxies.

My way of framing this conceptual test is to examine whether law regards people who receive medical treatment more as patients than as consumers. Consumer status signifies the generic contractual aspects of a standardized professional service. A person who considers the need for medical service weighs the costs against the perceived benefit and seeks care from the provider that offers the best value,⁷ much like people go about deciding on automobile repairs. In contrast, a status as patient connotes dependency, suffering, and need

4. These labels are based on Frank H. Easterbrook, *Cyberspace and the Law of the Horse*, 1996 U. CHI. LEGAL F. 207, 207–08 and George J. Annas, *Health Law at the Turn of the Century: From White Dwarf to Red Giant*, 21 CONN. L. REV. 551, 553 (1989). For more on the “law of the horse” and health care law, see Richard A. Epstein, *The Erosion of Individual Autonomy in Medical Decisionmaking: Of the FDA and IRBs*, 96 GEO. L.J. 559, 560–61 & nn. 6–8 (2008).

5. See generally Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463 (2002).

6. For various views of other health law scholars, see, e.g., M. Gregg Bloche, *The Invention of Health Law*, 91 CAL. L. REV. 247 (2003); Peter D. Jacobson, *Health Law 2005: An Agenda*, 33 J.L. MED. & ETHICS 725 (2005); Symposium, *The Field of Health Law: Its Past and Future*, 14 HEALTH MATRIX 1 (2004); Symposium, *Rethinking Health Law*, 41 WAKE FOREST L. REV. 341 (2006).

7. See generally Judith H. Hibbard & Edward C. Weeks, *Consumerism in Health Care: Prevalence and Predictors*, 25 MED. CARE 1019 (1987).

for care.⁸ Patients, typically and quintessentially, are “sick, sometimes desperate, sometimes dying, seeking care, comfort, direction, and (sometimes life-saving) aid from others with the resources, special skills and knowledge to help.”⁹ These opposing characterizations make fundamentally different assumptions about people’s capacities when purchasing medical treatment.

Someone who is ill and seeking help—unlike someone who is purchasing a pair of socks or a pound of sausages—is often vulnerable, certainly worried, sometimes uncomfortable, and frequently frightened. [The term] [c]ustomer, like the other obvious choices—clients, consumers, and users—erases something that lies at the heart of medicine: compassion and a relationship of trust.¹⁰

Charging a fee is the most basic consumerist, transactional aspect of medical service. Therefore, we can learn a great deal about law’s attitude toward the patient/consumer tension by examining legal treatment of patients’ obligations to pay their medical bills. Family law scholar Jill Hasday explains that one of the “central ways that the law marks the intimacy of a relationship—recognizes its dignity and establishes its distinctiveness from other relationships—is by regulating how economic resources are exchanged within the relationship.”¹¹ For example, the “law’s regulation of economic exchange between intimates, which restricts but does not bar economic transfers, helps to define and construct the legal understanding of intimacy, and to mark the dignity and specialness of intimate relations.”¹²

Similarly, the inquiry here, for medical care, is: Do normal rules of contract apply between providers and patients, as if these were generic commercial transactions? The answer, in short, is no. Law has always regarded those who receive medical care much more as patients than as consumers. Like family law, medical law is as much about status as it is about contract. Patients’ and physicians’ contractual obligations are forged in the context of someone who is

8. “Patient” derives from the Latin *patiens*, which means “to suffer.” WEBSTER’S NINTH NEW COLLEGIATE DICTIONARY 863 (1988).

9. Lois Shepherd, *Assuming Responsibility*, 41 WAKE FOREST L. REV. 445, 450 (2006).

10. Raymond Tallis, Commentary, *Do We Need a New Word for Patients? Leave Well Alone*, 318 BRIT. MED. J. 1756, 1757–58 (1999); see also Hibbard & Weeks, *supra* note 7 (questioning whether patients are willing to act as consumers); Deborah Lupton, Cam Donaldson & Peter Lloyd, *Caveat Emptor or Blissful Ignorance? Patients and the Consumerist Ethos*, 33 SOC. SCI. MED. 559, 567 (1991) (critiquing the attempt to convert patients to medical consumers as inconsistent with “universal cultural beliefs in developed capitalist societies” about the desired relationship to physicians); Wendy K. Mariner, *Standards of Care and Standard Form Contracts: Distinguishing Patient Rights and Consumer Rights in Managed Care*, 15 J. CONTEMP. HEALTH L. & POL’Y 1 (1998) (outlining differences between patients and medical consumers); William M. Sage, *Relational Duties, Regulatory Duties, and the Widening Gap Between Individual Health Law and Collective Health Policy*, 96 GEO. L.J. 497 (2008).

11. Jill Elaine Hasday, *Intimacy and Economic Exchange*, 119 HARV. L. REV. 491, 496 (2005).

12. *Id.* at 493.

sick and vulnerable seeking care in a therapeutic relationship that entails special responsibility for the patient's welfare. This Essay documents how this contextualized view of medical transactions affects law's treatment of the most consumerist element of all—charging and collecting payment for service.¹³

I. CONSUMER-DRIVEN HEALTH CARE

The tension between patient status and consumer status has a long social history.¹⁴ Policy analysts began to think about the potential role of patients as customers in the 1930s, in response to the rapidly rising costs of medical care.¹⁵ Medical law and ethics embraced an implicit consumerist ethos starting in the 1960s, as an aspect of the patients' rights movement that challenged physician paternalism.¹⁶ The consumerist view gained additional force in the 1980s when public policy embraced market dynamics to restrain and rationalize medical expenditures.¹⁷ As debate ensued over the need to shield patients from various undesirable features of managed care that emerged from competitive health insurance, scholars focused on whether such laws should be expressed paternalistically, as patient protections, rather than in the more autonomy-enabling parlance of consumer rights.¹⁸

The backlash against managed care is now being expressed most forcefully in a movement trumpeted as "consumer-directed health care,"¹⁹ which seeks to reestablish the economic primacy of the direct doctor-patient relationship, free from interference by health insurers. In the simplest form, some physicians are converting to cash-only practices that refuse all forms of insurance, and major retail chains are opening in-store, walk-up clinics that offer limited menus of

13. One might expect that, by now, legal publications would have thoroughly canvassed these most elemental questions regarding one of the world's oldest professions. To the contrary, modern scholarship has been devoid until very recently of systematic analysis of the legal bases under which physicians and other providers seek to charge their patients. Largely because health insurance has covered the great majority of medical bills for the past half century, we lack any general legal or historical analysis of the contractual foundations of patients' relationships with doctors, hospitals, and other medical care providers. For more extensive analysis than space permits here, see Mark A. Hall & Carl E. Schneider, *Patients as Consumers? Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. (forthcoming Feb. 2008).

14. See generally Nancy Tomes, *Patients or Health-Care Consumers?: Why the History of Contested Terms Matters*, in HISTORY AND HEALTH POLICY IN THE UNITED STATES: PUTTING THE PAST BACK IN 83 (Rosemary A. Stevens et al. eds., 2006).

15. See generally, e.g., COMMITTEE ON THE COSTS OF MEDICAL CARE, MEDICAL CARE FOR THE AMERICAN PEOPLE (1932).

16. See GEORGE J. ANNAS, THE RIGHTS OF PATIENTS 77–78 (Eve Cary ed., 3d ed. 2004). See generally Tomes, *supra* note 14.

17. See generally, e.g., CLARK C. HAVIGHURST, HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM (1995).

18. See, e.g., George J. Annas, *A National Bill of Patients' Rights*, 338 NEW ENG. J. MED. 695, 696–97 (1998). See generally Mariner, *supra* note 10.

19. See generally TIMOTHY S. JOST, HEALTH CARE AT RISK: A CRITIQUE OF THE CONSUMER-DRIVEN MOVEMENT (2007); Amy B. Monahan, *The Promise and Peril of Ownership Society Health Care Policy*, 80 TUL. L. REV. 777 (2006).

basic services for everyday ailments.²⁰ More prominent in public policy is the increasing adoption of high-deductible “catastrophic” health insurance. Prompted by a new tax shelter for “health savings accounts,” employers and individuals increasingly are purchasing health insurance that requires subscribers to pay for much or most of their normal medical costs out-of-pocket.²¹ Most pervasively, virtually all forms of health insurance use varying levels of copayments (or coinsurance) to sensitize patients to the costs of treatment options. For instance, managed care plans charge people much more for using doctors or hospitals outside the contracted network, and the amount that patients must pay for prescription drugs varies several fold according to whether the drug is a generic or a non-preferred brand.

All of these techniques are meant to turn patients into consumers by placing them, rather than physicians, insurers, or the government, in the driver’s seat for making medical spending decisions.²² This consumer characterization is the emerging centerpiece of health care policy. Informed by their doctors or by their own research, and activated by their own financial interest, people with consumer-driven health insurance are expected to determine which items of health care are worth the cost and which are not, at each point of purchase in the health care delivery system.

While this consumerist ideology has taken on renewed prominence, it is not at all new to health policy. The patient/consumer duality is a permanent feature of medicine. Requiring patients to pay for their own health care is as old as medicine itself. Although the focus may shift dramatically from patient to consumer and back over time, the following section reveals that it has always been necessary to balance or accommodate both aspects of treatment relationships in some manner—not only in public policy, professional practice, and ethics, but also in law.

II. THE CONTRACTUAL FOUNDATIONS OF TREATMENT RELATIONSHIPS

A. PHYSICIANS’ FEES IN EUROPEAN LEGAL HISTORY

Throughout much of history, law has regarded medical care as something other than an ordinary business transaction. “In ancient Greece, taking money in exchange for providing life-saving services was grounds for electrocution by the gods.”²³ In both ancient Rome and in eighteenth-century England, physi-

20. See Frank Pasquale, *The Three Faces of Retainer Care: Crafting a Tailored Regulatory Response*, 7 YALE J. HEALTH POL’Y L. & ETHICS 39, 43–54 (2007); Ranit Mishori, *Is “Quick” Enough?*, WASH. POST, Jan. 16, 2007, at F1.

21. See generally M. Gregg Bloche, *Consumer-Directed Health Care*, 355 NEW ENG. J. MED. 1756 (2006).

22. See MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS 15–61 (1997).

23. Nancy M. Kane, *Tax-Exempt Hospitals: What Is Their Charitable Responsibility and How Should It Be Defined and Reported?*, 51 ST. LOUIS U. L.J. 459, 459 (2007). This characterization of the attitude in ancient Greece is based, however, on only a single incident—Zeus striking Asclepius (the

cians, like lawyers or barristers, had no legal right to bill for their services. Instead, they were either paid honoraria, or they received a government salary.²⁴ The fine points and reasons for this legal treatment differed among times and places, but an apparent shared sentiment was the inappropriateness of commercializing medical services.²⁵ Law in prior epochs often regarded the sale of medical services with a dim view similar to the one we have today about commodifying body parts used for medical (or any other) purposes.

Naturally, this does not mean physicians worked for free, only that “the fees of a physician are honorary, and not demandable of right.”²⁶ Physicians found a variety of other ways to realize their expectations for payment at different times and places.²⁷ But, regardless of the professional and social norms that governed the necessary financial element, both the common law and civil law originally did not regard paying for physician services as an ordinary commercial transaction. The prevailing legal attitude early in the nineteenth century is reflected in Thomas Percival’s enormously influential *Medical Ethics* (which initially was

founder of medicine) with a thunderbolt upon learning that he accepted bribes for resurrecting the dead.
Id.

24. See JOHN ORDRONAU, *THE JURISPRUDENCE OF MEDICINE IN ITS RELATIONS TO THE LAW OF CONTRACTS, TORTS, AND EVIDENCE* 10–14, 34–41 (Arno Press 1973) (1869); Catherine Crawford, *Patients’ Rights and the Law of Contract in Eighteenth-Century England*, 13 *SOC. HIST. MED.* 381, 392–95 (2000); Alexander B. Siegel, *Recent Decisions*, 8 *COLUM. L. REV.* 49, 58 (1908). The historical and legal bases for barring physicians from suing for fees has not been studied as thoroughly as it has been for lawyers. It appears that, in ancient Rome, accepting honoraria was an aspect of physicians’ stature among the liberal professions, which were of a higher social status than mere artisans. Also, there was a reciprocal social compact among Roman nobility that called on them to serve each other voluntarily. See BARRY NICHOLAS, *AN INTRODUCTION TO ROMAN LAW* 187–89 (1962); ROSCOE POUND, *THE LAWYER FROM ANTIQUITY TO MODERN TIMES* 51–55 (1953); REINHARD ZIMMERMANN, *THE LAW OF OBLIGATIONS: ROMAN FOUNDATIONS OF THE CIVILIAN TRADITION* 413–20 (1996). Medieval Roman law codified the ancient practice based in part on concerns that physicians were overcharging their patients. See THOMAS PERCIVAL, *MEDICAL ETHICS; OR, A CODE OF INSTITUTES AND PRECEPTS ADAPTED TO THE PROFESSIONAL CONDUCT OF PHYSICIANS AND SURGEONS* 175–76 (The Classics of Medicine Library 1985) (1803). In Renaissance England, the rule appears to be based more on the notion of legal recognition of professional norms; that is, refusing to find an implied promise to pay when the common practice at the time was to receive honoraria. However, it seems there was no rule barring physicians from making and enforcing an express contract. See *Rondel v. Worsley*, (1969) 1 A.C. 191, 237 (Morris, L.), 280 (Upjohn, L.) (H.L. 1967) (appeal taken from Eng.) (U.K.), *overruled by Arthur J.S. Hall & Co. v. Simons*, (2000) 3 All. E.R. 673 (H.L.) (appeal taken from Eng.) (U.K.); PERCIVAL, *supra*, at 177–78 (noting that courts could enforce fees agreed to by contract).

25. Samuel Coleridge, for instance, commented that

[Although] the honorary character of the fees of Barristers and Physicians . . . seems a shadowy distinction, I believe it . . . contributes to preserve the idea of a Profession—of a class belonging to the Public—in the employment and remuneration of which no law interferes, but the citizen acts as he pleases *in foro conscientiae*.

14 THE COLLECTED WORKS OF SAMUEL TAYLOR COLERIDGE: TABLE TALK I 330 (Carl Woodring et al. eds., 1990).

26. *Chorley v. Bolcot*, (1791) 100 Eng. Rep. 1040, 1041 (Kenyon, L., Ch. J.).

27. British physicians, for instance, could charge for medications if not for advice and care. Crawford, *supra* note 24, at 395. Also, they could, as barristers did, withhold their services unless patients volunteered a sufficient gratuity in advance. *Id.* at 394; see J.H. Baker, *Counsellors and Barristers, An Historical Study*, 27 *CAMBRIDGE L.J.* 205, 227–28 (1969).

entitled *Medical Jurisprudence*). Percival referred to physician payments with exceeding delicacy as “pecuniary acknowledgements” that physicians should expect to receive “as a point of honour.”²⁸

At the time, the medical terrain was divided quite differently, between practitioners of physic, also known as professors of medicine, and surgeons, who sometimes also treated animals.²⁹ The British restriction on charging for service applied only to physicians, owing to their higher professional and social stature,³⁰ and not to surgeons. Nevertheless, British law in earlier centuries regarded surgeons as being engaged in a “public calling.”³¹ This classification was used mainly to ease the plaintiff’s burden of proof in liability suits for personal injury,³² but it also carried with it an obligation to avoid unreasonable refusals of service.³³ Moreover, classification as a public calling required surgeons to limit fees to amounts that courts judged to be reasonable.³⁴

Thus, British common law regarded medical relationships as meriting special contractual treatment in several ways that both reflected and shaped prevailing social attitudes and market conditions. As summarized by medical historian Catherine Crawford, the

rights of English patients . . . [were] shaped in legal practice by prevailing notions of ethics . . . [as] defined by the expectations and views of the men who sat on juries Both the healing relationship and its cash nexus began with a contract, which was subject to the rule of law. If the market-place was fundamental to eighteenth-century English medicine, legal contracts and their social implications in turn shaped the market-place.³⁵

28. PERCIVAL, *supra* note 24, at 39–40. Percival also devoted an entire section of his appendix to discussing the British rule adopted from Roman law that precluded physicians from suing to collect fees. *Id.* at 174–79. Percival opposed the rule, arguing that the honorary stature of fees would not be diminished if suit were allowed because fees “would continue to be increased, at the discretion of the affluent, . . . and diminished, at the option of the physician, to those who may, from particular circumstances, require his beneficence.” *Id.* at 177–78.

29. Also, apothecaries prescribed as well as dispensed medications and so overlapped with physicians. See Darrin Baines & Catherine Hale, *New Apothecaries: How Pharmacists Can Protect Their Independence in the NHS*, 273 PHARMACEUTICAL J. 684, 684 (2004), available at <http://www.pjonline.com/Editorial/20041106/agenda/p684independence.html>.

30. See ORDRONAUX, *supra* note 24, at 10–14; Crawford, *supra* note 24, at 392; Siegel, *supra* note 24, at 58. Crawford documents that, by the end of the eighteenth century, surgeons and apothecaries frequently sued patients to collect their bills. See Crawford, *supra* note 24, at 383 n.7.

31. “[T]he curing of man or beast was considered a public calling.” 1 BRUCE WYMAN, *THE SPECIAL LAW GOVERNING PUBLIC SERVICE CORPORATIONS AND ALL OTHERS ENGAGED IN PUBLIC EMPLOYMENT* § 6 (1911).

32. At the time, when liability was established under the general writ of “trespass on the case,” there was not a clear distinction between tort and contract, so all liability actions required a showing of an “assumpsit” or undertaking to avoid harm or provide a certain level of care. For surgeons, and other “common callings,” it was not necessary to plead or show an explicit assumpsit because one was inferred from the general holding out to serve the public at large in a particular line of business. *Id.*

33. See *id.*

34. See Crawford, *supra* note 24, at 383–85.

35. *Id.* at 408–09.

B. THE CONTRACTUAL STATUS OF MEDICAL CARE IN THE U.S.

1. Conventional Contract Law

Most of the legal precedents just described were not retained when British law migrated to the American colonies. Here, medical services have always been squarely rooted in fairly standard contract and commercial law. In colonial Massachusetts, for instance, a five-judge superior court ruled that house calls by “physicians, their drugs and attendance, had as fixed a price as goods sold by a shopkeeper,” and that “the custom here had always been in such cases” to allow a contract action even though that would “not do” in England.³⁶ Nor were physicians regarded in the U.S. as members of a public calling.³⁷ A 1901 Indiana case, for example, held that in

obtaining the state’s license (permission) to practice medicine, the state does not require, and the licensee does not engage, that he will practice at all or on other terms than he may choose to accept. Counsel’s analogies, drawn from the obligations to the public on the part of innkeepers, common carriers, and the like, are beside the mark.³⁸

This U.S. rejection of British legal history did not create as sharp a contrast as first appears. These two histories developed in different spans of time. England abolished by statute in 1858 the common law rule that barred physicians from suing for fees,³⁹ and its treatment of surgeons as public callings occurred mainly in the fifteenth and sixteenth centuries.⁴⁰ American law, however, grew out of the industrial revolution, which, both in England and the United States, drove private law to a thorough embrace of freedom of contract.⁴¹ Nevertheless, these nineteenth-century *laissez faire* principles continue to govern U.S. physicians today. The 1901 Indiana case is still widely cited as stating the prevailing position, codified in the AMA’s Code of Medical Ethics

36. *Pychon v. Brewster* (Mass. 1776), reprinted in JOSIAH QUINCY JR., REPORTS OF CASES ARGUED AND ADJUDGED IN THE SUPERIOR COURT OF THE PROVINCE OF MASSACHUSETTS BAY, BETWEEN 1761 AND 1772 at 224–25 (Boston, Little, Brown, & Co. 1865). This was a suit by the executor of a physician’s estate for a “long doctor’s bill for medicines, travel into the country and attendance.” *Id.*

37. The only notable exception is in California, where one court found that the sole physician group in town was a public calling. See *Leach v. Drummond Med. Group, Inc.*, 192 Cal. Rptr. 650, 657–58 (Cal. Ct. App. 1983). No other courts have followed that decision. Notably, California far exceeds other states in extending public service law beyond a narrow set of historical precedents. Only it, for instance, regards health insurance as a business that “significantly affects the public interest” for purposes of applying a common law requirement of fair procedure on a private enterprise. See *Potvin v. Metro. Life Ins. Co.*, 997 P.2d 1153, 1160 (Cal. 2000).

38. *Hurley v. Eddingfield*, 59 N.E. 1058, 1058 (Ind. 1901).

39. Crawford, *supra* note 24, at 381, 394.

40. See Edward A. Adler, *Business Jurisprudence*, 28 HARV. L. REV. 135, 149–50 (1914); Bruce Wyman, *The Law of the Public Callings as a Solution of the Trust Problem*, 17 HARV. L. REV. 156, 157 (1903).

41. See generally MORTON J. HORWITZ, *THE TRANSFORMATION OF AMERICAN LAW, 1780–1860* (1977).

since 1912, that a “physician is free to choose whom he will serve.”⁴² The primary qualifications to this rule are themselves based on contract theories. For instance, a duty to accept patients can arise if patients are third-party beneficiaries of service agreements that physicians make with hospitals or health insurers.⁴³ Patients’ obligations to pay also are governed, for the most part, by normal commercial law. According to Professor Jacoby’s summary of modern law, “patients and providers assume legal rights and duties defined by a system of commercial debtor-creditor laws that generally cannot and do not account for the health-related origin of the debt or its implications for the debtor’s health.”⁴⁴

2. Deviations from Conventional Contract Law Governing Providers

Despite these conventional contractual foundations, there are several important respects in which U.S. law regards medical service differently than normal arm’s-length commercial transactions. First, although physicians have no legal obligation unless they first agree to accept a patient, the law applies a hair-trigger test for whether physicians (or hospitals) have in fact initiated care and therefore have voluntarily begun a treatment relationship. Actions as slight as talking to a patient, conducting a cursory examination, or scheduling an appointment have formed the basis for imposing treatment obligations on physicians.⁴⁵ This contrasts sharply with the rules governing legal services, which allow lawyers ample opportunity to meet with prospective clients and discuss a potential case before agreeing to take on the representation.⁴⁶ Medical law is much quicker to impose full-blown professional responsibilities because of the urgency and dependency with which many patients seek medical attention. As summarized by Professor Siliciano, “The quasi-fiduciary nature of the physician’s role, the vulnerability and possible incompetence of the patient, the exigency that often surrounds illness, and the tremendous complexity of modern medicine all serve to impair the prospects for effective bargaining over the scope and nature of treatment rendered by the physician.”⁴⁷

Another way courts relax normal contract rules is to enforce a *physician’s* contractual obligations even when the patient makes no reciprocal promise to pay for them, or indeed even when patients insist they cannot pay.⁴⁸ Physicians

42. R.B. BAKER ET AL., *THE AMERICAN MEDICAL ETHICS REVOLUTION* 347 (1999).

43. See *Hiser v. Randolph*, 617 P.2d 774, 777 (Ariz. 1980) (physician bound to accept emergency room patients under hospital’s rules); *St. Charles v. Kender*, 646 N.E.2d 411, 412 (Mass. App. Ct. 1995) (insurance subscriber is a third-party beneficiary of the insurer’s contracts with its physicians to be available to treat).

44. Melissa B. Jacoby, *The Debtor-Patient: In Search of Non-Debt-Based Alternatives*, 69 *BROOK. L. REV.* 453, 454 (2004).

45. See generally James L. Rigelhaupt, Jr., Annotation, *What Constitutes Physician-Patient Relationship for Malpractice Purposes*, 17 *A.L.R.4TH* 132 (1982).

46. See Hall & Schneider, *supra* note 13.

47. John A. Siliciano, *Wealth, Equity, and the Unitary Medical Malpractice Standard*, 77 *VA. L. REV.* 439, 446 (1991).

48. See *ORDRONAUX*, *supra* note 24.

are under the same legal obligations for both compensated and gratuitous treatment because courts do not regard monetary consideration as necessary to generate a contractually based duty of care.⁴⁹ Physicians' legal obligations take hold with the slightest manifestation of intent to treat despite the lack of normal consideration, and the content of such obligations is determined largely by mandatory norms regarding patients' rights and the standard of care, which physicians are not (by and large) free to alter by contract.⁵⁰ This set of common law rules broadly resembles those that once applied to common carriers and other public callings.⁵¹ Although physicians are not officially classified as such,⁵² they receive similar legal treatment in that most of their legal obligations arise independently from the terms of an agreement or normal contract doctrine.

Physicians, of course, are not the only providers of medical care. For hospitals, courts have sometimes ruled that they are private enterprises and therefore may "conduct [their] business largely as [they] see[] fit."⁵³ However, courts have devised inventive ways to impose treatment obligations on hospitals, such as finding (with little or no evidence) that patients rely on a hospital's perceived custom of not turning patients away in emergencies.⁵⁴ Moreover, a significant number of courts have embraced a much different characterization of hospitals than physicians regarding their quasi-public status. Courts in about half the states that have considered the issue have ruled that even private hospitals are businesses affected with a public interest, akin to the historical examples of innkeepers and common carriers, and therefore must act fairly in deciding which physicians to accept.⁵⁵ Although these public service rulings do not apply directly to hospitals' relations with patients, they apply to patients indirectly. The reason courts require hospitals to accept all qualified doctors is that being too restrictive would deny patients ready access to their personal physicians.⁵⁶

The quasi-public characterization of hospitals has rarely entered into caselaw

49. 23 WILLISTON ON CONTRACTS § 62:15 (4th ed. 2002).

50. See generally Maxwell J. Mehlman, *Fiduciary Contracting: Limitations on Bargaining Between Patients and Health Care Providers*, 51 U. PITT. L. REV. 365 (1990).

51. See WYMAN, *supra* note 31, §§ 4–6.

52. See *supra* note 37 and accompanying text.

53. *Wilmington Gen. Hosp. v. Manlove*, 174 A.2d 135, 137 (Del. 1961); see *id.* at 140 (finding that hospital liability may be imposed if the patient relied on the "well-established custom of the hospital to render aid in such a case").

54. See generally Karen Rothenberg, *Who Cares? The Evolution of the Legal Duty To Provide Emergency Care*, 26 HOUS. L. REV. 21 (1989).

55. See generally Craig W. Dallan, *Understanding Judicial Review of Hospitals' Physician Credentialing and Peer Review Decisions*, 73 TEMP. L. REV. 597 (2000).

56. See, e.g., *Greisman v. Newcomb Hosp.*, 192 A.2d 817, 824 (N.J. 1963) (explaining that, unless all qualified physicians are accepted, a patient's "personal physician would have no opportunity of participating [sic] in his treatment").

apart from physicians' challenges to their exclusion from medical staffs.⁵⁷ Perhaps this is because private hospitals themselves generally acknowledge and embrace their public service obligations as part of the industry's own self-imposed norms. These public service undertakings are necessary in order to receive the private accreditation that is a virtual requirement for avoiding financial ruin.⁵⁸ This self-imposed public service mission does not obligate hospitals to treat non-emergency patients for free, but it does oblige them to accept patients regardless of their source of payment, that is, regardless of whether they are paying out of pocket, through good insurance, or through the Medicaid program for the poor.⁵⁹

The most visible respect in which U.S. law alters the normal contractual status of medical care is to declare in a variety of contexts that physicians owe fiduciary-like duties to their patients. Multiple cases say something to the effect that

there is more between a patient and his physician than a mere contract under which the physician promises to heal and the patient promises to pay. There is an implied promise, arising when the physician begins treating the patient, that the physician will refrain from engaging in conduct that is inconsistent with the 'good faith' required of a fiduciary. The patient should, we believe, be able to trust that the physician will act in the best interests of the patient thereby protecting the sanctity of the physician-patient relationship.⁶⁰

These fiduciary qualities are cited as the basis for numerous special legal rules that reject a normal arm's-length relationship between doctors and patients. Prominent examples include the doctrine of informed consent, the confidentiality of medical information, the refusal to enforce waivers of liability, and the

57. A rare exception is *Payton v. Weaver*, 182 Cal. Rptr. 225, 230 (Cal. Ct. App. 1982), which considered whether a hospital may refuse to treat a disruptive patient. The court stated in dictum that a hospital "is arguably in the nature of a 'public service enterprise' and should not be permitted to withhold its services arbitrarily, or without reasonable cause," but it declined to impose a duty to treat because this argument had not been raised, and it would be unfair for a single hospital to bear the entire burden alone of ongoing treatment for a patient with serious chronic illness. See Stella L. Smetanka, *Who Will Protect the "Disruptive" Dialysis Patient?*, 32 AM. J.L. & MED. 53, 71-73 (2006). Once again, it is notable that this unusual decision comes from California. See *supra* note 37.

58. The standards of the hugely influential Joint Commission on Accreditation of Healthcare Organizations require, inter alia, that hospitals accept patients without discrimination and regardless of their source of payment. See MARK A. HALL, MARY ANNE BOBINSKI & DAVID ORENTLICHER, *HEALTH CARE LAW AND ETHICS* 118 (7th ed. 2007).

59. *Id.*

60. *Petrillo v. Syntex Labs., Inc.*, 449 N.E.2d 952, 961 (Ill. App. Ct. 1986). For description and analysis of this body of law, see PETER D. JACOBSON, *STRANGERS IN THE NIGHT: LAW AND MEDICINE IN THE MANAGED CARE ERA* 222-49 (2002); Maxwell J. Mehlman, *Dishonest Medical Mistakes*, 59 VAND. L. REV. 1137, 1147-49 (2006); Frances Miller, *Secondary Income from Recommended Treatment: Should Fiduciary Problems Constrain Physician Behavior?*, in *THE NEW HEALTH CARE FOR PROFIT: DOCTORS AND HOSPITALS IN A COMPETITIVE ENVIRONMENT* 153, 153-68 (Bradford H. Gray ed., 1983).

prohibition of lawyers' *ex parte* contacts with opposing parties' physicians.⁶¹

For hospitals, the fiduciary characterization is less prominent in the case-law,⁶² but it is supported by several academic commentators.⁶³ A few courts have held that hospitals have fiduciary duties to disclose medical errors to patients⁶⁴ and to not unreasonably exclude physicians.⁶⁵ Even if hospitals are not classic fiduciaries, courts recognize patients' vulnerabilities by refusing to enforce contracts with hospitals to waive liability, or (sometimes) to arbitrate disputes.⁶⁶ One California court, for instance, explained that, "[t]o the ordinary person, admission to a hospital is an anxious, stressful, and frequently a traumatic experience . . . [in which the patient] normally feels he has no choice but to . . . accede to all of the terms and conditions for admission, including the signing of all forms presented to him."⁶⁷ To believe otherwise would "require us to ignore the stress, anxiety, and urgency which ordinarily beset a patient seeking hospital admission."⁶⁸

III. PATIENTS' OBLIGATION TO PAY

We turn next to the contractual rudiments for patients. While providers are covered by a thicket of contractual, tort, and fiduciary obligations, patients are

61. See HALL, BOBINSKI & ORENTLICHER, *supra* note 58, at 161, 175, 197, 348.

62. See, e.g., *Sherwood v. Danbury Hosp.*, 896 A.2d 777, 797 (Conn. 2006) ("The plaintiff has provided scant reason to conclude that a hospital owes a patient the duty of a fiduciary.").

63. See, e.g., Robert Gatter, *The Mysterious Survival of the Policy Against Informed Consent Liability for Hospitals*, 81 NOTRE DAME L. REV. 1203, 1268–70 (2006) ("As hospitals have taken on responsibilities to organize the delivery of health care to their patients, they enter into fiduciary relationships with each of their patients as well."); Mehlman, *supra* note 50, at 366 n.6 ("Hospitals, as health care providers, must also fulfill the obligations imposed by their fiduciary relationship with their patients.").

Some commentators also characterize health insurers as fiduciaries for certain purposes. See, e.g., JACOBSON, *supra* note 60, at 222–49; Clifford A. Cantor, *Fiduciary Liability in Emerging Health Care*, 9 DEPAUL BUS. L.J. 189, 212 (1997); Peter D. Jacobson & Michael T. Cahill, *Applying Fiduciary Responsibilities in the Managed Care Context*, 26 AM. J. L. & MED. 155, 157 (2000).

64. These duties arise in the context of tolling the statute of limitations based on fraudulent concealment. See, e.g., *Keithley v. St. Joseph's Hosp.*, 698 P.2d 435, 439 (N.M. Ct. App. 1984) (stating that a hospital's and physician's breach of their fiduciary duty to disclose medical information to patients may toll the statute of limitations).

65. See, e.g., *Silver v. Castle Mem'l Hosp.*, 497 P.2d 564, 570–71 (Haw. 1972) (a "hospital occupies a fiduciary trust relationship between itself, its [physician] staff and the public it seeks to serve"); *Greisman v. Newcomb Hosp.*, 192 A.2d 817, 824–25 (N.J. 1963) (a hospital's authority to exclude physicians is "rightly viewed . . . as [a] fiduciary power[] to be exercised reasonably and for the public good"). Professor Dallan, however, questions this characterization, noting that, in this context, patients do "not entrust hospitals with any confidential information or property, nor does the hospital make decisions on behalf of the public. A hospital's credentialing decisions are made based on the interests of the hospital itself." Dallan, *supra* note 55, at 666.

66. See HALL, BOBINSKI & ORENTLICHER, *supra* note 58, at 161, 422.

67. *Wheeler v. St. Joseph Hosp.*, 133 Cal. Rptr. 775, 786 (Cal. Ct. App. 1976) (refusing to enforce an agreement to arbitrate).

68. *Id.* at 789.

subject only to the simple obligation to pay.⁶⁹ Here too, contract law makes several adjustments to accommodate the special circumstances of medical care. For instance, patients must pay for their treatment even if they never agreed to do so, and even if it was impossible for them to agree because of incompetence.⁷⁰ Emergencies require that quasi-contracts substitute for actual agreements; otherwise, providers might be less willing to respond to emergencies.⁷¹ Therefore, when a patient is incapacitated the law resorts to the doctrine of quantum meruit to impose a payment obligation, even without any request.⁷² The “necessaries” doctrine requires parents or guardians to pay for treatment rendered to minors or incompetent patients, again despite any agreement to be financially responsible.⁷³

For more typical situations of adult patients receiving routine care, the law prior to 1960 allowed physicians to charge patients widely different amounts for the same services based on patients’ differing abilities to pay.⁷⁴ In so doing, courts explicitly rejected the contention that the value of medical services

can be rightly determined by regarding the physician’s and surgeon’s professional services as involving no elements differing from a merchant selling a yard of cloth or a laborer digging a ditch. Such a view disregards the essential purpose of the employment of the physician or surgeon, which is to relieve the pain, restore the health, avert the death, and prolong the life of a human being.⁷⁵

Instead, courts reasoned that

physicians should not have their services valued, as you would commodities in trade, by a fixed standard; what would be a proper charge for the same service to a man fully able to pay would be excessive to a man of limited means, and what would be willingly done for the indigent, without thought of financial reward, should be compensated for by one who can afford to pay on the scale which doctors of repute measure as the proper one. Only on such a

69. It is sometimes said that patients are also under an obligation to behave reasonably, such as by telling their doctors the truth and following their recommendations. But these are not primary obligations of the treatment relationship because the only consequence for their breach is possibly to limit patients’ ability to recover for medical injury. See Carol J. Miller, Annotation, *Patient’s Failure To Reveal Medical History to Physician as Contributory Negligence or Assumption of Risk in Defense of Malpractice Action*, 33 A.L.R.4TH 790, 792 (1984).

70. See WILLISTON ON CONTRACTS, *supra* note 49, § 62:15.

71. See RICHARD A. POSNER, *ECONOMIC ANALYSIS OF LAW* 134–35 (7th ed. 2007).

72. See Haavi Morreim, *High-Deductible Health Plans: New Twists on Old Challenges from Tort and Contract*, 59 VAND. L. REV. 1207, 1249–50 (2006).

73. See Melissa B. Jacoby & Elizabeth Warren, *Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress*, 100 NW. U. L. REV. 535, 567–68 (2006).

74. See, e.g., D.E. Evins, Annotation, *Ability To Pay as Factor in Determining Reasonableness of Charge of Physician or Surgeon*, 97 A.L.R.2D 1232 (1964); J.W. Holloway, Jr., *Physician’s Fees in Relation to Wealth of Patient*, 23 AM. MED. ASSOC. BULL., Mar. 1933, at 49, 49–52 (reviewing caselaw).

75. *Caulk v. Anderson*, 37 S.W.2d 1008, 1009 (Tex. 1931).

basis can those who devote their lives to ministering to human suffering in some degree be fairly paid.⁷⁶

Although this body of law no longer applies,⁷⁷ modern law treats the basic payment obligation specially in other ways. Patients must pay for medical care even when there is no real basis for inferring a particular price term. The same implied contract that obligates a physician to continue care he has undertaken also obligates the patient to pay for the care, regardless of its success.⁷⁸ The law could in theory be more demanding about requiring some basis for inferring actual price terms, but doing so would conflict with widespread and longstanding professional and industrial practices (discussed elsewhere⁷⁹) of providers and patients not wanting, or being able, to discuss costs prior to treatment. Recognizing these special circumstances, the law implies or imposes contractual obligations on both parties regardless of actual contractual formalities.

CONCLUSION

In summary, law regards medical care as forming what Melvin Eisenberg calls a “thick relationship,” one “characterized by an involvement that is personally intensive, broad in scope, and potentially long-lasting.”⁸⁰ Courts assert more heavy-handed control of the substantive content of such relationships because, as Professor Eisenberg explains, the “limits of cognition are especially troublesome in the context of contracts to govern thick relationships.”⁸¹ Accordingly, while U.S. law has always grounded medical treatment relationships in contract law, the doctrinal particulars are far from standard commercial fare.

A medical provider’s obligations, rather than being determined primarily by contract, can be best thought of as a bundle of mandatory duties wrapped by a contractual skin. The beginning and ending of treatment relationships are nominally determined by contract principles, but most of the content of a

76. *Pfeiffer v. Dyer*, 145 A. 284, 285 (Pa. 1929) (allowing a surgeon to bill \$3000, much more than normal, for a successful life-saving operation).

77. See Hall & Schneider, *supra* note 13.

78. See David A. Hyman & Charles M. Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 90 CORNELL L. REV. 893, 966 (2005).

79. Hall & Schneider, *supra* note 13.

80. Melvin Aron Eisenberg, *The Limits of Cognition and the Limits of Contract*, 47 STAN. L. REV. 211, 251 (1995).

81. *Id.* Professor Eisenberg elaborates:

The nature of thick relationships makes it virtually impossible to predict, at the time the contract is made, the contingencies that may affect the relationship’s future course. Furthermore, at the time the contract is made, each party is likely to be unduly optimistic about . . . the willingness of the other party to avoid opportunistic behavior or unfair manipulation of the relevant contractual rules as the relationship unfolds.

Id. at 51–52.

medical provider's obligation is determined by substantive rules of tort and fiduciary law (such as medical malpractice, informed consent, and confidentiality) that are attuned to the interpersonal dynamics and psychological realities of medical treatment relationships. Even the contractual shell differs substantially from normal commercial law. The initiating event does not consist of offer, acceptance, and consideration. Owing to patients' vulnerability and dependence, medical law is quick to infer the start of a professional relationship simply by a physician manifesting intent to undertake some aspect of care for a patient. And, physicians may not cease their undertaking in a way that would harm patients.⁸² During the course of the implicit contract, providers are bound by a thick rope of largely non-negotiable legal duties whose content is based explicitly on the substantive realities of people who are ill and seeking care from medical professionals.

In these various ways, U.S. law has always regarded those who receive medical care much more as patients than as consumers. To this extent, the core of medical law, like family law, is as much about status as about contract. As summarized by Professor Mariner:

the laws generally applicable to consumers differ in significant respects from those applicable to patients Although in the nineteenth century Sir Henry Maine characterized "the movement of progressive societies [as] a movement from Status to Contract," the rights of patients in the twentieth century developed because of their unequal status in a relationship with a medical professional. Today, this inherent imbalance in knowledge and skill remains a defining characteristic of the physician-patient relationship.⁸³

Seeing that the special features of treatment relationships hold sway in even the most transactional parts of medical law provides strong support to the essentialist view of health care law sketched at the outset of this Essay. We learn that law takes account of illness, vulnerability, trust, and professionalism not just in the most sensitive areas of confidentiality, liability, and fiduciary duty. These universal features of medical care permeate the field, touching even the most commercialized aspects of patients' contractual relationships with providers. They give health care law its scope and coherence—helping to identify its core and articulate its legal and public policy significance.

82. See C.T. Drechsler, Annotation, *Liability of Physician Who Abandons Case*, 57 A.L.R.2D 432, 437 (1958); LEON L. MCINTIRE, COMMENT, *THE ACTION OF ABANDONMENT IN MEDICAL MALPRACTICE LITIGATION*, 36 TUL. L. REV. 834, 835–36 (1962).

83. Wendy K. Mariner, *Can Consumer Choice Plans Satisfy Patients? Problems with Theory and Practice in Health Insurance Contracts*, 69 BROOK. L. REV. 485, 492 (2004); see also Janet L. Dolgan, *Debating the Conflicts: Medicine, Commerce, and Contrasting Ethical Orders*, 35 HOFSTRA L. REV. 705, 706–17 (2006).