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Making an Offer That Can't Be Refused: The Need for Reform in the Rules Governing Informed Consent and Doctor-Patient Agreements

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MAKING AN OFFER THAT CAN'T BE REFUSED: THE NEED FOR
REFORM IN THE RULES GOVERNING INFORMED CONSENT
AND DOCTOR-PATIENT AGREEMENTS

TIMOTHY C. MACDONNELL*

ABSTRACT

On a daily basis, throughout the country, patients are required to sign informed consent forms regarding the care they receive from their doctors. Informed consent forms are an important part of ensuring patients are making an intelligent, autonomous decision regarding their healthcare based on the facts related to their particular situation. However, frequently these consent forms contain what amount to contract-like terms that require patients to permit doctors to substitute other healthcare providers to care for the patient under the doctor's supervision (substituted caregiver terms). Often these terms are presented to patients on the eve of surgery and on a take-it-or-leave-it basis.

This approach to informed consent is wholly wrong and harmful to the trust necessary to the doctor-patient relationship. The doctrine of informed consent is intended to aid and empower patients when making healthcare decisions, not benefit doctors and hospitals. The practice described above, requiring patients to sign consent forms that benefit doctors or hospitals, is contrary to various doctrines associated with contract law, fiduciary duties, and medical ethics. Further, this approach can interfere with the doctor-patient relationship.

It can be argued that substituted caregiver terms serve important societal interests. When viewed in the best light, substituted caregiver terms allow doctors, hospitals, and medical schools to train the next generation of doctors. When viewed from a different perspective, the terms benefit doctors and hospitals because the terms allow doctors and hospitals to make more money.

Because the current approach to informed consent employed by some doctors and hospitals is inconsistent with concepts of fairness contained in contract law, fiduciary duties, medical ethics, and is destructive to the trust necessary to an effective doctor-patient relationship, this article proposes a different approach. This approach would require a clear delineation of the various documents in the doctor-patient relationship. These documents include: the contract; Health Insurance Portability and

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Accountability Act (HIPAA) disclosure; conflict or potential conflict of interest; and informed consent. Further, to enhance patient understanding, each document would be explained to the patient in a face-to-face meeting. This Article's proposal permits doctors and hospitals to include substituted caregiver terms, but these terms must be optional and be included in the doctor-patient contract. Absent an emergency, doctors and patients would sign these contracts at the beginning of the doctor-patient relationship. Finally, informed consent forms would be used strictly to aid patients in understanding the risks and rewards of a particular procedure and the risks and rewards of appropriate alternatives.

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INTRODUCTION

Michael Corleone: So my father went to see this bandleader and offered him \$10,000 to let Johnny go, but the bandleader said no. So the next day, my father went back, only this time with Luca Brasi. Within an hour, he had a signed release for a certified check of \$1,000.

Kay Adams: How did he do that?

Michael Corleone: My father made him an offer he couldn't refuse.

Kay Adams: What was that?

Michael Corleone: Luca Brasi held a gun to his head, and my father assured him that either his brains or his signature would be on the contract.¹

IMAGINE yourself having difficulty hearing out of one of your ears. You go to your primary care doctor and discover that your ear canal is obstructed by something. As time passes, you eventually lose all hearing in the affected ear. Your primary care doctor refers you to a specialist at the local teaching hospital. You go to your appointment with the specialist, and she tells you that the bones in your ear canal have grown together. To make matters worse, the bones in your other ear are also growing together, albeit at a slower rate. You assume this must be a fairly common occurrence and ask the specialist how often she has encountered this condition. Your doctor tells you that the extent of your condition is unusual, and the doctor has only encountered a handful of cases as bad as yours in her thirty-year career. After several appointments and attempts to abate the problem, the specialist recommends surgery.

You ask what is involved in the surgery. You are informed that you will be placed under general anesthesia. The specialist will cut around the top of your ear and fold the ear down, exposing the ear canal. Next, the surgeon will use a drill to remove the bony growths in the ear. Then, the tissue around the eardrum will be sutured and the outer ear will be reattached. The doctor explains the dangers of the surgery, including the possibility of death and deafness in the affected ear. You ask a few questions, including how many of these surgeries the doctor has done and her success rate. She informs you that she has done this procedure less than five times and all those outcomes were favorable (the patients had improved hearing after the surgery). You ask the doctor if you should seek a specialist who has done the procedure more frequently, but your doctor informs you that your condition is so uncommon that she does not know any other doctors with more experience doing this procedure. After examining your options, you agree to the surgery and make arrangements to be out of work for a day or two.

A week before the surgery, you go to the specialist's office for a final appointment before the procedure. After speaking with the specialist, a

1. THE GODFATHER (Paramount Pictures 1972).

nurse comes into the examining room and gives you a “Consent to Treatment” form. You read the form. While reading you see a term that states:

I understand that my doctor may choose other qualified practitioners, including residents (doctors who have finished medical school and are getting more training in an effort to become certified in a particular field of medicine), to do or help with procedures. These practitioners may perform significant surgical tasks, including: opening and closing incisions, harvesting grafts, dissecting tissue, removing tissue, implanting devices, and altering tissues.²

Since this is an unusual procedure and it involves the use of a drill in your skull, you are uncomfortable permitting anyone but the surgeon you have been meeting with to do your surgery. Because you do not want to agree to this term, you draw a line through the offending clause. The nurse comes to retrieve the form and sees the lined through item. She asks: “What is this?” You explain that you do not consent to the lined through items. The nurse tells you that she does not think you are permitted to alter the form. You ask to speak to the doctor. The doctor comes in and states that she understands your concern about having a resident do part of the surgery. She then explains that in order to train the next generation of doctors, teaching hospitals must be allowed to have doctors-in-training practice under the supervision of more experienced doctors. You tell your doctor that you understand the need and you do not object to student doctors observing the operation, but given that the doctor herself has done the procedure less than five times and the operation involves one of your sensory organs, you do not want anyone but the specialist conducting the procedure. The doctor then tells you she is not sure how to proceed because the facility is a teaching hospital and the policy is to have residents participate.³ A pause occurs, you are not sure what to do.

2. See Richard Shapiro, *Surgical Mistakes and Informed Consent: Everything You Don't Know but Should*, L. EXAM'R: VA. BEACH INJ. L. NEWS (Dec. 10, 2018), <https://virginiabeach.legalexaminer.com/legal/legal-issues/surgical-mistakes-and-informed-consent-everything-you-dont-know-but-should/> [https://perma.cc/NEG8-Z37Q]. For other examples of informed consent form language, including from the University of Pittsburgh Medical Center Group and University of California Medical School, see UNIV. PITT. MED. CTR., *CONSENT TO SURGERY* (Aug. 9, 2017), <https://www.upmc.com/-/media/upmc/locations/hospitals/hamot/patients-visitors/before-your-stay/documents/consent-to-surgery.pdf?la=en&hash=4AD0973470D75BD1F939AA7AE0F22BE9D20F1C00> [https://perma.cc/TFB4-V5F7]; UCLA HEALTH, *Consent for Surgery or Special Diagnostic or Therapeutic Procedure(s)*, <https://www.uclahealth.org/neurosurgery/Workfiles/Site-Neurosurgery/Consent-Sx.pdf> [https://perma.cc/CSY2-WMWZ] (last visited July 12, 2022). See also Steven Petrow, *Who Owns Your Medical Data? Most Likely Not You.*, WASH. POST (Nov. 25, 2018, 8:00 AM), https://www.washingtonpost.com/national/health-science/who-owns-your-medical-data-most-likely-not-you/2018/11/23/28785efc-e77d-11e8-a939-9469f1166f9d_story.html [https://perma.cc/8SQH-H9PY].

3. See Brendan M. Reilly, *Don't Learn on Me—Are Teaching Hospitals Patient-Centered?*, 371 NEW ENG. J. MED. 293, 293–95 (2014).

You propose that the doctor agree to handle the part of the surgery involving the drill. The doctor agrees, and you sign a new unredacted consent form.

As you leave the appointment, you cannot help feeling like there was something wrong with the process you just experienced. What would have happened if you did not read the form as closely as you did? You have met with the doctor several times and discussed surgery on those occasions. Should not someone have told you at the beginning of the process that the doctor you trusted might only be coaching a different doctor during your procedure? Should not the doctor have volunteered exactly what she would be doing verses the resident? You also wonder how many patients want to have a potentially contentious conversation with the doctor who is about to perform surgery on them. The way the consent form process was treated, you felt you had to take-it-or-leave-it—and that did not seem fair.⁴

The approach of some doctors and hospitals today regarding patient consent often leaves patients feeling they are in a take-it-or-leave-it situation. In fact, this is exactly how one doctor described the situation in a 2014 article in the *New England Journal of Medicine* entitled *Don't Learn on Me—Are Teaching Hospitals Patient Centered?*⁵ In that article, the doctor describes treating an eighty-two-year-old woman who was brought to the emergency room at a teaching hospital after she collapsed in the street. The patient stated she did not want to be treated by any student doctors. The author, Dr. Brendan Reilly, describes how his usual response would have been: “That’s not the way we do things here. This is a teaching hospital. If you don’t want residents or students participating in your care, you should go somewhere else.”⁶ He then went on to explain how his usual answer seemed wrong and to explain the dilemma that doctors face when hospital policy seems to conflict with a patient centered approach to medical care.⁷

Additionally, some hospitals and doctors choose to provide consent forms and privacy documents to patients on the day the patient is scheduled for surgery—adding to the take-it-or-leave-it effect.⁸ The consent forms often contain boilerplate language that does not provide an option

4. The fact pattern described above is an amalgam of various experiences described by individuals in news stories, case law, and during interviews conducted by the author, as well as the author’s own experiences. See Heather Perlberg, *The Doctor Will See You Once You Sign This Binding Arbitration Agreement*, BLOOMBERG BUSINESSWEEK (Dec. 28, 2020, 5:00 AM), <https://www.bloomberg.com/news/features/2020-12-28/the-doctor-will-see-you-once-you-sign-this-binding-arbitration-agreement> [<https://perma.cc/9Q8P-CZFC>]; Petrow, *supra* note 2.

5. Reilly, *supra* note 3, at 293.

6. *Id.*

7. See *id.*

8. See, e.g., *Mettias v. United States*, Civ. No. 12-00527 ACK, 2015 WL 1931082, at *23 (D. Haw. Apr. 21, 2015); *Quintanilla v. Dunkelman*, 133 Cal. App. 4th 95, 105 (Cal. Ct. App. 2005); *Giffords v. Melone*, 2020 N.Y. Misc. LEXIS 2677, at *8 (N.Y. Sup. Ct. June 12, 2020); *Kornberg v. United States*, No. 12-cv-1961-JAD-PAL, 2016 U.S. Dist. LEXIS 21049, at *5 (D. Nev. Feb. 19, 2016), *aff’d* *Kornberg v.*

to opt out of the term.⁹ Some facilities do not even provide a hard copy of consent forms or privacy documents, instead having the patients review the documents on an electronic pad and requiring the patient sign the documents electronically.¹⁰ Also, because some hospitals and doctors do not adequately explain the documents, when a patient discovers something in the documents that they do not agree with, the patient may reasonably feel as though the doctor or hospital is trying to take advantage of

United States, 693 F. App'x 542 (9th Cir. 2017); *Mills v. Pate*, 225 S.W.3d 277, 282 (Tex. App. 2006).

9. For example, at the UCLA Health webpage there is a blank consent form that contains the following language:

UCLA is a teaching institution. Resident physicians and students may work with the [S]uregon. Resident physicians may do part of the surgery. The Surgeon will decide at the time of the surgery which residents will take part. What they are allowed to do will depend upon their skill and the Patient's condition. Residents will be under the supervision of the Surgeon. There are times when an attending Surgeon will oversee the care provided by teams in two operating rooms simultaneously, defined as concurrent staffing. The Surgeon or an attending designee will be present for all the critical parts of the procedure/surgery. The Surgeon may be out of the operating room for some or all of the surgical tasks done by residents if the Surgeon decides it is safe to do so.

UCLA HEALTH, *supra* note 2, at 1. The Hartford Hospital website also contains a consent form that uses the following language: "I understand that residents, medical students, physician assistants and/or advanced practice registered nurses may also be in attendance, and/or assisting in the performance, and/or performing significant medical/surgical tasks within the above specified surgery and/or special procedure/treatment." HARTFORD HOSPITAL, *Authorization for Surgery and/or Special Procedure/Treatment*, <https://hartfordhospital.org/File%20Library/Hartford%20Hospital%20Forms/Consent%20Forms/571084.pdf> [<https://perma.cc/K6SV-HFLH>] (last visited July 12, 2022). The form from Piedmont Healthcare includes similar language. Piedmont Healthcare is a private not-for-profit organization that provides care for patients in eleven hospitals and several urgent care centers, principally in Georgia. The consent form on their webpage states:

I hereby voluntarily request and consent to the performance of the procedure(s) described/referenced herein by: . . . M.D. and such other physicians, including but not limited to residents, fellows and physicians-in-training, under his/her supervision or other qualified medical professionals as are needed to assist him/her to perform the procedure(s). I understand that these practitioner(s) will assist him/her in performing the procedure(s) and that the practitioner(s) will perform only tasks that are within their scope of practice and privileges and in accordance with hospital policies. I understand that not all practitioner(s) may be known at the time this consent is given. I consent to and authorize the physician to involve those practitioner(s) he/she deems necessary to perform significant surgical tasks, and procedures, including, but not limited to, opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices and altering tissues.

PIEDMONT HEALTHCARE, *Consent to Surgical, Diagnostic, Therapeutic, Blood transfusion or Tissue Implantation Procedure(s)*, <https://www.piedmont.org/PWASC/media/file/ConsentforSurgery.pdf> [<https://perma.cc/R8HA-34UH>] (last visited July 12, 2022).

10. See, e.g., *Kornberg*, 2016 U.S. Dist. LEXIS 21049, at *5.

them—damaging the trust that is critical to the doctor-patient relationship.¹¹

Throughout the country, hospitals and doctors use consent forms on a daily basis.¹² These forms are an important part of doctors fulfilling their obligation to inform patients regarding their proposed treatment and care.¹³ Generally, informed consent requires a doctor to disclose to the patient all the information that would be significant to a reasonable person in the patient's situation¹⁴ or, said another way, all the relevant information necessary in order to ensure the patient can make an informed decision regarding their care.¹⁵ Thus, the informed consent process is usually directed toward giving the necessary information to a patient so they can make an intelligent decision about their own treatment.¹⁶ However, informed consent forms can be used to secure what appear to be concessions from patients regarding their care. These con-

11. See *Avila v. Aszterbaum*, No. G057969, 2021 WL 3239381, at *2–10 (Cal. Ct. App. July 30, 2021), *reh'g denied* (Aug. 27, 2021), *review denied* (Oct. 20, 2021); *Davis v. Physician Assistant Bd.*, 66 Cal. App. 5th 227, 237–42 (Cal. Ct. App. July 2, 2021).

12. See 42 C.F.R. § 482.51(b)(2) (2021).

13. See FAY A. ROZOVSKY, *CONSENT TO TREATMENT: A PRACTICAL GUIDE* 1–3, 2–5 (5th ed. 2014).

14. See *Ward v. Schaefer*, No. 16-12543-FDS, 2021 WL 1178291, at *17 (D. Mass. Mar. 29, 2021); *Stuart v. Camnitz*, 774 F.3d 238, 251 (4th Cir. 2014) (“Traditional informed consent requirements derive from the principle of patient autonomy in medical treatment. Grounded in self-determination, obtaining informed consent prior to medical treatment is meant to ensure that each patient has ‘the information she needs to meaningfully consent to medical procedures.’ As the term suggests, informed consent consists of two essential elements: comprehension and free consent. Comprehension requires that the physician convey adequate information about the diagnosis, the prognosis, alternative treatment options (including no treatment), and the risks and likely results of each option.” (quoting Br. of Am. Coll. of Obstetricians & Gynecologists and the Am. Med. Ass’n as *Amici Curiae* Supporting Plaintiffs-Appellees, at 5, 7 (citations omitted))). See, e.g., N.C. GEN. STAT. § 90-21.13(b) (2022).

15. See *Canterbury v. Spence*, 464 F.2d 772, 787 (D.C. Cir. 1972). In *Canterbury*, the court fashioned a rule that required disclosure of material risks to a patient. The court explained that the “risk is thus material when a reasonable person, in what the physician knows or should know to be the patient’s position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy.” *Id.* (quoting Jon R. Waltz & Thomas W. Scheuneman, *Informed Consent to Therapy*, 64 *Nw. U.L. Rev.* 628, 640 (1970)).

16. See *id.* at 783 n.36; Daniel E. Hall, Allan V. Prochazka & Aaron S. Fink, *Informed Consent for Clinical Treatment*, 184 *CAN. MED. ASS’N J.* 533 (2012); *White v. Napoleon*, 897 F.2d 103, 114 n.4 (3d Cir. 1990) (“Although both White’s and Rogers’[s] allegations speak in terms of ‘a right to make informed decisions’ and ‘informed consent,’ they cannot in fairness be read to state a claim based on the tort doctrine of informed consent. That tort is, in reality, a form of professional negligence. Typically, plaintiffs in these actions allege that a doctor negligently failed to disclose all the risks associated with an operation that the plaintiff consented to the operation and was injured as a result. The correct legal standard governing these cases, according to the Restatement, is whether the doctor, in advising the patient, exercised the skill and knowledge normally possessed by

cessions are frequently presented in boilerplate documents and as though the terms are a *fait accompli*, with the health care workers providing the documents not understanding the form or if patients can alter the terms. There is something deeply concerning about this approach.

As described above, informed consent terms that permit doctors to substitute other healthcare providers during surgical procedures are terms that inure to the benefit of the doctor or hospital. Often, these terms are introduced well after the doctor-patient relationship is established. Frequently, they are presented in the body of other complicated documents or sometimes given to patients directly before a surgical procedure. Some hospitals do not provide patients with a physical copy of the documents—rather they provide the patient with a computer tablet with an electronic version of the document.

The use of the informed consent process to establish terms that are potentially adverse to patients is contrary to the essence of the doctor-patient relationship. Professional ethics, the spirit of the law of contracts, and the essentially fiduciary nature of the doctor-patient relationship all call out for a different approach to seeking concessions from patients that goes beyond money for services. Since these concessions are frequently presented as necessary to receive treatment, there is a strong whiff of coercion present.

This Article argues that where a hospital or a doctor seeks a benefit from a patient that is beyond monetary consideration, that benefit ought to be agreed upon at the outset of the patient's relationship with the doctor and the facility. Further, when the benefit is beyond traditional forms of compensation (money for services), there should be an additional obligation placed on the doctor or facility to establish knowing and voluntary consent—more than just a signature on a consent form. I also argue that doctors and facilities should be required to clearly delineate between documents that inform a patient regarding their care and those that describe the patient's agreement with the doctor. Also, providing patients hardcopies of any contract, agreement, or consent to treat form regarding treatment should be required. Further, doctors and hospitals ought to provide these documents to the patient well before nonemergency treatment or surgery—thus allowing patients to review the documents without the pressure of impending surgery. Finally, this Article asserts that patients must be given a genuine option to not concede to these non-traditional compensation terms that benefit hospitals or doctors (i.e., the patient can say no and still receive care).

To support this proposition, the Article is divided into four parts. Part I discusses the unique nature of the doctor-patient relationship. This Part discusses the professional ethical responsibility of doctors to patients, the fiduciary nature of the relationship, and how the law has addressed

members of his profession in good standing in similar communities." (citations omitted)).

contracting between doctors and patients. In Part II, the rise of the doctrine of informed consent is discussed. Part III overlays informed consent obligations and a doctor's fiduciary, contractual, and ethical obligations. This Part discusses why the current approach applied by some doctors and hospitals of securing patient capitulation to substituted caregiver terms is unfair. Finally, Part IV offers a proposal for regulating informed consent and doctor-patient agreements more broadly. This Part will draw a distinction between treatment informed consent and other aspects of the doctor-patient agreement. This Part suggests a regime that establishes the doctor-patient agreement more completely at the beginning of the doctor-patient relationship, which includes multiple methods of communicating the agreement information, and real alternatives for patients to the terms of agreement.

I. DOCTOR-PATIENT RELATIONSHIP AND AGREEMENTS

The doctor-patient relationship is one of the most important and intimate professional relationships in our society.¹⁷ Since the time of Hippocrates, it has been recognized as something that verges on the sacred. The Hippocratic Oath, a form of which is still often taken by doctors around the world today, is a clear declaration of this unique trust-based relationship.¹⁸ That Oath, as described in one article, states, in part:

The regimen I adopt shall be for the benefit of my patients according to my ability and judgment, and not for their hurt or for wrong Whatsoever house I enter, there will I go for the benefit of the sick, refraining from all wrongdoing or corruption, and especially from any seduction, of male or female, of bond free. Whatsoever things I see or hear concerning the life of men, in my attendance on the sick or even apart there from, which ought not be noised abroad, I will keep silence thereon, counting such things to be as sacred secrets.¹⁹

The Oath discusses so much more than the concept of “do no harm.”²⁰ It demands that when a doctor enters into the care of a patient,

17. See Suzanne Ost, *Breaching the Sexual Boundaries in the Doctor-Patient Relationship: Should English Law Recognise Fiduciary Duties?*, 24 *MED. LAW. REV.* 206, 206–07 (2016); Roger B. Dworkin, *Getting What We Should From Doctors: Rethinking Patient Autonomy and the Doctor-Patient Relationship*, 13 *HEALTH MATRIX* 235, 236–67 (2003).

18. See Melissa Bailey, *So Long, Hippocrates. Medical Students Choose Their Own Oaths*, *STAT* (Sept. 21, 2016), <https://www.statnews.com/2016/09/21/hippocratic-oath-medical-students-doctors/> [<https://perma.cc/RBT7-BQ5R>].

19. R. Kaba & P. Sooriakumaran, *The Evolution of the Doctor-Patient Relationship*, 5 *INT'L J. SURGERY* 57, 58 (2007) (alteration in original).

20. It is noteworthy that the Hippocratic Oath never actually states “do no harm” but instead encompasses the idea when it states: “I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is delirious and mischievous.” Robert H. Shmerling, *First, Do No Harm*, *HARV. MED. SCH.: HARV. HEALTH BLOG* (June 22,

it is for the patient's benefit. The doctor must keep the patient's secrets, and not take advantage of the unique access the doctor receives when providing care. However, what does the doctor receive in return? The simplest and most intuitive answer is money.²¹ Doctors receive payment for their services from the patient, the patient's insurance company, or the government. The next section discusses the doctor-patient relationship in greater detail including its formation, its fiduciary aspects, and the contractual side of the arrangement.

A. *Formation of the Doctor-Patient Relationship*

When a doctor-patient relationship is established is an important question, both in the law and medical ethics.²² Although answering this question requires reference to state law, some general rules can be described.²³ As a general matter, a doctor-patient relationship is formed when a doctor takes an affirmative action in the treatment of a patient.²⁴ The affirmative action can be as little as a consultation or examination.²⁵ The doctor-patient relationship is a consensual one, which is to say, the doctor agrees to treat the patient and the patient agrees to be treated.²⁶ A doctor generally cannot be forced to care for a particular patient and a patient cannot be forced to receive care.²⁷ Also, a doctor's agreement

2020), <https://www.health.harvard.edu/blog/first-do-no-harm-201510138421> [<https://perma.cc/LD2P-Z47A>]. The quote from the Hippocratic Oath provided in this footnote is different than the one provided by Drs. Kaba and Sooriakumaran—this is likely due to a variation in the Greek-to-English translation, or Drs. Kaba and Sooriakumaran may have been paraphrasing the Oath. See Kaba & Sooriakumaran, *supra* note 19.

21. See *Horne v. Patton*, 287 So. 2d 824, 831 (Ala. 1973) (“Any time a doctor undertakes the treatment of a patient, and the consensual relationship of physician and patient is established, two jural obligations (of significance here) are simultaneously assumed by the doctor. Doctor and patient enter into a simple contract, the patient hoping that he will be cured and the doctor optimistically assuming that he will be compensated.” (quoting *Hammonds v. Aetna Cas. & Sur. Co.*, 243 F. Supp. 793, 801 (N.D. Ohio 1965))).

22. See generally Valarie Blake, *When Is a Patient-Physician Relationship Established?*, 14 AM. MED. ASS'N J. ETHICS 403 (2012).

23. See *id.* at 403.

24. See *id.* at 404.

25. See *White v. Harris*, 36 A.3d 203, 206–07 (Vt. 2011); *Kelley v. Middle Tenn. Emergency Physicians, P.C.*, 133 S.W.3d 587, 593 (Tenn. 2004); *Woodruff v. Gitlow*, 91 A.3d 805 (R.I. 2014).

26. See *Walters v. Rinker*, 520 N.E.2d 468, 471 (Ind. Ct. App. 1988) (“In affirming the trial court's grant of summary judgment in favor of the company and its physician, the court noted that the ‘physician-patient relationship is a consensual one, wherein the patient knowingly seeks the assistance of a physician and the physician knowingly accepts him as a patient.’” (quoting *Ahnert v. Wildman*, 376 N.E.2d 1182, 1185 (Ind. Ct. App. 1978))); Stephen McDonald, Student Article, *Where Does It Hurt? The Practice of Telemedicine Beyond State Lines and Personal Liability*, 11 CHARLESTON L. REV. 553, 563–66 (2017).

27. See *Castillo v. Emergency Med. Assocs. P.A.*, 372 F.3d 643, 648 (4th Cir. 2004).

with a healthcare facility may leave the doctor with “no discretion to decline treatment of the hospital’s clients.”²⁸

The act of creating a doctor-patient relationship carries with it obligations on the part of the doctor and the patient. The doctor is required to adhere to the rules and regulations that govern him or her in the particular state where the care is being provided. Also, the doctor must provide care and treatment to the patient that, at a minimum, meets the standard of care in the particular circumstances, which includes securing informed consent from a patient. A doctor who fails to secure informed consent from a patient may face disciplinary action or a potential malpractice claim.²⁹ The patient is obligated to reasonably compensate the doctor for the care provided. These obligations exist absent an express contract.³⁰ Thus, when a doctor provides a service to a patient, it implies that the doctor will be reasonably compensated.³¹ Further, even in the absence of an implied contract with a patient or a traditional doctor-patient relationship, a court might find that a doctor owes a standard of care to an individual.³² This might occur when a doctor is hired by a company to interpret prescreening x-rays of potential employees.³³

B. *Doctor-Patient Contracting*

The doctor-patient relationship can be a contractual one—but discovering the four corners of that contract can be difficult. Doctor-patient contracting is generally subject to the same rules as other contracts, thus a court reviewing a cause of action will ask whether there was an offer and acceptance.³⁴ That is all well and good, but think back to the last time you went to a new doctor or perhaps you had to go to an emergency room. It is likely that you did not receive a document entitled “Contract for Services.” Rather, you likely received several documents with different titles. These documents often explain your rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and commits you to pay the doctor or hospital if your insurance does not pay for the doctor’s services. You likely filled out documents explaining your medical history, including your current complaint (if any), and there is commonly a consent to treat form. Which of these documents comprises the contract between the doctor and patient? It is difficult to say. This difficulty is

28. *St. John v. Pope*, 901 S.W.2d 420, 424 (Tex. 1995).

29. Dworkin, *supra* note 17.

30. *See* 61 AM. JUR. 2D *Physicians, Surgeons, and Other Healers* § 349 (2022); *Midwest Neurosurgery, P.C. v. State Farm Ins. Cos.*, 686 N.W. 2d 572, 578 (Neb. 2004) (“Even in the absence of an express contract, the rendering of medical services creates an implied contract between the provider and the person being given medical care.”).

31. *See Midwest Neurosurgery, P.C.*, 686 N.W.2d. at 578.

32. *See, e.g., Green v. Walker*, 910 F.2d 291, 295–96 (5th Cir. 1990).

33. *See Stanley v. McCarver*, 92 P.3d 849, 851–52 (Ariz. 2004). *But see Woodruff v. Gitlow*, 91 A.3d 805, 805–16 (R.I. 2014).

34. *See Hughes. v. Olin*, 69 Va. Cir. 46, 47–48 (Va. Cir. Ct. 2005).

exacerbated by the fact that it is often unclear if a document is being supplied for contracting purposes, informed consent, or as part of a statutory obligation. Several courts have taken up issues related to doctor-patient contracting and provided some guidance discussed below.

At its most fundamental, the formation of a doctor-patient relationship also generally signals the formation of a contract. When a doctor agrees to care for a patient and the patient agrees to the care, a contract exists.³⁵ The patient hopes the doctor will help cure what ails the patient and the doctor hopes to be reasonably compensated.³⁶ Some courts have recognized an implied contractual obligation of confidentiality that is owed to the patient from the doctor.³⁷ Moving beyond the implied contract between a doctor and patient is difficult—some written documents are more clearly a part of the doctor-patient contract than others.

One of the most outwardly contractual doctor-patient written agreements discussed in court cases are arbitration agreements.³⁸ Doctor-patient arbitration agreements are a commonly litigated issue in medical malpractice cases and have been described as basically a separate second contract between the doctor and patient.³⁹ Although most aspects of arbitration are governed by federal law, “state law generally governs whether an enforceable contract or agreement to arbitrate exists.”⁴⁰ Arbitration agreements are usually easy to recognize as contractual in nature. Arbitration agreements between doctors and patients are sometimes completed as separate documents⁴¹ (i.e., not included in the informed consent documents, HIPAA form, or General Information).⁴² These documents will sometimes advise the patient to read the document completely, ensure the patient fully understands the terms, and seek legal advice. Further, some

35. See 61 AM. JUR. 2D *Physicians, Surgeons, and Other Healers* § 349 (2022).

36. See *Spencer v. West*, 126 So. 2d 423, 426 (La. Ct. App. 1960); *Hammonds v. Aetna Casualty & Surety Co.*, 243 F. Supp. 793, 801 (N.D. Ohio 1965); *Stubbs v. N. Mem'l Med. Ctr.*, 448 N.W.2d 78, 82 (Minn. Ct. App. 1989).

37. See *Clayman v. Bernstein*, 38 Pa. D. & C. 543, 548 (Ct. Com. Pl. 1940); *Givens v. Mullikin*, 75 S.W.3d 383, 407 (Tenn. 2002); but see *Willeford v. Klepper*, 597 S.W.3d 454, 478–79 (Tenn. 2020) (holding *Givens* was partially superseded by statute). See also *Leger v. Spurlock*, 589 So. 2d 40, 43 (La. Ct. App. 1991); but see *Curtis v. Fairfax Hosp.*, 34 Va. Cir. 290, 294 (Va. Cir. Ct. 1994).

38. See Stephen A. Plass, *Federal Arbitration Law and The Preservation of Legal Remedies*, 90 TEMP. L. REV. 213 (2018). Plass discusses the objectives, history, and evolution of the Federal Arbitration Act (FAA) and the how state and federal arbitration law come together. He notes that the purpose of the FAA was to ensure arbitration contracts were “enforce[d] . . . as any other contract would be enforced.” *Id.* at 215.

39. See David Zukher, *The Role of Arbitration in Resolving Medical Malpractice Disputes: Will a Well-Drafted Arbitration Agreement Help the Medicine Go Down?*, 49 SYRACUSE L. REV. 135, 141–42, 162 (1998).

40. *Caley v. Gulfstream Aerospace Corp.*, 428 F.3d 1359, 1368 (11th Cir. 2005).

41. See *Holifield v. Beverly Health & Rehab. Servs.*, No. 3:08CV-147-H, 2008 WL 2548104 (W.D. Ky. June 20, 2008).

42. See *Hilleary v. Garvin*, 238 Cal. Rptr. 247, 248 (Cal. Ct. App. 1987).

doctors' offices will have staff discuss the arbitration agreement with the potential patients.

Another common part of doctor-patient contracting is payment terms. Frequently, doctors or hospitals will require patients to expressly agree to two conditions in writing: first, that the doctor's office is allowed to communicate with the patient's insurance carrier; second, the patient will pay any sums of money owing for the patient's care.⁴³ Again, these terms, like an arbitration agreement, look very much like a contract—I agree to treat you and you agree to pay me whatever is not paid by your insurance company. One challenge that can arise with payment terms is that the terms can be contained in documents that obscure the fundamentally contractual nature of the term. Consider the case of *Anticaglia v. Lynch*.⁴⁴ In *Anticaglia* the plaintiff performed surgery on the defendant and then sued the defendant-patient to recover the money that the insurance company had not reimbursed the doctor.⁴⁵ The plaintiff relied on a document entitled "General Information" that explained to the defendant that:

Depending on your policy, part or all of the cost of the surgery or testing procedures may be covered by the insurance policy. You are responsible for the balance. If you do not have the forms today, and they are needed, kindly bring them to the office the following day or mail them to us. In general, we do not submit insurance forms for office visits.⁴⁶

The trial court found the General Information document was not a contract; rather, it was just what it claimed to be—general information.⁴⁷ The trial court relied on the title of the document and other information contained in it to conclude the General Information document was nothing more than a description of the doctor's usual billing procedures.⁴⁸

Another area of the doctor-patient relationship that sometimes straddles the line between contracting and a doctor's professional or fiduciary responsibilities is confidentiality. Several courts have concluded that a patient may bring a cause of action against their doctor for a breach of confidentiality.⁴⁹ Most often these actions are brought as a tort for a violation of a fiduciary duty or an implied obligation arising out of the doctor-patient relationship.⁵⁰ Some plaintiffs have brought actions for a breach of a

43. See *Gianetti v. Riether*, No. CV020398555S, 2011 WL 4347211 (Conn. Super. Ct. Aug. 23, 2011), *aff'd.*, 139 Conn. App. 909, 56 A.3d 474 (2012).

44. No. 90C-11-175, 1992 WL 138983 (Del. Super. Ct. Mar. 16, 1992).

45. See *id.* at *1.

46. *Id.* at *2.

47. See *id.*

48. See *id.*

49. See *McCormick v. England*, 494 S.E.2d 431, 435–36 (S.C. Ct. App. 1997).

50. See, e.g., *Byrne v. Avery Ctr. for Obstetrics & Gynecology, P.C.*, 175 A.3d 1, 15 (Conn. 2018); *McCormick*, 494 S.E.2d at 435–36; see also *Judy E. Zelin*, Annota-

contractual duty when a doctor or a hospital violates the patient's confidentiality.⁵¹

Although confidentiality is an implicit component in the doctor-patient relationship, patients may agree to doctors sharing their medical or personal information. Since its passage into law in 1996, HIPAA has required doctors and hospitals to explain to patients how the doctor or hospital will use patient information. It is important to note that HIPAA violations do not give rise to a private cause of action under the statute. However, a doctor could violate a patient's confidentiality in such a way that the doctor both violates the privacy terms described in the HIPAA form and gives rise to a cause of action for a breach of confidentiality—whether the jurisdiction recognizes the action as a breach of contract or some form of a tort.⁵²

Finally, another aspect of the doctor-patient relationship commonly expressed in writing is informed consent, but it is seldom treated as a contractual term. As will be discussed later, a doctor's responsibility to provide a patient informed consent, like the obligation to meet the standard of care, flows principally from the doctor's obligations to their patient as part of the doctor-patient relationship. Although a physician's obligation to ensure they have informed consent from a patient exists regardless of whether it is a "contract term," failure to do what was promised when securing informed consent can, according to some courts, give rise to a breach of contract.⁵³ Take, for example, the circumstance where one doctor agrees to conduct a surgery, but then allows another doctor to take his or her place. This practice is sometimes called "ghost surgery."⁵⁴ Courts have allowed plaintiffs to proceed on multiple legal bases when alleging a ghost surgery, including as a tort and rarely as a breach of contract.⁵⁵

tion, *Physician's Tort Liability For Unauthorized Disclosure of Confidential Information About Patient*, 48 A.L.R. 4th 668, *7 ("In a number of jurisdictions, it has been held or recognized that a patient may have a cause of action against his physician for disclosing confidential information, on the ground that such disclosure constitutes a breach of a confidential or privileged relationship existing between patient and physician."). Several jurisdictions have refused to find a separate cause of action when a doctor discloses confidential information. Compare that to other jurisdictions that have recognized a cause of action for a breach of a duty of confidentiality—whether it be a contract theory or fiduciary breach.

51. See, e.g., *Horne v. Patton*, 287 So. 2d 824, 831–32 (Ala. 1973).

52. *But see Ramsdell v. Hartford Hosp.*, No. HHDCV176082676S, 2019 Conn. Super. LEXIS 97, at *15 (Conn. Super. Ct. Jan. 14, 2019) (holding that a violation of a privacy document that was required by law could not be used as the basis for a cause of action).

53. See, e.g., *Murphy v. Implicito*, No. A-3172-03T3, 2005 WL 2447776, at *8 (N.J. Super. Ct. App. Div. Sept. 22, 2005); *Dingle v. Belin*, 749 A.2d 157, 168–70 (Md. 2000).

54. See *Grabowski v. Quigley*, 684 A.2d 610, 617 (Pa. Super. Ct. 1996); *Dingle*, 749 A.2d at 158; *but see Kovacs v. Freeman*, 957 S.W.2d 251, 256 (Ky. 1997) (finding a signed consent form between and doctor and a patient was not a contract).

55. See *Grabowski*, 684 A.2d at 617; *Dingle*, 749 A.2d at 158.

Perhaps the greatest challenge in determining a doctor's obligations under contract law is determining what parts of the doctor-patient relationship are contractual. The cases are confusing. Courts seem to agree that the foundation of the doctor-patient relationship is contractual, but some courts have found that some of the doctor's obligations toward their patients flow from the formation of the doctor-patient relationship, or the doctor's fiduciary obligation, rather than their contractual obligations, or that documents signed by the patient that appear to create an obligation are not contractual terms.

C. *The Fiduciary Obligations of the Doctor*

The question of whether a doctor is a legal fiduciary to a patient is perhaps more complicated than expected.⁵⁶ Many state courts have expressly recognized the doctor-patient relationship as fiduciary, while a few have rejected it, and still others have found the relationship exists but denied an independent cause of action based on the relationship.⁵⁷ Despite the disagreement, the doctor-patient relationship would appear to align perfectly with the hallmarks of the fiduciary relationship. One scholar has described those hallmarks in the following manner:

Conventional wisdom holds that a relationship triggers the fiduciary duty of loyalty whenever one party (the principal) has reposed special trust and confidence in another (the fiduciary), thereby exposing herself or others (the beneficiaries) to a heightened risk of injury.⁵⁸

Other aspects of fiduciary relationships include special knowledge possessed by the fiduciary and vulnerability and dependence on the part of the beneficiary—which can be described as an asymmetry between the principal and the fiduciary. Further, the relationship between the principal and the beneficiary is one that public policy encourages.⁵⁹ Thus, one scholar has recently stated, “fiduciaries are at their most desirable when entrustors lack the time, resources, or capability to (1) do what fiduciaries

56. See generally Maxwell J. Mehlman, *Why Physicians Are Fiduciaries for Their Patients*, 12 IND. HEALTH L. REV. 1 (2015) (providing a thorough discussion of the controversy over whether doctors are or should be considered fiduciaries to their patients).

57. See Claudia E. Haupt, *Licensing Knowledge*, 72 VAND. L. REV. 501, 547–48 (2019); Mehlman, *supra* note 56, at 3–6 n.5, 12–14 n.12 (providing an extensive review of courts and cases that have found a fiduciary responsibility and addressing scholarly articles that discuss court decisions that have limited the application of fiduciary law in the doctor-patient relationship).

58. Evan J. Criddle, *Liberty in Loyalty: A Republican Theory of Fiduciary Law*, 95 TEX. L. REV. 993, 994 (2017).

59. See Thomas L. Hafemeister & Selina Spinos, *Lean on Me: A Physician's Fiduciary Duty to Disclose an Emergent Medical Risk to the Patient*, 86 WASH. U.L. REV. 1167, 1187 (2009); Criddle, *supra* note 58, at 1014–15.

can do and/or (2) effectively monitor them when they're doing it."⁶⁰ Examples of some well-recognized fiduciary relationships are: attorney–client, guardian–ward, and trustee–beneficiary.⁶¹ The application of fiduciary duties are meant to enhance the trust necessary for the fiduciary relationship. Although how courts define fiduciary duties varies, some commonly recognized duties are: honesty, loyalty, confidentiality, and the absence of conflicting interests.⁶²

The commentators and courts that have concluded that doctors are fiduciaries to their patients have observed that there is little doubt that patients place special trust in their doctors,⁶³ that the patient faces a heightened risk of injury, and there is an asymmetry of power and knowledge between the doctor and patient.⁶⁴ These conclusions have deep historic roots, with at least symbolic support coming from the Hippocratic Oath, discussed earlier. The Oath, as described in one article, states: “Whatsoever house I enter, there I go for the benefit of the sick, refraining from all wrongdoing or corruption”; “The regimen I adopt shall be for the benefit of my patients according to my ability and judgment”; and “Whatsoever things I see or hear concerning the life of men, in my attendance on the sick or even apart there from, which ought not be noised abroad, I will keep silence thereon counting such things to be as sacred secrets.”⁶⁵ Over 2,000 years ago, the unique and essentially fiduciary relationship between doctor and patient was recognized in the Oath.

The commentators and courts that have rejected the fiduciary relationship between doctors and patients have done so for pragmatic reasons.⁶⁶ Some courts in Minnesota have refused to accept physicians as fiduciaries for fear that plaintiffs could avoid medical malpractice statutes

60. Sam F. Halabi, *Against Fiduciary Utopianism: The Regulation of Physician Conflicts of Interest and Standards of Care*, 11 U.C. IRVINE L. REV. 433, 439 (2020).

61. *See id.* at 440.

62. *See* Susan M. Freeman, *Are DIP and Committee Counsel Fiduciaries for Their Clients' Constituents or the Bankruptcy Estate? What is a Fiduciary, Anyway?*, 17 AM. BANKR. INST. L. REV. 291, 336–44 (2009); COLLIER HANDBOOK FOR CREDITORS' COMMITTEES ¶ 16.02 (Richard Levin & Henry J. Sommer eds. 2022).

63. *See* Hafemeister & Spinos, *supra* note 59, at 1186–92; Haupt, *supra* note 56, 547–48; Mehlman, *supra* note 56, at 3–6 n.5, 12–14 n.12; *Hammonds v. Aetna Cas. & Sur. Co.*, 243 F. Supp. 793, 803 (N.D. Ohio 1965); MARC A. RODWIN, *MEDICINE, MONEY, AND MORALS: PHYSICIANS' CONFLICTS OF INTEREST* 8 (1993); *Youngs v. PeaceHealth*, 316 P.3d 1035, 1042 (Wash. 2014); *but see* *Brant v. Summa Health Sys.*, No. 5:10CV1296, 2012 WL 1409408 (N.D. Ohio Apr. 23, 2012).

64. *See* Hafemeister & Spinos, *supra* note 59, at 1188; Haupt, *supra* note 57, at 532; Mehlman, *supra* note 56, at 2–3.

65. Kaba & Sooriakumaran, *supra* note 19, at 58.

66. *See* Mehlman, *supra* note 56, 23–30.

of limitation.⁶⁷ Also, in *Pegram v. Herdrich*,⁶⁸ the United States Supreme Court rejected the assertion that an Health Maintenance Organization (HMO) could be sued for a breach of fiduciary duties under the Employee Retirement Income Security Act (ERISA).⁶⁹ Although it could be argued that the Supreme Court's decision was limited to what qualified as a fiduciary within the meaning of ERISA, Justice Souter, writing for a unanimous Court, was expansive in his reasoning.⁷⁰ According to Justice Souter, permitting a suit against the doctors in *Pegram* for a breach of fiduciary duties would defeat the purpose of forming an HMO—"[r]ecovery would be warranted simply upon showing that the profit incentive to ration care would generally affect mixed decisions, in derogation of the fiduciary standard to act solely in the interest of the patient without possibility of conflict."⁷¹ Thus, the Court decided that Congress did not intend to have HMO doctors treated as fiduciaries under ERISA because such an arrangement would seem contrary to Congress' intention to encourage the formation of HMOs. This conclusion is not the same as finding that the doctor-patient relationship is not the sort of arrangement that would call for fiduciary duties and protection,⁷² rather, the Court concluded the obligations on a fiduciary contained in ERISA did not apply to doctors who formed an HMO.

Finally, at least one court in Delaware has asserted, arguably in dicta, that the doctor-patient relationship is not fiduciary. In *McMahon v. New Castle Associates*,⁷³ a group of tenants brought a class action against a landlord in the Chancery Court of Delaware (a court of equity).⁷⁴ The Court of Chancery granted a motion to dismiss for lack of jurisdiction because the court held that the matter was not an action in equity. Of significance to the current discussion was the court's treatment of the plaintiff's claim that the landlord tenant relationship was fiduciary.⁷⁵ The court held that it was not. During its discussion of what qualifies as a fiduciary relationship, the court stated that not all relationships that require trust are fiduciary.⁷⁶ Regarding the doctor-patient relationship the court wrote:

67. See *D.A.B. v. Brown*, 570 N.W.2d 168, 171–72 (Minn. Ct. App. 1997); *Hemmerlin-Stewart v. Allina Hosps. & Clinics*, No. A05-100, 2005 WL 2143691 (Minn. Ct. App. Sept. 6, 2005); but see *Jones v. Smilanich*, No. 27-CV-18-9098, 2020 Minn. Dist. LEXIS 170, at *14 (Minn. Dist. Ct. Apr. 21, 2020) (holding that "[n]owhere in *D.A.B.* did the court state that the plaintiffs could not sue their physician based upon a tort theory other than negligence, such as breach of fiduciary duty").

68. 530 U.S. 211, 232–33 (2000).

69. See Mehlman, *supra* note 56, at 24–26.

70. See *Pegram*, 530 U.S. at 230–33; Mehlman, *supra* note 56, at 32–33.

71. *Pegram*, 530 U.S. at 232–33.

72. See Mehlman, *supra* note 56, at 24–26.

73. 532 A.2d 601 (Del. Ch. 1987).

74. See *id.* at 602.

75. See *id.* at 603.

76. See *id.* at 604.

Thus, when this court, for example, said “A fiduciary relationship is a situation where one person reposes special trust in another or where a special duty exists on the part of one person to protect the interests of another,” attention must be paid to the word “special” lest the statement be thought to describe too broadly chancery’s concerns with relationships where an element of trust, as commonly understood, is present. One may place trust in a workman of any sort and does place trust in one’s physician, but it would hardly be contended that such trust would warrant chancery’s assuming jurisdiction over a claim that a workman or physician caused injury by want of due care—although a claim of that very type against a trustee will be entertained in a court of equity.⁷⁷

Notwithstanding the Court of Chancery’s conclusion, at least one Delaware Court has found that the doctor-patient relationship is fiduciary in nature.⁷⁸

In *Anticaglia v. Lynch*,⁷⁹ the court resolved a dispute between a doctor and a patient regarding fees. While resolving that dispute the court stated:

The relationship between physician and patient has been described as fiduciary in nature. It is one in which the doctor has a duty of good faith and fair dealing which extends, not only to his professional obligations, but also to “other transactions” between the physician and his patient. I fully apply that principle to Dr. Anticaglia and all of his dealings, including those financial, with Mr. Lynch.⁸⁰

Finally, it is worth noting that the largest organization of practicing physicians in the United States, the American Medical Association (AMA), has recognized the doctor-patient relationship as fiduciary. In the AMA’s Code of Ethics opinion dealing with the termination of the doctor-patient relationship it states in part, “Physicians’ fiduciary responsibility to patients entails an obligation to support continuity of care for their patients.”⁸¹

Despite broad, albeit not universal, agreement about the fiduciary nature of the doctor-patient relationship—how far and what duties apply to it have been a point of disagreement. Also, the nuances and complexity of fiduciary law are significant and unnecessary for this discussion. Rather, the general recognition that doctors owe a fiduciary duty to their patients

77. *Id.* (quoting *Cheese Shop Int’l, Inc. v. Steele*, 303 A.2d 689, 690 (Del. Ch. 1973)).

78. See generally *Anticaglia v. Lynch*, No. 90C-11-175, 1992 WL 138983 (Del. Super. Ct. Mar. 16, 1992).

79. No. 90C-11-175, 1992 WL 138983 (Del. Super. Ct. Mar. 16, 1992).

80. *Id.* at *8.

81. *Terminating a Patient-Physician Relationship*, AM. MED. ASS’N, <https://www.ama-assn.org/delivering-care/ethics/terminating-patient-physician-relationship> [<https://perma.cc/T4Y5-5CEW>] (last visited July 12, 2022).

and what is included in that duty is relevant to our discussion. Thus, it is generally accepted that doctors owe their patients a duty of: honesty, loyalty, confidentiality, and the absence of conflicting interests.

D. *Doctor Ethics*

The ethical rules that govern doctor conduct are instructive in understanding what doctors believe their obligations are to their patients.⁸² By examining these codes, it may become easier to find compromises that assist in meeting both the interests of doctors and patients. This section examines the AMA Code of Medical Ethics,⁸³ and touches on sections of several state codes.

One of the oldest codes of medical ethics in the United States is the AMA's Code of Medical Ethics, initially adopted in 1847.⁸⁴ Since it was first adopted, the Code has been revised several times.⁸⁵ The Code's most recent revision was published in 2017.⁸⁶ The Ethics Code includes two components: the principles of medical ethics, and the opinions of the AMA's Council on Ethical and Judicial Affairs.⁸⁷ The AMA Code contains nine principles of medical ethics.⁸⁸ As would be expected with any set of principles that guide the practice of a profession, the AMA ethical principles are somewhat vague. If the AMA Code were a compass, the principles would do no more than orient a practitioner to north, south, east, and west. However, particularly relevant to our discussion is principle eight. Of the nine principles, principle eight deals most directly with the doctor-patient relationship. It states, "A physician shall, while caring for a patient, regard responsibility to the patient as paramount."⁸⁹

The opinions of the AMA Council, as compared to the principles, are more specific and helpful. Of note to our discussion are the opinions that relate to the doctor-patient relationship (Chapter One)⁹⁰ and informed

82. *Code of Medical Ethics: Preface & Preamble*, AM. MED. ASS'N, <https://www.ama-assn.org/about/publications-newsletters/code-medical-ethics-preface-preamble> [<https://perma.cc/X3GM-MDDT>] (last visited July 12, 2022).

83. *Code of Medical Ethics: Overview*, AM. MED. ASS'N, <https://www.ama-assn.org/delivering-care/ethics/code-medical-ethics-overview> [<https://perma.cc/3B8J-6TJG>] (last visited July 12, 2022).

84. See Frank A. Riddick Jr., *The Code of Medical Ethics of the American Medical Association*, 5 OCHSNER J. 6, 6 (2003).

85. *Id.*

86. *AMA Publishes Updated Code of Medical Ethics for Contemporary Medicine*, AM. MED. ASS'N (Jan. 23, 2017), <https://www.ama-assn.org/press-center/press-releases/ama-publishes-updated-code-medical-ethics-contemporary-medicine> [<https://perma.cc/47K9-PRTH>].

87. Riddick Jr., *supra* note 84, at 6.

88. *AMA Principles of Medical Ethics*, AM. MED. ASS'N, <https://www.ama-assn.org/about/publications-newsletters/ama-principles-medical-ethics> [<https://perma.cc/4R8W-39GU>] (last visited July 12, 2022).

89. *Id.*

90. *Code of Medical Ethics: Patient-Physician Relationships*, AM. MED. ASS'N, <https://www.ama-assn.org/delivering-care/ethics/code-medical-ethics-patient>

consent (Chapter Two).⁹¹ The AMA opinions in Chapters One and Two are strongly patient-centered and emphasize patient autonomy. In the context of this Article “patient-centered” is used to mean, “an individual’s specific health needs and desired health outcomes are the driving force behind all health care decisions and quality measurements.”⁹²

The very first opinion in the Code of Ethics, entitled *Patient-Physician Relationship*, states in part, “The relationship between a patient and a physician is based on trust, which gives rise to physicians’ ethical responsibility to place patients’ welfare above the physician’s own self-interest or obligations to others, to use sound medical judgment on patients’ behalf, and to advocate for their patients’ welfare.”⁹³ This patient-centered approach is also reflected in *Opinion 1.1.3 Patient Rights*, which notes that patient rights include the right “to make decisions about the care the physician recommends and to have those decisions respected. A patient who has decision-making capacity may accept or refuse any recommended medical intervention.”⁹⁴ Again, in *Opinion 1.1.6*, addressing quality of medical care the Code states in part, “As professionals dedicated to promoting the well-being of patients, physicians individually and collectively share the obligation to ensure that the care patients receive is safe, effective, patient centered, timely, efficient, and equitable.”⁹⁵ The Code notes that although the responsibility to share information flows both to and from the patient, the doctor bears the primary responsibility to ensure a patient or the family of a patient are informed regarding treatment:

While responsibility for quality of care does not rest solely with physicians, their role is essential. Individually and collectively, physicians should actively engage in efforts to improve the quality of health care by . . . [h]olding themselves accountable to patients, families, and fellow health care professionals for communicating effectively and coordinating care appropriately.⁹⁶

physician-relationships [<https://perma.cc/7CW6-VRDK>] (last visited July 12, 2022).

91. *Code of Medical Ethics: Consent, Communication, and Decision Making*, AM. MED. ASS’N, <https://www.ama-assn.org/delivering-care/ethics/code-medical-ethics-consent-communication-decision-making> [<https://perma.cc/LX2Q-RMKX>] (last visited July 12, 2022).

92. *What is Patient Centered Care?*, NEW ENG. J. MED. CATALYST (Jan. 1. 2017), <https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0559> [<https://perma.cc/9RL8-LWZ6>].

93. *Code of Medical Ethics: Opinion 1.1.1*, AM. MED. ASS’N, <https://www.ama-assn.org/delivering-care/ethics/patient-physician-relationships> [<https://perma.cc/3LSM-BGUZ>] (last visited July 12, 2022).

94. *Code of Medical Ethics Opinion 1.1.3*, at (d), AM. MED. ASS’N, <https://www.ama-assn.org/delivering-care/ethics/patient-rights> [<https://perma.cc/6KQ2-54JU>] (last visited July 12, 2022).

95. *Code of Medical Ethics Opinion 1.1.6*, AM. MED. ASS’N, <https://www.ama-assn.org/delivering-care/ethics/quality> [<https://perma.cc/E7YW-C6E5>] (last visited July 12, 2022).

96. *Id.*

These sections of the AMA Code place an obligation on doctors to ensure individual patients are at the center of the doctor-patient relationship and to provide the necessary information to patients so they can make informed decisions about their medical care.

Chapter Two of the Code deals with the doctor's ethical obligation to receive informed consent from a patient or the patient's surrogate before providing care. This Chapter notes that doctors have an obligation to verify patients are competent to make "independent, voluntary"⁹⁷ decisions about their care. Further, doctors should supply patients with information about: "the diagnosis (when known); [t]he nature and purpose of recommended interventions; [and] [t]he burdens, risks, and expected benefits of all options, including foregoing treatment[.]"⁹⁸ Chapter Two also specifically addresses the circumstance where a surgeon intends to substitute another qualified individual to conduct part or all of a surgical procedure. *Opinion 2.1.6* states in part, "Patients are entitled to choose their own physicians, which includes being permitted to accept or refuse having an intervention performed by a substitute."⁹⁹ The opinion goes on to say that when a surgeon seeks to use a substitute they have an ethical responsibility to "[o]btain the patient's or surrogate's informed consent."¹⁰⁰

It is important to observe that the AMA Code of Medical Ethics also suggests that patients have obligations as well as doctors. It could be argued that a professional organization has no authority to impose ethical standards on individuals that are not part of the organization. Regardless of the AMA's authority, *Opinion 1.1.4 Patient Responsibilities*¹⁰¹ asserts that successful medical care requires collaboration¹⁰²—patients need to be honest with their physicians and follow the agreed upon course of treatment.¹⁰³ A potentially objectionable assertion is contained in 1.1.4(d) which states patients have a responsibility to "[a]ccept care from medical students, residents, and other trainees under appropriate supervision."¹⁰⁴ It is difficult to determine from where the AMA concludes that patients have any obligation to accept care from doctors in training—in fact such a suggestion is incongruent with the essence of the doctor-patient relationship. Perhaps the Council recognized their overreach by including in

97. *Code of Medical Ethics Opinion 2.1.1*, AM. MED. ASS'N, <https://www.ama-assn.org/delivering-care/ethics/informed-consent> [<https://perma.cc/ST35-NWD3>] (last visited July 12, 2022).

98. *Id.* at (b).

99. *Code of Medical Ethics Opinion 2.1.6*, AM. MED. ASS'N, <https://www.ama-assn.org/delivering-care/ethics/substitution-surgeon> [<https://perma.cc/H7L2-JN5E>] (last visited July 12, 2022).

100. *Id.* at (b).

101. *Code of Medical Ethics Opinion 1.1.4*, AM. MED. ASS'N, <https://www.ama-assn.org/delivering-care/ethics/patient-responsibilities> [<https://perma.cc/5BQQ-7RUN>] (last visited July 12, 2022).

102. *Id.*

103. *Id.*

104. *Id.* at (d).

Opinion 1.1.4(d) the statement, “[p]articipation in medical education is to the mutual benefit of patients and the health care system; nonetheless, patients’ (or surrogates’) refusal of care by a trainee should be respected in keeping with ethics guidance.”¹⁰⁵

The ethical requirements described in the AMA Code of Medical Ethics are similar, if not the same, as those in numerous state medical codes of ethics. For example, the Texas Medical Association Board of Councilors and the Washington State Medical Association have expressly considered or incorporated the AMA Code of Medical Ethics’ nine principles.¹⁰⁶ The Virginia Regulations Governing the Practice of Medicine echoes AMA *Opinion 2.1.1(a)(1–3)* when it states a “practitioner shall accurately inform a patient or his legally authorized representative of his medical diagnoses, prognosis and prescribed treatment or plan of care.”¹⁰⁷ Also, the Washington State Medical Association Code of Ethics includes an opinion that states, “[t]o have another physician operate on one’s patient without the patient’s knowledge and consent is deceit. The patient is entitled to choose his own physician, and he should be permitted to acquiesce in or refuse to accept . . . substitution.”¹⁰⁸ This portion of the Washington Ethics Opinion is very similar to the AMA *Opinion 2.1.6*.

The various ethical codes discussed above carry forward many of the themes present in the Hippocratic Oath. They reflect a professional ethos that is patient centered. Doctors are ethically obliged to put the patient’s needs ahead of their own, to provide patients the information necessary for them to make an intelligent decision about their own care and doctors must provide that information to their patients in a fashion the patient can understand.

II. THE RISE OF INFORMED CONSENT

The doctrine of informed consent has undergone a dramatic and rapid evolution in medicine and the law. Informed consent is both an ethical duty for doctors as well as a legal one.¹⁰⁹ The fundamental requirements of informed consent are that before a patient agrees to a given treatment (undergoes a test, takes a medication, follows a treatment plan, is the subject of a surgery), a healthcare professional should explain: why the treatment is being suggested; describe the treatment; explain the likely

105. *Id.*

106. *TMA Board of Councilors Current Opinions: Preamble*, TEX. MED. ASS’N, <https://www.texmed.org/CurrentOpinions/> [<https://perma.cc/A27U-EGPQ>] (last visited July 12, 2022); WASH. STATE MED. ASS’N, PRINCIPLES OF MEDICAL ETHICS AND OPINIONS OF THE JUDICIAL COUNCIL (2005) [hereinafter PRINCIPLES OF MEDICAL ETHICS], available at <https://wsma.org/policies> [<https://perma.cc/8D49-E8GV>].

107. 18 VA. ADMIN. CODE § 85-20-28(A)(1) (2005).

108. PRINCIPLES OF MEDICAL ETHICS, *supra* note 106, § 8.15.

109. See RUTH R. FADEN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT 4 (1986).

benefits and risks of the treatment; describe alternatives and the likely benefits and risks of the alternatives; and explain to the patient the likely consequences of declining the treatment or alternatives.¹¹⁰ Despite the rapid rise and ubiquity of the informed consent doctrine in both law and in medicine, its objectives and values do not match its enforcement mechanisms.

Numerous authors have addressed the origins of informed consent in medicine and how the rise of that doctrine has accompanied a fundamental shift in the doctor-patient relationship.¹¹¹ The approach of U.S. doctors when fulfilling their obligation to provide care has evolved from what some authors describe as a paternalistic model to an autonomous one.¹¹² The paternalistic model emphasized the doctor's role in making health care decisions while the patient was merely the recipient of that care. The paternalistic approach can be traced as far back as ancient Greece,¹¹³ where documents from that era suggest that a doctor should not reveal to a patient the true state of their medical condition because such a disclosure may harm the patient.¹¹⁴ The paternalistic approach to medicine held sway in the United States until just recently,¹¹⁵ and has been supplanted by a patient autonomy model.¹¹⁶

The origins of informed consent have been traced to different times or events in history. Some authors have suggested its origins can be traced to Alexander the Great giving public consent to medical treatment to alleviate the treating physician's fear of retribution should the procedure go badly.¹¹⁷ Others suggest an embryonic form of informed consent can be observed when, in the sixth century, a doctor refused to conduct surgery on Emperor Justin II unless the Emperor handed the doctor the scalpel.¹¹⁸ Some scholars have linked the evolution of informed consent to broader political and social movements. The rise of the Lockean theory that sovereigns rule by and through the consent of the governed is offered by an author as linked to informed consent.¹¹⁹

110. ROZOVSKY, *supra* note 13, at 1–11.

111. *See id.*; FADEN & BEAUCHAMP, *supra* note 109, at 4; OONAGH CORRIGAN, JOHN McMILLAN, KATHLEEN LIDDELL, MARTIN RICHARDS & CHARLES WEIJER, *THE LIMITS OF CONSENT: A SOCIO-ETHICAL APPROACH TO HUMAN SUBJECT RESEARCH IN MEDICINE* 12–16 (2009); SHEILA A. M. MCLEAN, *AUTONOMY, CONSENT AND THE LAW*, 29–39 (2010); Hall, Prochazka & Fink, *supra* note 16.

112. *But see* Ben A. Rich, *Medical Paternalism v. Respect for Patient Autonomy: The More Things Change the More They Remain the Same*, 10 MICH. ST. U.J. MED. & L. 87, 106 (2006).

113. *Id.* at 94.

114. *Id.*

115. An examination of the American Medical Associations Ethics Opinions clearly demonstrates the primacy of patient autonomy over paternalism.

116. *See* Dworkin, *supra* note 17, at 235.

117. Nandini K. Kumar, *Informed Consent: Past and Present*, 4 PERSP. CLINICAL RSCH. 21, 22 (2013).

118. TOM O'SHEA, *CONSENT IN HISTORY, THEORY AND PRACTICE* 9–10 (2012).

119. *Id.* at 12.

In the United States, the earliest cases addressing informed consent involved allegations of assault and battery.¹²⁰ Two cases in particular, *Mohr v. Williams*¹²¹ and *Pratt v. Davis*,¹²² have been cited as the earliest significant informed consent cases in the United States.¹²³ Both cases were civil actions for battery brought against surgeons who conducted unauthorized procedures.¹²⁴ In *Mohr*, the doctor was supposed to operate on a patient's right ear and after the patient was under anesthesia, the doctor determined that the left ear was more severely affected by the patient's conditions, so he operated on that ear.¹²⁵ In *Pratt*, a doctor conducted an unauthorized hysterectomy.¹²⁶ Although both actions involved harm to the patient, the courts focused heavily on the violation of the patient's autonomy.¹²⁷ In both cases (*Mohr* quotes *Pratt*), the courts stated, "the free citizen's first and greatest right, which underlies all others—the right to the inviolability of his person; in other words, his right to himself . . ."¹²⁸ The conclusions of the courts in *Mohr* and *Pratt* were echoed by Justice Cardozo in *Schloendorff v. Society of N.Y. Hospital*,¹²⁹ affirming the validity of trespass and battery claims against a doctor for conducting an unconsented to surgery.

As the twentieth century progressed, so did the doctrine of informed consent. One author has described the period of 1905–1930 as the Era of Consent, and 1957 onward as the Era of Informed Consent.¹³⁰ As time passed, more and more courts recognized a negligence theory of informed consent in lieu of a battery approach.¹³¹ Under the negligence theory, the elements of a cause of action are: a doctor-patient relationship existed between the plaintiff and defendant; the doctor failed to disclose certain information; the information not disclosed was material (this is defined differently depending on the jurisdiction); the patient (or a reasonable patient) would not have consented to the treatment if they had the undisclosed information; the failure to disclose was the proximate

120. Lydia A. Bazzano, Jaquail Durant & Paula Rhode Brantley, *A Modern History of Informed Consent and the Role of Key Information*, 21 OCHSNER J. 81, 82 (2021).

121. 104 N.W. 12 (Minn. 1905), *overruled in part by* Genzel v. Halvorson, 80 N.W.2d 854 (Minn. 1957).

122. 118 Ill. App. 161 (Ill. App. Ct. 1905), *aff'd* 79 N.E. 562 (Ill. 1906).

123. See Bazzano, Durant & Brantley, *supra* note 120, at 81.

124. *Id.* at 81–82.

125. *Mohr*, 104 N.W. at 13.

126. *Pratt*, 118 Ill. App. at 171.

127. See *Pratt*, 118 Ill. App. at 166; *Mohr*, 104 N.W. at 14–15.

128. *Pratt*, 118 Ill. App. at 166; *Mohr*, 104 N.W. at 14.

129. 105 N.E. 92 (N.Y. 1914), *abrogated by* Bing v. Thunig, 143 N.E.2d 3 (N.Y. 1957).

130. Anthony Szczygiel, *Beyond Informed Consent*, 21 OHIO N.U. L. REV. 171, 175, 190 (1994).

131. See Bryan J. Warren, *Pennsylvania Medical Informed Consent Law: A Call to Protect Patient Autonomy Rights by Abandoning the Battery Approach*, 38 DUQ. L. REV. 917, 929–33 (2000).

cause of the damages.¹³² Although medical battery is still recognized as a cause of action, courts have drawn a distinction between it and a cause of action under informed consent.¹³³

When applying the negligence standard in an informed consent cause of action, there is a split regarding how to evaluate the materiality of information and causation.¹³⁴ Regarding materiality, some jurisdictions measure materiality from the doctor's perspective, what would the reasonably prudent doctor have disclosed.¹³⁵ Other courts follow the standard described in the seminal case, *Canterbury v. Spence*,¹³⁶ where the standard for materiality is what would the reasonable patient wish to know.¹³⁷ The split in causation turns on whether a plaintiff can establish causation of damages. All but four jurisdictions require that a patient-plaintiff establish that a reasonable person would not have undergone the surgery or procedure had they known the information that was not provided as part of the informed consent process.¹³⁸

As discussed in Part I of this Article, physicians have an ethical obligation to secure a patient's informed consent. Each state's medical board has its own mechanism for enforcing its standards of medical practice. A review of one year of the disciplinary actions taken by two states revealed that it was uncommon for the boards to take disciplinary action of a violation of informed consent rules. Rather, the majority of medical board actions seem focused on patterns of major medical malpractice, sexual misconduct, criminal activity, and alcohol and drug abuse by practitioners.¹³⁹

III. CAPITULATION IS NOT CONSENT

The word consent means agreement to do something,¹⁴⁰ but that agreement cannot be coerced. As a general matter, coerced consent is not legally operative consent. In the area of sex crimes, a victim who "consents" to intercourse is still raped if the "consent" is acquired by a threat of

132. *Id.* at 930–31.

133. See *Cooper v. Mandy*, No. M201901748COAR9CV, 2020 WL 6748795, at *11 (Tenn. Ct. App. Nov. 17, 2020), *appeal granted* (Apr. 7, 2021), *rev'd* 639 S.W.3d 29 (Tenn. 2022); *Bryant v. HCA Health Servs. of Tenn.*, 15 S.W.3d 804 (Tenn. 2000).

134. Evelyn M. Tenenbaum, *Revitalizing Informed Consent and Protecting Patient Autonomy: An Appeal to Abandon Objective Causation*, 64 OKLA. L. REV. 697, 713–17, 736–37 (2012).

135. See *id.* at 736–37; *Brown v. Capanna*, 782 P.2d 1299, 1302–03 (Nev. 1989).

136. 464 F.2d 772 (D.C. Cir. 1972); see also *Largey v. Rothman*, 540 A.2d 504, 507–08 (N.J. 1988).

137. See Tenenbaum, *supra* note 134, at 737–38.

138. *Id.* at 716–17.

139. See *infra* note 214 and accompanying text.

140. See *Consent*, MERRIAM-WEBSTER, <https://www.merriam-webster.com/dictionary/consent> [<https://perma.cc/Z7EP-FR9U>] (last visited July 12, 2022).

violence.¹⁴¹ When assessing whether suspects have waived their Fifth Amendment rights against self-incrimination, it is not enough that the suspects signed a *Miranda* waiver document.¹⁴² If a court determines a suspect's will was overcome by police coercion, then the Fifth Amendment waiver is invalid.¹⁴³ In contract law, consent to contract under duress is voidable by the leave of the coerced party.¹⁴⁴ So why are substituted caregiver terms permitted when they are secured by take-it-or-leave-it tactics?

Currently, doctors and hospitals who demand that patients submit to substituted caregiver terms cannot be said to be truly receiving informed consent, rather they are receiving informed capitulation. Below I discuss why under the essence of contract law, fiduciary law, and medical ethics the manner in which many hospitals approach these terms should be changed.

A. *Contracting for Care*

As discussed at length above, the doctor-patient relationship can be contractual. Although violations of informed consent are rarely treated as contract violations, principles of fairness contained in contract law seem to be violated. When a patient begins a relationship with a doctor, particularly a surgeon, the patient reasonably expects the surgeon they are speaking to will be the surgeon doing the procedure. There are at least two potential issues with the approach some doctors and hospitals take when including substituted caregiver terms in consent forms. The first issue re-

141. See Josephine Ross, *Blaming the Victim: 'Consent' Within the Fourth Amendment and Rape Law*, 26 HARV. J. RACIAL & ETHNIC JUST. 1, 11 (2010).

142. See *Moran v. Burbine*, 475 U.S. 412, 421 (1986).

143. See *id.*

144. M.C. Dransfield, Annotation, *Ratification of Contract Voidable for Duress*, 77 A.L.R. 2d 426, *1 (1961) (“[T]he general rule to the effect that a contract entered into under duress is voidable and not void . . .”). “Typically, however, the victim of duress has manifested consent to a coerced bargain where he or she has no reasonable alternative. Such duress makes a contract voidable.” 1 CORBIN ON PENNSYLVANIA CONTRACTS § 28.02 (2022). When “threats are made that leaves the victim no reasonable alternative but to sign a contract, the contract is voidable.” 1-6 MURRAY ON CONTRACTS § 94 (2011). “‘Improper threats’ include threats of a crime or tort, criminal prosecution, the threat of civil process made in bad faith, or a threat constituting a breach of the duty of good faith and fair dealing.” *Id.*

Since consent given under duress is a consent not “freely” given, and not one in error, that consent may have been given by a party to a contract when that party was not “free” of mind and spirit because another person, known of that party, was actually the target of the violence or duress, so much so that the party to the contract “feared” for that person’s life, property or reputation. Therefore, LSA-C.C. Art. 1960 states: “Duress vitiates consent also when the threatened injury is directed against the spouse, an ascendant, or descendant of the contracting party.”

ALAIN LEVASSEUR, LOUISIANA LAW OF CONVENTIONAL OBLIGATIONS: A PRÉCIS § 4.3.1(B) (2d ed. 2015).

lates to alteration of the agreement after the parties have begun performance. The second issue relates to the doctrine of unconscionability.

1. *Revising the Agreement*

The doctor-patient agreement—say for a particular surgery—looks in some ways like a type of sequenced contract.¹⁴⁵ The doctor and patient enter into a relationship, the patient undergoes and pays for examinations, the doctor recommends the patient undergo surgery, the patient agrees, the patient likely meets with the doctor again prior to the surgery and pays for the encounter, the patient makes arrangements for insurance to cover the costs of the care, and takes the necessary steps so the patient can miss work and be prepared for the effects of the surgery, then the doctor performs the surgery. The danger of this sort of sequenced agreement is that the doctor has an increased power position in the agreement due to the patient's sunk cost.¹⁴⁶ Thus, if the doctor comes to the patient the day of or the day before the surgery and requires the patient to accept a substituted caregiver term, the patient has very little power to say no.

As a general matter, the law of contracts seeks to discourage, if not prevent, one contracting party from taking advantage of another party, after performance has begun.¹⁴⁷ Two doctrines in contract law seek to prevent such opportunistic renegotiations—the doctrines of consideration and duress.¹⁴⁸ The doctrine of consideration holds that no modification of a contract is enforceable absent consideration. If this doctrine is applied to the circumstance where a doctor requires a patient to agree to a substituted caregiver term, the substituted caregiver term would be unenforceable unless the doctor offers the patient some sort of consideration in exchange for the modification which the patient is willing to accept. The doctrine of consideration is derived from the common law, while duress-induced contractual modification is most commonly associated with the Uniform Commercial Code (UCC).¹⁴⁹ The UCC permits contractual modification without consideration, but any modification is subject to the

145. See generally G. Richard Shell, *Opportunism and Trust in the Negotiation of Commercial Contracts: Toward a New Cause of Action*, 44 VAND. L. REV. 221, 222 (1991). Richard Shell describes sequencing contracts, "In a complex economy, many business transactions take place sequentially—one party performs in part or in full before the other side executes its side of the bargain. Sequencing has many advantages, but it creates an unfortunate incentive." *Id.* at 222.

146. See Jeffrey N. Gordon, *The Mandatory Structure of Corporate Law*, 89 COLUM. L. REV. 1549, 1589–90 (1989).

147. See *Wis. Knife Works v. Nat'l Metal Crafters*, 781 F.2d 1280, 1285 (7th Cir. 1986).

148. *Id.* at 1285–86.

149. *Id.*

good faith requirements of the UCC.¹⁵⁰ Thus, the modification of a contract is unenforceable if it is achieved through duress.¹⁵¹

It could be argued that the doctor-patient relationship described above is not a single agreement but multiple ones. If there are multiple agreements, then the inclusion of a substituted caregiver term does not necessarily involve a modification of the agreement, and so the doctrine of consideration or duress are not appropriate analogies. Many doctors would likely find this argument appealing, and the argument might be presented in the following fashion. When a surgeon meets with a patient for a consult they are not agreeing to do a surgery on the patient—it is merely a consult. After the consult, the surgeon may suggest a course of action other than surgery and advise the patient to let the surgeon know how the plan of action works out. The patient could then follow the non-surgical course of action and be “cured,” or they could come back to the surgeon claiming the plan of action did not work. The surgeon might then do another examination and then suggest surgery. Thus, it could be argued there were at least two agreements—one for consultation and a non-surgical intervention, and a second for consultation and a surgical intervention. This argument recognizes that the doctor-patient relationship is fluid.

However, the above argument is flawed. First, when a patient is sent to a specialist who is also a surgeon, the relationship is usually for treatment, not just consultation. Although the doctor and patient have to agree on a treatment plan (i.e., the patient cannot force the doctor to undertake a treatment plan the doctor believes is ill advised, nor can a doctor force the patient to submit to a treatment plan the patient does not agree with), surgery is merely one of the many options available to fulfill their agreement. Second, even if the two-agreement theory described above was accepted, often substituted caregiver terms are interjected well into the doctor-patient relationship after the parties have agreed that the doctor will conduct the surgery.¹⁵²

150. U.C.C. § 2-209, cmt. 2.

However, modifications made thereunder must meet the test of good faith imposed by this Act. The effective use of bad faith to escape performance on the original contract terms is barred, and the extortion of a “modification” without legitimate commercial reason is ineffective as a violation of the duty of good faith. Nor can a mere technical consideration support a modification made in bad faith.

Id.

151. *See Wis. Knife Works*, 781 F.2d at 1286.

152. This Article does not assert that any jurisdiction in the United States would conclude that the inclusion of a substituted caregiver term violates the doctrines of consideration or duress. Rather, the Article asserts that the core concepts of fairness that underlie the doctrines of consideration and duress are offended by the current practice used by some doctors and hospitals regarding substituted caregiver terms.

2. *Unconscionability*

The contract doctrine that seems to fit most comfortably with the situation where a doctor or hospital seeks to compel a patient to accept a substituted caregiver term, is unconscionability. Unconscionability, as a doctrine, seeks to prevent what one scholar has described as “‘rotten deals;’ that is, substantively unfair and one-sided terms.”¹⁵³ In order for a contract term to be unconscionable, and thereby unenforceable, it generally must have two components: procedural unconscionability and substantive unconscionability.¹⁵⁴ At least one jurisdiction has found that, “[u]nconscionability can be analyzed from both the substantive perspective and the procedural perspective. Although the presence of both forms of unconscionability increases the likelihood of a court invalidating the agreement, there is no requirement that both forms be present.”¹⁵⁵

Contract terms that are procedurally unconscionable are also sometimes referred to as adhesive terms. However some courts treat the question of whether there is a contract of adhesion separately from whether there is procedural unconscionability.¹⁵⁶ Some courts first ask if there is a contract of adhesion and then if there is, they proceed to determine if the contract is unconscionable.¹⁵⁷ Procedural unconscionability or contracts of adhesion generally involve contracts that are written on standardized forms prepared by the stronger of the two contracting parties and presented as a take-it-or-leave-it contract.¹⁵⁸ When courts address procedural unconscionability they sometimes examine the circumstances surrounding the formation of the contract, asking: whether there was a time

153. Lauren Henry Scholz, *Fiduciary Boilerplate: Locating Fiduciary Relationships in Information Age Consumer Transactions*, 46 J. CORP. L. 143, 178 (2020) (quoting Jacob Hale Russell, *Unconscionability's Greatly Exaggerated Death*, 53 U.C. DAVIS L. REV. 965, 973–78 (2019)). See also RESTATEMENT (SECOND) OF CONTRACTS § 208 (AM. L. INST. 1981) (describing an unconscionable contract as: “If a contract or term thereof is unconscionable at the time the contract is made a court may refuse to enforce the contract, or may enforce the remainder of the contract without the unconscionable term, or may so limit the application of any unconscionable term as to avoid any unconscionable result.”). Although the traditional definition of unconscionability has been described as a contract or term that “no man in his senses and not under delusion would make on the one hand, and as no honest and fair man would accept on the other” that standard has evolved. See *Hume v. U.S.*, 132 U.S. 406, 411 (1889).

154. RESTATEMENT OF THE LAW, CONSUMER CONTRACTS § 5(b) (AM. L. INST., Tentative Draft Apr. 18, 2019).

155. Peavy *ex rel.* Peavy v. Skilled Healthcare Grp., Inc., 470 P.3d 218, 221–22 (N.M. 2020).

156. See *Poublon v. C.H. Robinson Co.*, 846 F.3d 1251, 1260–61 (9th Cir. 2017); *LaFrontera Ctr., Inc. v. United Behav. Health, Inc.*, 268 F. Supp. 3d 1167, 1203 (D.N.M. 2017).

157. See, e.g., *Seawright v. Am. Gen. Fin. Servs., Inc.*, 507 F.3d 967, 975–76 (6th Cir. 2007); *LaFrontera*, 268 F. Supp. 3d at 1203; *Alexander v. Pro. Exch. Serv. Corp.*, No. F059647, 2011 WL 1490906, at *6–11 (Cal. Ct. App. Apr. 20, 2011).

158. *Seawright*, 507 F.3d at 975 (2007).

pressure,¹⁵⁹ whether the terms of the contract were explained to or understood by the weaker party,¹⁶⁰ or whether the party claiming unconscionability was mentally compromised in some way.¹⁶¹ In the context of substituted caregiver terms, this part of the agreement will likely meet the requirements of the first prong—they are prepared by the hospital or doctor, they are offered on a take-it-or-leave-it basis, and the doctor/hospital is clearly in a superior bargaining position.

The more challenging question on unconscionability is whether substituted caregiver terms are substantively unconscionable. Courts have described substantive unconscionability in a variety of ways. The Supreme Court of New Mexico stated, “Substantively unconscionable contract provisions include provisions that unreasonably benefit one party over another.”¹⁶² The California Supreme Court has written, “Substantively unconscionable terms may take various forms, but may generally be described as unfairly one-sided.”¹⁶³ It is important to note that unconscionability, in general, is analyzed at the time of contracting, so in the context of the doctor-patient relationship, it is evaluated at the time a patient signs the agreement. Further, some courts have asserted that procedural and substantive unconscionability are looked at together. Thus, a contract term may be voidable if it is overwhelmingly unconscionable from a procedural perspective, even though it is less substantively unconscionable, and vice versa.¹⁶⁴

Other jurisdictions, like Arizona, have added a basis for determining that a procedurally unconscionable term (or a contract of adhesion) is unenforceable.¹⁶⁵ According to the Arizona Supreme Court, when a contract is procedurally unconscionable (or is a contract of adhesion) and a term of the contract is not within the reasonable expectation of the adhering party, the term is unenforceable.¹⁶⁶

Several jurisdictions have examined aspects of doctor-patient and hospital-patient contracts for unconscionability.¹⁶⁷ A commonly litigated

159. See *Grand Prospect Partners, L.P. v. Ross Dress for Less, Inc.*, 182 Cal. Rptr. 3d 235, 252 (Cal. Ct. App. 2015).

160. See *Cleveland v. Mann*, 942 So.2d 108, 114 (Miss. 2006).

161. See *Taylor Bldg. Corp. of Am. v. Benfield*, 884 N.E.2d 12, 22–23 (Ohio 2008).

162. *Peavy ex rel. Peavy v. Skilled Healthcare Grp., Inc.*, 470 P.3d 218, 222 (N.M. 2020).

163. *Gentry v. Superior Ct.*, 165 P.3d 556, 572 (Cal. 2007).

164. See *Brown v. Genesis Healthcare Corp.*, 729 S.E.2d 217, 226–27 (W. Va. 2012).

165. *Broemmer v. Abortion Servs. of Phx., Ltd.*, 840 P.2d 1013, 1018 (Ariz. 1992).

166. *Id.*

167. See generally *Brown*, 729 S.E.2d at 217; *Buraczynski v. Eyring*, 919 S.W.2d 314 (Tenn. 1996); *Cleveland v. Mann*, 942 So. 2d 108 (Miss. 2006); *Culler v. Johnson*, 98 Va. Cir. 470 (Va. Cir. Ct. 2014); *Moore v. Woman to Woman Obstetrics & Gynecology, LLC*, No. A-0683-11T1, 2013 WL 4080947 (N.J. Super. Ct. App. Div. Aug. 14, 2013); *Sosa v. Paulos*, 924 P.2d 357 (Utah 1996); *Strausberg v. Laurel*

doctor-patient contract term has been arbitration clauses.¹⁶⁸ These cases provide some insight into how courts analyze unconscionability in the context of the doctor-patient relationship.

Arbitration clauses and agreements vary in their exact terms, but in essence they require patients to bring legal actions against their doctors through arbitration. Arbitration agreements can vary in detail and length, but usually they are clearly written stand-alone documents. Many cases involving doctor-patient arbitration agreements result in the agreements being enforced. However, there are several notable exceptions that are discussed below. Further, in the cases where arbitration agreements are upheld, there are critical differences between arbitration agreements and substituted caregiver terms.

Courts frequently find written arbitration agreements between doctors and patients are contracts of adhesion. This is no surprise. As discussed above, the hallmarks of a contract of adhesion are two-fold: the contract is on a form created by the stronger party and the weaker party must agree to the term or contract as presented or there will be no contract. This is exactly how doctor-patient arbitration agreements are generally presented—they must be signed either before seeing the doctor or before the doctor will perform a particular service. A finding that the contract is a contract of adhesion is usually necessary to finding a contractual term is unconscionable, but often not sufficient in itself. Next, courts that distinguish between contracts of adhesion and procedural unconscionability will take up the procedural unconscionability issue. Whether the court finds procedural unconscionability turns on how the agreement was executed. Was the agreement presented as a separate document, or was it contained in some other document?¹⁶⁹ Was the agreement explained to the patient?¹⁷⁰ Was the agreement provided in advance of the care or on the day of care? Was the patient's capacity compromised in some way? These are just some of the questions courts may ask when determining procedural unconscionability in the arbitration context.

Next, courts have examined whether doctor-patient arbitration agreements were substantively unconscionable, which usually means unfairly one-sided. In this area courts have frequently concluded that the arbitration agreement was not substantively unconscionable and so the agreement was enforceable. An exception to this trend is *Peavy ex rel. Peavy v.*

Healthcare Providers, LLC, 304 P.3d 409 (N.M. 2013); *Miner v. Walden*, 422 N.Y.S.2d 335 (N.Y. Sup. Ct. 1979).

168. See cases cited *supra* note 167.

169. *Cleveland*, 942 So. 2d at 114–15. The court noted that procedural unconscionability focuses on whether the weaker party lack knowledge of the alleged unconscionable term. *Id.* at 114. “A lack of knowledge is demonstrated by a lack of understanding of the contract terms arising from inconspicuous print or the use of complex, legalistic language, disparity in sophistication of parties, and lack of opportunity to study the contract and inquire about contract terms.” *Id.* (quoting *Vicksburg Partners, L.P. v. Stephens*, 911 So.2d 507, 517 (Miss. 2005)).

170. *Broemmer*, 840 P.2d at 1016.

*Skilled Care Group, Inc.*¹⁷¹ In that case, a plaintiff brought a wrongful death suit against a skilled nursing home and alleged that the arbitration agreement was unenforceable because it was unfairly one-sided. The New Mexico Supreme Court found the agreement was unfairly one-sided and so was substantively unconscionable. Another case, *Broemmer v. Abortion Services of Phoenix, Ltd.*,¹⁷² also found a doctor-patient arbitration agreement unenforceable. In *Broemmer*, the Arizona Supreme Court found an arbitration agreement was unenforceable where the agreement required the arbitration to take place before an OBGYN arbiter and the arbiter term was outside the plaintiff's reasonable expectations.¹⁷³ Another example can be seen in *Beynon v. Garden Grove Medical Group*,¹⁷⁴ where the arbitration agreement gave the medical group the unilateral right to reject an arbiter's decision and require another arbitration (the patient would be responsible for paying one half of the arbiter's fee in either arbitration).¹⁷⁵

Based on how courts have approached doctor-patient arbitration agreements, it seems likely that substituted caregiver terms would run afoul of aspects of unconscionability. In the context of a surgical procedure, these terms are often contained in a single document that includes other information regarding a patient's procedure. Usually this document is entitled "consent for care" or "informed consent." Frequently, these terms are not discussed or described to patients. Oftentimes the consent document is provided to a patient shortly before the procedure or surgery. The consent document is given to the patient in a take-it-or-leave-it fashion—if you want the surgery, sign the form. Depending on the particulars of patients' situations, they may be experiencing significant pain or emotional upheaval or they may be in a location where the local teaching hospital is the only facility for hundreds of miles capable of providing the patient the necessary care.

Of course, not all substituted caregiver terms appear to be unconscionable. Depending on the circumstances, a patient may have many options for care, especially for elective procedures in metropolitan areas. Although substituted caregiver terms inure to the benefit of the doctor or hospital, they are not, on their face, unfairly one-sided. The doctor who enters into the doctor-patient relationship is still responsible for meeting the standard of care in the procedure. As many substituted caregiver terms are usually written, the doctor must supervise the substituted caregiver.

Despite the fact that courts would likely differ on whether substituted caregiver terms have a degree of unconscionability, the essence of the doctrine calls for doctors and hospitals to cease these take-it-or-leave-it terms.

171. 470 P.3d 218 (N.M. 2020).

172. 840 P.2d 1013 (Ariz. 1992).

173. *Id.* at 1017.

174. 161 Cal. Rptr. 146 (Cal. Ct. App. 1980).

175. *Id.* at 148.

The core violation of an unconscionable term is to the freedom of the weaker party to the agreement and to the fundamental requirement of fair play in contracting. These violations are made worse by the fact that these terms usually are introduced after the doctor-patient relationship has begun—making the introduction of these terms appear even less fair and making the patient feel like he or she has even less freedom.

Finally, in response to the arguments regarding revising the doctor-patient agreement and unconscionability, it could be said that the informed consent aspect of the doctor-patient relationship is not part of the contract between the doctor and patient. If patients wish to ensure the doctor they are speaking with will be conducting the surgery then they should ask for that term at the outset of the relationship. Further, if the doctor works at a teaching hospital, the patient should have known the surgeon would likely have students assisting in the procedure. Although potentially valid, these arguments miss the essence of the contractual fairness argument. Even if the informed consent part of the doctor-patient relationship is not technically part of the doctor-patient contract, the concepts of fairness contained in contract law should apply. Further, the law recognizes that when parties are not engaged in arms-length negotiations, the normal rules of contracting bend. These arguments that deny the unfair aspects of many substituted care giver terms miss the unique nature of the doctor-patient relationship that make it a contract-plus relationship.

B. *Fiduciary Duty*

The essence of a fiduciary's duty is to put the beneficiary's interests first and to not take advantage of the unique power they have over the beneficiary. It is difficult to see how the use of a take-it-or-leave-it approach to securing substituted caregiver terms is not a violation of this core expectation of a fiduciary. Fiduciary duties like loyalty, honesty, and the absence of conflicting interests all argue against the take-it-or-leave-it approach.

Most courts that have taken up the issue have concluded that the doctor-patient relationship is a fiduciary one. In a number of cases courts have examined whether doctors violated their fiduciary duty to a patient by disclosing confidential information. A few notable decisions have addressed the question of a fiduciary violation by a doctor in other circumstances.¹⁷⁶ One of the most important court decisions regarding informed consent, *Moore v. Regents of the University of California*,¹⁷⁷ was framed as a breach of fiduciary duty.¹⁷⁸

176. See generally *King v. Bryant*, 795 S.E.2d 340 (N.C. 2017); *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479 (Cal. 1990).

177. 793 P.2d 479 (Cal. 1990).

178. *Id.*

In *Moore*, the plaintiff suffered from leukemia and went to the University of California at Los Angeles (UCLA) Medical Center for care.¹⁷⁹ Moore's primary doctor treating him for leukemia, Dr. Golde, recommended Moore have his spleen removed to slow the progress of his disease, but then the doctor conducted research on the removed spleen without informing Moore.¹⁸⁰ Over several years Dr. Golde advised Moore to return to UCLA's Medical Center to have blood, bone marrow, and other bodily samples removed.¹⁸¹ Moore alleged that the research being conducted on his blood, bone marrow, and other fluids was not for his treatment.¹⁸² Using Moore's tissue, Dr. Golde patented a particular cell line from Moore's T-lymphocytes.¹⁸³ Moore alleged that neither Dr. Golde nor UCLA Regents informed him of their financial interest in his tissue.¹⁸⁴ Moore sued Dr. Golde, the hospital where he was being treated, and others.¹⁸⁵

The California Supreme Court ruled that Moore's complaint was adequate to sustain a claim for breach of fiduciary duty.¹⁸⁶ In arriving at this conclusion the court explained that a doctor has a fiduciary duty to disclose all the information material to a patient in making the decision to undergo treatment.¹⁸⁷ Part of the information necessary for informed consent is whether a doctor has "personal interests unrelated to the patient's health, whether research or economic, that may affect the physician's professional judgment."¹⁸⁸

Another case discussing the fiduciary duties of a doctor beyond confidentiality is *King v. Bryant*.¹⁸⁹ In *King*, the North Carolina Supreme Court found that a doctor breached his fiduciary duty to a prospective patient when he sought the proposed patient's signature on a one-sided arbitration agreement.¹⁹⁰ The plaintiff's primary care physician referred him to the defendant, a surgeon, for a consultation regarding a hernia.¹⁹¹ Dr. Bryant's receptionist gave Mr. King several documents that he was required to complete and sign before seeing Dr. Bryant.¹⁹² Among the documents Mr. King was required to complete was an arbitration agreement.¹⁹³ According to the trial court, the agreement was confusing,

179. *Id.* at 480, 486–87.

180. *Id.* at 481–82.

181. *Id.* at 481.

182. *See id.* at 486.

183. *Id.* at 481–82.

184. *Id.* at 485–86.

185. *Id.* at 482, 486–87.

186. *Id.* at 485–86.

187. *Id.* at 497.

188. *Id.* at 483.

189. 795 S.E.2d 340 (N.C. 2017).

190. *See id.* at 350–52.

191. *Id.* at 344.

192. *Id.*

193. *Id.*

technical, poorly written, and one-sided (the panel of three arbiters must include at least one physician and can include all three physician arbiters).¹⁹⁴

King is a striking case for at least two reasons. First, in *King* the court found a fiduciary relationship existed between the plaintiff and defendant regardless of whether the doctor-patient relationship had been formed.¹⁹⁵ The mere act of being referred to Dr. Bryant and seeking his consultation was enough for a majority of the court to find a fiduciary relationship and corresponding duties.¹⁹⁶ Second, after finding the existence of a fiduciary relationship, the North Carolina Supreme Court concluded that Dr. Bryant breached his fiduciary duty by including the arbitration agreement within a stack of other documents and failing to specifically bring the arbitration agreement to Mr. King's attention and explain its impact.¹⁹⁷

Although *King* and *Moore* deal with different breaches of a doctor's fiduciary duty, they both reject doctors using the doctor-patient relationship to their advantage. In *Moore*, the doctor and hospital failed to describe their interest in the plaintiff, beyond the doctor-patient relationship. In *King*, the doctor appears to have taken advantage of the trust between doctors and potential patients, to secure a favorable legal position with regard to the patient. The correlations between *Moore* and *King* and the circumstance where doctors or hospitals pursue substituted caregiver terms are substantial. In both *King* and *Moore*, doctors sought patient consent for agreements that benefited the doctors, potentially at the patient's expense. This is the same circumstance when doctors and hospitals ask patients to agree to substituted care terms.

When a doctor or surgeon at a teaching hospital elects to supervise a procedure rather than conducting it themselves, that action cannot reasonably be described as being for the patient's benefit. The practice of substituted caregivers benefits doctors by allowing them to fulfill their mentoring and teaching duties. In some circumstances, this approach allows a doctor to supervise more than one procedure at a time.¹⁹⁸ Substituted caregiver agreements allow teaching hospitals to teach and thus enable the associated medical school to attract students. The medical student (intern) or resident gains critical experience. Even the greater public gets a benefit by increasing the number of competent doctors to treat everyone. But what of the patients, what do they get? It is often argued that patients get the benefit of more eyes on their case—the primary doc-

194. *Id.* at 344–45.

195. *Id.* at 350.

196. *Id.*

197. *Id.*

198. The process of an attending physician supervising two surgeries at once is called “running two rooms” and is controversial. Sandra G. Boodman, *Double-Booked: When Surgeons Operate on Two Patients at Once*, KAISER HEALTH NEWS (July 12, 2017), <https://khn.org/news/double-booked-when-surgeons-operate-on-two-patients-at-once/> [https://perma.cc/VWL7-ALRH].

tor, a resident, and perhaps even an intern. But this benefit is not achieved by the resident or intern conducting part of the surgery or medical procedure—that particular event, all things being otherwise equal, would presumably always be best done by the teaching physician or surgeon.

In *King*, part of why the court found a breach of fiduciary duty was because of the manner in which the doctor provided King the arbitration agreement. The doctor's receptionist included the agreement with many other documents, no one in the doctor's office explained the agreement, and the agreement itself did not recommend the patient seek out the advice of an attorney (as some arbitration agreements do).¹⁹⁹ It is quite common for doctors and hospitals to provide informed consent forms to patients without explaining the details of the document because the doctor and patient have already discussed the medical procedure. When an explanation is provided, it generally relates to the actual medical procedure rather than the substituted care terms. Even more concerning than the arbitration agreement in *King* is substituted care terms are frequently not in stand-alone documents. Rather, they are sometimes buried in the middle of informed consent documents that otherwise relate specifically to the advantages and disadvantages of a particular medical procedure. It is also worth noting that to patients undergoing a procedure or surgery, the informed consent form can appear as a mere technical formality. These forms cover information that a patient's doctor will have already discussed with the patient when making the decision to undergo a procedure or surgery. Thus it is even more likely that a patient will either not read the informed consent form or read it incompletely. Further, unlike the arbitration agreement in *King*, which was provided to the plaintiff well before the proposed surgery, informed consent forms are commonly given to patients within days of, if not on the day of, surgery.²⁰⁰

Because of the reasons described above, there is a strong argument that the current approach to informed consent regarding substituted care terms used by some doctors and hospitals breaches the essence of the fiduciary duty that a doctor owes a patient. This breach can leave a patient feeling taken advantage of and damage the trust between doctor and patient. The patient who has developed a relationship with a particular surgeon over the course of weeks or months can easily feel coerced when shortly before the surgery they are asked to let a doctor in training conduct part of the surgery. Worse, that same patient may feel bamboozled if

199. *King*, 795 S.E.2d at 350.

200. See David Wahlberg, *Surgical Consent Altered at UW After Case Involving Hysterectomy*, CHIPPEWA HERALD (Mar. 29, 2021), https://chippewa.com/news/state-and-regional/surgical-consent-altered-at-uw-after-case-involving-hysterectomy/article_c8854c35-dfac-57a1-90a2-453f16b2e71c.html [<https://perma.cc/X6YD-Z92X>]. See also *Mettias v. United States*, No. 12-00527 ACK-KSC, 2015 WL 1931082, at *20–22 (D. Haw. Apr. 21, 2015) (noting a doctor gave a patient an informed consent form to sign on the day of surgery).

they discover after the surgery that the doctor in training conducted part of the procedure and the patient had agreed to the substitution in a document they did not read.

C. *Medical Ethics*

As discussed above, doctors possess an ethical obligation to secure informed consent from their patients prior to providing care. This ethical requirement reflects the medical profession's recognition and commitment to the value of patient autonomy and the need for a trust-based relationship between doctors and patients. The current approach to informed consent regarding substituted care giver terms used by some doctors and hospitals is inconsistent with a doctor's ethical responsibilities, as they are described by the AMA.

The ethical foundation of both clinical and research medicine has been described as resting on four principles: individual autonomy, beneficence, justice, and non-maleficence (do no harm).²⁰¹ The principle of autonomy can be expressed as the right of individuals to make their own decisions regarding their health care.²⁰² Beneficence is where a doctor helps a patient by preventing harm, removing harm, or promoting good.²⁰³ Justice, although an inherently abstract principle, in this context means that a doctor extends to a patient what is "fair, due, or owed."²⁰⁴ Finally, the principle of non-maleficence can be best understood as a commitment to "do no harm."²⁰⁵ To one degree or another, these principles can be seen underpinning the AMA Code. Section 1.1.1 of the AMA Ethical Code emphasizes the personal and private nature of the doctor-patient relationship. The doctor is the caregiver for the patient, with duties to that patient and that relationship—rather than some broader, amorphous duty to the health of society (although there are occasions where a doctor's duty of confidentiality to a particular patient may be outweighed by a duty to protect the public).²⁰⁶

201. This description was first provided in BEAUCHAMP & CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* (1979). See Sahin Aksoy & Ali Tenik, *The 'Four Principles of Bioethics' as Found in 13th Century Muslim Scholar Mawlana's Teachings*, 3 *BMC MED. ETHICS* 1, 1 (2002) (citing TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* (1979)). The principles described by Beauchamp and Childress have deep historic roots in the medical profession. See *id.* at 1.

202. R. Gillon, *Ethics Needs Principles—Four can Encompass the Rest—and Respect for Autonomy Should be "First Among Equals"*, 29 *J. MED. ETHICS* 307, 310 (2003).

203. FADEN & BEAUCHAMP, *supra* note 109.

204. *Id.* at 14.

205. Adrian Aldcroft, *Measuring the Four Principles of Beauchamp and Childress*, *BMC: SERIES BLOG* (July 13, 2012), <https://blogs.biomedcentral.com/bmcseries-blog/2012/07/13/measuring-the-four-principles-of-beauchamp-and-childress/> [<https://perma.cc/XU3R-P9VY>].

206. See *Code of Medical Ethics Opinion 1.1.1*, *AM. MED. ASS'N*, <https://www.ama-assn.org/delivering-care/ethics/patient-physician-relationships> [<https://perma.cc/M5UG-Q895>] (last visited July 13, 2022).

The approach used by some doctors and hospitals to secure consent for substituted caregiver terms is inconsistent with the four principles of medical ethics and the AMA Code. Of the four principles, autonomy seems most offended by this approach. Autonomy cannot be exercised when individuals are unaware that they are making a decision—further, the more individuals are coerced into a particular decision the less they have exercised autonomy. Although beneficence and non-maleficence do not appear particularly compromised by the substituted caregiver terms, they are not advanced. Further, the likelihood of doing harm and failing to actively advance a patient's health are increased in circumstances where a less experienced caregiver is learning how to do a procedure on a patient. Finally, the principle of justice would seem harmed by these terms where patients are not getting what they are due—control over their bodies.

It certainly can be argued that substituted caregiver terms are an ethical good because they serve society's needs. Substituted caregiver terms allow tomorrow's doctors to learn their craft. But these terms, by themselves, are not the problem; the problem is the manner in which doctors and hospitals seek to have patients consent to these terms. Doctors and hospitals can seek true informed consent²⁰⁷ regarding these terms by getting patients to agree to substituted caregiver terms without violating the principles of medical ethics.

The AMA Code of Medical Ethics places a high premium on patient autonomy, noting in *Opinion 1.1.4* “[a]utonomous, competent patients control the decisions that direct their health care.”²⁰⁸ When it comes to receiving care from student doctors (such as interns and residents) the AMA Code states patients should accept care from these individuals but “refusal of care by a trainee should be respected in keeping with ethics

The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare.

Id.

207. See *infra* Part IV. This Part explains in detail what this Author means by “true informed consent.” Briefly, true informed consent regarding substituted caregiver terms requires disclosure of the term at the outset of the doctor-patient relationship. The substituted caregiver term would be explicitly explained in the doctor-patient “contract.” Further, the patient must have the option to opt out of the term and still receive treatment. During the initial meeting with the doctor, the doctor would set aside time for questions from the patient regarding the “Doctor-Patient Contract” and the substituted caregiver term.

208. *Code of Medical Ethics Opinion 1.1.4*, AM. MED. ASS'N, <https://www.ama-assn.org/delivering-care/ethics/patient-responsibilities> [<https://perma.cc/HVN2-X2MK>] (last visited July 13, 2022).

guidance.”²⁰⁹ Chapter II of the AMA Code focuses on informed consent, again placing a premium on autonomy. The Code recognizes that “[p]atients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care.”²¹⁰ With regard to substituted care, the Code states, “[p]atients are entitled to choose their own physicians, which includes being permitted to accept or refuse having an intervention performed by a substitute.”²¹¹ When doctors and hospitals require substituted care terms in their informed consent forms on a take-it-or-leave-it basis—it conflicts with doctors’ obligations to respect the free will choices of their patients.

IV. TRUE INFORMED CONSENT

The practice of burying substituted caregiver terms in informed consent forms should be discontinued. It is inconsistent with the essence of fundamental principles of contract law, fiduciary law, and medical ethics. The practice is made worse by the commonplace use of strong arm take-it-or-leave-it tactics regarding these terms and the introduction of these terms late into the doctor-patient relationship. Below, this Article discusses why the current systems for redressing these improper tactics are inadequate to address the problem. Next, this Part will address what possibly underlies why doctors and hospitals engage in these practices and why these tactics are unnecessary. Finally, the Part will propose an approach to correct the problematic aspects of this practice while also permitting doctors and hospitals to receive truly informed, uncoerced consent from patients regarding substituted care.

A. *Why Today’s Enforcement Mechanisms Are Inadequate*

As described above, the essence of contract law, fiduciary law, and medical ethical rules all argue against the practice of requiring patients to agree to substituted caregiver terms. If this statement is correct, then patients can simply bring a cause of action for breach of a contract or fiduciary duty or make a complaint to a doctor’s licensing board. But is this an effective method of redressing the problem? None of the vehicles available to patients are practical to ensure they are not required to consent to substituted caregiver terms.

As mentioned above, the flow of events where a doctor seeks a substituted caregiver term makes preventative legal action highly impractical and potentially impossible. Often, these terms are not included in the

209. *Id.*

210. *Code of Medical Ethics Opinion 2.1.1*, AM. MED. ASS’N, <https://www.ama-assn.org/delivering-care/ethics/informed-consent> [<https://perma.cc/DP8V-6EN3>] (last visited July 13, 2022).

211. *Code of Medical Ethics Opinion 2.1.6*, AM. MED. ASS’N, <https://www.ama-assn.org/delivering-care/ethics/substitution-surgeon> [<https://perma.cc/H7L2-JN5E>] (last visited July 12, 2022).

agreements that form the doctor-patient relationship, making a breach of contract claim difficult, if not impossible. Even supposing a patient could claim that the substituted caregiver term is unconscionable, and so unenforceable, that will do the patient no good. These terms frequently are placed in consent forms that are provided to a patient shortly before surgery. If the patient does not agree to the term, the surgery will not happen. The patient will have to reschedule the surgery and find a new doctor.²¹² The downside to such a step far outweighs any recovery a patient may get if a court permitted an action for a breach of contract or fiduciary duty.

If a patient tried to pursue a cause of action based on a violation of informed consent claiming the consent was unwilling, such a cause of action would be extremely difficult to win. Nearly all the jurisdictions in the United States have stopped applying a battery approach to informed consent actions, adopting a negligence theory instead.²¹³ Applying a negligence theory of informed consent would provide little benefit to a plaintiff. First, the action would have to overcome the fact that the patient was informed and consented. Second, unless some actual harm flowed from the forced consent (beyond the sense of being forced to agree to an objectionable term) there would be little incentive for a plaintiff to bring an action.

Perhaps the best chance for a patient to receive redress might be through a complaint to a medical ethics board. State medical boards hear hundreds of complaints alleging doctor misconduct every year. A review of the published opinions of two state medical boards revealed several disciplinary complaints and actions for violating rules governing informed consent.²¹⁴ However, these actions tend to focus on failure to adequately provide information about a procedure or possible side effects. Further,

212. It would be wrong to ignore that patients do not want to get on the wrong side of their doctors for fear of being blacklisted by the doctor. This concern is common enough to have been the basis of a storyline in the comedy television series *Seinfeld*. *Seinfeld: The Package* (NBC television broadcast Oct. 17, 1996).

213. Medical battery is still a viable cause of action where a doctor and patient agree to surgery A and then the doctor conducts surgery B. “Thus, in a medical battery case, the plaintiff may recover by establishing ‘a total lack of consent to the procedure performed, that the treatment was contrary to the patient’s will, or that the treatment was at substantial variance with the consent granted.’” *Fiala v. Bickford Senior Living Grp., LLC*, 43 N.E.3d 1234, 1240 (Ill. App. Ct. 2015) (quoting *Curtis v. Jaskey*, 759 N.E.2d 962, 962 (Ill. App. Ct. 2001)).

214. The actions of Florida’s and Virginia’s medical disciplinary boards were reviewed with a total of 610 decisions and actions between March 17, 2021 and March 17, 2022. See *Case Decisions History*, VA. DEP’T HEALTH PROS., https://www.dhp.virginia.gov/enforcement/cdecision/cd_advsearch.asp?profID=1&pname=medicine [<https://perma.cc/5GKK-7QD6>] (last visited July 13, 2022); Medical Quality Assurance Search Services: Discipline & Administrative Actions, FLA. DEP’T HEALTH, <https://mqa-internet.doh.state.fl.us/MQASearchServices/EnforcementActionsPractitioner> [<https://perma.cc/4SX6-BVJG>] (last visited July 13, 2022). It is noteworthy that not all 610 actions taken by the Florida and Virginia medical boards were disciplinary opinions. Many of the actions were

appealing to the state medical board will do nothing to help patients in the week before surgery when they are presented with an informed consent document that includes a substituted caregiver term. As the system currently exists, there is no reasonable or practical redress for a patient who does not want to submit to substituted caregiver terms. The patient either agrees to the term, does not get the surgery, negotiates a compromise with the doctor and trusts that the doctor will follow the oral agreement between doctor and patient, or is fortunate enough to have a doctor willing to honor the patient's wishes.

B. *Why Pursue Take-It-or-Leave-It Consent*

Preserving the autonomy of patients and trust between doctors and patients while also training future generations of doctors and promoting the advancement of medical research are all simultaneously possible. The suggestion that these goals are at odds is incorrect. Underlying this suggestion appears to be an assumption that patients, if given true informed consent, would refuse to permit substituted caregivers. Although it is true that some studies suggest greater reluctance among patients undergoing surgery to have a student doctor assist with the procedure, studies also suggest that reluctance can be overcome. The desire to assist in the advancement of science and to alleviate the suffering of others is not unique to the medical profession. This altruistic desire is seen daily when people agree to donate blood or participate in research studies. In 2018, Steven Petrow, a journalist and cancer survivor, described his and his mother's personal experience with participating in research. Mr. Petrow explained how both he and his mother had signed medical releases containing relinquishment of biologic material terms without understanding what they had signed. He stated:

Had Mom been asked directly for permission, I'm certain she would have said yes, especially knowing it would aid research. Likewise, I'd sign away if I saw that it might help develop more accurate diagnoses or new lifesaving therapies. But looking at that onerous consent language, all I can think is, "Wow—we really should have read those consent forms more closely." And, "That was not the right time to be trying to make sense of such important information."²¹⁵

It is also noteworthy that in 2021 in the United States over 40,000 organ donations were received, with 6,500 of those being from live do-

complaints filed or other actions like statements that a doctor's obligations had been satisfied.

215. Petrow, *supra* note 2.

nors.²¹⁶ So the suggestion that individual patients would not be willing to sign substituted caregiver terms seems incorrect.

A similar set of assumptions were at play over fifty years ago when the United States Supreme Court decided *Miranda v. Arizona*.²¹⁷ The *Miranda* decision established the requirement that police advise criminal suspects of their constitutional rights under the Fifth Amendment prior to subjecting them to police dominated interrogations.²¹⁸ Shortly after the decision Congress, convinced that the *Miranda* decision would significantly inhibit criminal investigations, passed a statute attempting to overturn *Miranda*.²¹⁹ Ultimately that statute was found to be unconstitutional,²²⁰ but what is more significant is that it was found to be unnecessary. At least one study revealed that most individuals waived their right to remain silent or to counsel after being read their *Miranda* rights.²²¹ The reasons for this phenomenon are difficult to know, but in an experiment that simulated a criminal investigation researchers found that “innocent” individuals waived their rights based on a belief that truth would prevail, while “guilty” individuals waived their rights in an effort to not look guilty.²²² Why individuals choose to waive their *Miranda* rights is difficult to say, but the assumption that if individuals understand their rights they will invoke them has been proven wrong.

Medical studies have been conducted regarding substituted caregiver situations. Among the studies that have been done assessing patient attitudes toward receiving care from a doctor in training (most studies assess patient attitudes regarding resident involvement in care), there appears to be greater apprehension regarding resident involvement in surgery versus other types of care.²²³ Studies demonstrate that even though some pa-

216. *All-Time Records Again Set in 2021 For Organ Transplants, Organ Donation From Deceased Donors*, UNITED NETWORK FOR ORGAN SHARING (Jan. 11, 2022), <https://optn.transplant.hrsa.gov/news/all-time-records-again-set-in-2021-for-organ-transplants-organ-donation-from-deceased-donors/> [<https://perma.cc/F89J-8G95>].

217. 384 U.S. 436 (1966).

218. *Id.* at 504.

219. Richard A. Leo, *The Impact of Miranda Revisited*, 86 J. OF CRIM. L. & CRIMINOLOGY 621, 622 (1996).

220. *See* Dickerson v. United States, 530 U.S. 428, 444 (2000).

221. Leo, *supra* note 219, at 653.

222. Saul M. Kassir & Rebecca J. Norwick, *Why People Waive Their Miranda Rights: The Power of Innocence*, 28 L. AND HUM. BEHAV. 211, 217–18 (2004).

223. Compare Jessica Bryce, Silvio Ndoja, Prateek Goyal, Brent Lanting & James Howard, *Patients' Perspectives on the Extent of Resident Participation in the Operating Room for Total Hip or Knee Arthroplasty*, 12 CAN. MED. EDUC. J. e21, e21 (2021) (“Patient confidence in residents performing part or all of their surgery increases with resident experience and supervision Most patients do not understand the educational progression of medical trainees and would like to know more about the education level of the resident involved in their care. Further work should explore how we can help patients better understand resident involvement in their surgical care.”), and Katherine H. Carruthers, James D. McMahan, Anne Taylor, Gregory Pearson, Pankaj Tiwari & Ergun Kocak, *Patient Attitudes Toward Resident Participation in Cosmetic vs Reconstructive Outpatient Consultations*, 72 J. SURGI-

tients are apprehensive regarding resident involvement in their care, that apprehension is significantly reduced when patients are provided more detailed information regarding the resident's training and how the resident will be supervised.²²⁴ Further, it appears that many patients do not object to the involvement of residents in their care, but they do expect to be asked for consent.²²⁵ Thus, there is data regarding patient attitudes toward substituted caregiver consent that suggests that patients are more likely to give consent when they receive more information about the resident and their involvement in care. Also, the evidence suggests that many patients understand and are willing to be a part of the teaching process for the next generation of medical professionals, but they expect to be asked.

C. *Clarifying the Lines*

Correcting the problem of take-it-or-leave-it informed consent should be approached at many levels. Changing laws and regulation, clarifying medical ethical codes, and instituting best practice approaches at the doctor and hospital level should all be considered to achieve truly voluntary informed consent. In just the last few years, several state legislatures have enacted informed consent laws regarding pelvic exams of unconscious patients.²²⁶ This action was taken when the public was outraged to learn that it was a common practice at some hospitals for doctors in training to conduct pelvic exams on female patients while the patient was under anesthesia.²²⁷ This sort of direct action legislation can be very effective at solving specific isolated issues in informed consent. For example, a state statute that requires surgeons to provide their patients an informed consent document no later than ten days before a non-emergency procedure involving general anesthesia could be effective at reducing the pressure patients feel when they receive an informed consent document on the day of surgery. However, it would be difficult to use state or federal legislation to solve the broader problem of take-it-or-leave-it consent in medicine.

CAL EDUC. 477, 480 (2015) ("Our data did, in fact, indicate that some plastic surgical patient subpopulations were hesitant to include residents in their treatment process."), with Christine E. Malcolm, Kevin K. Wong & Ruth Elwood-Martin, *Patients' Perceptions and Experiences of Family Medicine Residents in the Office*, 54 CAN. FAM. PHYSICIAN 570, 570 (2008) ("Respondents reported very positive experiences with having family medicine residents in the office. Overall comfort and satisfaction with seeing family medicine residents was reported to be extremely high, and most patients surveyed would choose to have family medicine residents involved in their care. Patients needed to know more about the resident's level of training and the role of residents in patient-resident interactions.").

224. Bryce, Ndoja, Goyal, Lanting & Howard, *supra* note 223, at e26.

225. See generally studies cited *supra* note 223.

226. Maya M. Hammoud, Kayte Spector-Bagdady, Meg O'Reilly, Carol Major & Laura Baecher-Lind, *Consent for the Pelvic Examination Under Anesthesia by Medical Students: Recommendations by the Association of Professors of Gynecology and Obstetrics*, 134 OBSTETRICS & GYNECOLOGY 1303, 1304-05 (2019).

227. See Robert P. Carpenter, Carly J. Dziekan & Kali Ruth Helen Schreiner, *Health Law*, 71 SYRACUSE L. REV. 191, 210 (2021).

Changes to regulations or medical ethical codes could help with some of the details necessary to make informed consent genuine. Regulations or codes could elaborate on informed consent, making it clear that in order for consent to be voluntary the patient must have a genuine alternative—i.e., no take-it-or-leave-it clauses regarding substituted caregiver terms.

Finally, it will be the hospitals and doctors that must create and implement best practices. These best practices will be where the flesh is put on the bones of any informed consent approach described in the law, regulations, and codes. The best practices should offer suggestions on how to most effectively provide patients the relevant information regarding their care and ensure patients are given the opportunity to make well considered voluntary decisions about their health care. Below are some suggestions that could be incorporated into a best practices approach.

D. *Suggested Best Practices*

Although the doctor-patient relationship should be fundamentally a contract—it seems like neither party wants to think of it that way. Few doctors call their engagement agreements contracts and they rarely provide patients with a list of how much their services will cost,²²⁸ as if it would be unseemly to suggest that the doctor-patient relationship was a money-for-services arrangement. Of course, it is not just doctors—patients seem equally uninterested in treating their relationship with their doctor as a form of contract. This fact is supported by studies that demonstrate patients frequently do not read the documents they receive from their doctors.²²⁹ Despite the reluctance on the part of doctors and patients to treat their relationship as a contract, it is a contract and more. The documents that form the foundation of the doctor-patient relationship should reflect this contract-plus relationship. Below, are suggestions regarding how the fundamental documents involved in the doctor-patient relationship could be divided and provided to patients. In most situations, four documents would be necessary: the contract; financial and other conflict of interest statement; HIPAA disclosure documents (I will not be provid-

228. A possible exception to this broad statement exists in elective care, where a patient pays the doctor directly without the involvement of an insurance company. Patient and doctor relationships with HMOs can create confusion regarding with whom the patient and doctor are contracting and raise questions of whether the doctor and patient are contracting with each other or the HMO.

229. See Andrew Coombes, *Do Patients Read Consent Forms?*, BMJ (Sept. 19, 2000), <https://www.bmj.com/rapid-response/2011/10/28/do-patients-read-consent-forms> [<https://perma.cc/XUQ2-TVFB>] (explaining that in a study of one hundred elderly patients, only one actually read the form); *Informed Consent: Hospitals Explore Personalizing Risks*, AM. MED. NEWS (May 17, 2010), <https://amednews.com/article/20100517/profession/305179950/2/> [<https://perma.cc/8T8J-6H9B>] (“Some 60% to 70% of patients do not read or understand informed-consent forms . . .”).

ing a discussion of this form as HIPAA is fairly clear as to what must be disclosed to patients); and informed consent.

1. *The Contract*

In an effort to ensure clarity, this document should be described as a contract. I suggest that it include a minimum of terms for: the initiation and termination of the doctor-patient relationship; payment; the type of care to be provided; other forms of monetary compensation the doctor receives associated with caring for the patient; consent to receive care; substituted caregiver terms (if they are to be part of the contract); and relinquishment of biologic materials (if they are to be part of the contract). Of course, additional terms may be appropriate depending on the type of medical practice involved.

Case law varies from state to state as to when a doctor-patient relationship begins, however, it makes sense that the initiation and termination of the relationship should be part of the doctor-patient contract. Generally, patients can terminate their relationship with a doctor whenever and for whatever reason they choose. Doctors can also terminate their relationship with a patient, but not as freely as the patient. Doctors who wish to end a doctor-patient relationship are required to continue to provide care to a patient until a suitable substitute can be found.²³⁰

Payment terms are a natural component of any contract, although it seems to be more difficult in the area of healthcare. Currently many doctor-patient agreements regarding payment say something like, “patients or their legal representative are ultimately responsible for all charges for services rendered,”²³¹ but the agreement does not describe how much the services are. Such an open-ended arrangement is problematic. Service rates from doctors vary depending on the arrangement the doctor or hospital has made with different insurance companies. To the extent possible, health care professionals should provide a fee sheet for the services they will provide for the patient and this sheet should be part of the agreement.

The type of care a patient receives from a doctor should be described in the contract so that patients and doctors clearly understand one another’s expectations. For example, when a patient begins a doctor-patient relationship with a family medicine practitioner, it would make sense that the doctor explain that the doctor is responsible for the general health of the patient. This care includes, but is not limited to: annual physicals; care for non-emergency medical concerns; and review and referral of requests for specialty services; etc. A description of care is perhaps more

230. *Code of Medical Ethics Opinion 1.1.5*, AM. MED. ASS’N, <https://www.ama-assn.org/delivering-care/ethics/terminating-patient-physician-relationship> [https://perma.cc/X6L4-8D78] (last visited July 13, 2022).

231. *Financial Policy*, PRIVIA MED. GRP., https://www.gwmfm.com/wp-content/uploads/2015/03/Financial_Policy.pdf [https://perma.cc/866E-QQT8] (last visited July 18, 2022).

important when a patient is referred to a specialist. Patients need to know which doctor is responsible for what care they are receiving to ensure they are coordinating with the right doctor. A patient with a cardiologist and pulmonologist may be confused about to whom they should report information regarding changes in their health and to whom they should direct heart-related questions versus lung-related questions.

The subject of physicians receiving indirect compensation related to patient care (for example HMO payments for keeping patient expenses low; payments for research regarding the patient's biologic material; and payments from a medical school for training medical students and residents) has been an area of some controversy recently. As explained in *Moore*, doctors who receive compensation as a result of research related to a patient generally ought to disclose that arrangement to the patient.²³² I suggest this section of the contract deal with direct compensation regarding this patient. Other types of compensation that a doctor receives for research in a general area that may relate to a patient but do not come directly from treatment of a particular patient would be more appropriately listed in the potential conflict of interest document.

The consent to receive care term would serve both as a contract term and as part of the initial informed consent. This term would serve as part of the informed consent necessary to the first encounter with the doctor and any treatment that can be identified as commonly or nearly universally conducted by the doctor. This would also outline the scope and expectations of the first meeting with the doctor. In a technical sense, doctors ought to receive informed consent for every procedure or test they subject a patient to, from blood draws to a physical to surgery. The consent to receive care from a family care provider could look something like:

I consent to receive care from ____ as my family care provider. I consent to undergo an annual physical examination that includes: the taking of a blood sample; measuring blood pressure; taking of body temperature; an examination of the body; and other tests that will be explained to me at the time of the physical. I consent to receive that care as deemed necessary by doctor ____ after it has been explained to me and I have agreed.

Substituted caregiver terms should be clear, explicit, and thorough. Although such terms would vary from one doctor to another based on how that doctor uses substituted caregivers, it would likely remain similar for each patient. The substituted caregiver term should include an option to opt out of such care. By including the option to not participate with substituted care, the contract can avoid the claim that the term is adhesive and unconscionable. Further, when a patient agrees to the term after reading the contract and having the term explained in person by individuals from the doctor's office, the doctor can be confident that the patient

232. *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479, 483 (Cal. 1990).

has freely given consent to such care. A substituted caregiver term should also allow the patient to change their mind if, at a later time, their attitude changes.

Relinquishment of biological material, like a substituted care term, should be explicit and clear as to what the patient is giving up and how that material is to be used. Fortunately, there are a number of research hospitals that have clear statements regarding biological material and involvement in scientific research. Again, critical to the validity of this term and avoiding claims that the contract is unconscionable is an opt-out provision for such a clause. Given the nature of how biological material is used during research, this clause should include an explanation of when, if at all, the patient can withdraw consent after it has been initially given.

2. *Statement of Potential Conflicts of Interest*

In *Moore*, the California Supreme Court noted that doctors might violate their fiduciary duty to patients if the doctors do not disclose a potential conflict of interest with regard to the financial interest they have in using patient's biological material as part of their research.²³³ Other scholars have explored the apparent conflicts of interest that exist when doctors work as part of an HMO.²³⁴ Often doctors who participate in HMOs receive incentives from the organization to keep medical expenses low. This arrangement can convey a healthcare advantage to patients where their doctors have an incentive to provide proactive healthcare in an effort to keep medical costs low. If, for example, a doctor knows a patient is at risk for a major cardiac event, the doctor may be more proactive in treating the patient to prevent the expense of a heart attack. However, an arrangement with an HMO can also appear to give doctors an incentive to forgo expensive tests for a particular patient in the hopes of securing a financial windfall for themselves. Although not required,²³⁵ this sort of arrangement should be disclosed to enhance the trust relationship between the doctor and patient.

3. *Informed Consent Form*

The law and medical ethics require a doctor secure informed consent prior to conducting a medical procedure or surgery. The informed consent form this article suggests would pick up with the consent to treatment where the contract leaves off. This form would be completed once a particular medical course of action had been decided upon between the doctor and patient. For example, one can imagine a patient who is suffering

233. *Id.*

234. Jamie Lynn Armitage, Case Note, *Pegram v. Herdrich: HMO Physicians as Fiduciaries*, 5 DEPAUL J. HEALTH CARE L. 341 (2002); Michael Nitardy, Student Article, *Does ERISA Impose on HMOs a Duty to Disclose Physician Incentive Contracts?: An Examination of Circuit Splits*, 31 N. KY. L. REV. 59 (2004).

235. See *Pegram v. Herdrich*, 530 U.S. 211 (2000). *But see* Nitardy, *supra* note 234.

from heart disease going to a cardiologist for a consultation. The contract with the cardiologist would explain that the patient is contracting with the cardiologist for the purpose of a cardiac consultation. As mentioned earlier, if there is a substituted care giver term, it should appear in the contract. The doctor or another health care professional would explain the contract, including the substituted care giver term and the option to opt out of the term. During the course of the consultation the doctor begins to suspect that the patient has a blockage in one or more of the arteries leading from the patient's heart. To better understand the patient's condition, the cardiologist recommends that the patient undergo a Magnetic Resonance Imaging test (MRI) of the chest. The doctor explains the reasons for the procedure, the benefits and potential risks, and the alternatives to the MRI and those attendant benefits and risks. The patient agrees to undergo the MRI. It would be at this time that the informed consent form would be produced and signed. The form would review all the matters that had been discussed during the oral consultation. The informed consent form would also identify who will be conducting the procedure (this identification could be a general one that describes the individual's position at the hospital—for example a hospital radiology technician).

Experts in medical informed consent have repeatedly emphasized that informed "consent is a process, not a form."²³⁶ As described above, this Article recommends that any procedure, test, or surgery be preceded by a conversation with a medical professional who explains to the patient all that is required to secure informed consent. Next, the medical professional should give the patient the opportunity to ask questions. After this process has occurred, the patient should receive the informed consent document, read it, sign it, and receive a copy of the document.

Some medical facilities have experimented with using a multimedia approach to informed consent. Facilities could use online presentations to convey information related to particular procedures. For example, a doctor or facility that conducts a large number of bronchoscopies (a medical procedure where a lighted tube is placed up a patient's nose or in the mouth and snaked down into the large airways of the lungs)²³⁷ could use a computer-based presentation to convey to patients some of the information necessary for informed consent. Other offices might use prerecorded presentations that patients watch prior to undergoing a surgery that explains how the surgery is conducted. This sort of multimedia approach could also be used prior to a patient visiting a doctor for the first time to ensure the patient understands the doctor-patient contract and the consent aspect of the first meeting. These multimedia approaches can help to secure informed consent, but should not be considered adequate substi-

236. ROZOVSKY, *supra* note 13, at 2–5.

237. See *Tests for Lung Disease*, NAT'L HEART, LUNG & BLOOD INST., <https://www.nhlbi.nih.gov/health/lung-tests> [<https://perma.cc/W9RN-9U3V>] (last updated Mar. 24, 2022).

tutes to one-on-one conversations between a medical professional and a patient and a well-drafted informed consent document.

To save time and facilitate greater understanding, it would be valuable to include multimedia approaches to all the documents described above. Many individuals are uncomfortable signing contracts or other similar documents. Form contracts are rarely read.²³⁸ For example, several studies found that most people do not read service agreements or contractual terms when they engage in online purchasing.²³⁹ It is likely that individuals do not read these contracts because they are overly complex and often seem ancillary to the consumer's object—to gain use of something that the consumer is willing to pay for. Given the fiduciary nature of the doctor-patient relationship, doctors and hospitals have a heightened duty to ensure patients understand what they are agreeing to, especially when the terms they are agreeing to do not really benefit them. By providing the documents described above at the outset of the doctor-patient relationship, explaining those documents (in person and via multimedia vehicles), and encouraging patients to ask questions, doctors can ensure they are fulfilling their legal and ethical obligations to their clients, while also building greater trust with the patient.

CONCLUSION

Virtually all of us will form a doctor-patient relationship in our lives—in fact most of us will have that relationship throughout our entire lives. This is unlike most other professional relationships. Consider, for example, the attorney-client relationship. Many in our society will never hire an attorney, and only the very wealthy or the very troubled will have an attorney-client relationship their entire life. Further, unlike accountants or lawyers, medical care is often less easily understood and lends itself less to self-informed decision making. Although tax or legal regulations may be complicated, because both are man-made they often follow a line of reasoning that can be understood with enough diligent examination. Medicine, like other hard sciences, has its own logic which does not necessarily follow a line of reasoning that is as readily apparent as the reasoning in man-made systems. Moreover, medical decision-making often has an urgency that other professional decision-making does not. When an individual seeks medical care they are often actively in physical distress.²⁴⁰ The individual is in pain or is unable to work and cannot put off a solution to their situation.²⁴¹ Finally, we entrust in our doctors our physical wellbe-

238. See Randy E. Barnett, *Consenting to Form Contracts*, 71 *FORDHAM L. REV.* 627, 630 (2002).

239. Claire M. Amodio, Note, *23andMe: Attack of the Clones and Other Concerns*, 31 *FORDHAM INTELL. PROP., MEDIA & ENT. L.J.* 926, 962 (2021).

240. Hafemeister & Spinos, *supra* note 59, at 1188 (noting “patients generally seek the services of a physician when they are sick, injured, or concerned about their health”).

241. See *RODWIN*, *supra* note 63, at 6.

ing—our very lives in some circumstances. To ensure the effectiveness of this relationship, patients must be confident that they can trust their doctor.

Additionally, patients, even more than clients in other professional relationships, are particularly vulnerable to being taken advantage of in the doctor-patient relationship. Often individuals are emotionally and physically depleted when seeking care. They are usually seeking care because of an illness or injury. Rarely do doctors see patients in the patients' homes, so the patient is in an unfamiliar place, where, depending on the circumstances, they may not be able to leave. Patients understand that they are relying on their physician to make them well, or at least, make them better than they currently feel. Thus, patients will often seek to please their doctors—it is natural for an individual to curry the favor of the person who will be conducting surgery on them. Because of the unique trust demands in the doctor-patient relationship and the vulnerable state most patients are in when seeking treatment, special protections are necessary to ensure patient decision-making is free and without any coercion.

It is long past time we stopped the practice of compelling individuals to consent to care from doctors they did not choose. The practice of waiting until the eve of a surgery or procedure and then “informing” the patient (in a document they are unlikely to read) the doctor they have chosen and met with will be supervising a less experienced medical professional and then informing that same patient this is a take-it-or-leave-it situation is unacceptable. The coercive effect of these tactics is undeniable and should be rejected.

