PATIENT NEGLIGENCE

MICHELE GOODWIN*

L. SONG RICHARDSON**

I
INTRODUCTION

This project initiates a conversation about patient negligence and trust in the medical setting. It operates as a thought experiment, imagining tort law and the physician–patient relationship through an alternative lens—one that is inspired by the charge of this symposium[1] as well as recent high-profile events involving obvious fiduciary misdealings. The project examines the line at which a physician's impermissible conduct should become reasonably obvious to a patient and therefore trigger a reasonable response. Absent a reasonable response by patients, this project considers whether comparative negligence attaches.

This project is narrow in scope, but the import and impact of the question it poses and the possible answers it unpacks could prove quite significant as a policy matter. We approach this project as an initial casting of the pebble in the pond to anticipate possible effects: who might be harmed by and who would benefit from such a proposal. Further, as a pragmatic matter, we consider how the ripples created by the "pebble effect" impact the lives of those deemed most vulnerable to abuse in the physician–patient relationship. The conversation imagined for this project extends to policy debates on medical malpractice,

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* Everett Fraser Professor of Law and Professor of Medicine and Public Health, University of Minnesota; mgoodwin@umn.edu. We would like to thank Trina Jones for inspiring a very important interdisciplinary exchange among scholars. We are grateful to the student editors of *Law and Contemporary Problems*.

** Associate Professor of Law, DePaul University College of Law; J.D., Yale Law School; B.A., Harvard University.

1. Trina Jones has anointed a special project here: a challenge that junior and senior scholars collaborate to build a discussion that incorporates their relevant areas of scholarship. This article grows out of that charge, engaging tort law and medicine. It also incorporates Jones's second goal that race and class fit into its framework. Specifically, this project unpacks questions of trust and loyalty in the context of medicine. Due to page and time constraints we initiate a conversation in this article that will hopefully inspire additional comment. As a backdrop, this article provides a soft focus on trust in the reproductive context. In that way, it builds on the discussion in *Prosecuting The Womb*, but rather than urge reconsidering the value of fetal drug laws and explaining why states should be more wary about prosecuting such cases especially in the absence of a more consistent approach (which treats harm caused to babies by parental conduct more uniformly), this project assumes a different goal and approach. This article considers the reasonableness of relying on trust in the fiduciary relationship. *See* Michele Goodwin, *Prosecuting The Womb*, 76 GEO. WASH. L. REV. 1657 (2008).

patient accountability, health care reform, and the physician–patient relationship.

Animating this thought experiment are recent crises (outside of the medical realm) involving financial breaches of the public trust, which highlight the need for an engaged and searching inquiry into *trust* and *loyalty*. Prior scholarship tackles aspects of trust,[2] but most scholarship in this domain fails to scrutinize the reasonableness of client or patient reliance on trust and loyalty. Instead, trust is treated as an absolute entitlement that provides dividends to clients or patients upon a breach.[3] Due diligence, an aspect of loyalty, is treated as a value fiduciaries owe their clients, rather than a reasonable step that clients owe themselves.[4] Unmistakably absent from scholarly debates about trust are any discussions about whether it might be appropriate to impose an objective reasonableness standard on clients in their pursuit and expectation of services.[5]

In this collaboration, we imagine and unpack a new theory of trust; one which is animated by tort theory, and reads reasonableness and bi-directionality into the trust relationship. Motivating our interest here is a gap in traditional trust scholarship, which fails to capture a patient-focused standard of reasonableness. Recent studies suggest that quality patient care should be the focus of the physician–patient relationship. However, the notion that patients *owe* physicians blind trust may obscure that objective.

Most scholarly inquiry related to trust and loyalty rarely if ever pursues questions of complicity, contribution, and comparative fault of the client, patient, or consumer. Absent from the public debate are examinations of the meaning of *trust* and the risks of relying on *loyalty* in fiduciary relationships. Specifically, rather than accept the strict-liability logic that patients, clients, and consumers can always rely on their fiduciaries, perhaps it would be better to examine whether trusting a fiduciary is intuitively correct. Is the security that individuals feel in their assumption of a fiduciary's loyalty rational or reasonable?

Our inquiry into the reasonableness of relying on trust has considerable relevance in areas outside the medical setting. Consider the following:

In the frostbiting closing weeks of 2008, home foreclosures, plummeting stocks, and the narratives of defrauded investors dominated news headlines. At year's end, as snow blanketed the northeast, a cold reality set in among sophisticated, highly educated investors. Sixty-five billion dollars from charities

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2. *See generally* M. Gregg Bloche, Comment, *Trust and Betrayal in the Medical Marketplace*, 55 STAN. L. REV. 919 (2002); Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463 (2002); Claire A. Hill & Erin Ann O'Hara, *A Cognitive Theory of Trust*, 84 WASH. U. L.R. 1717 (2006); Christopher R. Leslie, *Trust, Distrust, and Antitrust*, 82 TEX. L. REV. 515 (2004).

3. *See* Tamar Frankel, *Fiduciary Law*, 71 CAL. L. REV. 795, 819–29 (1983) (discussing the law's protection of the fiduciary relationship through the imposition of nonreciprocal legal obligations).

4. *See, e.g.*, *id.* at 825 (noting that corporate fiduciaries are liable to the corporation for failing to exercise due diligence).

5. *See generally* MODEL CODE OF PROF'L RESPONSIBILITY (1980); MODEL RULES OF PROF'L CONDUCT (1983).

and individuals who had invested with Bernard Madoff cascaded into a virtual abyss. The largest Ponzi scheme in U.S. history began to unravel. Madoff, the financier at the center of the fraud, became a household name as charities and investors bewailed the profundity of their losses. How Madoff would be prosecuted and whether client losses could be recovered dominated news reports. Befuddled reporters continued to interview distraught, defrauded investors. How could such a betrayal be maintained over years—decades even?

Unlike the mortgage-crisis victims—individuals characterized as high-risk, less-sophisticated, and less-educated borrowers, duped by lenders trained in the art of persuasion—Madoff's victims hailed from an entirely different cultural and socioeconomic bracket. But are they so very different? Upon closer examination, common threads link manipulated borrowers and defrauded investors. In both cases, private losses became public problems. But, more importantly for purposes of this article, both groups relied on relationships built with their fiduciaries. Some of those relationships were rather short-lived, as in the cases of mortgage borrowers. Others, such as Madoff's mostly Jewish clientele, seemingly relied on an affinity relationship as much as on his reputation for steady returns over the years. The question that links the duped investors with the mortgage fraud victims is how reasonable was their trust either in Madoff or in the untested loyalty and commitment of mortgage brokers?

Discussions about defrauded investors and duped consumers of balloon mortgages might be enhanced by an exploration of the reasonableness of their reliance. In other words, perhaps "reasonableness" should be introduced into the discourse on fiduciary responsibility, much as it dominates torts and criminal-law discourses. Opening such a discussion might encourage us all to think about the subjective and objective tort dimensions of trust and loyalty.

An inattentive reading of this article might lead some to misconstrue its thesis as victim blaming. However, victim blaming disserves its message and import. This article seeks to affirm choice, empower patients, realign the doctor–patient vertical hierarchy, and disrupt the implied assumption that surrendering trust is a quid pro quo element of receiving quality health care. The goal here is to ask deeply challenging questions. At the center of this inquiry is whether patient negligence can exist, even when a patient has not committed an affirmative wrong, but simply acted blindly. This redirection might be better understood within the comparative framework of tort law, where contributory and comparative negligence doctrines have long and, in some cases, checkered pasts.

A few matters other than what might be viewed as victim blaming complicate this article's thesis or expose its weaknesses. First, this article displaces or complicates notions of innocence by asking whether an innocent patient can be legally at fault for personally negligent behavior. Second, some scholars might argue that this article proposes an unnecessary complication to or imposition on legal adjudication. Why not keep the legal (civil or criminal)

adjudication of these matters simple? By continuing a strict-liability approach, the argument goes, all liability is rightfully imposed on fiduciaries whose breach of trust results in harm. As a corollary, it could be argued that transaction costs are minimized or reduced when the law concerns itself solely with the primary wrongdoer. Finally, whether the defrauded client or aggrieved patient can also be a wrongdoer is a question that might be rejected intuitively on moral grounds.[6]

Assessing the appropriateness of applying negligence to patients requires confronting an unmistakable power dynamic[7] highlighted by information gaps that reify the victim status of patients and an imbalance of expertise. A patient's disadvantage in the physician–patient relationship is intensified when a patient lacks the capacity to properly investigate the fiduciary's work product. As a result, any exploration of patient culpability may seem deeply incongruous. Yet motivating this article are lofty ideas that relate to reducing social harms, protecting patients by requiring affirmative behaviors, bridging the gaps of accountability, and distinguishing the capacities of some consumer "victims" from others.

In this article, we attempt to take on a discrete aspect of such a reasonableness inquiry. We consider how a dialogue about trust might be recast with the application of reasonableness in the physician–patient relationship. Part II provides a very brief background in tort law's comparative negligence regime. In part III, we provide an overview of breaches of medical trust in the United States, locating contemporary reproductive monitoring in a historical context. Part IV considers whether the goals of established trust discourse properly and realistically align with contemporary problems. In part V, we begin to articulate the appropriate ex post inquiries for determining whether a patient acted reasonably in trusting the fiduciary. Here, we propose a test that considers the patient's competence, knowledge, prior experience, access to information, and resources to investigate. This test, we argue, provides a more nuanced approach for ascertaining the circumstances under which it might be reasonable for a patient to rely on a fiduciary. Naturally, an ex post inquiry

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6. Typically, "negligence" involves an obvious harm to a second or third party. Motivating the call for justice in typical negligence cases, then, are the externalities created from the breach of care. In the investor–broker context, most would not suggest that defrauded investors were negligent as a matter of law. In such an inquiry, fault would presumably flow from broker to defrauded investor (x•y). This article maintains the importance of keeping open the possibility of fault emanating from the client although not necessarily manifesting against the broker, but rather the investor's (client's) interests (y•). Equally, in more-extreme cases, it may be possible, although not nearly as often plausible, that negligence may flow from investor to a third party (y•z). In the *in utero* cases discussed later in this article, it is debatable whether there is an external third party harmed by the conduct of the patient. The legal status of fetuses is deeply contested in tort law, and courts typically dismiss claims for *in utero* injuries sustained by fetuses when no birth results. *See* Endresz v. Friedberg, 248 N.E.2d 901, 905 (N.Y. 1969) (holding that a woman could not recover for wrongful death because her twins were delivered stillborn).

7. *But see* Richard A. Epstein, *The Erosion of Individual Autonomy in Medical Decisionmaking: Of the FDA and IRBs*, 96 GEO. L.J. 559 (2008).

lacks the efficiency of an ex ante algorithm for determining patient or client negligence; however, we leave open as an important empirical matter whether deterrence is achieved by ex post deterrence measures (including reduced judgments). Part VI concludes.

II

COMPARATIVE FAULT: A BRIEF OVERVIEW

Tort law operates as a form of ex post insurance. It provides aggrieved (injured, defrauded, and otherwise harmed) individuals with access to courts to redress their harm. Tort law provides a remedy, which is usually financial, against wrong-doers for an individual's suffering. Commonly, the language of "making the plaintiff whole" is invoked to describe what tort law does. Others view tort law as restoring an individual to her previous or "pre-tort" condition. As an economic matter, rather than imposing (*or spreading*) the costs of an injury on members of society, our legal system generally seeks to narrow recovery and shift costs or impose penalties on the person committing the tort.[8] Overall, we assume this dynamic lowers the costs of accidents because it cabins the wrongdoing.[9] This function within tort law, to provide recovery for the injured and narrow costs to defendants, emanates from the doctrine's core principles.

A succinct view of tort law is that it facilitates compensation to aggrieved parties, while promoting social order.[10] At a glance, it removes the incentive for vigilantism or violent redress of a physical or emotional harm. But, such a narrow view of tort law overlooks its economic and broader social goals and interests. Tort law disincentivizes irresponsible conduct by imposing financial penalties on wrong-doers. Tort law illuminates defendants' conduct as having consequences that are beyond the individual plaintiff, and that spread to others in similar situations. Its compensatory function serves not only to disincentivize poor (reckless or negligent) behavior, but also operates as an incentive to improve conduct, elevate industry standards, self regulate, and impose internal checks. Moreover, tort law cannot focus exclusively on plaintiff's harm because doing so would distort the broader aims of tort law to minimize risks—even those that the plaintiff could have avoided. This view of tort law takes into account its moral foundations,[11] its liability origins,[12] its common law

8. Although industries spread costs of accidents among consumers in sometimes very indirect ways, an examination of cost-sharing is beyond the scope of this specific project.

9. *See* William P. Kratkze, *Some Recommendations Concerning Tort Liability of Government and Its Employees for Torts and Constitutional Torts*, 9 ADMIN. L.J. AM. U. 1105, 1127, (1996) ("[T]he purpose of tort law . . . is to minimize the combined costs of accident prevention and expected accident costs.").

10. *See, e.g.*, Cecil A. Wright, *Introduction to the Law of Torts*, 8 CAMBRIDGE L.J. 238, 238 (1944) ("The purpose of the law of torts is to adjust . . . losses and to afford compensation for injuries sustained by one person as the result of the conduct of another.").

11. *See generally* James Barr Ames, *Law and Morals*, 22 HARV. L. REV. 97 (1908).

12. *See* John H. Wigmore, *Responsibility for Tortious Acts: Its History*, 7 HARV. L. REV. 315

foundations, and contemporary aspirations of tort law operating as a living body of law.[13]

Tort law is based on the assumption that members of society owe a duty to their fellow citizens to avoid engaging in behaviors that could cause injury to others. To calibrate when a duty is owed, courts rely on a "reasonable person" standard. This objective standard inquires how a reasonable person would act in a like situation. The reasonable person framework is employed to calibrate both the defendant's culpability and the plaintiff's fault for ignoring the risks inherent in the activity.

Tort law doctrine uses the language of breach to describe when a person fails to comply with or obey this expectation. Most commonly, students associate the language of breach to negligence cases as the elements for that cause of action directly engage the language and action of breach. However, within the realm of intentional torts, we also expect individuals to comport with a generally accepted social code of conduct and not breach a duty to fellow citizens by resorting to fisticuffs, making threats that could place individuals in imminent apprehension of harm, or disturbing property.

Tort law's evolution in the twentieth century coincided with advancements in medical technology (and mistakes), automobile and railroad industries (crashes and mechanical failures), and industries using scientific advancements that happened to be big polluters. But tort law's evolution can also be traced to an identification and acknowledgement of broader social conceptions of harm, such as emotional distress, sexual assault, gender discrimination, and racial discrimination.

The contemporary landscape of tort law, which we address in this project, involves another evolution within tort law, and that is comparative negligence,[14] which turns the court's eye from the defendant's conduct to that of the plaintiff. Traditionally, courts dismissed plaintiffs' claims that involved any culpability or fault by the plaintiff.[15] Defendants could use the plaintiff's contributory negligence as an affirmative defense. A plaintiff's fault became a total bar to all

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(1894).

13. Michele Goodwin, *Expressive Minimalism and Fuzzy Signals: The Judiciary and The Role of Law*, 84 CHI.-KENT L. REV. 19 (2009).

14. Comparative negligence is an attempt to equitably assign liability and balance fault between the defendant and plaintiff. Comparative negligence acknowledges that victims make mistakes, take risks, and, in many cases, assume the roles of willful although negligent actors. DAN B. DOBBS, THE LAW OF TORTS 497–98 (2000). There are three approaches to the comparative negligence doctrine: pure, modified fifty percent, and modified forty-nine percent. Each approach rejects the notion that "at fault" plaintiffs must be barred from recovery. In all comparative negligence jurisdictions, findings of fact must be made on two issues: the amount of plaintiff's damages and the percentage of a plaintiff's fault. *See id.* at 505–06.

15. *See* Williams v. Delta Int'l Mach. Corp., 619 So. 2d 1330, 1333 (Ala. 1993) ("After this exhaustive study and these lengthy deliberations, the majority of the Court, for various reasons, has decided that we should not abandon the doctrine of contributory negligence, which has been the law in Alabama for approximately 162 years.").

recovery even when the fault was as low five percent.[16] As a contemporary matter, nearly all states have abandoned that rule for a more evolved and arguably more equitable, less draconian, standard of comparative negligence.[17]

By moving away from contributory negligence, courts repositioned the last clear chance doctrine.[18] Traditionally, the less vigilant plaintiff who fails to act with reasonable care would be barred from recovering if she had time to avoid the harm but failed to act. This move offered plaintiffs an opportunity to recover, even when they could have prevented the accident. A classic, relatable example is the car collision involving an oblivious pedestrian who steps into oncoming traffic without looking both ways. To reduce damages, a defendant is permitted to offer comparative negligence as an affirmative defense. Comparative negligence calibrates the percentage of a plaintiff's fault, and measures this against the damages she would otherwise be entitled to receive. In other words, a plaintiff that is found to be twenty percent at fault will have her total damages reduced by twenty percent.

This project adds an inquiry to comparative negligence given that in the medical sphere, a patient's lack of culpability is generally assumed. In general, patients are presumed to act reasonably even when they might or should know that uncommon risks may be associated with receiving care from a particular physician (such as the physician who has a history of medical malpractice claims being filed against him or her; the physician who acts abusively toward the patient; the physician who refuses to answer questions). Indeed, patients are the most sympathetic plaintiffs because of the inherent misalignment of power relationships between doctors and their patients and the vulnerable status of the ill when they seek medical treatments.

But the realm of treatments or menu of options that doctors offer patients has also evolved and expanded. Not all medical treatments relate to illnesses, as was the case a century prior. Indeed, increasingly elective, invasive, and non-essential surgical procedures are on the rise both in the reproductive realm and in plastic surgery. This project proposes a more searching inquiry into patient accountability and reasonableness. It moves away from assuming that by simply being a patient, the reasonableness standard is satisfied.

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16. Contributory negligence serves as a complete bar to plaintiff claims in tort cases. "Contributory negligence was an affirmative defense . . . . [O]nce proved, the plaintiff's causal contributory negligence immunized the negligent defendant. The rule was extreme. The plaintiff who was guilty of only slight or trivial negligence was barred, even if the defendant was guilty of quite serious negligence . . . ." DOBBS, *supra* note 14, at 494.

17. Forty-six states now operate as comparative-negligence jurisdictions. Only Alabama, Maryland, North Carolina, and Virginia continue to bar plaintiffs' recovery for torts in which they too have been at fault. *Id.* at 504.

18. *See* McIntyre v. Balentine, 833 S.W. 2d. 52 (Tenn. 1992) (abandoning contributory negligence as a complete bar to plaintiff's recovery). Note that the last-clear-chance doctrine is not rendered obsolete by comparative negligence (despite the court framing it as such). Rather, it could be argued that the last-clear-chance doctrine is harmonized within the new framework. Thus if plaintiff could have prevented an accident, but failed to do so, her relative degree of fault will be calculated by the courts.

This project urges a rethinking of what transpires between physicians and patients in an effort to reduce accidents and avoid harms. It scrutinizes whether the language of trust in the physician–patient relationship distorts what really transpires between these actors. We suggest other dynamics motivate patients' passivity, compliance, or participation with physicians, including the specter of the law as an ex post protector against harm. At the core of this project is the question of reasonableness with regard to patient conduct. By offering patient negligence as a concept to be studied, we do not suggest that a patient's vulnerable status should be ignored. To the contrary, we hope to inspire greater patient independence (and empowerment) and a rethinking of the trust relationship.

III

MEDICAL TRUST BREACHES IN THE CONTEXTS OF SEX, RACE, AND CLASS

Class, race, and sex figure significantly and thematically in medical care. The strange history of race and class intersecting in U.S. medicine dates back to the antebellum period with medical experiments on enslaved women.[19] The power of this unique legacy is well captured in more contemporary contexts too, such as medical experimentation on vulnerable and often uninformed patients, including illiterate men, children, and prisoners. The Institute of Medicine Study in 2002 and the subsequent book, *Unequal Treatment*,[20] provide compelling evidence of contemporary discrimination in medicine. Indeed, the authors document that the only category of treatment that African Americans receive more often than their White counterparts are amputations, which the former are three times more likely to receive.[21]

The history of modern medicine is replete with far more instances of medical trust violations against specifically targeted groups than previously acknowledged.[22] Yet, only recently has the legacy of medical wrongs against vulnerable populations been addressed in popular academic scholarship. In particular, racial groups, especially African Americans, have been the unwitting victims in medical schemes that involved grave robbing,[23] skin and tissue transplantation,[24] clinical trials,[25] and other therapies.[26] Perhaps for this reason,

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19. *See infra* A.

20. INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE (Brian D. Smedley, Adrienne Y. Smith & Alan R. Nelson eds., 2003).

21. *Id*. at 6.

22. *See, e.g.*, HARRIET WASHINGTON, MEDICAL APARTHEID: THE DARK HISTORY OF MEDICAL EXPERIMENTATION ON BLACK AMERICANS FROM COLONIAL TIMES TO THE PRESENT (2006).

23. MICHELE GOODWIN, BLACK MARKETS: THE SUPPLY AND DEMAND OF BODY PARTS 173 (2006).

24. *See* Michele Goodwin, *Deconstructing Legislative Consent Law: Organ Taking, Racial Profiling, & Distributive Justice*, 6 VA. J.L. & TECH. 2, 2 (2001) (discussing doctors who harvested corneas from corpses without prior consent).

25. Holly Auer, *Clinical Trials Seek More Minorities AH: Too Few Enrolling in Key Research that Can Save Lives*, POST & COURIER (Charleston, S.C.), Apr. 25, 2005, at 1A (discussing minority

contemporary scholars who investigate such issues are skeptical about new therapies specifically targeted at African Americans.[27]

This section briefly addresses breaches of medical trust, illuminating stories of race, class, and medical wrongdoing. Medical trust discourse is of unique relevance to African Americans who count, as sufficient causes for alarm and mistrust, eugenic-focused (sterilization) practices in the second half of the last century,[28] HIV drug research on vulnerable African American children in foster care,[29] recent cornea transplant scandals involving unwitting families and the corpses of African American and Latino gun-violence victims,[30] and well-documented medical disparities. The section concludes by raising normative questions that push at the theme of this article, namely, the reasonableness of extending trust to medical professionals despite an often tormenting history of medical wrongs (often with government complicity) against African Americans. At the core of this inquiry are several questions. When African Americans appear to give consent or passively participate in medical decisions with physicians is this, in fact, trust? Or is it simply the perceived lack of options? Does trust attach at the same time that a patient accepts medical care? If trust does attach at the time that medical treatment begins, does this expose

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participation in clinical trials); Ta-Nehisi Paul Coates, *Suspicious Minds; The FDA Has Approved a Drug Specifically for Black Americans. But that Doesn't Mean They'll Buy It*, TIME, July 4, 2005, at 36 (discussing briefly the Tuskegee experiments).

26. *See, e.g.*, George T. H. Ellison et al., *Race, Pharmaceuticals, and Medical Technology: Flaws in the U.S. Food and Drug Administration's Rationale for Supporting the Development and Approval of BiDil as a Treatment for Heart Failure Only in Black Patients*, 36 J.L. MED. & ETHICS 449 (2008) (discussing FDA procedures for approving race-based clinical trials); Jonathan Kahn, *From Disparity to Difference: How Race-Specific Medicines May Undermine Policies to Address Inequalities in Health Care*, 15 S. CAL. INTERDIS. L.J. 105 (2005) (raising concerns regarding the use of racial categories in medical research); Jonathan Kahn, *How a Drug Becomes "Ethnic": Law, Commerce, and the Production of Racial Categories in Medicine*, 4 YALE J. HEALTH POL'Y L. & ETHICS 1 (2004) (discussing implications of using race as a research category).

27. *See, e.g.*, Rene Bowser, *Race as a Proxy for Drug Response: The Dangers and Challenges of Ethnic Drugs*, 53 DEPAUL L. REV. 1111 (2004) (suggesting that racial targeting in drug research may harm African Americans); Ruqaiijah Yearby, *Good Enough to Use for Research, but Not Good Enough to Benefit From the Results of that Research: Are the Clinical HIV Trials in Africa Unjust?*, 53 DEPAUL L. REV. 1127 (2004) (questioning the fairness of HIV drug trials conducted in Africa for drugs that will never be sold in Africa). To be clear, the African American experience only illumes further the Native American experience with radiation studies, or the use of mentally disabled persons in other government-sponsored medical research projects. Harriet Washington and Dorothy Roberts stand out amongst the field of scholars working vigorously to excavate and archive this record, placing it in a proper historical context.

28. *See infra* III.C.

29. Elizabeth Dwoskin, *The AIDS-Babies-as-Guinea-Pigs Story Is Finally Over. Right?*, THE VILLAGE VOICE, April 1, 2009 ("The majority of the 25 children who died during the trials were extremely sick with full-blown AIDS when they began the testing, which has led the researchers to believe it was unlikely that they died due to the medications. But they don't know for certain. Without medical records, [investigators] say[], it is also impossible to know what the actual effects of the drugs were on any of the children or how much they suffered.").

30. An even more recent example of such collusion is recent cornea-transplant scandals involving unwitting families and the corpses of African American and Latino gun-violence victims. *See* Ralph Frammolino, *Harvest of Corneas at Morgue Questioned*, L.A. TIMES, Nov. 2, 1997, at A1.

physicians to any additional liability or professional censure? Are there any lessons learned from the legal profession and the well developed literature on the professional ethics and responsibilities of lawyers? The answers, which we discuss in parts IV and V, relate to choice, information, and options.

A. Medical Trust and Government-Sponsored Medicine: An Antebellum Story

> "Black bodies often found their way to dissecting tables, operating amphitheaters, classroom or bedside demonstrations, and experimental facilities."[31]

Slaves were involuntary subjects of early American experimentation.[32] The Medical College of the State of South Carolina, "like other Southern medical schools, used live Africans extensively in medical demonstrations, and dead ones for dissection."[33] Doctors, through their use of female slaves as research fodder, developed gynecological advances, such as abdominal surgeries, the speculum, cesarean surgeries, and others that are still employed today. Medical accomplishments born on the bodies of enslaved Black women include Ephraim McDowell's successful removal of ovaries[34] and Francois Marie Prevost's perfected cesarean section operations.[35] Perhaps the most notorious example is James Marion Sims' experiments on enslaved women that earned him the distinction, "Father of Modern Gynecology."[36]

In his autobiography, *The Story of My Life*, Sims speaks passionately about experimenting on his female slaves year-round.[37] He preferred to perform surgeries on enslaved women without anesthesia, although postoperatively, he provided them with opium.[38] Dr. Sims wrote that Blacks endured pain far better than Whites,[39] basing this scurrilous medical assertion on the numerous medical experiments and gynecological surgeries he personally performed on his two special women slaves, Lucy and Anarcha.[40] Anarcha suffered through thirteen operations to correct her vesicovaginal fistula, a condition likely caused by her enslavement and the withholding of nutritious foods. Sims became famous for mastering the repair of vesicovaginal fistula.[41] In his own words —

> I was always anxious to see the result of all experiments; but this was attended with such marked symptoms of improvement, in every way, that I was more anxious now than ever. When the week rolled around—it seemed to me that the time would never come for the removal of the sutures—Anarcha was removed from the bed and carried to the operation-table. With a palpitating heart and an anxious mind, I turned her on

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31. Todd L. Savitt, *The Use of Blacks for Medical Experimentation and Demonstration in the Old South*, 48 J. S. LEGAL HIST. 331, 331 (1982).

32. *See* Martia Graham Goodson, *Enslaved Africans and Doctors in South Carolina*, 95 J. NAT'L MED. ASS'N, 225, 226 (2003) (describing the practice of "slave medicine").

33. *Id.* at 226.

34. WASHINGTON, *supra* note 22, at 70.

35. *Id.*

36. Goodson, *supra* note 32, at 229.

37. *See, e.g.*, J. MARION SIMS, THE STORY OF MY LIFE (1884).

38. WASHINGTON, *supra* note 22, at 66.

39. *Id.* at 65.

40. *Id*. at 63–65.

41. *Id.* at 66.

> her side, introduced the speculum, and there lay the suture apparatus just exactly as I had placed it . . . . I had made . . . one of the most important discoveries of the age . . . .[42]

Primum non nocere, "first do no harm," remains the ethical guidepost for all physicians and surely Sims was not ignorant of this medical tenet. However, he clearly did not view his research subjects as "patients" or as individuals to whom he owed a moral duty or ethical obligation. Neither the law nor his cohorts disabused Sims of his lower regard for his African American research subjects. The law treated slaves as chattel for legal and social purposes, allowing Sims to do as he pleased with them. And although he described his experiments with extreme candor, precision, and passion, leaving very little room for doubt about the abuse conducted with his knife and scalpel, he faced no critique from his peers, protégés, and bioethicists. This speaks largely to the status of his research subjects and less to the notion that his experiments were bioethically ambiguous. In fact, Sims' status was elevated rather than diminished by his medical conduct, likely because the medical benefits derived from his unrestrained research benefited wealthy, elite women.

Medical experiments on slaves[43] mark the beginning of a troubling era of scientific research and medicine involving African Americans. Complicating that period was the absence of a legal remedy for slaves used as research subjects. Their compromised legal status prevented them from bringing claims in battery and precluded criminal actions on their behalf. Furthermore, research protocols on which tort claims might have been based were decades from being enacted.[44] Finally, as slaves, they could not avoid medical demands made on their bodies without risking further harm.

B. Medical Trust and Government-Sponsored Medicine: A Deadly Syphilis Story

Medical betrayal plays out in the minds of many African Americans as more than episodic. It is viewed as part of a systemic pattern of abuse that continued into the twentieth century, punctuated by what has been called "The Tuskegee

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42. SIMS, *supra* note 37, at 245–46.

43. *See id.* (describing the frequent use of Blacks for surgical tests); *see also*, KATHERINE OLUKEMI BANKOLE, SLAVERY AND MEDICINE: ENSLAVEMENT AND MEDICAL PRACTICES IN ANTEBELLUM LOUISIANA (1998) (discussing the unethical medical treatment Blacks received in Louisiana when compared to Whites); Savitt, *supra* note 31, at 331 (noting Black bodies were often used in experiments and dissections); Katherine Olukemi Bankole, *A Critical Inquiry of Enslaved African Females and the Antebellum Hospital Experience*, 31 J. BLACK STUD. 517 (2001) (describing the treatment of slaves at the Touro Infirmary).

44. From the infamous prosecution and subsequent verdict against Nazi doctors, later known as the "Nuremburg Trial," emerged a new standard of medical ethics known as the Nuremburg Code. Chief among the ten points outlined in the Code are informed consent, avoiding unnecessary physical and mental suffering, and the liberty of medical subjects to end the experiment at anytime. *See* TRIALS OF WAR CRIMINALS BEFORE THE NUREMBERG MILITARY TRIBUNALS UNDER CONTROL COUNCIL LAW NO. 10 181–82 (U.S. Government Printing Office, 1949).

Study." The notorious syphilis study sponsored by the U.S. Public Health Service (PHS) and carried out over a period of forty years by government doctors not only epitomizes research betrayal, but also standard medical care for African Americans.[45] The infamous syphilis study was conducted on roughly 400 Black men in the late stages of syphilis from 1932 until 1972.[46] Researchers purposefully targeted these uneducated, mostly illiterate men, the majority of whom labored as sharecroppers in one of the poorest rural counties in Alabama.[47] The men suffered from tertiary syphilis, which can result in blindness, tumors, heart disease, insanity, paralysis, and ultimately death.[48] However, researchers purposefully avoided telling the men about the disease or how it destroys the body.[49] Instead, most were simply told that they tested positive for "bad blood."[50]

The purpose of the study was to collect data on the corpses of men ravaged by syphilis.[51] Since research was intended to truly begin at the autopsies,[52] these unwitting study participants were never informed when a relatively inexpensive cure became available.[53] They were meant to die during the period of observation. The PHS researchers attempted to justify their study and conduct, explaining the pressing social need to document and confirm that White bodies and Black bodies respond differently to diseases and even to medical treatments.[54]

The Tuskegee Study is thought to be the longest non-therapeutic medical study on human beings in the world.[55] By 1997, when President Clinton apologized for the government's complicity in conducting the study, only eight survivors remained.[56] Their fellow research subjects eventually died from syphilis or syphilis-related diseases.[57] The collateral toll extended to their families as well: forty wives were infected and at least nineteen children of the participants were born with congenital birth defects resulting from syphilis.[58]

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45. *See* Savitt, *supra* note 31, at 331 (noting that doctors used Blacks in medical demonstrations and dissections). Savitt writes, "Further investigation into this subject indicates that southern White medical educators and researchers relied greatly on the availability of Negro patients for various purposes." *Id.* at 331.

46. Jay Katz, *The Consent Principle of the Nuremberg Code: Its Significance Then and Now*, *in* THE NAZI DOCTORS AND THE NUREMBERG CODE: HUMAN RIGHTS IN HUMAN EXPERIMENTATION 230 (George J. Annas & Michael A. Grodin eds., 1992); WASHINGTON, *supra* note 22, at 163.

47. WASHINGTON, *supra* note 22, at 156, 161–66.

48. *Id*. at 159.

49. *Id*. at 161–66.

50. *Id*. at 162.

51. *Id*. at 164–66.

52. *Id*.

53. *Id.* at 165–68.

54. *See, e.g.*, *id.* at 37.

55. *Id.* at 169–70.

56. *Id*. at 184.

57. *Id*. at 168.

58. *Id*. at 166.

Coercion, fear, and social manipulation were the modus operandi for the researchers who collected and retained the men in the Tuskegee Study. In fact, the participants were promised free medical care and coerced through communications that warned of their "last chance" for free medical care.[59] The medical care provided included painful spinal taps and aspirin camouflaged in pink pills, described as "special pills," to the illiterate farmers.[60]

It was not the experiment alone that makes the syphilis study emblematic of medical betrayal. The Tuskegee Study survives in the memories of bioethicists and African Americans not only because the victims were coerced by doctors in their unfettered pursuit of syphilis-ridden corpses, but also because the experiment continued in the wake of international criticism of Nazi experimentation. Indeed, government doctors and lawyers condemned Nazi doctors for engaging in notorious medical experiments on concentration camp victims. However, the federally-funded syphilis study continued through liberal and conservative presidential administrations, transitions in Congress, the drafting of the Nuremberg Code and the Declaration of Helsinki, and the US adoption of the Code of Federal Regulations. The study continued even after the discovery of penicillin, the gold-standard treatment, which cures syphilis.[61]

According to former President Clinton, "The United States government did something that was wrong—deeply, profoundly, morally wrong. It was an outrage to our commitment to integrity and equality for all our citizens . . . ."[62] He remorsefully offered, "To our African American citizens, I am sorry that your federal government orchestrated a study so clearly racist."[63] Some African Americans remain leery of government-sponsored or related programs involving the body years after the infamous syphilis study.[64]

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59. *Id*. at 163.

60. FRED D. GRAY, THE TUSKEGEE SYPHILIS STUDY: THE REAL STORY AND BEYOND 53, 59 (1998); JAMES H. JONES, BAD BLOOD: THE TUSKEGEE SYPHILIS EXPERIMENT 127–31 (1981).

61. *Id*. at 165–68.

62. *Id*. 13.

63. WASHINGTON, *supra* note 22, at 184.

64. In testifying before a congressional subcommittee, Dr. Benjamin Payton, then-President of Tuskegee University, urged lawmakers to understand why "African Americans exhibit a disproportionately large amount of cynicism and lack of confidence in the U.S. health and research establishment. Some studies link that mistrust to a long history of medical abuse extending back as far as slavery. Others assert a more recent and direct relationship to what has come to be called 'The Tuskegee Experiment' that was conducted by the Public Health Service . . . on poor Black males in Alabama." *Hearings Before the H. Appropriations Comm. Labor, Health and Human Services, and Education Subcomm.*, 105th Cong. (1998) (prepared testimony of Benjamin F. Payton).

C. Medical Trust and Government-Sponsored Medicine: Eugenics—Silencing a Poor White Race

Race, reproduction, and medicine cannot be strictly defined by, or confined to, an African American narrative.[65] The perimeters of reproductive trust are bounded by the American tale of eugenics and the forced sterilization of thousands of White boys, girls, men, and women who were deemed socially unfit.[66] Paul Lombardo, the preeminent scholar tracking this woeful legacy, writes about government complicity in crafting statutes that permitted compulsory sterilization in order to prevent states from being "swamped" by the socially unfit.[67] Lawyers and doctors helped implement and enforce eugenic laws.

Indiana passed the first eugenics law in the nation[68] and, by the time of the infamous Supreme Court decision in *Buck v. Bell*[69] approving the constitutional legitimacy of compulsory sterilizations, dozens more states had followed Indiana's example.[70] Compulsory sterilization laws targeted poor, homeless, illiterate White citizens in states across the country, although the laws were often couched in public-health terms—to eradicate epilepsy, mental

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65. *See* Skinner v. Oklahoma, 316 U.S. 535 (1942) (striking down a state statute that forced sterilization on felons); Buck v. Bell, 274 U.S. 200 (1927) (condoning forced sterilization on feeble-minded Whites). African American women nonetheless figured prominently in the eugenics movement. *See* Rebecca Sinderbrand, *A Shameful Little Secret: North Carolina Confronts Its History of Forced Sterilization*, NEWSWEEK, Mar. 28, 2005, at 33 (describing the psychological trauma and continuing legal battle of African American women sterilized in North Carolina). For one victim, Sinderbrand reports the following:

> She soon learned that the operation had been performed by state order in North Carolina in 1968, when she was just 14, and had given birth to a baby after being raped. At the time, she'd assumed doctors were just performing a routine post-birth procedure. The sterilization-consent form had been signed by her neglectful father and her illiterate grandmother, who had marked her assent with an X.

Id. at 33*; see also* DOROTHY ROBERTS, KILLING THE BLACK BODY 59–76 (1997) (describing the birth of the eugenics movement in America and its interest in Blacks). Thousands of African American women were sterilized during the twentieth century. Many were considered feeble-minded or degenerates to society. Post-slavery African American women's once-exploited reproductive abilities were of little value and rather a "social" threat. State-sponsored sterilizations occurred in more than half of the United States long after the Nazi's horrible regime of experimental medicine had been exposed. *Cf.* Michele Goodwin, *The Black Woman In The Attic: Law, Metaphor & Madness in Jane Eyre*, 30 RUTGERS L.J. 597, 608 (1999) (noting Black women were targets of eugenic experiments in the late 1800s).

66. *See generally* Goodwin, *supra* note 1.

67. Paul A. Lombardo, *Taking Eugenics Seriously: Three Generations of ??? Are Enough?*, 30 FLA. ST. U. L. REV.191, 216 (2003).

68. STEPHEN TROMBLEY, THE RIGHT TO REPRODUCE: A HISTORY OF COERCIVE STERILIZATION 51 (1988).

69. 274 U.S. 200 (1927).

70. A complete list of sterilization laws in each state can be found in THE NATIONAL CENTER FOR FAMILY PLANNING SERVICES, U.S. DEP'T OF HEALTH, EDUCATION AND WELFARE, PUB. NO. 74-16001, FAMILY PLANNING, CONTRACEPTION, AND VOLUNTARY STERILIZATION: AN ANALYSIS OF LAWS AND POLICIES IN THE UNITED STATES, EACH STATE AND JURISDICTION (1971), cited in Stephanie Hyatt, *A Shared History of Shame: Sweden's Four-Decade Policy of Forced Sterilization and the Eugenics Movement in the United States*, 8 IND. INT'L & COMP. L. REV. 475, 490 n.98 (1998).

retardation, alcoholism, and criminality. Eugenicists erroneously believed that poverty, criminality, and homelessness were genetically inscribed.

The *Buck v. Bell* decision legitimized state suppression of reproductive freedom for poor Whites. Carrie Buck, a poor White teenager and the petitioner at the center of the case, had been raped.[71] According to Virginia state law, Buck qualified for compulsory sterilization because she was declared "feeble-minded" by doctors at the state facility where she, her mother, and other poor, illiterate Whites, were incarcerated.[72] The Supreme Court of Appeals of Virginia explained that forced sterilization of minors and others did not constitute cruel and unusual punishment, distinguishing it from "such bodily punishments as involve torture and are inhumane and barbarous."[73]

According to Justice Holmes in a nearly unanimous opinion (Butler dissenting), it would be odd if the state of Virginia could not impose upon those "who already sap the strength of the State for these lesser sacrifices, often not felt to be such by those concerned, in order to prevent our being swamped with incompetence."[74] Holmes expounded, "It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind . . . . Three generations of imbeciles are enough."[75] The Justices found that the regulations that promoted public health and safety, such as vaccination laws, provided the precedent and model for sterilization laws.[76]

The compulsory sterilization laws of the United States would later serve as the model for Nazi eugenics laws.[77] At the Nuremburg Trials years later, Nazi doctors used as their defense that they were only following the practices initiated in the United States decades prior.[78] Their observations were offensive, but true.

D. Medical Trust and Government-Sponsored Medicine: A Contemporary Story?

> "The irony is that anyone who knows anything about maternal care in prisons would never send a pregnant woman there to protect the fetus." [79]

Sex, race, and class continue to play a defining role in reproductive politics in the United States. Nowhere is that observation better captured than in Dr.

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71. Judith F. Daar, Accessing *Reproductive Technologies: Invisible Barriers, Indelible Harms*, 23 BERKELEY J. GENDER L. & JUST. 18, 79.

72. *Buck*, 274 U.S. at 205.

73. Buck v. Bell, 130 S.E. 516, 519 (Va. 1925), *aff'd*, 274 U.S. 200 (1927).

74. *Buck*, 274 U.S. at 207.

75. *Id*.

76. *Id*. ("The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes.") (citing Jacobson v. Mass., 197 U.S. 11 (1905)).

77. WOLFGANG WEYERS, M.D., THE ABUSE OF MAN: AN ILLUSTRATED HISTORY OF DUBIOUS MEDICAL EXPERIMENTATION 242 (2003).

78. *Id*. at 349–50.

79. Jean Reith Schroedel & Paul Peretz, *A Gender Analysis of Policy Formation: The Case of Fetal Abuse*, 19 J. HEALTH POL. POL'Y & L. 335, 350 (1994).

Marion Sims' home state, South Carolina, which became the first to prosecute drug-addicted women by relying on medical evidence gathered by doctors and nurses at the Medical University of South Carolina (MUSC) and voluntarily submitted to police and prosecutors.[80] South Carolina led the nation with the creation of fetal drug laws (FDLs) used to prosecute drug-addicted women essentially for becoming pregnant.[81]

The pregnant women sought, and were encouraged to receive, prenatal services through a public-service-announcement campaign.[82] Unbeknownst to the patients, the program focused on prosecuting women who used drugs during pregnancy.[83] Nurses and doctors at MUSC agreed to provide prosecutors with evidence of their patients' drug use by releasing the results of urine-sample tests to law enforcement.[84]

Among the dozens of women fighting for their freedom after prenatal exams was Paula Hale, a rape victim.[85] Hale was never offered rape counseling despite telling nurses at MUSC about the violence and abuse she suffered. Subsequently, like many girls and women with similar histories, she turned to illegal drugs.[86] When Hale became pregnant as a result of that rape, she sought treatment at the only hospital she knew to serve poor Black women like herself—the MUSC. Again, "no one bothered to link her with an appropriate drug treatment program or a trauma institute."[87] Instead, nurses and doctors collected evidence of her drug use to turn over to police and prosecutors.[88] Like the twenty-eight other Black women snagged by the MUSC, Hale was "dragged out of the hospital in chains and shackles."[89]

These haunting episodes conjure images of slavery.[90] Indeed, race seemed to dominate every aspect of pregnant patients' treatment at MUSC. With one exception, all the women turned over to police for using illegal drugs during

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80. *See* Goodwin, *supra* note 1, at 1677; Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 HARV. L. REV. 1419, 1420 (1991).

81. Roberts, *supra* note 80, at 1445–50.

82. Goodwin, *supra* note 1, at 1677.

83. Ferguson v. City of Charleston, 532 U.S. 67, 71–72 (2001).

84. *Id.* at 71–72.

85. South Carolina Advocates for Pregnant Women & Nat'l Advocates for Pregnant Women, *South Carolina: First in the Nation for Arresting African-American Pregnant Women—Last in the Nation for Funding Drug and Alcohol Treatment*, Jan. 8, 2003, http://advocatesforpregnantwomen.org/issues/briefingpaper.htm (last visited Feb. 9, 2008) [hereinafter *First in the Nation*]. Such prosecutions are epitomized as well by *State v. McKnight*, 576 S.E.2d 168 (S.C. 2003), in which Regina McKnight was convicted of homicide by child abuse after giving birth to a stillborn child who tested positive for cocaine.

86. *Id.*; *see also* Renae D. Duncan et al., *Childhood Physical Assault as a Risk Factor for PTSD, Depression, and Substance Abuse: Findings from a National Survey*, 66 AM. J. ORTHOPSYCHIATRY 437, 443 (1996) (showing victims of childhood assault were much more likely than nonvictims to take illegal drugs).

87. *First in the Nation*, *supra* note 85.

88. *Id.*

89. *Id.*

90. *Id.*

pregnancy were Black.[91] Regarding the exception, however, hospital officials made sure to note on her chart that the White patient "lives with her boyfriend who is a Negro."[92] Thus, it would appear that the program was racially motivated as well.[93]

What normative conclusions should emerge from the stories of medical breaches of trust contained in this part? One conclusion is that vulnerable populations, and particularly African Americans, should be cautious, and justifiably so, about the *type* and *quality* of relationships they seek to develop with the medical community and with government-supported medical programs.[94] Trust and loyalty are critical values and components of doctor-patient relationships. Yet, certain populations, like African Americans, have good reason to be skeptical while other populations may not. Ironically, however, these vulnerable populations who should be the most skeptical about medical trust and loyalty are also often the same populations that lack the opportunity and luxury of choice. This observation is critical to remember when considering our proposal for an ex post test of reasonableness in part V.

IV

TRUST AND LOYALTY

> "Without some minimal level of trust, patients would not seek care, submit to treatment, disclose necessary information, or follow treatment recommendations."[95]

If institutions are perceived as untrustworthy, inefficient, and biased, they will lose participant trust, loyalty, and confidence. This hypothesis holds true in many contexts. However, as demonstrated by the Madoff scandal and the spate of other recent financial debacles including Enron and Tyco, investors, consumers, and sometimes government officials will ignore relevant information at their peril.

This section analyzes whether the goals of established trust discourse properly and realistically align with contemporary challenges. It asks whether traditional trust discourses enable or burden patients. It resituates patients according to their abilities and capabilities. Subpart A. provides a brief analysis of the rationales for promoting a trust relationship between physicians and

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91. *Id.*

92. *Id.*

93. Goodwin, *supra* note 1, at 1677.

94. A defining literature in the fields of critical race scholarship, ethnic studies, women's studies, as well as empirical studies, documents disparities and inequality in the treatment of African Americans. *See, e.g.*, Cara A. Fauci, *Racism and Health Care in America: Legal Responses to Racial Disparities in the Allocation of Kidneys*, 21 B.C. THIRD WORLD L.J. 35, 35 (2001) (asserting that African Americans have "long been subjected to racism within the health care sector"); Sidney D. Watson, *Race, Ethnicity and Quality of Care: Inequalities and Incentives*, 27 AM. J.L. & MED. 203, 204 (2001) (urging "adoption of a systemic approach to reducing race-based treatment disparities that uses reporting systems and financial incentives to produce structural change."); Lindsey Tanner, *Blacks' Mental Care Lags that of Whites*, CHI. SUN-TIMES, Mar. 13, 2002, at 33 (noting African Americans receive poorer medical care than Whites in the area of mental illnesses).

95. Hall, *supra* note 2, at 478.

patients. Subpart B. examines the rationality and reasonableness of patient trust in light of inherent problems and conflicts within that relationship.

A. The Trust Relationship

Trust is the willingness of individuals to make themselves vulnerable to others in the face of risks.[96] Nowhere is this more prominently featured than in medicine, where patients must rely on diagnoses, information, and treatment decisions from their doctors. Within this context, patients expose themselves—their medical histories, social histories, genetic information, and sexual pasts.

Most scholars who address trust in medical relationships contend that patients benefit from a presumption of trust in their physicians.[97] According to Mark Hall, "trust is the core, defining characteristic of the doctor/patient relationship, or, as is sometimes said, the "glue' that holds the relationship together and makes it possible."[98] According to Grant Morris, "trust is vitally important for therapeutic purposes. With trust, the patient is willing to share sensitive and confidential information, to be confident in the physician's clinical judgment, and to comply with the physician's recommended treatment."[99] Frances Miller notes that patient trust is integral to the healing process, and that patients who trust their physicians are more likely to follow their physicians' recommendations.[100]

More explicitly, Robert Gatter, a leading medical-law scholar, urges that patients' trust in their physicians should be presumptive "because most patients are not able to treat themselves or. . .direct the medical treatment they receive from another."[101] His observation is grounded in the principle that "[t]rust is at

96. Hill, *supra* note 2, at 1724. Distrust involves a pessimistic attitude, a wariness, about the risk of making oneself vulnerable to another. Hall, *supra* note 2, at 513.

97. *See* Kathy L. Cerminara, *The Class Action Suit As A Method of Patient Empowerment in the Managed Care Setting*, 24 AM. J.L. & MED. 7, 17 (1998) (arguing that "[p]atients who trust their caregivers often report more favorable treatment outcomes"); Robert Gatter, *Unnecessary Adversaries at the End of Life: Mediating End-of-Life Treatment Disputes to Prevent Erosion of Physician–patient Relationships*, 79 B.U. L. REV. 1091, 1099 (1999); Leon R. Kass, *Neither for Love nor Money: Why Doctors Must Not Kill*, PUBLIC INTEREST, Winter 1989, at 25, 35 (implying that patients' wholehearted trust in physicians is ideal and that "[t]he patient's trust in the doctor's wholehearted devotion to the patient's best interests will be hard to sustain" if doctors assist with suicides); Peter D. Jacobson & Michael T. Cahill, *Apply Fiduciary Responsibilities in the Managed Care Context*, 26 AM. J.L. & MED. 155, 157 (2000) ("The basic need for trust . . . is incontrovertible. Absent trust, managed care cannot survive."); Frances H. Miller, *Trusting Doctors: Tricky Business When It Comes to Clinical Research*, 81 B.U. L. REV. 423, 426–27 (arguing that patient trust is a critical ingredient in the physician–patient relationship); Starla Kay Roels, *HIPAA and Patient Privacy: Tribal Policies as Added Means For Addressing Indian Health Disparities*, 31 AM. INDIAN L. REV. 1 (2006) (explaining how HIPAA regulations will foster trust and suggesting that when patients trust their doctors they will "more fully participate in their own care").

98. See Mark A. Hall, *Trust, Law, and Medicine: Towards a Therapeutic Jurisprudence of Health Care Delivery*, 55 STAN. L. REV. 463 (2002).

99. *See* Grant H. Morris, *Dissing Disclosure: Just What the Doctor Ordered*, 44 ARIZ. L. REV. 313, 344 (2002).

100. Miller, *supra* note 97, at 426.

101. Gatter, *supra* note 97, at 1099.

the ethical core of the physician–patient relationship and is essential to the process of medical decision-making."[102] Gatter explains that the physician–patient relationship requires this level of engagement. Gatter challenges the proposition (espoused in this project) that the physician–patient relationship is vertically positioned, with physicians at the top holding disproportionate power. He argues that this portrayal inaccurately captures the relationship.[103]

This article takes a different approach, arguing for greater nuance in trust discourse and articulating the inherent weaknesses in patients' presuming trust in physicians based on little more than an assumption that trust is warranted, deserved, or necessary. In traditional trust discourse, the concern for patient and physician fidelity is framed as a moral issue. In other words, patients should trust their physicians because it is the right thing to do; physicians will better serve patients whom they believe trust them; and patients should trust that physicians are qualified to provide the treatments they offer. At some point, the arguments become circular.

Missing is an alternative, but equally credible theory, to capture the patient-physician interaction. For example, is it a morally grounded trust that inspires patients' confidence in physicians or an understanding that physicians are obligated by law to be licensed to practice medicine? Is trust grounded in the understanding that, absent a physician's due diligence and competence in a medical procedure, a patient can turn to courts to vindicate their concerns?

Medical law scholars gravitate to the language of trust when other dynamics offer equally and perhaps more plausible explanations of a patient's perspective in the medical suite. Traditional discourse explains that trust in physicians is essential—and patients voluntarily surrender it—because physicians possess "requisite medical knowledge and technical skill to effectively treat patients."[104] For some patients, trust is not what motivates their compliance with physicians. Rather, a lack of alternatives or an emergency prompts their obedience. For others, it may be intimidation or simple acquiescence because it seems to be the right thing to do. And yet for others, reliance may be the dynamic that best describes the interaction between patients and physicians, with trust adding little value to the patients' experience. In this way, some patients may perceive themselves as contracting parties with physicians, rather than purveyors of trust.

Medical law scholarship portrays alternative values and dynamics (to trust) in the physician patient relationship as either destructive or absent. But, neither tort law nor medical ethics require physician competence because of patient trust. Rather, that physicians are held to an elevated standard of competency, skill, and professionalism has very little if anything to do with patient trust. Instead, physician professionalism and the obligation to render care with competence are grounded in physician ethics (i.e. fidelity to the profession) and

102. *Id.*
103. *Id.*
104. *Id.*

tort law. Thus, perhaps what patients really cling to is not medical trust, but the strength of the law to deter physician negligence, and the specter of tort law remedies to incentivize good behavior.

The goal of this project is not to suggest that trust has no place or value within the physician–patient relationship.[105] The most salient and persuasive arguments for promoting the trust relationship between physicians and their patients are grounded in the public health. As a public-health matter, society has a vested interest in the health and well-being of its communities. The inability to trust the quality, effectiveness, and confidentiality of care received from medical professionals erodes confidence in the medical system. When confidence in medical institutions and doctors erode, individuals are less likely to seek treatment for medical ailments. If and when the sick seek treatment from untrustworthy medical institutions, it is likely as a last resort, at a time when their medical conditions may be incurable or infectious. On the other hand, when trust is maximized and broadly realized, unhealthy people are likely to seek medical care and reduce the spread of disease. Thus, trust can be seen as promoting public health.

Patients come to their physicians at their most vulnerable. Their vulnerability is demonstrated not only by their maladies but by the inability to diagnose, treat, prescribe medications, and rehabilitate on their own. Ethicists and scholars describe this vulnerability as creating a mental and physical state in patients that generates the desire to trust physicians.[106] To ease their suffering or doubts about the quality of their care and treatment during periods of high vulnerability, it may be less stressful for patients to rely blindly on the loyalty of their physicians. Trust thus serves a medical function in that it likely reduces stress, tension, worry, skepticism, and second–guessing in the physician–patient relationship.

B. The Reasonableness of Relying on the Trust Relationship

Yet there are problems in relying on the trust relationship. As a result of "blind trust,"[107] patients may rely too much on doctors and fail to adequately investigate treatment options. In essence, willful blindness disserves patient interests as well as the legitimacy of the medical profession.

Patients generally believe that physicians have their best interests in mind as part of the relationship.[108] But whether such a perception emanates from individual relationships, or is imposed by an external ethic, is debatable. Whether trust in these relationships is *always* rational or reasonable might also

105. It is also important here to point out that we are not taking a prophylactic stand against trust. Rather, what this article builds towards is the importance of demonstrable actions, information, behaviors, and other indicators that would signal to a patient that trust has been earned.

106. Gatter, *supra* note 97, at 1099.

107. This article uses "blind-trust" to mean undeserved loyalty and commitment to a physician in absence of demonstrable care, concern, commitment, expertise, medical history, and common goals.

108. Hall, *supra* note 2, at 474 (noting those who trust believe the trustee has their best interests at heart).

be debatable.[109] For example, is it rational and reasonable to trust if a patient fears that projecting a lack of trust will result in inferior care ?[110] Is it rational and to the patient's benefit to blindly trust a doctor whose behavior or history demonstrates negligence, abuse, or significant conflicts of interests? In both instances, we think not.

Patients trust doctors because doing so is likely the easiest course of action when an illness first develops. To some extent, patients trust doctors in much the same way that they trust the police. That is to say, trust arises not from the promise of a uniquely personal relationship, but rather by necessity, by what patients perceive *they should or must do*.[111] In an emergency, a burglarized home owner knows to call the police, but might choose not to be picky about who responds to the 911 call (or equally, might be afraid to articulate disagreement or discontent with the officer's treatment of the case because of relative positions of power and authority). Similarly, patients may initially trust their doctors because of their need for information, care and treatment, even when they have no say in choosing the physician who treats them.

But, continuing to trust is not necessarily rational. Trust can cause patients to ignore signals relevant to evaluating whether a positive, effective relationship can develop with her medical professional. Signs that would certainly be relevant in other interpersonal contexts may be ignored, such as a physician's dismissive behavior, impatience when questions are asked, reliance on ultimatums, rude or belittling comments, and an overt lack of respect towards the patient. Furthermore, because of over-reliance or "over trust," patients might fail to seek relevant medical information, alternative treatment possibilities, and second medical opinions.

Relying too much on trust could mean that patients fail to engage in reasonable, responsible behaviors to monitor their health and to critique the treatment options provided. These issues become more relevant in a biotech-transfer age, in which patient–physician conflicts of interest are more apparent than ever before, and in which patients believe that there is more to lose. These conflicts might involve patient-data mining,[112] a physician's financial interest in prescribing patients a certain treatment or drug,[113] in patenting and profiting

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109. It is, in part, emotional because it assumes that the trustee is "benevolent and caring." *Id*.

110. It could also be argued that trust derived from fear of reprisal is really coerced trust and not pure trust.

111. For example, the Hippocratic Oath instructs physicians to act selflessly and forthrightly in the care and treatment of the patient. However, that oath is not one that emanates between the physician and patient, but rather, from the patient's perspective, is an external charge to doctors, the violation of which affects their place within their profession, but does not build or restore a relationship with the patient.

112. *See* Moore v. Regents of the Univ. of Cal., 793 P.2d 479 (1990) (claiming doctors harvested cells from a patient for lucrative medical research without patient consent).

113. Frances H. Miller, *Trusting Doctors: Tricky Business When It Comes to Clinical Research*, 81 B.U. L. REV. 423, 424 (2001) ("[T]he boundaries separating medical research from clinical practice are becoming increasingly hard to trace . . . . [S]ome drug and device manufacturers now compensate primary care physicians for enrolling their patients in clinical studies.").

from cell lines or therapies derived from patients without their consent,[114] or in the conflicts inherent in some assisted-reproductive strategies[115] and in plastic surgeries.[116]

Conflicts may arise in any professional relationship. With physicians, however, those conflicts can be more damaging because, unlike financial losses, the harms can be very difficult to mitigate. In the physician–patient relationship, patients invest by disrobing physically and emotionally, providing deeply confidential information often unshared with family and friends. As the MUSC prosecutions demonstrate, the fiduciary breaches in these contexts are not only harmful to patients, but more devastating than in other situations.[117] In the MUSC cases, fiduciary breaches resulted in pregnant women giving birth while their legs were shackled, and in some being transported to prison while still bleeding from after birth.

Furthermore, when medical trust is violated, as arguably occurred in the MUSC cases, few if any viable recourses exist for victims. In the worst cases, unlike other fiduciary relationships, the criminal law is rarely involved to address the "public breach" aspect of physician malfeasance even when significant harms, including death, result.[118] Why should investor fraud be treated as a public breach and not medical fraud—such as deceptively luring patients to engage in dangerous clinical trials or to submit to unnecessary, costly medical procedures—when the consequences of medical fraud are much more devastating? These questions are beyond the scope of this article. However, the lack of criminal sanctions removes a significant deterrent to physician breaches of trust. Hence, it is more important for patients to constantly and carefully evaluate whether trust is deserved.

V
EVALUATING TRUST

Society is often disrupted by fiduciary breaches of trust. Recent scandals involving Enron, Madoff, and Tyco provide an economic counterpart to medical fraud. Defrauded investors and their advocates lament their losses and

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114. *Moore*, 793 P.2d 479 (claiming doctors harvested cells from a patient for lucrative medical research without patient consent); Greenberg v. Miami Children's Hosp. Research Inst., 264 F. Supp. 2d 1064 (2003) (claiming doctors secretly patented a deadly gene derived from volunteer patient research and then sought to enjoin any future research and treatment).

115. Michele Goodwin, *Assisted Reproductive Technology & The Doublebind: the Illusory Choice of Motherhood*, 9 J. GENDER RACE & JUST. 1, 3 (2005) (noting the inherent conflict between fetal safety and making a profit in assisted reproductive procedures).

116. Rhonda Gay Hartmon, *Face Value: Challenges of Transplant Technology*, 31 AM. J. L. & MED. 7 (2005) (exploring issues related to facial transplants).

117. Upon learning that his doctor had surreptitiously mined his body for valuable cells, John Moore stated that he felt "violated for dollars," "invaded," and "raped." *See* LORI ANDREWS & DOROTHY NELKIN, BODY BAZAAR: THE MARKET FOR HUMAN TISSUE IN THE BIOTECHNOLOGY AGE 28 (1999).

118. *See* L. Song Richardson, *When Human Experimentation Is Criminal*, 99 J. CRIM. L. & CRIMINOLOGY 89 (2008).

the betrayal of trust. Against the backdrop of those cases are pressing questions: How preventable were the losses? To what extent was trust a factor in the fiduciary breach? Was reliance on the fiduciary reasonable? These questions are often unspoken. But if those defrauded were in the best position to prevent their losses, how should tort law respond? Is strict liability the best approach in fiduciary-breach scenarios, or would a comparative negligence approach work better—holding clients, consumers, and patients accountable for unreasonably relying on fraud or malpractice-prone fiduciaries?

History is replete with examples of medical wrongs that explain why it might be reasonable for some groups to mistrust the profession.[119] Implicit in that observation is a normative question: Why should those harmed by their doctors continue to trust without requiring the doctors to demonstrate care, concern, commitment, and loyalty? Why should tort law provide a remedy for patients without imposing some duty to mitigate?

Without patient trust, some scholars believe the "conceptual foundation of a good and just physician–patient relationship would erode."[120] We do not argue against trust in the physician–patient relationship. Rather, we urge that the trust relationship be reconceptualized to read a patient-focused standard of reasonableness into the trust relationship. Quality patient care should be the focus of the physician–patient relationship, and achieving that objective may be obscured by the notion that patients *owe* physicians blind trust.

Part IV builds from the prior section, judging victimhood and empowerment on a conceptual scale. It articulates why a reframing of the trust dialogue in the physician–patient context is necessary. In this section, we begin to articulate what the more appropriate ex-post inquiries might be to determine reasonable conduct. Here, we establish a test that considers consumer competence; knowledge; prior experience; information availability; and resources to investigate. Such a test, we argue, provides a more nuanced approach to ascertain whether and in what instances it might be reasonable for a client or patient to rely on a fiduciary.

A. Owed Trust

As a matter of first principles, this project explicitly acknowledges the value of a healthy, well-functioning medical profession. The trust relationship is a central component in determining how best to achieve that goal. But why should patients owe physicians loyalty in the absence of demonstrated competence, compassion, care, concern, and loyalty?

When patients believe that trust is owed to physicians and must be surrendered without demonstration of loyalty, a hierarchy is reified in the relationship that places the patient at the bottom of the vertical scale and physicians at the top. The problems located within the hierarchy are the

119. *See supra* notes 21–87.
120. Gatter, *supra* note 97, at 1104.

disempowerment of patients, creating instant victims, rather than active participants in the patients' own medical goals. Trust should be treated as an option (to be strived for and earned) within the physician–patient relationship.

Rather than patients owing physicians trust, patients should realize independent options. The physician–patient relationship can be judged on a scale similar to personal relationships—such as those in a business, a contract, or between friends and spouses—that involve choice, respect, expressions of loyalty, demonstrable signs of care, concern, and commitment. In those instances, trust is a value that must be earned, not one relinquished upon demand or by coercion.

Normatively, it might not make sense for patients to always trust their physicians, particularly when risks are high. In high-risk medical scenarios, patients may have more to lose through physician malfeasance, and the relative gains might not always be clear (particularly where conflicts arise). "The willingness to take th[e] risk [to trust] turns on both the magnitude of the perceived risk and the degree of harm that the truster will suffer if it turns out that the trust was misplaced."[121]

What changes in a reframing of trust? By reframing trust from an implicit obligation on the part of patients to one that is shared with their physicians, based upon a reasonable conclusion that trust is deserved, patients become empowered in their ability to choose. The value of choice should not be underestimated, for blind trust can lead to uninformed decision-making, lack of empowerment, frustration, poor health outcomes, and litigation. Blind trust is an irrational and unreasonable option for the patient. When trust is reframed, patients assume greater responsibility for their medical care, thereby shifting from powerlessness to sharing some fault (possibly) in *preventable*, poor medical choices.

B. Reasonableness: The Patient Negligence Test

A modified trust framework could achieve a few important social goals. By realigning trust, patients would become better healthcare consumers, likely to be better informed about their choices in medical care, including their selection of doctors. They would also understand the importance of asking questions about the type of care they receive, engage in independent research, scrutinize medical opinions, seek second and third options, and be more discerning in reading the signs of loyalty. Importantly, reframing trust and creating better consumers of patients will inure benefits to doctors as well as patients.

Better-informed patients are likely to seek out doctors who share similar values, concerns, and acceptable styles of interaction. One significant problem in the physician–patient relationship may be the inability to effectively communicate. A patient who no longer feels obligated to expend trust and invest in a relationship plagued with poor communication will likely seek a

121. Hill, *supra* note 2, at 1752.

doctor with a better bedside manner. In this way, patient and physician styles of interaction might better align to forge healthier relationships that are defined by choice rather than by obligation. As a corollary, doctors are less likely to feel guilty, stressed, and obligated to serve patients whom they feel less comfortable about treating.

Splicing reasonableness into a trust framework holds many potential benefits for patients and physicians. But how should reasonableness be determined? Should it be an objective standard or one subjective to the patient? A subjective standard would view the level of reasonableness from the perspective of each individual patient, requiring an inquiry into the frame of mind of each during the period leading up to fiduciary breach. An objective standard would give less deference to the internal psychology of individual patients and base reasonableness on community standards, akin to the test for reasonable care in a medical malpractice suit.[122] In most medical malpractice cases, the standard of care is the fundamental issue to be established by the plaintiff. The critical question centers on what standard is to be applied, namely what is the community standard for the particular medical treatment in question. The answers are generally derived locally, except where there is conflict between a well-established national protocol and that of doctors in the local community.

In this case, the standard should be an objective one, taking the perspective of a reasonable person in the plaintiff's position. The reason for this standard is that the very nature of this proposal urges patients to be more invested in their medical decision-making. At first glance, such a standard might appear to disserve the most vulnerable patients such as Paula Hale, whose use of the MUSC medical facility was based on a seeming lack of options, as she was indigent, pregnant, and addicted to drugs.[123] However, by judging reasonableness from the perspective of a reasonable person in the plaintiff's situation, the Patient Negligence Test (PNT), which we propose, considers the spectrum of patient options and abilities. Under the PNT, there are five patient-focused factors for courts to consider: competence, knowledge, prior experience, access to information, and resources to investigate. The PNT provides a more nuanced approach to ascertain whether, and in what instances, it might be reasonable for a client or patient to rely on a fiduciary. This standard would apply to tort litigation in which patients are seeking remedies for physician malfeasance. In all cases, patient negligence should be capped at ten percent of the harm's value.

By incorporating a reasonableness test that considers our five factors, courts would be more likely to make sound decisions as to how reasonable it was for a patient to have followed a physician-prescribed protocol that was detrimental to

122. Cairelli v. Vakilian, 80 Fed. Appx. 979 (2003) (finding that a doctor could not be held liable in a suit brought by decedent's estate when his actions were consistent within a community standard of medical treatment).

123. Goodwin, *supra* note 1, at 1677.

her health or that affected a legal right. And unlike traditional tort law, a patient of limited mental competence would not be comparatively liable for failure to make astute choices regarding her physician. Equally, a patient who lacked financial options to make alternative choices or who was limited by geography to seek alternative medical care might reasonably have trusted a physician who was otherwise not ideal. On the other hand, a competent, well-informed, and educated patient, with access to good information, might be comparatively negligent in medical-malfeasance scenarios when it would have been unreasonable to opt for medical treatment from a physician who had already committed malpractice.

There are limits to this approach that we acknowledge. Equally, there are questions that deserve a more thorough vetting than is provided for in this thought experiment. For example, an empirical study would corroborate or contradict the assumption pushed in most medial law scholarship that patient trust is presumptive; that it leads to better outcomes (for patients and physicians); and that it inspires physicians to provide better care to patients. Indeed, an empirical study analyzing whether the specter of the law (and its ability to provide remedies for patients and punish wrongdoers) equally motivates or satisfies patients' concerns about seeking medical help would benefit the literature in this domain.

To this end, qualitative data analyzing patients' attitudes on trust will help to illuminate what really transpires between physicians and patients. Particularly, African Americans should be participants in such a study. Because of the historical use of African Americans as *vulnerable* rather than *informed* research subjects, and ongoing contemporary health disparities, we predict that African Americans will articulate a different version of what transpires between physicians and patients. For some African Americans, it may not be trust in operation that inspires their interaction with doctors, but rather reliance, and there is a distinction.

As well, absent implementation of the model test promoted in this project, we will not know whether such a rubric provides greater equilibrium in the physician–patient relationship, and fosters greater equity, efficiency, and efficacy. Finally, some might question whether the concept of *patient negligence* would erode what is already a fragile relationship between some local hospitals and the communities they serve.

In this project, we provide answers to questions based on case studies, medical legacy, intuition, and reasoned assumptions. And while no data exists to contradict our conclusions, there are other concerns that we must acknowledge. Since this article is a preliminary thought experiment, we do not attempt to offer more than a narrow framework here. This framework, however, provides a new, clearer lens through which one might begin to evaluate patient conduct as part of the larger physician–patient relationship. Evaluating patient conduct does not impose a punitive standard, but rather reconceptualizes patient autonomy and choice, thereby equalizing the

physician–patient relationship, reordering the vertical nature of the relationship, and reframing trust as an owed value to one that is rightfully earned.

VI
CONCLUSION

Patients trust in doctors based largely on what they do not know. "Because most patients are not able to treat themselves or to direct the medical treatment they receive from another, they turn their care over to the discretion and skill of a physician, laying their bodies and lives open to the physician."[124] In this space of vulnerability, patients are typically expected to give up reason as a feature of their exposure, susceptibility, and defenselessness. In other words, patients are not expected to advocate for themselves, and, as a result, they do not seek to empower themselves by becoming better-informed, better-prepared, or by making better choices—if they make any choices at all. At the backend of this, medical malpractice is used to rectify physician mistakes, even those that might have been predictable and preventable. We argue that too much trust might impose a heavy burden on patients and facilitate compliance with physician negligence.

Behind the veil of trust are assumptions untenable for contemporary medicine. In an era rife with conflicts of interest involving pharmaceutical companies, clinical trials, patient mining, and high-cost non-therapeutic surgeries, patients should be wary about blind trust and loyalty. Indeed, medical practitioners should desire that patients become better informed about treatment plans and options.

Thus, this article rejects the notion that trusting patients are better served patients; medical malpractice cases demonstrate the perversity of that logic. Nor does this article attempt to displace patient trust. We recognize trust as an important philosophical, legal, and ethical aspect of the physician–patient relationship: misaligned trust hurts patients' interests. Yet misaligned trust might go undetected if patients fear their medical options will be limited or that they will be denied a high quality of care because of a failure to trust.

Introducing comparative fault and reasonableness into the physician–patient trust framework dispels the notion that trust is a fixed concept. Perceiving trust as something patients owe to physicians disables patients and reifies a vertical, hierarchical patient–physician relationship. This power imbalance can lead patients to believe that trusting a physician is something they should or must do, rather than a choice to be bestowed upon a demonstration of merit. By turning the trust dialogue and framework on its head, we hope to disentangle what patients feel they must or should do from what they can do upon physicians' demonstrating care, concern, commitment, competence, and loyalty. The Patient Negligence Test for reasonableness in trust scenarios is an objective

124. Gatter, *supra* note 97, at 1099.

standard, which will inform patients as well as courts. It considers competence, knowledge, prior experience, access to information, and resources to investigate as important criteria to evaluate the reasonableness of trust or *patient negligence.*