

5-1-2019

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Recommended Citation

Mary A. Bobinski, *Law and Power in Health Care: Challenges to Physician Control*, 67 Buff. L. Rev. 595 (2019).

Available at: <https://digitalcommons.law.buffalo.edu/buffalolawreview/vol67/iss3/13>

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Buffalo Law Review

VOLUME 67

MAY 2019

NUMBER 3

Law and Power in Health Care: Challenges to Physician Control

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I. INTRODUCTION

It was an honor to participate in the Baldy Center for Law & Social Policy's Fortieth Anniversary Conference. The Baldy Center has provided a home for countless scholars and students interested in studying the law as both an intellectual discipline and as a force shaping our lives. The Center fosters interdisciplinary dialogue that has helped us to understand law's theoretical underpinnings and its real-

† Dean, Emory University School of Law. Completion of this article was greatly aided by research support I received while serving as Professor, Allard School of Law (ALS), University of British Columbia, Vancouver, BC Canada. Thanks to ALS students Chris Lee and Coco Wiens-Paris for research assistance. Special thanks to SUNY Distinguished Professor Errol E. Meidinger as well as to the other organizers and participants in *Tempering Power*, The Baldy Center's 40th Anniversary Conference, November 10, 2018 for their thoughtful comments and the many provocative insights found in the Conference presentations and papers. This article is part of a larger comparative research project considering the characterization of the physician-patient relationship in the United States, Canada, Australia and the United Kingdom. I therefore wish to acknowledge with gratitude the support I received while serving as a visiting scholar at the Petrie-Flom Center for Health Law Policy, Biotechnology, and Bioethics at Harvard Law School, the University of Sydney Law School, the Melbourne Law School and the Faculty of Law at Oxford University. At Oxford University, I also benefited from the collegial advice and support provided through a Plumer Visiting Research Fellowship at St. Anne's College.

world impact. Thanks to the Center's efforts, we have been allowed to see more clearly the limits of law, the impact of law on people, and the successes and failures of the efforts of individuals and organizations to change the law to serve their own purposes.¹ Moreover, the Baldy Center's ambitious vision includes the promotion of global engagement through faculty research projects and visitor programs for scholars from around the world. Here too, one can see the impact of the Baldy Center's support on virtually every continent. Professor John Braithwaite's Mitchell Lecture on Tempered Power, Variegated Capitalism, Law & Society reflects the Baldy's Center's vision and mission. Professor Braithwaite is well-recognized as one of the world's leading scholars on topics such as peacebuilding, restorative justice, criminology and responsive regulation.²

Many of the papers presented at this year's Baldy Conference reflect Professor Braithwaite's nuanced and thoughtful consideration of significant global developments, such as the rise of authoritarian capitalism and challenges to the neoliberal democratic state. This Article resonates with Professor Braithwaite's calls to appreciate the role of law in tempering power and to consider carefully the conflicts and complexities below the surface of our facile

1. John Braithwaite, *Tempered Power, Variegated Capitalism, Law and Society*, 67 BUFF. L. REV. 527 (2019); Susan Bibler Coutin, 'Otro Mundo Es Posible': *Tempering the Power of Immigration Law through Activism, Advocacy, and Action*, 67 BUFF. L. REV. 653 (2019); Heinz Klug, *Transformative Constitutions and the Role of Integrity Institutions in Tempering Power: The Case of Resistance to State Capture in Post-Apartheid South Africa*, 67 BUFF. L. REV. 701 (2019); Martin Krygier, *What's the Point of the Rule of Law?*, 67 BUFF. L. REV. 743 (2019); Kwai Hang Ng, *Is China a "Rule-by-Law" Regime?*, 67 BUFF. L. REV. 793 (2019); Nimer Sultany, *What Good is Abstraction? From Liberal Legitimacy to Social Justice*, 67 BUFF. L. REV. 823 (2019); David A. Westbrook & Mark Maguire, *Those People [May Yet Be] a Kind of Solution" Late Imperial Thoughts on the Humanization of Officialdom*, 67 BUFF. L. REV. 889 (2019); Peer Zumbansen, *Transnational Law as Socio-Legal Theory and Critique: Prospects for "Law and Society" in a Divided World*, 67 Buff. L. Rev. 909 (2019).

2. For an overview of Professor Braithwaite's scholarly work and public engagement, see JOHN BRAITHWAITE: WAR, CRIME, REGULATION, <https://johnbraithwaite.com/> (last visited Apr. 1, 2019).

characterization of capitalist or non-capitalist economies, or liberal democracies and authoritarian states. However, this Article moves away from meta-theoretic, global concerns to focus on the story of power within one segment of the American economy—health care—and perhaps even more narrowly, to the position of two groups of actors—physicians and patients—within the health care sector.³

In this Article, I argue that law has played a major role in creating and shifting the balance of power in health care but that market forces have now displaced law in several important respects. The Article explores whether the effort to use law to affect power in health care should be affirmed or abandoned. Part II of this Article describes the role of law in establishing the power of physicians in health care. Part III explores the fundamental importance of law in empowering patients and a series of law-based challenges to physician supremacy. In Part IV, I will turn to consider a key issue in the role of law today: whether and how law can successfully harness physicians' power, knowledge, and expertise to serve patients' interests. In Part V, I offer some concluding thoughts about the past and future role of law in allocating power in the patient-physician relationship.

II. THE LAW AS A SOURCE OF PHYSICIAN CONTROL

A. *Overview*

It is commonplace today to think of law in opposition to

3. In 2016, there were nearly a million practicing physicians in the United States. Aaron Young, et al., *A Census of Actively Licensed Physicians in the United States, 2016*, 103 J. MED. REG. 7, 7 (2017) (the census counted actively licensed allopathic and osteopathic physicians in the United States, serving a population of 323 million). Professor Braithwaite is an influential scholar on various health care law topics, including the regulation of pharmaceutical companies and nursing homes. See, e.g., JOHN BRAITHWAITE, ET AL., *REGULATING AGED CARE: RITUALISM AND THE NEW PYRAMID* (2007); GRAHAM DUKES, JOHN BRAITHWAITE & J.P. MALONEY, *PHARMACEUTICALS, CORPORATE CRIME AND PUBLIC HEALTH* (2014).

medicine. There are countless jokes about the suspicion or even hostility of physicians toward lawyers. Yet, law played an important role in creating and solidifying the dominance of the medical profession and it is law, in part, that allowed physicians to control a significant portion of the health care system in the United States in the period from the late 1800s to the 1950s.

The story of the birth of the medical profession is compellingly told by Paul Starr in his Pulitzer Prize winning book, *The Social Transformation of American Medicine*.⁴ Professor Starr traces the history of medical practice in the United States and identifies the late nineteenth and early twentieth centuries as the time period in which the medical profession “[rose] to sovereignty.”⁵ At various stages and in

4. PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1982) [hereinafter STARR, *SOCIAL TRANSFORMATION*]. Dr. Starr is Professor of Sociology and Public Affairs and Stuart Professor of Communications and Public Affairs at Princeton University. He remains a thoughtful commentator on health care and health care reform in the United States. See, e.g., Paul Starr, *Rebounding with Medicare: Reform and Counter-Reform in American Health Care*, 43 J. HEALTH POL., POL'Y & L. 707 (2018) (noting that major U.S. health reforms have been achieved only after significant setbacks and arguing that the next reform effort should focus on the expansion of Medicare to include persons fifty to sixty-four years old).

Professor Starr's views on the history of medicine have attracted both praise and criticism, with some scholars contesting his emphasis on the role of physicians, which at least implicitly and often explicitly deprivileges the roles of other providers, patients, and economic or political actors. See, e.g., John Harley Warner, *Grand Narrative and Its Discontents: Medical History and the Social Transformation of American Medicine*, 29 J. HEALTH POL., POL'Y & L. 757, 765 (2004). Yet Starr's overview of the rise of the medical profession continues to resonate. See, e.g., Timothy Stoltzfus Jost, *The Uses of the Social Transformation of American Medicine: The Case of Law*, 29 J. HEALTH POL., POL'Y & L. 799, 799 (2004) (noting that the book was “clearly the most cited single source in law review articles dealing with health law.”).

5. STARR, *SOCIAL TRANSFORMATION*, *supra* note 4, at 4. Professor Starr argues that “[t]he history of medicine has been written as an epic of progress, but it is also a tale of social and economic conflict over the emergence of new hierarchies of power and authority, new markets, and new conditions of belief and experience. In America, no one group has held so dominant a position in this new world of rationality and power as has the medical profession.” *Id.* Although Professor Starr did not focus on the role of law, he notes some key legal developments, such as the role of licensure. See *id.* at 102–03.

various ways, law played an essential role in supporting the medical profession's growing autonomy and control. The power of the profession can be linked to three legal domains: licensure law, the corporate practice of medicine doctrine, and medical malpractice.

B. *Licensure and Self-Regulation*

Licensure laws are an important example of both the limits and power of law as a legitimating tool. Licensure may protect the public by restricting the provision of services to those who have met certain education and training criteria.⁶ Licensing regimes might also protect the public to the extent that regulatory authorities monitor the capacity, skill, and judgment of licensed practitioners.⁷ Licensing can strengthen the profession from within by reinforcing professional identity and permitting the development and enforcement of practice standards and ethics-based requirements. In addition, licensure may provide economic benefits by excluding some potential competitors from offering services within the licensed field of practice.⁸

Today, licensure as a component of professional practice seems so ingrained as to be inevitable. Yet the early battles over medical licensure in the United States demonstrate otherwise. A number of states enacted medical licensure

6. See generally MARK A. HALL, DAVID ORENTLICHER, MARY ANNE BOBINSKI, NICHOLAS BAGLEY & I. GLENN COHEN, *HEALTH CARE LAW AND ETHICS* 1256–69 (9th ed. 2018) [hereinafter *HEALTH CARE LAW AND ETHICS*]; Nadia N. Sawicki, *Character, Competence, and the Principles of Medical Discipline*, 13 J. HEALTH CARE L. & POL'Y 285 (2010).

7. Richard E. Burney, *Oversight of Medical Care Quality: Origins and Evolution*, 101 J. MED. REG. 8, 11 (2015) (noting oversight functions of state boards).

8. For well-known critiques of licensure laws as unwarranted restrictions on the market designed to benefit the licensees rather than the public, see generally MILTON FRIEDMAN, *CAPITALISM AND FREEDOM* 137–160 (U. Chicago Press 2002) (1962); Walter Gellhorn, *The Abuse of Occupational Licensing*, 44 U. CHI. L. REV. 6 (1976). For a more recent critique, see generally Kevin Dayaratna et al., *Reforming American Licensure*, 42 HARV. J. L. & PUB. POL'Y 253 (2019).

laws in the late 1700s and early 1800s, yet by the mid-1800s much of the legislation had been repealed.⁹ Professor Starr argues that these early licensure provisions were rejected as illegitimate, as an “expression of favor rather than competence.”¹⁰ Professor Lewis Grossman further contends that this initial rejection of licensure demonstrates a popular belief in “freedom of therapeutic choice” that is reflected, to this day, in recurring debates over the balance between government regulation and freedom of choice in health care.¹¹ The end result was that medical practitioners of widely differing philosophies, education, training, and experience were free to offer their services to patients in the mid- to late-1800s.

Licensure reemerged to play an important role in developing a coherent, powerful medical profession only when coupled with the legitimating rationale of science.¹² There were several competing schools of medical thought in the late nineteenth century, which were united only by the belief that licensure regimes should be implemented to prevent “untrained practitioners” from treating patients.¹³ They succeeded in promoting a new round of licensing initiatives focused on ensuring that practitioners had diplomas, although the legislation typically exempted current practitioners from entry requirements.¹⁴ These licensure regimes slowly began to become more detailed and exacting.

9. STARR, SOCIAL TRANSFORMATION, *supra* note 4, at 58.

10. *Id.* (“A license was useful as a means of establishing authority only if it was accepted as evidence of objective skill. But the belief that medical societies and boards of censors were merely closed corporations, like the banks and monopolies, utterly subverted their value as agencies of legitimation.”).

11. Lewis Grossman, The Origins of American Health Libertarianism, 13 YALE J. HEALTH POL’Y L. & ETHICS 76, 80 (2013).

12. See STARR, SOCIAL TRANSFORMATION, *supra* note 4, at 58–59.

13. *Id.* at 102 (noting the alliance of “regular” physicians with “homeopaths and Eclectics”). See also, Grossman, *supra* note 11, at 80.

14. STARR, SOCIAL TRANSFORMATION, *supra* note 4, at 10.

Legal challenges to physician licensure in the late 1800s and early 1900s were rejected by courts up to and including the Supreme Court of the United States.¹⁵ In *Dent v. West Virginia*, the United States Supreme Court considered the validity of a state statute criminalizing the practice of medicine by those who had not obtained a certificate from the state board of health.¹⁶ A claimant who had been convicted under the legislation argued that it violated the Due Process Clause of the Amendment because it deprived the defendant of his “vested right and estate in his profession.”¹⁷ The Court recognized that members of a profession had a potentially valuable interest in being able to continue to practice that could not be removed arbitrarily under the Due Process Clause.¹⁸ However, the Court noted that “[t]he power of the State to provide for the general welfare of its people authorizes it to prescribe all such regulations as, in its judgment, will secure or tend to secure them against the consequences of ignorance and incapacity as well as of deception and fraud.”¹⁹ States had wide latitude to impose

15. See Lawrence Friedman, *Freedom of Contract and Occupational Licensing 1890–1910: A Legal and Social Study*, 53 CAL. L. REV. 487, 493 n.29 (1965) (citing cases); see also STARR, SOCIAL TRANSFORMATION, *supra* note 4, at 105–06.

16. West Virginia’s legislation

requires every practitioner of medicine . . . to obtain a certificate from the State Board of Health that he is a graduate of a reputable medical college in the school of medicine to which he belongs, or that he has practiced medicine in the State continuously for the period of ten years prior to the eighth day of March, 1881 or that he has been found, upon examination by the Board, to be qualified to practice medicine in all its departments, and makes the practice of, or the attempt by any person to practice, medicine, surgery, or obstetrics in the State without such certificate, unless called from another State to treat a particular case, a misdemeanor punishable by fine or imprisonment, or both, in the discretion of the court.

Dent v. West Virginia, 129 U.S. 114, 115 (1889).

17. *Id.* at 121.

18. *Id.* at 122.

19. *Id.*

entry criteria subject only to the requirements that the criteria must bear some relation to the profession and that they could be attained through “reasonable study and application.”²⁰

The Court noted the special characteristics of medical practice that warranted regulations designed to protect patients from potential harm:

Few professions require more careful preparation by one who seeks to enter it than that of medicine. It has to deal with all those subtle and mysterious influences upon which health and life depend, and requires not only a knowledge of the properties of vegetable and mineral substances, but of the human body in all its complicated parts, and their relation to each other, as well as their influence upon the mind. The physician must be able to detect readily the presence of disease, and prescribe appropriate remedies for its removal. Every one may have occasion to consult him, but comparatively few can judge of the qualifications of learning and skill which he possesses. Reliance must be placed upon the assurance given by his license, issued by an authority competent to judge in that respect, that he possesses the requisite qualifications.²¹

20. *Id.*

21. *Id.* at 122–23. The Court also recognized that licensure requirements could become more stringent over time without violating the Due Process Clause:

The same reasons which control in imposing conditions, upon compliance with which the physician is allowed to practice in the first instance, may call for further conditions as new modes of treating disease are discovered, or a more thorough acquaintance is obtained of the remedial properties of vegetable and mineral substances, or a more accurate knowledge is acquired of the human system and of the agencies by which it is affected. It would not be deemed a matter for serious discussion that a knowledge of the new acquisitions of the profession, as it from time to time advances in its attainments for the relief of the sick and suffering, should be required for continuance in its practice, but for the earnestness with which the plaintiff in error insists that, by being compelled to obtain the certificate required, and prevented from continuing in his practice without it, he is deprived of his right and estate in his profession without due process of law. . . . No one has a right to practice medicine without having the necessary qualifications of learning and skill; and the statute only requires that whoever assumes, by offering to the community his services as a physician, that he possesses such learning and skill, shall present evidence of it by a certificate or license from a body designated by the State as competent

In *Dent* and other cases, state police powers were found to be sufficiently broad to sustain licensure regimes that could protect the public from incompetent or unethical practitioners.²² Licensure thereafter played an increasingly important role in building the medical profession in a number of ways, including through the imposition of ever more stringent education and training requirements, which, combined with other factors, led to a reduction in the number of medical students, the closure of marginal, low quality medical schools, and reduced competition.²³ Medical licensing boards were also given authority to safeguard the public by disciplining physicians for, among other things, deficiencies in knowledge, skills, ethics, or capacity to provide appropriate care.²⁴

Medical licensure certainly played an important role in building the profession, but self-regulation ensured that physicians would maintain control over their own destiny. The primary justification for self-regulation is implicit in the Supreme Court's reasoning in *Dent*: the complex scientific and practice-oriented aspects of medical practice mean that establishing and applying regulatory standards requires the active involvement of members of the medical profession itself.²⁵ For much of the twentieth century, the health care

to judge of his qualifications.

Id. at 123.

22. *Id.* (“Due consideration, therefore, for the protection of society may well induce the State to exclude from practice those who have not such a license, or who are found upon examination not to be fully qualified . . . We perceive nothing in the statute which indicates an intention of the legislature to deprive one of any of his rights.”). See also Friedman, *supra* note 15, at 493 n.29 (citing cases); STARR, SOCIAL TRANSFORMATION, *supra* note 4, at 105–06.

23. See STARR, SOCIAL TRANSFORMATION, *supra* note 4, at 103–04 (discussing the implementation of more rigorous standards); *id.* at 112–23 (noting the reduction in number of students and the importance of the Flexner Report on medical education, which recommended significant changes for medical education, including the closure of low-performing medical schools).

24. See generally HEALTH CARE LAW AND ETHICS, *supra* note 6 at 1256–69; Sawicki, *supra* note 6.

25. See *Dent*, 129 U.S. at 122–23 (noting that “comparatively few can judge of

market in the United States was dominated by physicians, who also controlled the regulation of medical practice through state medical licensing boards led by physicians.²⁶ The arrangement has been said to reflect a grand bargain, in which the profession was given a monopoly over medical care in exchange for agreeing to serve patients and to protect the public.²⁷ Yet, licensure combined with self-regulation creates the obvious risk that the professed goal of protecting the public may be weakened or subverted by the self-interest of the profession.²⁸ The medical profession's successful use of licensure to secure prestige and power attracted both critics and imitators, as will be discussed in Part III below.

C. *Maintaining Physician Control: Ethics and the Corporate Practice of Medicine*

Professional dominion over both technical and ethical aspects of physician competence is another important feature of medical licensure.²⁹ The ethical requirements may be reflected in general prohibitions, such as “[c]onduct in the practice of medicine which evidences moral unfitness to

the qualifications of learning and skill” of medical practitioners).

26. See, e.g., Peter D. Jacobson, *Regulating Health Care: From Self-Regulation to Self-Regulation*, 26 J. HEALTH POL. POL'Y & L. 1165, 1167 (2001) (“The predominant regulatory activity [before federal enactment of Medicare and Medicaid] was through state licensure laws, which traditionally gave almost complete control over who can practice medicine to the medical profession itself.”).

27. Dr. Arnold S. Relman, who at the time served as the highly influential editor of the *New England Journal of Medicine*, observed that “the medical profession has an implicit contract with the state, which grants it a licensed monopoly and a considerable degree of autonomy in exchange for a commitment to serve patients and maintain its own professional standards.” Arnold S. Relman, *Professional Regulation and the State Medical Boards*, 312 NEW ENG. J. MED. 784, 785 (1985).

28. For a particularly sharp commentary on this topic, see FRIEDMAN, *supra* note 8.

29. See generally Sawicki, *supra* note 6 (discussing modern medical licensure).

practice medicine.”³⁰ The guidelines for professional practice also typically include provisions governing specific concerns, such as performing procedures without appropriate consent,³¹ sexual activity with patients,³² undue influence over patients,³³ business relationships with other types of licensed or unlicensed practitioners,³⁴ advertising,³⁵ maintenance of patient confidentiality,³⁶ and violations of codes of medical ethics.³⁷ Many of these ethical standards seem premised on the notion that physicians owe a duty of loyalty to their patients, which is sometimes expressed as the duty of physicians to serve patients’ interests over their own self-interests in certain defined circumstances. The precise nature of a physician’s duty of loyalty to his or her patients has emerged as a contested issue in recent decades and will be discussed further in Part IV.³⁸

Importantly, these ethical rules also serve to shape the permissible bounds of physicians’ relationships with other professionals, health care payers, and other actors in the

30. N.Y. EDUC. LAW § 6530(20) (McKinney 2019); *see also id.* § 6524(7) (to qualify for a physician’s license, applicants must “be of good moral character as determined by the department”). Professor Nadia Sawicki observes that medical boards frequently pursue disciplinary actions in “character”-related cases, such as those brought after a physician has been convicted of a crime that is not directly related to patient care; she argues that boards should shift their disciplinary resources to address deficiencies in competency and patient care. Sawicki, *supra* note 6, at 320–23.

31. *E.g.* EDUC. § 6530(26).

32. *E.g. id.* § 6530(44) (pertaining to psychiatrists and their patients).

33. *E.g. id.* § 6530(17) (including exploitation for financial gain).

34. *E.g. id.* § 6530(11) (permitting or facilitating unlicensed practice); *id.* § 6530(18) (prohibiting referral fees); *id.* § 6530(19) (regulating fee splitting).

35. *E.g. id.* § 6530(27) (prohibiting certain types of advertising).

36. *E.g. id.* § 6530(23) (prohibiting unauthorized disclosure of a patient’s personally identifiable information).

37. Sawicki, *supra* note 6, at 293 (noting that “violations of codes of medical ethics” may give rise to disciplinary action against physicians for “unprofessional conduct”).

38. *See infra* text accompanying notes 171–201 for a discussion of fiduciary duty.

health care system. The corporate practice of medicine doctrine is a particularly important example of the use of law to reinforce physician control of health care. The doctrine, which applies in a majority of states through legislation, regulations, or court decisions, prohibits corporations from engaging in the practice of medicine by directly employing or otherwise controlling a physician's practice of medicine.³⁹ The rule has a number of different justifications, but corporate control of medicine is typically considered to be inconsistent with state licensure rules, which prohibit unlicensed practice and then limit licenses to individual applicants meeting certain eligibility criteria. Corporate entities cannot meet these eligibility standards and therefore are not permitted to practice medicine, directly or indirectly through control of licensed practitioners.⁴⁰ The prohibition also reinforces both the centrality of the physician-patient relationship in the health care system and the importance of shielding the physician's duty of loyalty to his or her patient from external influence.⁴¹ The doctrine insulates physicians

39. See generally HEALTH CARE LAW AND ETHICS, *supra* note 6, at 1332–45; Todd A. Rodriguez, *Rethinking the Corporate Practice of Medicine Doctrine in the Age of Consolidation*, in 30 HEALTH LAW HANDBOOK 156–58 (Alice C. Gosfield, ed. 2018); CORPORATE PRACTICE OF MEDICINE, 50 STATE STATUTORY SURVEYS: HEALTH CARE: HEALTH CARE FACILITIES (2018), Westlaw 0100 Surveys 6; Annotation, *Right of Corporation or Individual, Not Himself Licensed, to Practise Medicine, Surgery, or Dentistry through Licensed Employees*, 103 A.L.R. 1240 (1936). States often provide exceptions for certain types of authorized entities, such as professional corporations, or licensed health care organizations, such as hospitals. See, e.g., *Berlin v. Sarah Bush Lincoln Health Ctr.*, 688 N.E.2d 106, 112–14 (Ill. 1997); *Cent. Kan. Med. Ctr. v. Hatesohl*, 425 P.3d 1253, 1264–67 (Kan. 2018) (noting that corporate practice of medicine doctrine does not prevent licensed ambulatory surgical center (ASC) from employing physicians to carry out licensed services, but voiding a physician's employment contract with an ASC where services fell outside scope of ASC license).

40. See generally HEALTH CARE LAW AND ETHICS, *supra* note 6, at 1332–45; see also sources cited *supra* note 39.

41. See, e.g., *Corporate Practice of Medicine*, MED. BOARD CAL., http://www.mbc.ca.gov/Licensees/Corporate_Practice.aspx (last visited Apr. 22, 2019) (“The policy . . . is intended to prevent unlicensed persons from interfering with or influencing the physician's professional judgment”). Interestingly, the American Medical Association is no longer permitted to enforce its ethics-based

from typical forms of organizational control.⁴²

D. *Physician Control of the Standard of Care in Medical Malpractice*

Medical malpractice law is the third major legal doctrine establishing the power of the medical profession. This claim may seem counterintuitive because medical malpractice law is typically viewed as a means of empowering patients to secure compensation for injuries caused by the negligence of their physicians. Yet, a closer examination of malpractice rules relating to the standard of care and expert witnesses demonstrates the role of medical malpractice in establishing and maintaining physician control over the practice of medicine from the late 1800s to the mid- to late-1900s.

prohibition on the corporate practice of medicine because of the potential impact on competition. *See infra* text accompanying notes 126–27; HEALTH CARE LAW AND ETHICS, *supra* note 6, at 1342; *Am. Med. Ass'n v. FTC*, 638 F.2d 443 (2d Cir. 1980), *aff'd by an equally divided court*, 455 U.S. 676 (1982).

42. The doctrine's imprint can be seen in a number of disparate areas:

This body of law may appear obscure and antiquated, but it continues to have fundamental importance for the structure of institutional and economic relationships in American medicine. Observe, for instance, that the prohibition of institutions charging for medical services explains why doctors are paid separately from hospitals and why there used to be a distinction between Blue Cross and Blue Shield and still is between Medicare Part A and Part B. This doctrine also explains why, only in North America, hospital medical staffs are independent and self-governing. Elsewhere in the world, hospital physicians are uniformly employed or compensated by the hospital.

HEALTH CARE LAW AND ETHICS, *supra* note 6, at 1340. Many commentators view the doctrine as an obstacle to health care reforms that could promote efficiency, reduce costs, and facilitate integrated or team-based health care. *See, e.g.*, Rodriguez, *supra* note 39 (arguing that the doctrine prevents investment and integration of physicians within health systems); Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 510 (1988) (noting challenges for effective cost containment); Nicole Huberfeld, *Be Not Afraid of Change: Time to Eliminate the Corporate Practice of Medicine Doctrine*, 14 HEALTH MATRIX 243, 276–91 (2004) (advocating federal intervention to ensure that physicians can participate in integrated health care practices); Cassandra Burke Robertson, *Private Ordering in the Market for Professional Services*, 94 B.U. L. REV. 179, 193–94 (2014) (noting the impact of the doctrine on raising costs and reducing access).

The traditional approach to the standard of care in medical malpractice cases focused on the “custom” of the profession.⁴³ As Professor Philip Peters observes:

In most negligence actions, the defendant’s compliance with industry customs is simply one factor for the jury to consider. While evidence of applicable customs is admissible, the jury is free to demand more precautions than industry norms require. . . . [For roughly 100 years, beginning in] the late nineteenth century, however, courts . . . treated physicians quite differently. Medical customs [were] not merely admissible, they define[d] the physician’s legal standard of care. In the words of Dean Prosser, the custom-based standard of care “gives the medical profession . . . the privilege, which is usually emphatically denied to other groups, of setting their own legal standards of conduct, merely by adopting their own practices.” . . . The jury’s job . . . [has been] merely to determine whether the defendant has complied with the industry norms.⁴⁴

The customary practice standard was associated with a number of related doctrines. The “respectable minority” rule protected physicians from liability so long as the care they provided was consistent with that which would have been offered by some other group of “respectable” physicians.⁴⁵ Another doctrine protected physicians from liability for bad outcomes resulting from “mere errors in judgment.”⁴⁶ Moreover, the locality rule protected physicians from liability so long as the care they provided was consistent with local

43. Philip G. Peters, Jr., *The Role of the Jury in Modern Malpractice Law*, 87 IOWA L. REV. 909, 911 (2002) [hereinafter Peters, *Role of the Jury*].

44. *Id.* at 912–13 (footnotes omitted).

45. See HEALTH CARE LAW AND ETHICS, *supra* note 6, at 304, 306–07; Philip G. Peters, Jr., *The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium*, 57 WASH. & LEE L. REV. 163, 168 (2000) [hereinafter Peters, *Quiet Demise*]. See also Kenneth S. Abraham, *Custom, Noncustomary Practice, and Negligence*, 109 COLUM. L. REV. 1784, 1812 (2009) (noting the exceptional approach adopted in medical malpractice cases regarding admissibility and the potential conclusive impact of evidence that a defendant’s conduct complied with a respectable minority or school of thought).

46. HEALTH CARE LAW AND ETHICS, *supra* note 6, at 304 (noting the relationship of “errors in judgment” to the respectable minority rule); Peters, *Quiet Demise*, *supra* note 45, at 167.

custom.⁴⁷ The locality rule also created real barriers to claims as physicians were often reluctant to offer expert testimony critical of the care provided by other physicians in their own communities.⁴⁸

III. LAW AND THE RISE OF THE AUTONOMOUS PATIENT/CONSUMER

A. *Overview*

Part II's brief overview of the development of the medical profession built on Paul Starr's classic historical account by highlighting the role of law in establishing physician dominance and control over health care in the United States. By the 1950s, the profession was in an enviable state. Physician licensure established control over the delivery of health care and self-regulation meant that the monitoring and discipline functions were relatively weak.⁴⁹ The corporate practice of medicine doctrine ensured that physicians remained free from control by non-physician employers or institutions.⁵⁰ The medical malpractice standard provided substantial protection for physicians providing care within a broad range of customary practice. The expert witness requirements and the reluctance of physicians to testify against their colleagues made it difficult for patients to pursue claims.⁵¹ The stage was set for a new

47. See HEALTH CARE LAW AND ETHICS, *supra* note 6, at 307–08. See generally Jay M. Zitter, Annotation, *Standard of Care Owed to Patient by Medical Specialist as Determined by Local, "Like Community," State, National, or Other Standards*, 18 A.L.R.4th 603 (1982); James O. Pearson, Jr., Annotation, *Modern Status of "Locality Rule" in Malpractice Action Against Physician Who Is Not a Specialist*, 99 A.L.R.3d 1133 (1980).

48. See Marc D. Ginsberg, *The Locality Rule Lives! Why? Using Modern Medicine to Eradicate an Unhealthy Law*, 61 DRAKE L. REV. 321, 332–33 (2013) (noting the impact of the locality rule on the availability of experts).

49. See *supra* text accompanying notes 6–28.

50. See *supra* text accompanying notes 29–42.

51. See *supra* text accompanying notes 43–48.

set of legal battles and economic changes that would, in combination, significantly alter the balance of power in health care.

As the profession entered the 1960s, its “golden era” was about to end. A number of factors joined together in a deep challenge to the profession’s control over health care. In retrospect, it is clear that the profession had been able to exert control because of the absence of powerful counterweights in the health care system. Although hospitals were growing in importance, physicians maintained significant control through the self-governing nature of the medical staff within each institution.⁵² Health insurance had become more prevalent beginning during World War II, particularly as a benefit of employment,⁵³ but insurers still typically provided reimbursement in accordance with customary rates and were not prone to second-guessing physician treatment decisions.⁵⁴

Major changes in the organization and funding of health care beginning in the 1960s would have a profound impact on the profession.⁵⁵ The enactment of the Medicare and Medicaid programs in 1965 meant that governments became keenly conscious of the growth of health care costs⁵⁶ and

52. See *supra* note 41 (discussing corporate practice of medicine doctrine and hospital staff structure).

53. STARR, SOCIAL TRANSFORMATION, *supra* note 4, at 311.

54. See, e.g., Thomas Bodenheimer & Kevin Grumbach, *Reimbursing Physicians and Hospitals*, 272 JAMA 971, 972 (1994) (discussing different approaches to paying for physician services, including fee-for-service payment at “usual, customary, and reasonable” rates).

55. The second half of Professor Starr’s history of the medical profession in the United States charts a series of challenges to medical power, including the rising power of public and private payers. Cf. STARR, SOCIAL TRANSFORMATION, *supra* note 4 (“Book Two: The Struggle for Medical Care”).

56. *Id.* at 383–84 (“Although medical costs were rising before 1965, they had been regarded mainly as a problem for individuals and families. Congress generally favored increasing total health expenditures in the belief that medical care was a prudent and popular social investment. After 1970, however, public officials began to regard the aggregate costs of health care as too high and to doubt that the investment was worth the return in health.”).

government as payer quickly became government as regulator. Employers saddled with increasingly expensive health care plans began to look for ways to reduce exposure by distributing a portion of health care costs to their employees and through new forms of coverage designed to restrain costs.⁵⁷ Physician control of the health care system meant that efforts to control costs invariably involved—or perhaps more accurately, targeted—physicians.⁵⁸ A series of reforms, including the growth of managed care and capitated payment systems, were designed to give physicians incentives to reduce health care expenditures.⁵⁹

Without understating the importance of these economic changes, this section will seek to highlight the role of law in challenging physician control and in strengthening the power of other actors in the health care system. The profession's successful use of law to cement control in the late nineteenth and early twentieth century virtually ensured that future battles over control in health care would have a substantial legal component. Part III of this Article will focus on two major law-based assaults to physician dominance beginning in the 1960s: judicial efforts to rebalance the power in the physician-patient relationship through informed consent law and challenges to the medical profession's use of licensure to control the health care marketplace.

57. *Id.* at 444 (“Private insurers and employers want[ed] medical expenditures to be controlled.”)

58. These cost-containment efforts clearly challenged physician control. For a particularly thoughtful analysis, see generally Hall, *supra* note 42.

59. *See id.* at 436–37. Physicians subject to new payment systems became even more entrepreneurial actors in the health care marketplace. *See, e.g.*, Arnold S. Relman, *The Future of Medical Practice*, HEALTH AFF., Summer 1983, at 5, 11–13 (commenting on rise of physician entrepreneurialism). The federal government, concerned about the impact of physician entrepreneurialism on the quality and cost of health care, increased legislative and enforcement initiatives designed to restrict certain types of entrepreneurial activities. *See, e.g.*, ALICE G. GOSFIELD, MEDICARE AND MEDICAID FRAUD AND ABUSE, Westlaw (database updated June 2018); HEALTH CARE LAW AND ETHICS, *supra* note 6, at 1444–65 (discussing referral fee laws.).

B. *Empowering Patients through Informed Consent Law and Medical Malpractice Law*

Legal theorists sometimes debate the transformative power of law, questioning whether new legal rules truly change society or whether a new legal approach merely reflects the influence of societal changes already underway.⁶⁰ That debate surely will not be resolved here. Yet, within health care law, the best potential example of the transformative power of law undoubtedly comes from the development of modern informed consent law.

The basic right of patients to consent to, or to refuse to consent to, health care has a long history within the law of battery.⁶¹ As the New York Court of Appeals famously stated in *Schloendorff v. Society of New York*, “Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault, for which he is liable in damages.”⁶² The battery action has certain advantages for the plaintiff. For example, the action does not require the use of expert witnesses and carries with it the potential for a punitive damage award.⁶³ Yet there are disadvantages: courts may limit battery actions

60. Cf. MICHAEL J. KLARMAN, FROM JIM CROW TO CIVIL RIGHTS: THE SUPREME COURT AND THE STRUGGLE FOR RACIAL EQUALITY (2004) (analyzing the origins and impact of the Supreme Court’s major civil rights decisions); PUBLIC OPINION AND CONSTITUTIONAL CONTROVERSY (Nathaniel Persily et al. eds., 2008) (exploring the relationship between major Supreme Court decisions and public opinion).

61. See generally W.E. Shipley, Annotation, *Liability of Physician or Surgeon for Extending Operation or Treatment Beyond the Expressly Authorized*, 56 A.L.R.2d 695 (1957).

62. 105 N.E. 92, 93 (N.Y. 1914), *abrogated on other grounds by* Bing v. Thunig, 143 N.E.2d 3 (N.Y. 1957).

63. See HEALTH CARE LAW AND ETHICS, *supra* note 6, at 172–73. Courts occasionally are confronted with battery claims brought by plaintiffs seeking to avoid expert witness or other requirements established for medical malpractice claims. See, e.g., *Humbolt Gen. Hosp., v. Sixth Judicial Dist. Court*, 376 P.3d 167 (Nev. 2016) (battery claim raising informed consent issues must comply with medical expert requirement established for medical malpractice actions).

to a narrow range of medical treatment that involves physical intrusion into the body and the claims generally have shorter limitations periods.⁶⁴ In addition, “consent” in a battery action typically is understood to involve basic consent to the procedure itself.⁶⁵

The courts began to develop a broader conception of consent located within medical malpractice law rather than battery. Here, the question was whether the physician had provided sufficient information to the patient to ensure that the consent was “informed.” There was a significant debate about the existence of and scope of the physician’s duty to obtain informed consent. One major problem was the standard of care within medical malpractice law, which was defined by customs of the profession and which offered protection from liability so long as the physician followed general custom or at least a respectable minority approach to the provision of information.⁶⁶ The physician’s duty to provide information about a proposed treatment therefore was limited by the customs of the profession, which at the time did not include substantial discussion of the risks and benefits of treatment and its alternatives.⁶⁷

Nearly fifty years ago, in *Canterbury v. Spence*, the

64. HEALTH CARE LAW AND ETHICS, *supra* note 6, at 172–73. *See also* RESTATEMENT (SECOND) OF TORTS § 13 (AM. LAW INST. 1965) (stating battery requires “harmful or offensive contact.”); *see generally* E.H. Schopler, Annotation, *Statute of Limitations Applicable to Malpractice Action Against Physician, Surgeon, Dentist or Similar Practitioner*, 80 A.L.R.2d 320 (1961).

65. HEALTH CARE LAW AND ETHICS, *supra* note 6, at 172–73. *See also* RESTATEMENT (SECOND) OF TORTS § 53 (AM. LAW INST. 1965) (“Consent to the particular conduct applies to intentional invasions of interests of personality.”).

66. *See supra* text accompanying notes 43–45.

67. In *Canterbury v. Spence*, the court noted that

[t]here are, in our view, formidable obstacles to acceptance of the notion that the physician’s obligation to disclose is either germinated or limited by medical practice. To begin with, the reality of any discernible custom reflecting a professional concensus [sic] on communication of option and risk information to patients is open to serious doubt.

464 F.2d 772, 783 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1064 (1972).

District of Columbia Court of Appeals adopted a new approach which had a transformative impact on the power balance in the physician-patient relationship.⁶⁸ The court considered the case of Jerry Canterbury, a nineteen year old clerk with a history of back pain who had sought care from Dr. William Spence, who was a Washington, D.C. neurosurgeon.⁶⁹ Dr. Spence recommended a laminectomy and secured consent for the procedure from Mr. Canterbury and his mother; Mr. Canterbury had consented without “prob[ing] into [the operation’s] exact nature.”⁷⁰ Mrs. Canterbury had a telephone conversation with the surgeon in which she asked whether the “operation was serious”; Dr. Spence characterized the procedure as “not anymore [sic] than any other operation.”⁷¹ Although the operation was uneventful, Mr. Canterbury developed partial paralysis after falling out of his hospital bed during his recovery.⁷² Mr. Canterbury brought various claims against the surgeon and hospital, including a claim of negligence for failing to inform him about the risks of the procedure, but he was unable to present expert testimony to support his claims.⁷³ The trial court awarded directed verdicts to the defendants and Canterbury appealed.⁷⁴

The appeals court reversed, holding that the evidence was sufficient to establish a prima facie violation of the physician’s duty to obtain informed consent.⁷⁵ The court took a novel path to this conclusion through various potential

68. *Id.* Although *Canterbury* is typically recognized as the leading informed consent case, the California Supreme Court offered a similar approach in *Cobbs v. Grant*, 502 P.2d 1 (Cal. 1972) (limiting the need for expert testimony in cases involving alleged violations of the physician’s duty to disclose risks).

69. *Canterbury*, 464 F.2d at 776.

70. *Id.* at 777.

71. *Id.*

72. *Id.* at 777–78.

73. *Id.* at 778.

74. *Id.*

75. *Id.* at 779.

sources of law and into specific rulings about important matters, such as the scope of the duty to disclose,⁷⁶ limits to the duty,⁷⁷ the role of causation,⁷⁸ and the limited need for experts.⁷⁹ I will focus on two key aspects of the decision here: the source and the scope of the duty to disclose.

Given the need to avoid the restrictions of traditional malpractice actions during this time period, the *Canterbury* court took a broad view regarding the sources of the duty to disclose that wove together a review of legal doctrines and an assessment of the power relationship between physicians and their patients. The *Canterbury* decision draws on battery law, medical malpractice, and fiduciary law to develop the

76. *Id.* at 786–87 (“The scope of the physician’s communications to the patient, then, must be measured by the patient’s need, and that need is the information material to the decision[,]” measured objectively, from the standpoint of a reasonable patient).

77. The *Canterbury* court outlined several limits to the duty to disclose: (a) the emergency exception permitted treatment without consent if the patient was incapacitated and no relative was available to provide substituted consent; and (b) the therapeutic privilege permitted physicians to withhold information from the patient where disclosure would “present a threat to the patient’s well-being,” though substituted consent from a relative might be required. *Id.* at 788–89. The court also suggested that physicians could not be held liable for failures to disclose information that the patient already knew. *Id.* at 792 (referring to “patient’s lack of knowledge of the risk”).

78. The court established an objective standard of causation in informed consent cases. Causation was to be determined from the standpoint of what “a prudent person in the patient’s position would have decided if suitably informed of all perils bearing significance. If adequate disclosure could reasonably be expected to have caused that person to decline the treatment because of the revelation of the kind of risk or danger that resulted in harm, causation is shown, but otherwise not.” *Id.* at 791 (citations omitted). The court rejected the subjective approach to causation due to concerns that this approach would “place[] the physician in jeopardy of the patient’s hindsight and bitterness.” *Id.* at 790–91 (noting as well the burden placed on the fact finder to speculate about causation “shadowed” by the knowledge that the undisclosed risk had materialized).

79. The court noted that many aspects of the informed consent claim could be established by lay witnesses, offering “relative freedom of broad areas of the legal problem of risk nondisclosure from the demands for expert testimony that shackle plaintiffs’ other types of medical malpractice litigation.” *Id.* at 792 (citation omitted).

scope of a physician's duty to disclose.⁸⁰

After citing *Schloendorff's* stirring paean to the protection of individual autonomy via battery law, the court noted:

True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each. The average patient has little or no understanding of the medical arts, and ordinarily has only his physician to whom he can look for enlightenment with which to reach an intelligent decision. From these almost axiomatic considerations springs the need, and in turn the requirement, of a reasonable divulgence by physician to patient to make such a decision possible.⁸¹

The court thus relied on battery law to establish the centrality of choice in the protection of individual autonomy but then relied on the knowledge imbalance between physician and patient to demonstrate the need to impose disclosure to ensure "true consent."⁸²

Medical malpractice law offered a vehicle for holding physicians liable for injuries caused by a deviation from the standard of care. The key question, of course, was how to define the standard of care for disclosure. As a preliminary matter, the court focused on establishing that the duty of care could incorporate a duty to disclose information:

A physician is under a duty to treat his patient skillfully but proficiency in diagnosis and therapy is not the full measure of his responsibility. The cases demonstrate that the physician is under an obligation to communicate specific information to the patient when the exigencies of reasonable care call for it. Due care may require a physician perceiving symptoms of bodily abnormality to alert the patient to the condition. . . . It may oblige the physician to advise the patient of the need for or desirability of any alternative treatment promising greater benefit than that being pursued. Just as plainly, due care normally demands that the physician warn the

80. Mary Anne Bobinski, *Autonomy and Privacy: Protecting Patients from Their Physicians*, 55 U. PITT. L. REV. 291, 342 n.184 (1994).

81. *Canterbury*, 464 F.2d at 780 (citations omitted).

82. *Id.*

patient of any risks to his well-being which contemplated therapy may involve.⁸³

Significantly, the court addressed malpractice through the lens of reasonableness, rather than custom. The court recognized that a majority of jurisdictions considering the issue had adopted a custom-based standard of care and acknowledged that there likely was no custom or practice of providing disclosure.⁸⁴ However, the court noted that there was little need to resort to custom “where the physician’s activity does not bring his medical knowledge and skills peculiarly into play” and held that the duty to disclose would be measured by what is “reasonable under the circumstances.”⁸⁵

Finally, the court relied on principles drawn from fiduciary law to justify departing from the standard of care measured by custom to impose a standard of disclosure measured by the informational needs of the patient. The court noted:

The patient’s reliance upon the physician is a trust of the kind which traditionally has exacted obligations beyond those associated with arms-length transactions. His dependence upon the physician for information affecting his well-being, in terms of contemplated treatment, is well-nigh abject. . . . [L]ong before the instant litigation arose, courts had recognized that the physician had the responsibility of satisfying the vital informational needs of the patient. More recently, we ourselves have found “in the fiducial qualities of [the physician-patient] relationship the physician’s duty to reveal to the patient that which in his best interests it is important that he should know.” We now find, as a part of the physician’s overall obligation to the patient, a similar duty of reasonable disclosure of the choices with respect to proposed therapy and the dangers inherently and potentially involved.⁸⁶

In effect, the *Canterbury* court mixed together battery,

83. *Id.* at 781 (citations omitted).

84. *See supra* text accompanying notes 66–67.

85. *Canterbury*, 464 F.2d at 785.

86. *Id.* at 782 (citations omitted).

malpractice and fiduciary law and, through judicial alchemy, created a new doctrine that both recognized and challenged physician authority over health care. Because physicians held the power and knowledge in the relationship, patients were unlikely to make inquiries or to question their physicians' treatment recommendations.⁸⁷ True consent therefore required a judicially-mandated transfer of information from physician to patient. The court imposed a negligence-based duty on the physician to disclose the material risks and benefits of the proposed care and its alternatives, that is, to provide the information that a reasonable patient would need in deciding whether or not to undergo a recommended treatment.⁸⁸

The *Canterbury* court's new, "patient-centered" approach to the physician's duty to disclose had wide ranging effects.⁸⁹ It reduced the profession's control over an important aspect of medical practice. At the same time, it used the transfer of knowledge to empower patients within the physician-patient relationship. The case reinforced the roles of patients as decision-makers and of physicians as loyal servants of patients' interests. It also sowed seeds for future debates about the extent to which courts would use common law doctrines such as fiduciary obligations to protect vulnerable patients in other circumstances.⁹⁰

The *Canterbury* decision initiated a state-by-state debate about the appropriate standard of disclosure in informed consent cases that was carried out in the courts and

87. *Id.* at 783 n.36.

88. *Id.* at 786–87 (“The scope of the physician’s communications to the patient, then, must be measured by the patient’s need, and that need is the information material to the decision”) (citations omitted).

89. As important as *Canterbury* is from a legal perspective, it must be noted that it yielded little benefit for Jerry Canterbury, as Dr. Spence won a defense verdict at trial. Sam Roberts, *Jerry Canterbury, Whose Paralysis Led to Informed Consent Laws, Is Dead at 78*, N.Y. TIMES (May 16, 2017), <https://www.nytimes.com/2017/05/16/us/jerry-canterbury-medical-consent-paralysis.html>.

90. See *infra* text accompanying notes 177–202.

legislatures. *Canterbury's* patient-centered, material risk standard is used in about half of the states with almost as many states retaining the professional or “regular” medical malpractice standard.⁹¹ This jurisdictional tally might suggest that *Canterbury's* impact has been overstated. But, it is important to recognize that the *Canterbury* approach has been largely adopted by the medical profession itself—which means that the idea of the empowered patient is present in every jurisdiction.⁹² In one classic decision, the Indiana Supreme Court even held that the “reasonably prudent physician” standard adopted for medical malpractice cases subsumed within it the American Medical Association’s (AMA’s) acceptance of the physician’s ethical obligation to provide patients with the information needed to decide whether or not to consent to treatment.⁹³

The *Canterbury* court’s analysis of the limits of the

91. HEALTH CARE LAW AND ETHICS, *supra* note 6, at 171 (noting as well that two states use a hybrid approach). See also Robin Fretwell Wilson, *The Promise of Informed Consent*, in THE OXFORD HANDBOOK OF U.S. HEALTH LAW 218 (I. Glenn Cohen et al., eds. 2017).

92. For a seminal discussion of the physician-patient relationship that directly addresses the role of information in securing autonomy, see JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT (Revised Ed., 2002). An analysis by decade of articles published in the New England Journal of Medicine demonstrates the integration of “informed consent” into medical discourse. From 1950–59, no articles used the expression “informed consent.” The phrase appeared in 38 articles from 1960–69. In the 1970s, the decade of the *Canterbury* decision, 508 published articles used the phrase. By the 1990s, 1,500 articles included the phrase. The article total has hovered around 1,800 per decade over the past two decades. This rough counting system reflects raw numbers and does not analyze context or control for the number of articles published per decade. However, it is worth noting in contrast the trend for the use of words “malpractice” or “negligence” (but excluding “negligible”). There were 32 articles using these words in the 1950s. The tally rose to a high of 196 articles in the 1980s. Only 64 articles using these words have been published in the 2010s as of November 6, 2018. Analysis conducted November 6, 2018, using New England Journal of Medicine “Advanced Search” Function. Data on file with the author.

93. See *Culbertson v. Mernitz*, 602 N.E.2d 98, 103–04 (Ind. 1992). The court’s retention of the traditional malpractice frame for informed consent was nonetheless significant as the standard required plaintiffs to present expert witnesses regarding the precise scope and potential breach of the disclosure standard. *Id.* at 106 (Dickson, J., dissenting).

custom-based malpractice standard also reflected a wider debate about the appropriate standard of care to employ in medical malpractice cases more generally, outside of informed consent. The profession enjoyed the protection of the “custom” rule into the 1970s, when courts began to move away from that standard and toward the implementation of the “reasonably prudent physician” standard.⁹⁴ In many states, the standard of care is now expressed as the care that would be expected of a reasonably prudent, minimally competent physician in similar circumstances, though jurisdictions use slightly different formulas of words, deviations from which can have significant legal consequences.⁹⁵ Although the reasonable physician standard for medical malpractice claims maintains a strong element of physician control, as medical experts will be required in the vast majority of cases,⁹⁶ the reasonableness standard is typically viewed as less deferential to physicians.⁹⁷

94. Peters, *Quiet Demise*, *supra* note 45, at 164; *see also* Peters, *Role of the Jury*, *supra* note 43, 913–16 (reviewing movement from custom to reasonableness in state court decisions).

95. HEALTH CARE LAW AND ETHICS, *supra* note 6, at 294–95.

96. *See generally* H.H. Henry, Annotation, *Necessity of Expert Evidence to Support an Action for Malpractice against a Physician or Surgeon*, 81 A.L.R.2d 597 (1962).

97. *See* John W. Ely et al., *Determining the Standard of Care in Medical Malpractice: The Physician’s Perspective*, 37 WAKE FOREST L. REV. 861, 869 (2002) (reporting that a focus group of physicians generally viewed customary standard of care as more protective than reasonable physician standard). The potential for liability under the reasonableness standard has in turn sparked discussion about whether physician adherence to practice guidelines—a new form of “custom”—might create a presumption of compliance with the standard of care. For a thoughtful discussion of efforts to use practice guidelines to reassert professional control over the standard of care, *see* Maxwell J. Mehlman, *Professional Power and the Standard of Care in Medicine*, 44 ARIZ. ST. L. J. 1165, 1188 & 1230–32 (2012).

C. *Autonomous Patients Become Health Care Consumers in an Expanded Medical Marketplace*

1. Overview

The informed consent doctrine can be seen as the beginning of an important shift in the position of the recipients of medical services. The mandated transfer of information from physician to patient at least theoretically empowered patients to exercise greater control over health care decisions.⁹⁸ An equally profound shift in the physician-patient relationship has occurred in the decades since *Canterbury v. Spence*: the move from patient to consumer.

There are many extra-legal explanations for the shift from the “empowered patient” to “health care consumer.” Skepticism about authority grew beginning in the 1960s and has become ubiquitous.⁹⁹ Waves of patient advocacy on critical issues such as women’s health,¹⁰⁰ mental illness,¹⁰¹

98. Many medical and legal commentators have addressed informed consent from a range of salutary and critical perspectives. Professor Carl E. Schneider has been a particularly influential critic of the disclosures mandated under the informed consent doctrine. See, e.g., CARL E. SCHNEIDER, *PATIENTS, DOCTORS AND MEDICAL DECISIONS* (1998); OMRI BEN-SHAHAR & CARL E. SCHNEIDER, *MORE THAN YOU WANTED TO KNOW: THE FAILURE OF MANDATED DISCLOSURE* (2014) (critiquing use of mandated disclosure to protect autonomy in a number of settings, including informed consent).

99. Vaccine debates are an important, current example of skepticism about medicine. See, e.g., Steve P. Calandrillo, *Vanishing Vaccinations: Why Are So Many Americans Opting Out of Vaccinating Their Children?*, 37 U. MICH. J. L. REFORM 353, 388–406 (2004); Ron Klain, *Politics and Pandemics*, 379 NEW ENG. J. MED. 2191 (2018).

100. See, e.g., SANDRA MORGEN, *INTO OUR OWN HANDS: THE WOMEN’S HEALTH MOVEMENT IN THE UNITED STATES, 1969–1990* (2002) (presenting a history of the women’s health movement, including efforts to move the locus of control from physicians to women themselves).

101. Two significant critiques of psychiatry were published early in the 1960s: MICHEL FOUCAULT, *MADNESS AND CIVILIZATION* (Richard Howard trans., Vintage Books 1988) (1961) and THOMAS SZASZ, *THE MYTH OF MENTAL ILLNESS: FOUNDATIONS OF A THEORY OF PERSONAL CONDUCT* (Harper & Row 1974) (1961). Patients turned to activism in the 1960s–70s. See generally Norman Dain, *Critics and Dissenters: Reflections on “Anti-Psychiatry” in the United States*, 25 J. HIST. OF BEHAV. SCI. 3 (1989).

breast cancer,¹⁰² and HIV/AIDS¹⁰³ have challenged the medical establishment's views about appropriate care. Moreover, there has been a dramatic expansion in the amount of medical information available to patients outside of the physician—patient relationship. Initially, this information could be found in magazines and popular books,¹⁰⁴ but the arrival of the Internet dramatically increased access to health-related information.¹⁰⁵ The web also facilitated patient-patient communication about diseases, treatments, and health providers.¹⁰⁶ Finally,

102. See, e.g., Susan Braun, *The History of Breast Cancer Advocacy*, 9 BREAST J. S101 (Suppl. 2) (2003); Barron H. Lerner, *Breast Cancer Activism: Past Lessons, Future Directions*, 2 NATURE REVIEWS CANCER 225 (2002); Janet R. Osuch et al., *A Historical Perspective on Breast Cancer Activism in the United States: From Education and Support to Partnership in Scientific Research*, 21 J. WOMEN'S HEALTH 355 (2012).

103. See, e.g., DAVID FRANCE, *HOW TO SURVIVE A PLAGUE: THE INSIDE STORY OF HOW CITIZENS AND SCIENCE TAMED AIDS* (2016); Robert M. Wachter, *AIDS, Activism, and the Politics of Health*, 326 NEW ENG. J. MED. 128 (1992) (discussing history of AIDS-related activism; noting relationship with other forms of patient activism).

104. For example, Prevention Magazine, which was founded in 1950, was originally marketed as “a medical journal for the people.” Brian Pedersen, *Rodale's Prevention magazine to go ad-free, increase price by 25 percent*, LVB.COM (Feb. 2, 2016, 10:43 AM), <https://www.lvb.com/rodales-prevention-magazine-to-go-ad-free-increase-price-by-25-percent/>. The magazine was finally sold to Hearst in 2018. *Hearst Completes Acquisition of Rodale Inc. Magazine Media Brands*, HEARST (Jan. 1, 2018), <http://www.hearst.com/newsroom/hearst-completes-acquisition-of-rodale-inc-magazine-media-brands>. See also *Our Story*, OUR BODIES OUR SELVES, <https://www.ourbodiesourselves.org/our-story/> (last visited Apr. 29, 2019) (providing historical resources for the iconic self-help book first published in 1969).

105. See, e.g., Madison K. Kilbride & Steven Joffe, *The New Age of Patient Autonomy: Implications for the Patient-Physician Relationship*, 320 JAMA 1973, 1973 (2018) (“Today's patients, informed by the internet and social media, are increasingly less dependent on their physicians for access to medical information and resources.”).

106. See, e.g., A. Benetoli et al., *How Patients' Use of Social Media Impacts Their Interactions with Healthcare Professionals*, 101 PATIENT EDUC. & COUNSELING 439, 440 (2018) (noting most study participants “reported improvement in the patient-[healthcare provider] relationship due to increased knowledge, better communication, and empowerment”); Gunther Eysenbach et al., *Health Related Virtual Communities and Electronic Support Groups: Systematic Review of the Effects of Online Peer to Peer Interactions*, 328 BMJ 1166

relating to patients as consumers has become increasingly important in health coverage initiatives such as consumer-driven health care¹⁰⁷ and the Affordable Care Act's healthcare marketplace.¹⁰⁸

The evolution—or transmogrification—from passive patients, to empowered patients, to consumers, occurred alongside several significant changes in the licensure bulwark that had protected the medical profession and the profession's control over health care. I will focus on three licensure-related developments here: (1) the addition of public or consumer board members; (2) the growth of antitrust challenges to professional control; and (3) the emergence of new types of providers.

2. Changes to the Composition of Medical Boards

As noted above, the medical profession's control over medical licensure creates the risk that the process might be redirected, subtly or substantially, away from protection of the public.¹⁰⁹ Indeed, numerous studies have suggested that risk has become reality, and that medical boards have at least sometimes adopted regulatory standards, employed processes, and achieved outcomes that serve the profession

(2004) (noting dearth of research into impact of “consumer led peer to peer communities,” including online support groups).

107. See generally Mark Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts and the New Medical Marketplace*, 106 MICH. L. REV. 643 (2008) (discussing “consumer-driven health care” initiatives such as health care savings accounts that require patients to negotiate directly with health care providers about charges and payment; noting need for further protections for patient-consumers).

108. The “healthcare marketplace” was one of several key components of the Affordable Care Act. The marketplace is a portal for individuals and families seeking health care insurance that is designed to “promote enrollment and rational consumer choice.” Jon Kingsdale, *After the False Start—What Can We Expect from the New Health Insurance Marketplaces?*, 370 NEW ENG. J. MED. 393, 394 (2014); *Get Coverage*, HEALTHCARE.GOV, <https://www.healthcare.gov> (last visited Apr. 29, 2019).

109. See *supra* text accompanying note 28.

more than the public interest.¹¹⁰ States concerned about the appearance or reality of regulatory capture initiated a range of reforms in the 1960s and 1970s.¹¹¹ The emergence of empowered patient/consumers offered one potential “antidote” to board self-interest and states began to add

110. Some of the criticism stems from studies carried out by media or public interest organizations. *See, e.g.*, ALAN LEVINE ET AL., PUBLIC CITIZEN, STATE MEDICAL BOARDS FAIL TO DISCIPLINE DOCTORS WITH HOSPITAL ACTIONS AGAINST THEM (2011), <https://www.citizen.org/our-work/health-and-safety/state-medical-boards-fail-discipline-doctors-hospital-actions-2>; Carrie Teegardin & Lois Norder, Abusive Doctors: How the Atlanta Newspaper Exposed a System That Tolerates Sexual Misconduct by Physicians, 19 AM. J. BIOETHICS, no. 1, 2019, at 1; Lisa Girion & Scott Glover, *Dying for Relief, Reckless Prescribing of Narcotics Endangers Patients, Eludes Regulators*, L.A. TIMES (Dec. 9, 2012), <https://www.latimes.com/local/la-xpm-2012-dec-09-la-me-prescription-oversight-20121209-story.html>.

The criticisms are mirrored in professional and academic articles. *See, e.g.*, James M. DuBois et al., *Serious Ethical Violations in Medicine: A Statistical and Ethical Analysis of 280 Cases in the United States from 2008–2016*, 19 AM. J. BIOETHICS, no. 1, 2019, at 16, 25 (“We would argue that the data presented in this article suggest that the field of medicine has self-regulated in a manner that protects self-interests above patient interests.”); Dayaratna et al., *supra* note 8, at 268–72 (summarizing critique of patient protection rationale for licensure.); John Alexander Harris & Elena Byhoff, *Variations by State in Physician Disciplinary Actions by U.S. Medical Licensure Boards*, 26 BMJ QUALITY & SAFETY 200 (2017) (finding and expressing concern about “significant, fourfold variation” in annual rates of disciplinary actions across states.); Timothy S. Jost, *Oversight of the Quality of Medical Care: Regulation, Management or the Market*, 37 ARIZ. L. REV. 825, 863–64 (1995) (noting the reluctance of physician-dominated medical boards to challenge the competency of physicians.); Relman, *supra* note 27, at 785 (after noting the high degree of variability in disciplinary rates among the states, Dr. Relman concludes that “[a]ll the evidence suggests, therefore, that most if not all the states have been too lax—not too strict—in their enforcement of medical professional standards.”). For contrary views, see, e.g., Humayun J. Chaudhry et al., *Ensuring Competency and Professionalism Through State Medical Licensing*, 313 JAMA 1791 (2015) (providing a generally laudatory perspective on the enduring success of state medical boards.); Marc T. Law & Zeynep K. Hansen, *Medical Licensing Board Characteristics and Physician Discipline: An Empirical Analysis*, 35 J. HEALTH POL. POL’Y & L. 63, 90–91 (2010) (describing a study of the relationship between selected characteristics of medical boards and rates of disciplinary activity; the authors contrast the “golden age of power and prestige” for medical profession, in which boards focused on protecting economic interests, with modern era, in which “the medical establishment found it to be in its own self-interest to monitor doctors more carefully.”).

111. *See* DAVID A. JOHNSON & HUMAYUN J. CHAUDHRY, MEDICAL LICENSING AND DISCIPLINE IN AMERICA 155–198 (2012).

“public” or “consumer” members to state medical boards in the 1960s.¹¹² Public members are commonplace on medical boards today.¹¹³ Despite the promising nature of this reform, studies have not found a significant impact on the rates of disciplinary actions.¹¹⁴

3. Antitrust Challenges to the Domination of the Medical Profession

The second key licensure-related development involves the growing use of antitrust law to challenge professional domination. As noted in Part II, physician licensure allowed physicians to exclude competitors from a broad swath of medical care services and, through rules governing physician relationships with other providers and institutions, to ensure continuing physician control over the health care marketplace.¹¹⁵ This high level of marketplace control was justified by the profession’s expertise, its adherence to ethical standards, and its commitment to selfless service of patients and the public.¹¹⁶ Of course, another way of describing the situation would be that the profession had a monopoly power over the provision of medical services that permitted it to exclude competitors and to extract higher payment for services than might otherwise be the case.

112. See Chaudhry et al., *supra* note 110, at 1791 (noting that the Medical Board of California named a public member in 1961.).

113. *Id.* (“[A]lmost all state medical boards include public members”).

114. See, e.g., Law & Hansen, *supra* note 110, at 87 (“[T]he share of outside membership on the board has no statistically significant effect on the degree of physician discipline”; the authors also note the addition of lay members coincided with “changes in the health care environment [that] forced medical boards to become more accountable in general.”). In addition, public members typically occupy a relatively small percentage of board positions, leaving physicians with effective control through a majority or supermajority of members. Carrie H.K. Yam et al., *Ten Key Trends Emerging from an International Review*, 102 J. MED. REG., Mar. 2016, at 16, 21–22 (2016) (noting an international trend toward public involvement, but reporting the percentage of lay members for Florida at 20% and Texas at 37%).

115. See *supra* text accompanying notes 26–28, & 39.

116. See *supra* text accompanying notes 25–27 & 41.

Physician control thus raised concerns that lie in the realm of antitrust law. Yet antitrust challenges to physician control began to take root only in the late 1970s.¹¹⁷

In *Goldfarb v. Virginia State Bar*, the United States Supreme Court considered a challenge brought by a couple attempting to buy a home who were required as a part of the transaction to obtain a title examination.¹¹⁸ The couple were unable to find a lawyer willing to provide the service for less than the minimum fee established by the local and state bar associations and they, thereafter, filed a class action claim for price fixing under section 1 of the Sherman Act.¹¹⁹ The bar association argued it should be protected from antitrust scrutiny because Congress did not intend to “include the learned professions within the terms ‘trade or commerce’ in § 1 of the Sherman Act,” and because “competition is inconsistent with the practice of a profession because enhancing profit is not the goal of professional activities; the goal is to provide services necessary to the community.”¹²⁰ The Court rejected the assertion that professions should be exempt from antitrust principles, holding instead that “[t]he nature of an occupation, standing alone, does not provide sanctuary from the Sherman Act, nor is the public-service

117. In a few earlier cases, the United States Supreme Court had suggested that the medical profession might be protected from antitrust scrutiny to some extent. In *United States v. Oregon State Medical Society*, the court noted:

there are ethical considerations where the historic direct relationship between patient and physician is involved which are quite different than the usual considerations prevailing in ordinary commercial matters. This Court has recognized that forms of competition usual in the business world may be demoralizing to the ethical standards of a profession.

343 U.S. 326, 336 (1952) (citing *Semler v. Or. State Bd. of Dental Exam'rs*, 294 U.S. 608 (1935)).

118. 421 U.S. 773, 773 (1975).

119. *Id.*; Sherman Act, 15 U.S.C. § 1 (2012) (“Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal.”).

120. *Goldfarb*, 421 U.S. at 786.

aspect of professional practice controlling in determining whether § 1 includes professions.”¹²¹ However, the Supreme Court left the door open to moderating the impact of antitrust principles to reflect the special characteristics of professions in some cases.¹²²

Goldfarb was followed by a number of important decisions applying antitrust law to various health care arrangements.¹²³ For our purposes, the key rulings are those in which courts demonstrate a willingness to “look behind” rules facially based on the desire to help patients, to maintain the ethics of the profession, or to promote the quality of care, to address the profession’s potentially anticompetitive activities. For example, in *Arizona v. Maricopa County Medical Society*, the Supreme Court considered an antitrust challenge to a maximum fee schedule established by the majority vote of physician members of two medical foundations that would be applied to patients insured by foundation-approved plans.¹²⁴ The Supreme Court found the arrangement to be a *per se* unlawful price-

121. *Id.* at 787 (citations omitted).

122. In a famous footnote the Court noted:

The fact that a restraint operates upon a profession as distinguished from a business is, of course, relevant in determining whether that particular restraint violates the Sherman Act. It would be unrealistic to view the practice of professions as interchangeable with other business activities, and automatically to apply to the professions antitrust concepts which originated in other areas. The public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently. We intimate no view on any other situation than the one with which we are confronted today.

Id. at 788 n.17.

123. A full discussion of health care-related antitrust law is beyond the scope of this paper. For a summary of antitrust cases relating to health care, see HEALTH CARE LAW AND ETHICS, *supra* note 6, at 1379–1444 (discussing general principles, medical staff boycotts, price-fixing, and health care mergers); Spencer Weber Waller, *How Much of Health Care Antitrust Is Really Antitrust?*, 48 LOY. U. CHI. L.J. 643 (2017).

124. 457 U.S. 332, 332 (1982).

fixing arrangement under section 1 of the Sherman Act, despite the participants' claim that the arrangement would actually benefit patients.¹²⁵

Antitrust laws have also been used to challenge ethical rules or guidelines. In *American Medical Association v. FTC*, the United States Court of Appeals for the Second Circuit considered the validity of a Federal Trade Commission (FTC) order "require[ing] the AMA to cease and desist from promulgating, implementing and enforcing restraints on advertising, solicitation, and contract practices by physicians and on contractual arrangements between physicians and nonphysicians."¹²⁶ The court upheld the FTC's findings that these "ethical restraints"—including restrictions on the corporate practice of medicine—actually had the "purpose and effect of restraining competition."¹²⁷ Antitrust law also brought to an end the AMA's long-standing efforts to discredit chiropractic care and to prevent physicians from associating with chiropractors, despite the AMA's assertion that its policies were designed to protect patients from unscientific "quackery."¹²⁸ In *Wilk v. American Medical*

125. The Court noted:

The price-fixing agreements in this case . . . are not premised on public service or ethical norms. The respondents do not argue . . . that the quality of the professional service that their members provide is enhanced by the price restraint. The respondents' claim for relief from the *per se* rule is simply that the doctors' agreement not to charge certain insureds more than a fixed price facilitates the successful marketing of an attractive insurance plan. But the claim that the price restraint will make it easier for customers to pay does not distinguish the medical profession from any other provider of goods or services.

Id. at 349.

126. 638 F.2d 443, 447 (2d Cir. 1980), *aff'd by an equally divided court*, 455 U.S. 676 (1982). The FTC order targeted provisions in the 1971 version of the AMA's Principles of Medical Ethics under section 5 of the Federal Trade Commission Act. *Id.* at 449 (citing Federal Trade Commission Act, § 5(a) (1), 15 U.S.C.A. § 45(a) (1)).

127. *Id.* at 449.

128. The battle between chiropractors and the AMA is summarized in *Wilk v. American Medical Association (Wilk II)*, 895 F.2d 352, 355–57 (7th Cir. 1990).

Association, the United States Court of Appeal for the Seventh Circuit upheld a determination “that the AMA violated § 1 of the Sherman Act by conducting an illegal boycott of chiropractors” and affirmed the grant of an injunction against the AMA.¹²⁹

Finally, and most importantly from the standpoint of medical licensure, recent developments make clear that the actions of medical licensing boards that are controlled by physicians may also be subject to antitrust review. In *North Carolina State Board of Dental Examiners v. FTC*, the Supreme Court considered an order of the FTC prohibiting the dental board from various actions designed to exclude non-dentists from the provision of teeth whitening services.¹³⁰ North Carolina’s Dental Practice Act provided that the Board was “the agency of the State for the regulation of the practice of dentistry”; further, under the Act, “six of the Board’s eight members must be licensed dentists engaged in the active practice of dentistry.”¹³¹

In *Parker v. Brown*, the Supreme Court had determined that the antitrust laws “confer[red] immunity on anticompetitive conduct by States when acting in their sovereign capacity.”¹³² The Supreme Court rejected the Dental Board’s assertion that the *Parker* immunity doctrine

129. *Id.* at 378. In *Wilk I*, the appeals court had permitted the AMA to pursue a potential “patient care” defense to the antitrust action. *Wilk v. Am. Med. Ass’n (Wilk I)*, 719 F.2d 207, 227 (7th Cir. 1983) (establishing a four-part patient care defense). The AMA failed to prove the defense on remand. *Wilk II*, 895 F.2d at 362. In *Wilk II*, the court noted that recent cases had cast doubt on the continuing validity of the patient care defense but found that the AMA’s failure to prove the defense eliminated the need to resolve the question. *Id.*

130. 135 S. Ct. 1101, 1108–09 (2015).

131. *Id.* at 1107–08.

132. 135 S. Ct. 1101, 1110 (citing *Parker v. Brown*, 317 U.S. 341, 350–51 (1943)). See also *Goldfarb v. Va. State Bar*, 421 U.S. 773, 791 (rejecting application of the *Parker* immunity doctrine, noting “[t]he fact that the State Bar is a state agency for some limited purposes does not create an antitrust shield that allows it to foster anticompetitive practices for the benefit of its members.”).

applied to its actions.¹³³ Special rules applied to claims that “a nonsovereign actor controlled by active market participants—such as the Board—enjoys *Parker* immunity”¹³⁴ The Court noted:

Limits on state-action immunity are most essential when the State seeks to delegate its regulatory power to active market participants, for established ethical standards may blend with private anticompetitive motives in a way difficult even for market participants to discern. Dual allegiances are not always apparent to an actor. In consequence, active market participants cannot be allowed to regulate their own markets free from antitrust accountability.¹³⁵

The Board, therefore, was required to demonstrate: (1) that “the challenged restraint . . . [was] one clearly articulated and affirmatively expressed as state policy”; and (2) that “the policy . . . [was] actively supervised by the State.”¹³⁶ There was no doubt that the Dental Practice Act prohibited the unlicensed practice of dentistry, but “its Act [was] silent on whether that broad prohibition covers teeth whitening.”¹³⁷ Moreover, the Court held that there was no active state supervision of the Board’s determination that teeth whitening constituted the practice of dentistry or its decision to enforce the policy by “issuing cease-and-desist letters to nondentist teeth whiteners.”¹³⁸

133. *N.C. State Bd. of Dental Exam’rs*, 135 S. Ct. at 1110.

134. *Id.*

135. *Id.* at 1111.

136. *Id.* at 1110.

137. *Id.*

138. *Id.* The Court noted:

After receiving complaints from other dentists about the nondentists’ cheaper services, the Board’s dentist members—some of whom offered whitening services—acted to expel the dentists’ competitors from the market. In so doing the Board relied upon cease-and-desist letters threatening criminal liability, rather than any of the powers at its disposal that would invoke oversight by a politically accountable official. With no active supervision by the State, North Carolina officials may well have been unaware that the Board had decided teeth whitening

The North Carolina State Board of Dental Examiners case was hotly debated and courts and commentators are still working through the implications of the decision.¹³⁹ As noted above, medical licensure boards are dominated by members of the medical profession.¹⁴⁰ The Court's decision means that these boards must be able to demonstrate that contested decisions are within "clearly articulated and affirmatively expressed . . . state policy" and that there was active state supervision of the policy. At the very least, medical licensing boards may therefore have to relinquish some independence and power to secure the benefits of *Parker* immunity.¹⁴¹

constitutes "the practice of dentistry" and sought to prohibit those who competed against dentists from participating in the teeth whitening market. Whether or not the Board exceeded its powers under North Carolina law . . . there is no evidence here of any decision by the State to initiate or concur with the Board's actions against the nondentists.

Id. at 1116 (citations omitted).

139. See, e.g., Nick Robinson, *The Multiple Justifications of Occupational Licensing*, 93 WASH. L. REV. 1903, 1922–26 (2018); William M. Sage & David A. Hyman, *Antitrust As a Disruptive Innovation in Health Care: Can Limiting State Action Immunity Help Save a Trillion Dollars?*, 48 LOY. U. CHI. L. J. 723 (2017); Sandeep Vaheesan & Frank Pasquale, *The Politics of Professionalism: Reappraising Occupational Licensure and Competition Policy*, 14 ANN. REV. L. & SOC. SCI. 309, 321–22 (2018). As of June 2019, there were already 1047 citing references to North Carolina State Bd. of Dental Examiners in the Thomson Reuters Westlaw database, including 74 cases and 180 law review articles. Search results for 135 S. Ct. 1101 on June 22, 2019 (on file with the author).

140. See *supra* text accompanying notes 113–114.

141. The Court offered some guidance:

The Court has identified only a few constant requirements of active supervision: The supervisor must review the substance of the anticompetitive decision, not merely the procedures followed to produce it, the supervisor must have the power to veto or modify particular decisions to ensure they accord with state policy, and the "mere potential for state supervision is not an adequate substitute for a decision by the State[.]" Further, the state supervisor may not itself be an active market participant. In general, however, the adequacy of supervision otherwise will depend on all the circumstances of a case.

N.C. State Bd. of Dental Exam'rs, 135 S. Ct. at 1116–17 (citations omitted).

4. New Providers and Enhanced Patient Choice

The preceding sections have marked the rise of patients as consumers and the decline of the profession's ability to stifle competition through its control of medical licensure. The final licensure-related change has been a dramatic expansion of patient choice among different types of providers. As this subsection will discuss, health-related professions have seized the tool of licensure to gain recognition and, sometimes, to expand areas of practice free from physician control. Complementary and alternative health providers have proliferated. Technological developments have also broadened choices for patients/consumers who may secure medical advice and at least some forms of care online or through smartphone apps. Advances in artificial intelligence may create new competitors for physicians in the future.

The broad definition of medical practice found in medical licensing codes has given physicians presumptive control over most forms of health care. New York's scope of practice provision is typical in its breadth: "The practice of the profession of medicine is defined as diagnosing, treating, operating or prescribing for any human disease, pain, injury, deformity or physical condition."¹⁴² Physicians have had "exclusive" rights over all of these activities, which has meant that non-physicians who offered a diagnosis, recommended a treatment, or engaged in any of the other designated acts without suitable authority risked being charged with the unlicensed practice of medicine. Licensing acts for other professions, such as dentistry, therefore must include specific grants of authority to provide certain forms of care that have been carved out from the medical practice act.¹⁴³ State licensing schemes also establish a hierarchy in

142. N.Y. EDUC. LAW § 6521 (McKinney 2019).

143. Richard J. Manski et al., *Increasing Access to Dental and Medical Care by Allowing Greater Flexibility in Scope of Practice*, 105 AM. J. PUB. HEALTH 1755, 1757 (2015) ("Medical practice acts can be thought of as umbrella acts, allowing physicians to perform many functions that are permitted under other practice

which physicians directly control the provision of certain forms of care by other licensed professionals.¹⁴⁴ In New York, for example, registered professional nurses are granted a nursing scope of practice but may only carry out “medical regimens” as prescribed by physicians.¹⁴⁵

The medical profession’s singular dominance has been challenged in recent decades.¹⁴⁶ Some important changes

acts, such as nursing, dentistry, and chiropractic. These other areas of practice are essentially carveouts from the practice of medicine.”). Consistent with this approach, New York law gives dentists the specific authority to carry out certain forms of care that otherwise would fall within the scope of practice for medicine:

The practice of the profession of dentistry is defined as diagnosing, treating, operating, or prescribing for any disease, pain, injury, deformity, or physical condition of the oral and maxillofacial area related to restoring and maintaining dental health. The practice of dentistry includes the prescribing and fabrication of dental prostheses and appliances. The practice of dentistry may include performing physical evaluations in conjunction with the provision of dental treatment.

EDUC. § 6601.

144. See generally Barbara J. Safriet, *Closing the Gap between Can and May in Health-Care Providers’ Scopes of Practice: A Primer for Policymakers*, 19 YALE J. ON REG. 301 (2002).

145. New York’s scope of practice law for registered nurses provides:

The practice of the profession of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential health problems through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing medical regimens prescribed by a licensed physician, dentist or other licensed health care provider legally authorized under this title and in accordance with the commissioner’s regulations. A nursing regimen shall be consistent with and shall not vary any existing medical regimen.

EDUC. § 6902(1). In contrast, licensed practical nurses may only carry out tasks under the supervision of registered professional nurses or certain other licensed professionals. *Id.* § 6902(2).

146. See, e.g., *Miller v. Med. Ass’n of Ga.*, 423 S.E.2d 664, 665 (Ga. 1992) (affirming a lower court judgement striking down the state’s definition of medical practice, noting “[a]ll parties concede that the literal language of [the medical practice provision] violates due process and equal protection in that it is so broad that it prohibits much conduct that there is no rational basis to prohibit, including the administering of shots by nurses, the self-injection of insulin by a diabetic, the drawing of blood, the piercing of ears, embalming, and the tattooing of skin, to name a few.”). See generally Christopher Ogolla, *Litigating Hypocrisy:*

have been driven by enhanced education and training programs for existing health professions.¹⁴⁷ Nursing has moved from hospital-based training programs to university-based schools and graduate programs for advanced practitioners.¹⁴⁸ The rules governing these advanced nurse practitioners are now in flux. In New York, and elsewhere, nurse practitioners have been given the authority to practice “in collaboration with a licensed physician” and to prescribe “drugs, devices and immunizing agents . . . in accordance with the practice agreement and practice protocols[.]”¹⁴⁹ Other states, such as Arizona, provide for even greater scope of independent practice, explicitly permitting nurse practitioners to “[m]ak[e] independent decisions in solving complex patient care problems” and to “[d]iagnos[e], perform[] diagnostic and therapeutic procedures and prescrib[e], administer[] and dispens[e] therapeutic measures, including legend drugs, medical devices and controlled substances” within certain constraints.¹⁵⁰ Similar debates have emerged about expanding the scope of practice

Turf Wars Between Health Care Professionals Regarding Diagnosis, Evaluation and Treatment, 50 U. TOL. L. REV. 67 (2018) (giving an overview of the interprofessional challenges related to the scope of “diagnosis,” “evaluation,” and “treatment.”); Catherine Dower et al., *It Is Time to Restructure Health Professions Scope-Of-Practice Regulations to Remove Barriers to Care*, 32 HEALTH AFF. 1971 (2013).

147. Safriet, *supra* note 144, at 305.

148. Cf. Frank J. Cavico & Nancy M. Cavico, *The Nursing Profession in the 1990's: Negligence and Malpractice Liability*, 43 CLEV. ST. L. REV. 557 (1995) (providing a general discussion of varying levels of education, knowledge, and skills).

149. EDUC. § 6902(3) (effective until June 30, 2021; a similar provision comes into effect on that date). See also, Ashley Z. Ritter et al., *A Policy Analysis of Legally Required Supervision of Nurse Practitioners and Other Health Professionals*, 66 NURSING OUTLOOK 551, 553, 555 (2018).

150. ARIZ. REV. STAT. ANN. § 32-1601(22)(d) (2019). See also Sara Markowitz et al., *Competitive Effects of Scope of Practice Restrictions: Public Health or Public Harm?*, 55 J. HEALTH ECON. 201, 216–17 (2017) (indicating that varying levels of scope of practice restrictions for certified nurse midwives were not associated in differences in health outcomes; however, jurisdictions with fewer practice restrictions had lower rates of induced labor and Cesarean sections).

for other highly educated and trained health professionals.¹⁵¹

Patient/consumer choice has also been dramatically affected by the expansion of alternative forms of health care, often called “complementary and alternative medicine” (CAM).¹⁵² Despite limited evidence regarding efficacy,¹⁵³ about one-third of adults reported using complementary health approaches in 2012.¹⁵⁴ There were almost twice as many visits to CAM providers as there were to primary care physicians in 2005.¹⁵⁵ Some forms of alternative and complementary medical practice, such as chiropractic, naturopathy, and massage therapy have sought and gained professional status through licensure or certification.¹⁵⁶

151. See, e.g., Alex J. Adams & Krystalyn K. Weaver, *The Continuum of Pharmacist Prescriptive Authority*, 50 ANNALS PHARMACOTHERAPY 778 (2016) (reviewing state approaches to prescriptive authority for pharmacists.); Jean Yi Jinn Liu, *A Prescription for the Future of Illinois' Psychologists*, 23 ANNALS HEALTH L. ADVANCE DIRECTIVE 1, 1–2 (2013) (reviewing debate and legislation regarding prescriptive authority for psychologists).

152. “Complementary” health care is a “non-mainstream practice [that] is used together with conventional medicine[.]” “Alternative” health care is “a non-mainstream practice [that] is used in place of conventional medicine[.]” *Complementary, Alternative, or Integrative Health: What's In a Name?*, NAT'L CTR. FOR COMPLEMENTARY & INTEGRATIVE HEALTH, <https://nccih.nih.gov/health/integrative-health> (last visited Feb. 16, 2019) (emphasis omitted) [hereinafter *Complementary, Alternative, or Integrative Health*].

153. See, e.g., Kevin Smith et al., Editorial, ‘Complementary & Alternative Medicine’ (CAM): *Ethical and Policy Issues*, 30 BIOETHICS 60, 60 (2016) (“[T]he plausibility and evidence base of many CAM treatments is very limited[.]”); Yasamin Veziari et al., *Barriers to the Conduct and Application of Research in Complementary and Alternative Medicine: A Systematic Review*, 17 BMC COMPLEMENTARY & ALTERNATIVE MED. 166, (2017) (analyzing barriers to CAM research).

154. *Complementary, Alternative, or Integrative Health*, supra note 152 (citing a 2012 National Health Interview Survey with responses indicating that “more than 30 percent of adults and about 12 percent of children[]use health care approaches that are not typically part of conventional medical care or that may have origins outside of usual Western practice.”).

155. Sheryl R. Groden et al., *Use of Complementary and Alternative Medicine among Older Adults: Differences Between Baby Boomers and Pre-Boomers*, 25 AM. J. GERIATRIC PSYCHIATRY 1393, 1394 (2017).

156. See, e.g., Mabel Chang, *The Chiropractic Scope of Practice in the United States: A Cross-Sectional Study*, 37 J. MANIPULATIVE & PHYSIOLOGICAL

Other forms of CAM, such as meditation and yoga, remain outside the health care licensing system.¹⁵⁷ CAM expenditures were estimated to be nine billion in 2007 dollars; most CAM is an “out of pocket” expense for patients, though licensed professions may be covered by some health plans.¹⁵⁸

Finally, technology has altered the market for health care services in several ways. Advances in imaging, high speed data connections, and other technological developments mean that patients may now receive care through online platforms, x-rays may be read by remote practitioners, and cybersurgery equipment may allow surgeons to operate on patients in other jurisdictions. The numerous legal and economic impediments to these advances found in licensure, payment, and liability rules, are being addressed on a state-by-state basis, often through approaches that retain significant limits on the provision of care by out-of-state providers.¹⁵⁹ However, the New

THERAPEUTICS 363 (2014); Patricia M. Herman & Ian D. Coulter, *Mapping the Health Care Policy Landscape for Complementary and Alternative Medicine Professions Using Expert Panels and Literature Analysis*, 39 J. MANIPULATIVE & PHYSIOLOGICAL THERAPEUTICS 500, 502–03 (2016) (exploring state approaches to licensure/certification for acupuncture, chiropractic, naturopathic medicine, and massage therapy).

157. See Groden et al., *supra* note 155, at 1400.

158. Matthew A. Davis et al., *US Spending on Complementary and Alternative Medicine During 2002–08 Plateaued, Suggesting Role in Reformed Health System*, 32 HEALTH AFF. 45, 49 (2013).

159. A detailed discussion of the legal issues raised by telemedicine in the United States is beyond the scope of this Article. See generally Archie A. Alexander III, *American Diagnostic Radiology Moves Offshore: Is this Field Riding the “Internet Wave” into a Regulatory Abyss?*, 20 J. L. & HEALTH 199, 241–50 (2007); Coryell L. Barlow & Samuel D. Hodge, Jr., *Teleradiology: The Perks, Pitfalls and Patients Who Ultimately Pay*, 41 RUTGERS COMPUTER & TECH L. J. 1, 8–11 (2015); Michael W. King, *Telemedicine: Game Changer or Costly Gimmick?*, 95 DENV. L. REV. 289 (2018); Thomas R. McLean, *Cybersurgery—An Argument for Enterprise Liability*, 23 J. LEGAL MED. 167 (2002). See also Jay M. Zitter, Annotation, *Regulation and Liability Arising from Telemedicine*, 23 A.L.R.7th Art. 5 (2017). Some health systems are moving aggressively to foster online access to health care. See Gareth Iacobucci, *NHS Long Term Plan: All Patients to Have Access to Online GP Consultations by 2023–24*, 364 BMJ 187 (2019) (discussing

Interstate Medical Licensure Compact is designed, in part, to facilitate telemedicine services by creating an “expedited pathway to licensure for qualified physicians who wish to practice in multiple states.”¹⁶⁰ The impact of technological advances can be seen in personalized health information available through smartphone apps and wearable health devices.¹⁶¹ Artificial intelligence research is also moving into potential applications related to diagnosis and the development of treatment options—areas long within the core domain of medical practice.¹⁶² Slowly but surely, these technological advances are expanding patient choice by broadening the range of potential providers of medical care.

IV. THE NEXT STAGE OF TEMPERING POWER: PROFESSIONAL DUTIES TO PATIENTS OR COMMERCIAL RELATIONSHIPS WITH CONSUMERS?

A. Overview

As Parts II and III of this Article demonstrate, law played an important role in establishing and in moderating the power of physicians in relation to patients and other groups in the health care system. The Article describes a health care system that is increasingly complex in terms of

the English National Health Service’s online initiative).

160. FED’N OF STATE MED. BDS., U.S. MEDICAL REGULATORY TRENDS AND ACTIONS 6–7, 33, 97 (2018), <https://www.fsmb.org/siteassets/advocacy/publications/us-medical-regulatory-trends-actions.pdf>.

161. See, e.g., Fazal Khan, *The “Uberization” of Healthcare: The Forthcoming Legal Storm over Mobile Technology’s Impact on the Medical Profession*, 26 HEALTH MATRIX 123, 138–141 (2016); Nicholas P. Terry, *Appification, AI, and Healthcare’s New Iron Triangle*, 20 J. HEALTH CARE L. & POL’Y 117, 129–31 (2018).

162. See generally Jessica S. Allain, *From Jeopardy! To Jaundice: The Medical Liability Implications of Dr. Watson and Other Artificial Intelligence Systems*, 73 LA. L. REV. 1049 (2013); Lawrence A. Lynn, *Artificial Intelligence Systems for Complex Decision-Making in Acute Care Medicine: A Review*, PATIENT SAFETY SURGERY 6, (2019), <https://doi.org/10.1186/s13037-019-0188-2>; Nariman Noorbakhsh-Sabet et al., *Artificial Intelligence Transforms the Future of Healthcare*, 132 AM. J. MED. 795 (2019).

the types of participants, the range of economic incentives, and the sources of regulation. Moreover, the growing power of payers and integrated health care delivery systems has left both patients and physicians vulnerable. Although predictions are always pregnant with failure, it is an important moment to ask about whether and how law will influence the relative power of physicians and patients moving forward.

Part IV of this Article takes on this challenge by focusing on one contested aspect of the physician-patient relationship: whether the physician's oft-mentioned duty of loyalty should be more vigorously enforced through the application of fiduciary law to the physician-patient relationship. I will consider the status of efforts to establish a physician's fiduciary duty to serve patients' interests through the views of ethicists, legal scholars and the courts. The section will conclude with a brief discussion of future options.

B. *The Duty of Loyalty?*

Physicians have complicated and potentially conflicting roles. As patients within treatment relationships, we expect that our physicians will offer knowledge, skill and expertise to identify and address health challenges. We may be vulnerable due to lack of knowledge, the anxieties and physical distress of illness, or the sensitive nature of our condition. Research suggests that trust is an important feature of the treatment relationship.¹⁶³ It is not surprising

163. See, e.g., Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 470 (2002) ("Trust is the core, defining characteristic of the doctor-patient relationship—the 'glue' that holds the relationship together and makes it possible."). See also Robert J. Blendon et al., *Public Trust in Physicians—U.S. Medicine in International Perspective*, 371 NEW ENG. J. MED. 1570, 1570–71 (2014) (noting that the U.S. "ranks near the bottom in the public's trust in the country's physicians"; 58% of U.S. adults agree with the statement: "All things considered, doctors in [your country] can be trusted."); Allan H. Goroll, *Toward Trusting Therapeutic Relationships—In Favor of the Annual Physical*, 373 NEW ENG. J. MED. 1487 (2015) (noting the importance of trust and the role of the annual physical in creating a therapeutic relationship.); Ted J. Kaptchuk &

that trust might allow us to disclose important information to our physician and that it might help to create a confidence about our prospects for healing that on its own can help to offer relief.¹⁶⁴ Yet, as discussed in Parts II & III, physicians are more than healers; they are self-interested actors, entrepreneurs, gatekeepers and stewards of our health care system. The ethical and legal norms governing physicians reflect these potential conflicts.¹⁶⁵

The medical profession's ethical guidelines have long recognized the importance of patient trust and physician loyalty.¹⁶⁶ The AMA's Principles of Medical Ethics provide that "[a] physician shall, while caring for a patient, regard responsibility to the patient as paramount."¹⁶⁷ The AMA's Opinions on the Patient-Physician Relationship emphasize that "[t]he 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."¹⁶⁸ Despite the clarity and strength of

Franklin G. Miller, *Placebo Effects in Medicine*, 373 NEW ENG. J. MED. 8 (2015) (exploring placebo research, including impact of the treatment relationship on healing and the risk that use of placebos might diminish trust.).

164. Cf. Hall, *supra* note 58, at 470–81.

165. Physicians could be substituted for one of the figures in a Gestalt picture. As noted in a recent Journal of the American Medical Association article, "[i]ndividuals in the United States are adept at holding 2 competing views about healthcare: on the one hand, healthcare revolves around a sacred compact between patients and clinicians and local institutions; on the other hand, healthcare is a business that operates on (regulated) market principles." Selena E. Ortiz & Meredith B. Rosenthal, Editorial, *Medical Marketing, Trust, and the Patient-Physician Relationship*, 321 JAMA 40, 40 (2019).

166. See *infra* text accompanying notes 167–169.

167. CODE OF MEDICAL ETHICS, PRINCIPLES OF MEDICAL ETHICS (AM. MED. ASS'N 2016). The Preamble also establishes the primacy of the physician's duty to his or her patients: "The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self." *Id.*

168. CODE OF MEDICAL ETHICS Ch. 1 § 1.1 (AM. MED. ASS'N 2016),

the AMA's position, the organization is careful to note that its opinions "are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law."¹⁶⁹

The AMA and others within the medical profession also recognize the multitude of challenges created by real or potential conflicts of interest. The AMA's Ethics Opinions suggest that disclosure to patients is the primary mechanism for addressing these conflicts. Physicians are to "respect[] patients' right[] . . . [t]o be advised of any conflicts of interest their physician may have in respect to their care."¹⁷⁰

https://www.ama-assn.org/system/files/2019-01/code-of-medical-ethics-chapter-1_0.pdf.

Other important medical organizations have also recognized the importance of loyalty and trust in the relationship. For example, the Ethics Manual of the American College of Physicians provides:

The patient-physician relationship entails special obligations for the physician to serve the patient's interest because of the specialized knowledge that physicians possess, the confidential nature of the relationship, the vulnerability brought on by illness, and the imbalance of expertise and power between patient and physician. Physicians publicly profess that they will use their skills for the benefit of patients, not for other reasons, including their own benefit. Physicians must uphold this declaration, as should their professional associations as communities of physicians that put patient welfare first.

Lois Snyder Sulmasy & Thomas A. Bledsoe, *American College of Physicians, Ethics Manual: Seventh Edition*, 170 ANNALS INTERNAL MED. S1, S3 (2019). These general principles are also reflected in ethics positions on particular issues. See, e.g., Lois Snyder Sulmasy & Paul S. Mueller, *Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper*, 167 ANNALS INTERNAL MED. 576, 578, app. (2017) (noting, in the Position Paper, the impact of physician assisted suicide on trust; the appendix expands on theme: "The physician must earn the patient's trust, preserve his or her confidentiality, and act as a fiduciary.").

169. See, e.g., CODE OF MEDICAL ETHICS Ch. 1 (introductory statement).

170. *Id.* § 1.1.3 ("Patient Rights"). The AMA Opinions also address conflicts of interest arising in specific settings. *Id.* § 1.2.6 ("Work-Related & Independent Medical Examinations"); § 1.2.11 ("Ethically Sound Innovation in Medical Practice"); § 11.2.2 ("Conflicts of Interest in Patient Care[,]") which provides "[u]nder no circumstances may physicians place their own financial interests above the welfare of their patients." The AMA guidance occasionally incorporates an awareness of the potential for legal obligations. *Id.* § 1.2.12 ("Ethical Practice in Telemedicine[,]") which provides: "All physicians who

Beyond the AMA's guidance, there is a substantial body of medical literature on conflicts of interest generally and in specific areas, such as in research and the financial aspects of health care.¹⁷¹

From a legal perspective, notions of trust and loyalty are most often associated with the requirements of fiduciary law.¹⁷² Fiduciary principles are applied to certain relationships in which one party exercises significant control over a person, object, or other important matter, and the other party is vulnerable or the circumstances otherwise suggest the potential for abuse.¹⁷³ Fiduciary law can be the source of specific legal duties, such as the duty of loyalty, or can be referenced by courts as a justification for imposing more stringent or exacting contractual or tort duties than would otherwise apply to the parties.¹⁷⁴ Although the precise requirements of fiduciary law can vary from one relationship

participate in telehealth/telemedicine have an ethical responsibility to uphold fundamental *fiduciary obligations* by disclosing any financial or other interests the physician has in the telehealth/telemedicine application or service and taking steps to manage or eliminate conflicts of interests.”) (emphasis added).

171. For some particularly useful recent collections of articles on this topic, see *Conflict of Interest Theme Issue*, 317 JAMA 1717 (2017); Lisa Rosenbaum, *Reconnecting the Dots—Reinterpreting Industry-Physician Relations*, 372 NEW ENG. J. MED. 1860 (2015); Lisa Rosenbaum, *Understanding Bias—The Case for Careful Study*, 372 NEW ENG. J. MED. 1959 (2015); Lisa Rosenbaum, *Beyond Moral Outrage—Weighing the Trade-Offs of COI Regulation*, 372 New Eng. J. Med. 2064 (2015); *Conflicts of Interest in the Practice of Medicine*, 40 J. L. MED. & ETHICS 436, 441–522 (2012).

172. See generally Mark A. Hall, *Fiduciary Principles in Health Care*, in THE OXFORD HANDBOOK OF FIDUCIARY LAW (Evan J. Criddle et al. eds.) (forthcoming 2019).

173. HEALTH CARE LAW AND ETHICS, *supra* note 6, at 122. The person in the position of power is called “the fiduciary” and the vulnerable party is called the “entrustor.” See Tamar Frankel, *Fiduciary Duties as Default Rules*, 74 OR. L. REV. 1209, 1210 (1995).

174. See HEALTH CARE LAW AND ETHICS, *supra* note 6, at 122. “Confidential relationships” are closely related to but distinct from fiduciary relationships, “[t]he law does not assume that a position of trust exists in a confidential relation as quickly as it does in a fiduciary one, but where such trust exists, the duties are essentially the same.” *Id.* at n.2.

to another,¹⁷⁵ where it is deemed to apply, the fiduciary duty of loyalty mirrors the ethics-based duties established in the AMA's Code: a fiduciary has a legal duty of loyalty to the other party that requires placing the interests of that party above his or her own.¹⁷⁶

Courts have recognized the potential “match” between the attributes of the physician-patient treatment relationship and the factors giving rise to fiduciary relationships. There are many state court decisions affirming that the physician-patient relationship is a fiduciary one.¹⁷⁷

175. *Id.* at 122. *See also* Hall, *supra* note 163, at 489–91; L.S. Sealy, *Fiduciary Relationships*, 1962 Cambridge L. J. 69, 73 (establishing that a relationship that is a fiduciary one opens the door to the application of fiduciary responsibilities and remedies, but more is needed to determine which will be applied in the circumstances).

176. Frankel, *supra* note 173, at 1210–11 (“[F]iduciaries owe entrustors both a duty of care—to act carefully and not negligently—and a duty of loyalty—to perform their services in the interest of their entrustors and not in conflict of interest. In most cases fiduciaries can be relieved of these duties only if entrustors expressly or impliedly waive these duties; in some cases the duties are non-waivable.”).

177. *See, e.g.*, *Byrne v. Avery Ctr. for Obstetrics and Gynecology, P.C.*, 175 A.3d 1, 7 (Conn. 2018) (noting that the appeals court had recognized “the fiduciary nature of the physician-patient relationship, which is based on trust and confidence”); *Brandt v. Medical Defense Associates*, 856 S.W.2d 667, 670 (Mo. 1993) (en banc) (“[T]he courts of Missouri have recognized that ‘[a] physician occupies a position of trust and confidence as regards his patient—a fiduciary position’” (quoting *Moore v. Webb*, 345 S.W.2d 239, 243 (Mo. Ct. App. 1961)); *Chanko v. Am. Broad. Cos.*, 49 N.E.3d 1171, 1177 (N.Y. 2016) (considering whether “the confidentiality inherent in the fiduciary physician-patient relationship” has been breached.); *King v. Bryant*, 795 S.E.2d 340, 350 (N.C. 2017) (holding that a fiduciary relationship existed between a physician and patient at the time the patient was asked to sign an arbitration agreement and lack of “full disclosure of the nature and import of the arbitration agreement” constituted a violation of that fiduciary duty.); *Cromer v. Children’s Hosp. Med. Ctr. of Akron*, 142 Ohio St. 3d 257, 2015-Ohio-229, 29 N.E.3d 921, at ¶ 25 (“The physician-patient relationship arises from an express or implied contract between the physician and patient and imposes on the physician a fiduciary duty to exercise good faith.”); *Parris v. Limes*, 2012 OK 18, n. 3, 277 P.3d 1259, 1265 n.3 (“[T]he relationship between a physician and patient is a fiduciary and confidential relationship.”); *Youngs v. Peacehealth*, 316 P.3d 1035, 1038 (Wash. 2014) (en banc) (stating that the physician patient relationship is a fiduciary one; case involves *ex parte* contacts.); *State ex rel. Kitzmiller v. Henning*, 437 S.E.2d 452, 454 (W. Va. 1993) (“Information is entrusted to the doctor in the expectation

In some jurisdictions, the relationship is said to have fiduciary “characteristics” or to be a “confidential” relationship.¹⁷⁸ In many cases, the recitations are superficial rather than substantive.¹⁷⁹

In two landmark decisions, the special characteristics of the physician-patient relationship led courts to enhance physicians’ disclosure obligations to patients. In *Canterbury v. Spence*, the court characterized the patient’s “reliance on the physician” as “a trust of the kind which traditionally” involves special obligations.¹⁸⁰ The court’s creation of a patient-centered theory of informed consent—one in which the duty to disclose would be measured by the reasonable patient’s needs rather than the standards of the profession—was based in part on fiduciary principles.¹⁸¹

In the second case, *Moore v. Regents of the University of California*, the California Supreme Court considered a number of claims brought by a patient, John Moore, against various individual and institutional defendants, including

of confidentiality and the doctor has a fiduciary obligation in that regard”; case involved *ex parte* contacts.).

178. In *Moore v. Regents of the University of California*, 793 P.2d 479, 483 (Cal. 1990), the court held that “a physician has a fiduciary duty to disclose all information material to the patient’s decision[,]” but also noted that “in some respects the term ‘fiduciary’ is too broad. In this context the term ‘fiduciary’ signifies only that a physician must disclose all facts material to the patient’s decision. . . .” *Id.* at 485 n.10. See also *Aufrichtig v. Lowell*, 650 N.E.2d 401, 404 (N.Y. 1995) (noting, in slight contrast to the fiduciary reference in *Chanko*, 49 N.E.3d at 1177, that “[t]he physician-patient relationship thus operates and flourishes in an atmosphere of transcendent trust and confidence and is infused with fiduciary obligations.” (citations omitted)); *Humphers v. First Interstate Bank of Or.*, 696 P.2d 527, 536 (Or. 1985) (holding that a patient may bring claim against her physician for a “breach of confidentiality in a confidential relationship.”).

179. See, e.g., *Gables at Sterling Village Homeowners Ass’n v. Castlewood-Sterling Village I, LLC*, 2018 UT 04, ¶ 51, 417 P.3d 95, 109 (passing reference to the physician-patient relationship as a fiduciary relationship); *HCC Specialty Underwriters, Inc. v. Woodbury*, 289 F. Supp. 3d 303, 320 (D.N.H. 2018) (one of many cases in which the physician-patient relationship is noted to be a fiduciary one in a case that involves a different issue.).

180. 464 F.2d 772, 782 (D.C. Cir. 1972).

181. See *supra* text accompanying notes 86–88.

his physician, Dr. Golde.¹⁸² The case arose after Mr. Moore's treatment for hairy-cell leukemia, when he learned that the defendants had used cells and tissues that they had extracted from him to create and to patent a potentially valuable cell line.¹⁸³ The California Supreme Court held that Mr. Moore could challenge Dr. Golde's involvement as either a breach of his "fiduciary duty to disclose facts material to the patient's consent" or as a breach of his duty to obtain informed consent.¹⁸⁴ The court established a duty to disclose that focused on the problem of conflicts of interest, holding that "a physician must disclose personal interests unrelated to the patient's health, whether research or economic, that may affect the physician's professional judgment[.]"¹⁸⁵ Because the case was remanded for further proceedings, and later settled,¹⁸⁶ the courts did not resolve important issues, such as the appropriate test for causation and the measure of damages.¹⁸⁷

Over the past few decades, through waves of consumer empowerment and commercialization, many leading legal

182. 793 P.2d at 480–81.

183. *Id.* at 481–82.

184. *Id.* at 483.

185. *Id.* The court noted the problem of "potentially conflicting loyalties" in research:

[M]edical treatment decisions are made on the basis of proportionality—weighing the benefits *to the patient* against the risks *to the patient*. . . . A physician who adds his own research interests to this balance may be tempted to order a scientifically useful procedure or test that offers marginal, or no, benefits to the patient. The possibility that an interest extraneous to the patient's health has affected the physician's judgment is something that a reasonable patient would want to know in deciding whether to consent to a proposed course of treatment.

Id. at 484 (footnote omitted).

186. Dennis McLellan, Obituary, *John Moore*, 56; *Sued to Share Profits from His Cells*, L.A. TIMES (Oct. 13, 2001), available at: <http://articles.latimes.com/2001/oct/13/local/me-56770>.

187. These matters were debated in Justice Broussard's concurring and dissenting opinion, *Moore*, 793 P.2d at 500, and Justice Mosk's dissenting opinion, *id.* at 518–21.

scholars have relied on *Canterbury*, *Moore*, and other physicians-are-fiduciary cases to argue that fiduciary law can and should be used to protect vulnerable patients.¹⁸⁸ Fiduciary principles might be used to address risks arising within the patient-physician relationship. Scholars thus have relied upon fiduciary theories to address conflicts of interest arising from health care financing arrangements;¹⁸⁹ to guard against conflicts of interest in research;¹⁹⁰ to require disclosure of medical errors;¹⁹¹ to support claims that physicians should be required to disclose provider-associated risks, such as lack of experience;¹⁹² and to mandate

188. See, e.g., Hall, *supra* note 163; Maxwell J. Mehlman, *Why Physicians are Fiduciaries for Their Patients*, 12 IND. HEALTH L.J. 1 (2015). Although this Article focuses on recent debates, legal commentators have viewed the physician-patient relationship in fiduciary terms for nearly ninety years. See, e.g., LLOYD PAUL STRYKER, COURTS AND DOCTORS 9 (1932) (“The relationship of patient and physician is to the highest possible degree a fiduciary one, involving every element of trust and confidence.”).

189. See, e.g., Dayna Bowen Matthew, *Implementing American Health Care Reform: The Fiduciary Imperative*, 59 BUFF. L. REV. 715 (2011); Maxwell J. Mehlman, *Can Law Save Medicine?*, 36 J. LEGAL MED. 121, 155–57 (2015). But see Isaac D. Buck, *Furthering the Fiduciary Metaphor: The Duty of Providers to the Payers of Medicare*, 104 CALIF. L. REV. 1043 (2016) (arguing that the fiduciary concept should be expanded to include a physician duty of loyalty to Medicare as a payer.); Jessica Mantel, *A Defense of Physicians’ Gatekeeping Role: Balancing Patients’ Needs with Society’s Interests*, 42 PEPP. L. REV. 633, 636 (2015) (suggesting that physicians’ fiduciary duties be “limited by the physician’s competing obligations to society.”). For an article considering a different form of financial incentive, see Thomas L. Hafemeister & Sarah P. Bryan, *Beware Those Bearing Gifts: Physicians’ Fiduciary Duty to Avoid Pharmaceutical Marketing*, 57 U. KAN. L. REV. 491 (2009) (applying fiduciary principles to reduce risks to patients arising from pharmaceutical marketing programs).

190. See, e.g., Robert Gatter, *Walking the Talk of Trust in Human Subjects Research: The Challenge of Regulating Financial Conflicts of Interest*, 52 EMORY L.J. 327 (2003).

191. See e.g., 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 (2009). See also Nadia N. Sawicki, *Choosing Medical Malpractice*, 93 WASH. L. REV. 891, 965 (noting that the “fiduciary nature of the physician-patient relationship” requires that physicians make certain disclosures to patients before seeking to rely on assumption of risk or contractual waiver to avoid liability for care that would otherwise constitute malpractice).

192. Mary Anne Bobinski, *Autonomy and Privacy: Protecting Patients from*

disclosure of a physician's conscience-based limitations on medical practice.¹⁹³ Framing the patient-physician relationship as a fiduciary one might also reinforce efforts by physicians to maintain the distinctive nature of their bond with patients, even as patient-consumers choose from the ever-widening range of potential providers noted in Part III.¹⁹⁴ Affirming the physician-patient relationship's fiduciary character could support efforts by physicians to strengthen their ability to follow non-market ethical principles and to protect the treatment relationship itself from the impact of swirling market forces and pressures.¹⁹⁵

These scholarly commentaries suggest that fiduciary law could bolster protections for patients within an increasingly commercialized health care environment. Fiduciary law—by

Their Physicians, 55 U. PITT. L. REV. 291, 340–56 (1994).

193. Nadia N. Sawicki, *Mandating Disclosure of Conscience-Based Limitations on Medical Practice*, 42 AM. J. L. & MED. 85, 107–110 (2016). See also Michelle Oberman, *Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U. L. REV. 451 (2000) (arguing that cases currently understood as reflecting “maternal-fetal conflicts” should be reframed as potential violations of a physician's fiduciary duty to his or her pregnant patient.).

194. Although many courts have not considered the question, some have specifically rejected the application of fiduciary principles to other types of health care providers. See, e.g., *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479, 486 (Cal. 1990) (“The Regents, Quan, Genetics Institute, and Sandoz are not physicians. In contrast to Golde, none of these defendants stood in a fiduciary relationship with Moore or had the duty to obtain Moore's informed consent to medical procedures.”); HEALTH CARE LAW AND ETHICS, *supra* note 6, at 121–23. But see *Wohlgemuth v. Meyer*, 293 P.2d 816, 820 (Cal. Dist. Ct. App. 1956) (noting the fiduciary character of hospital-patient relationship); *Di Teresi v. Stamford Health Sys., Inc.*, 63 A.3d 1011, 1023–26 (Conn. App. Ct. 2013) (noting the possibility that a hospital could have a fiduciary relationship with its patients in some circumstances.); *Lee v. Williams*, 2018 UT App 54, 420 P.3d 88, 103 n.7 (noting that fiduciary duty of confidentiality could be extended to nurses.). See also Barry R. Furrow, *Patient Safety and the Fiduciary Hospital: Sharpening Judicial Remedies*, 1 DREXEL L. REV. 439 (2009) (exploring the potential application of fiduciary principles to health care institutions.).

195. Cf. Mehlman, *supra* note 189, at 154 (noting the possibility of permitting physicians to bring tortious interference with fiduciary duty claims against employers or health insurers that have attempted to induce the physicians to breach their duties of loyalty to their patients).

recognizing patient vulnerability—could be a source of patient empowerment. In addition, fiduciary analyses that recognize and rely upon ethical pronouncements about physicians’ duties to protect vulnerable patients, to foster trust, and to avoid divided loyalties, help to make those otherwise precatory statements “real,” that is, something that patients could actually rely upon. Yet, a brief review of the caselaw with these ideas in mind reveals that courts have not, by and large, accepted this ambitious vision of the role of fiduciary principles in health law.

First, many of the academic commentaries noted above rely on a small number of cases, typically involving direct financial or research conflicts of interest.¹⁹⁶ Second, the soaring language noting the special character of the physician-patient relationship found in some cases, such as those involving confidentiality or informed consent, may be narrowed considerably in other contexts. For example, a number of courts have rejected fiduciary claims brought to address physicians’ failure to provide information relating to the patient’s financial interests.¹⁹⁷ Third, courts sometimes

196. *E.g. id.* at 144 (“The most telling indication that law has dropped the ball, however, is that despite the types of disloyal physician behavior . . . [described in the article] there are only four reported cases in which patients sued physicians for breach of fiduciary duty, and in none of them were the physicians actually found liable.”).

An analysis of cases citing *Moore v. Regents of the University of California* also demonstrates the disparity between the level of discussion and impact. As of February 12, 2019, the case had 6,212 citing references on Thomson Reuters Westlaw. Of these, 1,348 were secondary sources and 694 were cases. Only 9 of the cases involved the highest “depth of treatment” with another 33 listed at a moderate level. (Westlaw search conducted re: *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479 (Cal. 1990), on June 22, 2019).

197. As one example, in *Arato v. Avedon*, the widow and children of Miklos Arato brought a claim against his physicians, arguing among other things that they violated their fiduciary obligations by failing to disclose his “statistical life expectancy.” The court noted:

[Plaintiffs argue] . . . “As fiduciaries it was the duty of defendants [physicians] to make a full and fair disclosure to plaintiff of all facts which materially affected his rights and interests.” Plaintiffs contend that since Mr. Arato’s contracting and real estate affairs would suffer if

view fiduciary claims as unwelcome efforts to avoid state tort and malpractice reforms designed to limit claims and damages.¹⁹⁸ These courts find that the fiduciary claims are “duplicative”¹⁹⁹ or are subsumed within state malpractice law.²⁰⁰ Fourth, fiduciary duty claims raise difficult questions about whether a physician’s disclosure of a conflict of interest really cures the harm to patients²⁰¹ as well as challenges

he failed to make timely changes in estate planning in contemplation of imminent death, and since these matters are among “his rights and interests,” his physicians were under a legal duty to disclose all material facts that might affect them, including statistical life expectancy information. We reject the claim as one founded on a premise that is not recognized in California. . . . The short answer to plaintiffs’ claim is our statement in Moore that a “physician is not the patient’s financial adviser.”

858 P.2d 598, 608 (Cal. 1993) (citations omitted). *See also* Thomas v. Archer, 384 P.3d 791, 796–97 (Alaska 2016) (finding that a physician’s alleged promise to secure preauthorization fell outside fiduciary duty.); Jarrell v. Kaul, 123 A.3d 1022, 1024 (N.J. 2015) (holding that a physician has no duty to disclose lack of malpractice insurance despite a rule requiring physicians to carry coverage).

198. *See* Mehlman, *supra* note 189, at 148–49.

199. *See e.g.*, Neade v. Portes, 739 N.E.2d 496, 502 (Ill. 2000) (refusing to recognize a breach of fiduciary duty claim arising from a physician’s failure to reveal financial incentives that might have affected a referral for an angiogram; court holds that the essence of a fiduciary claim would duplicate malpractice action); Freely v. Donnenfeld, 54 N.Y.S.3d 63, 65 (App. Div. 2017) (holding that “the proposed cause of action alleging breach of fiduciary duty was duplicative of the medical malpractice cause of action.”).

200. Bigler-Engler v. Breg, Inc., 213 Cal. Rptr. 3d 82, 121 (Ct. App. 2017) (finding that fiduciary duty claims were equivalent to a claim for lack of informed consent, a professional negligence claim subject to damage caps.); Johnson v. Jones, 759 S.E.2d 252, 254–55 (Ga. Ct. App. 2014) (recognizing that a specific claim for breach of fiduciary duty amounted to a claim of professional malpractice that was subject to medical malpractice statute of repose.). *But see* Hales v. Timberline Knolls, LLC, No. 15 C 2622, 2017 WL 25174, at *6–7 (N.D. Ill. Jan. 3, 2017) (in a case involving failure to return phone calls, finding a fiduciary duty claim did not require an expert report because it was distinct from a medical malpractice case).

201. There are a number of concerns about disclosure, including questions about whether patients understand the disclosure. *See* Christian P. DiPaola et al., *Surgeon-Industry Conflict of Interest: Survey of North Americans’ Opinions Regarding Surgeons Consulting with Industry*, 14 SPINE J. 584, 588 (2014) (“Approximately 80% of survey respondents felt surgeon involvement in consulting with industry would either be beneficial or not affect the quality of their health care and is an ethical practice.”). An additional concern is that

relating to the development of appropriate remedies.²⁰²

Part IV began with a promise to explore whether the special characteristics of the physician-patient relationship that are so often mentioned as the basis for self-regulation and physician control of health care—such as the need to foster patient trust and the physician’s duty of loyalty—should be more vigorously enforced through the application of fiduciary law to the physician-patient relationship. A review of ethical guidelines, court decisions, and commentaries indicates that academic enthusiasm has not been matched by the courts, and there are reasons to doubt that courts will adopt enhanced fiduciary protections for patients in the future. There are several possible responses to these observations.

patients might dismiss conflicts of interest because of their vulnerability and a desire to maintain a strong relationship with their physicians. For a particularly strong critique of disclosure, see BEN-SHAHAR & SCHNEIDER, *supra* note 98 (critiquing the use of mandated disclosure to protect autonomy in a number of settings, including informed consent). *But see* Roy Spece et al., *An Empirical Method for Materiality: Would Conflict of Interest Disclosures Change Patient Decisions?*, 40 AM. J. L. & MED. 253, 270 (reporting results of an empirical study involving mock patients; finding that “[d]isclosure and enhanced disclosure significantly and substantially increased the probability that the mock patient would reject the conflicted physician’s recommendations.”).

202. One concern is that it may be difficult for the patient to demonstrate that the physician’s breach of loyalty caused financial harm. Justice Mosk noted the problem in his dissent in *Moore v. Regents of the University of California*:

[Another] reason why the nondisclosure cause of action is inadequate for the task that the majority assign to it is that it fails to solve half the problem before us: it gives the patient only the right to *refuse* consent, i.e., the right to prohibit the commercialization of his tissue; it does not give him the right to *grant* consent to that commercialization on the condition that he share in its proceeds. “Even though good reasons exist to support informed consent with tissue commercialization, a disclosure requirement is only the first step toward full recognition of a patient’s right to participate fully. Informed consent to commercialization, absent a right to share in the profits from such commercial development, would only give patients a veto over their own exploitation”

793 P.2d 479, 520 (Cal. 1990) (Mosk, J., dissenting) (citation omitted). *See also* Caroline Forell & Anna Sortun, *The Tort of Betrayal of Trust*, 42 U. MICH. J. L. REFORM 557, 559 (2009) (arguing a statutory tort is necessary to provide remedy for, e.g., breaches of fiduciary duty causing non-monetary harm).

From one perspective, the physician's duty of loyalty has been widely adopted by professional organizations and within ethical standards. This ethical commitment could be celebrated on its own merits. Or, advocates might continue to work toward legal protections for still-vulnerable patients. Physicians who remain interested in preserving a portion of the health care marketplace that prioritizes the treatment relationship could be encouraged to work with professional organizations and licensing authorities to strengthen fiduciary ideals and to develop additional enforceable standards governing particular areas of concern, e.g., with respect to financial conflicts of interest. Patient advocates could join with physicians to argue for the retention of prohibitions on the corporate practice of medicine and for prohibitions of some forms of financial influence inconsistent with physicians' loyalty to their patients. If these activities seem hopelessly unrealistic and naïve, then perhaps there is one more alternative to consider. Given the weak to non-existent application of fiduciary law to the physician-patient relationship, is it time to encourage patients *not* to trust their physicians?

V. CONCLUSION

Professor John Braithwaite's Mitchell Lecture, *Tempered Power, Variegated Capitalism, Law & Society*, is an inspiring example of his long-standing commitment to understanding the relationship of law and power within complex systems. This Article has taken up his challenge by exploring the role of law in establishing, and then in dismantling, the power of physicians in our health care system by focusing in particular on the physician-patient relationship.

As described in Part II, law played an important role in establishing the sovereignty of physicians beginning in the late 1800s. The medical profession used licensure and self-regulation to establish its identity and its primacy in the health care system. The corporate practice of medicine

doctrine was particularly helpful in ensuring that the physician-patient relationship would remain free from corporate control. The custom-based approach to medical malpractice law also protected both individual physicians and the profession as a whole from external review.

The profession's dominance over patients and the health care system began to unravel in the 1960s. Some of these changes were driven by the economics of health care and the arrival of public and private health insurers bent on controlling costs. Part III of this Article analyzed a series of law-based assaults on physician power and control. The first major change came through court decisions designed to rebalance power in the physician-patient relationship through the informed consent doctrine. Thereafter, licensure-based challenges to physician dominance facilitated the transition from empowered patients to patient-consumers exercising choice in a more diverse health care marketplace.

In Part IV, I turned to the question of whether the physician-patient relationship retained special characteristics, such as the physician's duty of loyalty, that could and perhaps should be further recognized through fiduciary law. Despite the profession's longstanding statements about the special character of the physician's duties of loyalty to their patients, physicians might be expected to resist this potential expansion of liability. However, strengthening legal recognition of a physician's fiduciary duties to his or her patients could bolster physicians' efforts to insulate the profession from some types of market-based forces. From this perspective, I suggest that patients and physicians would both be better off if loyalty were more than an aspirational goal. Of course, if the physician's ethical duty of loyalty is not fully recognized in law, then perhaps it should no longer be considered to be a defining feature of the physician-patient relationship. Without an enforceable duty of loyalty, the physician-patient relationship may yet move more fully and firmly into an

ordinary commercial sphere, one among many in the health care system.