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FAITH, CONFIDENCE, AND HEALTH CARE: FOSTERING TRUST IN MEDICINE THROUGH LAW

Robert Gatter*

I. INTRODUCTION

When historians look back at this moment in the evolution of health policy in the United States, they will likely define it as a period of continued struggle with the virtues and vices of a market-based health care delivery system.^{1,2} They may also depict this as a

* Assistant Professor of Law, Penn State University, Dickinson School of Law. I am grateful to Mark A. Hall for his helpful comments. I also thank the organizers of and participants in the Health Law Scholars Workshop, sponsored by the American Society of Law, Medicine & Ethics and by St. Louis University School of Law, where an early version of this Article was presented in October 2002. In particular, I thank the workshop participants Brietta R. Clark, Jesse A. Goldner, Thomas L. Greaney, Sandra H. Johnson, Dayna Bowen Matthew, Benjamin W. Moulton, Robert L. Schwartz, Nicolas P. Terry, Sidney D. Watson, and Barbara J. Zabawa for their encouragement and suggestions. Finally, I thank Rebecca Finkenbinder, Richard Kocher, and Gabriel MacConaill for their outstanding research assistance. All copyrights reserved.

1. For example, James C. Robinson, summarizing historical trends in modern U.S. health care delivery, writes:

The corporate system of health care demonstrates daily its economic superiority over the traditional system of professional dominance and the only partially implemented systems of utility regulation and managed competition. But the long-term viability of an organizational system depends not merely on its economic prowess but also on its compatibility with the social culture and political institutions. The professional guild persisted for decades, despite changes in demography, epidemiology, and technology, due to its nostalgic appeal and financial support for legislative powerbrokers. In overturning so many traditional practices and expectations in such a short period, corporate health care has brought down upon itself the wrath of the American populist heritage that distrusts big business almost as much as it dislikes big government.

JAMES C. ROBINSON, *THE CORPORATE PRACTICE OF MEDICINE: COMPETITION AND INNOVATION IN HEALTH CARE* 213 (1999); see also M. Gregg Bloche, *The Market for Medical Ethics*, 26 J. HEALTH POL. POL'Y & L. 1099 (2001); Mark A. Hall, *Arrow on Trust*, 26 J. HEALTH POL. POL'Y & L. 1131 (2001) [hereinafter Hall, *Arrow on Trust*]; Clark C. Havighurst, *Is the Health Care Revolution Finished?—A Foreward*, 65 LAW & CONTEMP. PROBS. 1 (2002).

2. Here and throughout this Article, I use the phrase "health care delivery system" (in the singular form) to refer to the current patchwork of primarily

time when various pockets of discontentment with marketplace values in medicine coalesced around the concept of trust.³ As described below, recent empirical work on medical trust has added to our understanding of what medical trust is and how it affects health care delivery. This research appears to confirm intuitive claims that trust is central to health care, that it is fragile, and that it is not easily regained if lost.⁴ These new data, in turn, raise a question: How, if at all, should trust affect health care delivery at both the managerial and policy levels? Some propose that, as a matter of policy, the law should be used generally to preserve, if not promote, trust in medicine.⁵

The thesis of this Article is that a policy of preserving or promoting medical trust is unwarranted and potentially destructive. While pursuing a positive public perception of medical professionals and institutions may be necessary to the success of any health care delivery system, it is not clear that *trust* is necessary. More to the

private institutional and professional networks through which most health care is delivered. In that context, I do not intend the word “system” to suggest that health care delivery at the macro-level has been centrally organized. Elsewhere in this Article, I use the phrase “health care delivery systems” (in the plural form), which refers to particular institutional and professional provider networks as created by a health plan or a central corporate owner.

3. Just as scholarly interest in the general concept of trust has been interdisciplinary, see Francis Fukuyama, *Differing Disciplinary Perspectives on the Origins of Trust*, 81 B.U. L. REV. 479, 479 (2001), so too is recent scholarly interest in medical trust. See, e.g., Lynda A. Anderson & Robert F. Dedrick, *Development of the Trust in Physician Scale: A Measure to Assess Interpersonal Trust in Patient-Physician Relationships*, 67 PSYCHOL. REP. 1091 (1990); Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 501 (2002) [hereinafter Hall, *Law, Medicine, & Trust*]; David Mechanic, *The Functions and Limitations of Trust in the Provision of Medical Care*, 23 J. HEALTH POL. POL'Y & L. 661, 662-63 (1998) [hereinafter Mechanic, *Functions and Limitations of Trust*] (exploring concepts of trust in medicine from the perspective of law and health policy); David Mechanic & Sharon Meyer, *Concepts of Trust Among Patients with Serious Illness*, 51 SOC. SCI. & MED. 657 (2000); David H. Thom et al., *Further Validation and Reliability Testing of the Trust in Physician Scale*, 37 MED. CARE 510 (1999); Sally E. Thorne & Carole A. Robinson, *Reciprocal Trust in Health Care Relationships*, 13 J. ADV. NURSING 782, 783-84 (1988); Lorraine Trojan & Olive Yonge, *Developing Trusting, Caring Relationships: Home Care Nurses and Elderly Clients*, 18 J. ADV. NURS. 1903, 1905-09 (1993) (examining trust in medicine from the social science and experiential perspectives); Beiyao Zheng et al., *Development of a Scale to Measure Patients' Trust in Health Insurers*, 37 HEALTH SERV. RES. 187, 189 (2002); Katherine Hendrix, *Trust, Perceptions and Attitudes: Examining Underlying Reasons for Disparities in Health Outcomes for African-Americans and Caucasians with Diabetes in South Carolina* (unpublished presentation of doctoral dissertation research attempting to measure trust in health care delivery systems generally) (powerpoint presentation on file with author) (employing health services research tools to study trust in medicine empirically).

4. See *infra* Part II.

5. See *infra* notes 34-45 and accompanying text (discussing a recent article by Professor Mark A. Hall).

point, it is not clear that, what this Article refers to as *faith*—an emotionally based form of trust most often at issue in medical trust research⁶—is necessary. Rather, something more akin to consumer *confidence* may be sufficient.⁷

Part II describes what appears to be an emerging medical trust movement. Next, Part III argues that, by failing to consistently distinguish between faith and confidence, commentators often assume that public perception of our health care system must attain an emotional pedigree before health care can be maximally effective and efficient. The fact that the public relies on our highly institutionalized and increasingly impersonal health care system challenges this assumption, as does evidence of how individuals respond to betrayals of medical trust, suggesting that trust-as-faith in medicine may not be necessary.

Part IV then argues that pursuing faith in medicine as a matter of policy may hinder the creation of a fair and effective health care delivery system. First, a policy of preserving trust-as-faith in medicine could conflict with three decades of work designed to make savvy health care consumers out of patients. Because trusting patients are compliant and unlikely to question medical authority, a policy preserving faith effectively encourages a more docile patient. This could undercut the ability of patients to protect themselves in today's medical marketplace. Second, a policy of preserving trust-as-faith in medicine will likely abandon those who have lost their faith in medicine because, when conceived in emotional terms, trust is very difficult, if not impossible, to regain once it has been betrayed. Thus, a policy of preserving faith in medicine cannot respond to those who distrust medicine. In light of recent studies indicating that racial and ethnic minorities are less trusting of physicians and health care institutions than are those in the racial and ethnic majority, this could mean that the burdens of pursuing faith in medicine will disproportionately fall on racial and ethnic minorities.

Finally, Part V claims that a policy of pursuing trust-as-faith would hamstring lawmakers by limiting them to styles of regulation that will not undermine faith in health care providers. Various forms of regulation will affect trust-as-faith differently; self-regulation most clearly signals public trust in the regulated community while command-and-control regulation generally signals public distrust of the regulated community. Consequently, the more closely the law regulates health care professionals and institutions,

6. Throughout this Article, the term "trust-as-faith" is used to refer to this form of trust and to distinguish it from other conceptions of trust, such as confidence. See *infra* Sub-Part III.A for a description of this distinction.

7. Throughout this Article, the term "trust-as-confidence" is used to refer to a form of trust based on confidence and to distinguish this form of trust from trust-as-faith.

the more we should expect trust in them to diminish. So, if lawmakers are to promote public trust in medicine, they must avoid, at least presumptively, all but the most deferential forms of regulation. This, in turn, limits the ability of lawmakers to protect health care consumers from dangers associated with our market-based health care delivery system.

Given inconclusive evidence of the necessity of faith to good health care and risks of promoting faith through health policy, the Article concludes that the law should promote consumer confidence in health care. A shift from faith to confidence is a shift from promoting emotional dependence on the good will of health care providers to promoting rational observation of the competence and interests of those providers. By orienting health policy toward consumer confidence, the law may be able to achieve the advantages of faith-oriented health policy while also avoiding its drawbacks.

II. AN EMERGING MEDICAL TRUST MOVEMENT

While trust in medicine has long been recognized, it has received renewed attention in the era of managed health care. Some commentators argue that *medical trust*—a term used here to encompass trust in health care professionals, institutional health care providers, health plans and health insurers, and health care delivery systems—could be damaged if we allow the market to dictate our system of health care delivery.⁸ Presumably, such

8. See M. Gregg Bloche, *Trust and Betrayal in the Medical Marketplace*, 55 STAN. L. REV. 919, 925-26 (2002) (explaining that managed care—and its contractual reordering of health care delivery—can erode the trustworthiness of the medical profession and medical institutions by making appear optional traditional commitments associated with providing medical care); Hall, *Arrow on Trust*, *supra* note 1, at 1140 (“Managed care, especially, threatens to permeate the treatment environment with a climate of distrust. Even if managed care does not undermine the core physician-patient relationship, accessing and paying for care under conditions of distrust surely is not optimal.”) (citations omitted); Hall, *Law, Medicine, & Trust*, *supra* note 3, at 473 (explaining that trust has resurfaced in health law theory “as a result of the massive movement toward managed care, which has created many well-recognized threats to the integrity of treatment relationships and the trustworthiness of professionals and medical institutions”); Mechanic, *Functions and Limitations of Trust*, *supra* note 3, at 661-62; David Mechanic & Mark Schlesinger, *The Impact of Managed Care on Patients’ Trust in Medical Care and Their Physicians*, 275 JAMA 1693 (1996); Steven D. Pearson & Lisa H. Raeke, *Patients’ Trust in Physicians: Many Theories, Few Measures, and Little Data*, 15 J. GEN. INTERNAL MED. 509, 509 (2000) (“Although evidence shows that the majority of patients continue to trust physicians to act in their best interest, concern is growing that the rapid and far-reaching changes in the healthcare system have placed great pressure on that trust and may be undermining it.”); Bradford H. Gray, *Trust and Trustworthy Care in the Managed Care Era*, HEALTH AFF., Jan.-Feb. 1997, at 35-36 (explaining how the fiduciary ethic of physicians can be undermined by managed care’s cost control efforts).

renewed interest in medical trust is only enhanced by reports that confidence in medical institutions has in fact diminished in recent years,⁹ and by headlines about the betrayals of trust both inside and outside of medicine, such as revelations about financial conflicts of interest in medical research,¹⁰ accounting and stock fraud associated with the Enron collapse,¹¹ and sexual abuse and cover-up by the Catholic Church.¹²

In contrast to the theoretical approach of earlier writing about medical trust, current commentary has taken a decidedly empirical and practical turn. Researchers have developed surveys that, based on responses to ten or so questions, purport to measure medical trust on a five-point scale.¹³ There are scales to measure trust in one's own physician,¹⁴ another for trust in the medical profession generally,¹⁵ and one for trust in one's health insurer.¹⁶ Additional varieties appear to be in the pipeline as well.¹⁷

Moreover, researchers have established a positive correlation between medical trust and certain desirable health-related behaviors.¹⁸ Those who distrust their physician or institutional

9. See Robert J. Blendon & John M. Benson, *Americans' Views on Health Policy: A Fifty-Year Historical Perspective*, HEALTH AFF., Mar.-Apr. 2001, at 39 ("[T]he proportion of Americans reporting a great deal of confidence in the leaders of medicine has declined from 73 percent in 1966 to 44 percent in 2000.").

10. See Robert Gatter, *Walking the Talk of Trust in Human Subjects Research: The Challenge of Regulating Financial Conflicts of Interest*, 52 EMORY L.J. 327, 329-31 (2003) (describing cases of financial bias in medical research that may have led to the deaths of humans enrolled in the research).

11. See Bruce Horowitz, *Trust: Scandals Shake Public*, USA TODAY, Jul. 16, 2002, at A1 (reporting that public trust in corporate executives, stockbrokers, and accountants has declined since the Enron scandal); *SEC Chairman: 'The People Have Lost Confidence'* USA TODAY, Jul. 2, 2002, at A11 (interview).

12. See Gerald L. Zelizer, *Sex Scandals Rock Trust in all Religions' Leaders*, USA TODAY, April 23, 2002, at A11.

13. Mark A. Hall et al., *Measuring Patients' Trust in Their Primary Care Providers*, 59 MED. CARE RES. & REV. 293, 312 (2002) [hereinafter Hall et al., *Primary Care Providers*].

14. See Anderson & Dedrick, *supra* note 3, at 1099; Hall et al., *Primary Care Providers*, *supra* note 13, at 312; Audiey C. Kao et al., *Patients' Trust in Their Physicians: Effects of Choice, Continuity, and Payment Method*, 13 J. GEN. INTERNAL MED. 681 (1998); Thom et al., *supra* note 3.

15. See Mark A. Hall et al., *Trust in the Medical Profession: Conceptual and Measurement Issues*, 37 HEALTH SERVICES RES. 1419, 1431-32 (2002) [hereinafter Hall et al., *Medical Profession*].

16. See Zheng et al., *supra* note 3, at 188-89.

17. See, e.g., Hendrix, *supra* note 3.

18. One article notes,

[T]rust in physicians correlates positively with adherence to treatment recommendations, not changing physicians, not seeking second opinions, willingness to recommend a physician to others, fewer disputes with the physician, perceived effectiveness of care, and improvement in self-reported health. Trust in insurers correlates positively with

provider are less likely to seek medical care.¹⁹ Likewise, those with relatively high medical trust scores are more likely to comply with their doctors' orders.²⁰ They are also less likely to seek second medical opinions²¹ or to enter into disputes with their health care providers or their health plans.²² Additionally, patients with high medical trust scores tend not to switch physicians and health plans and instead tend to recommend their physicians and health plans to others.²³ Finally, such patients are also more likely to perceive that their care was effective and their health improved as a result.²⁴ Thus, the old adage that trust reduces transaction costs appears to apply in health care delivery.²⁵ Indeed, from an efficiency

lower desire to change insurers and fewer disputes with the insurer.

Mark A. Hall et al., *Trust in Physicians and Medical Institutions: What Is It, Can It Be Measured, and Does It Matter?* 79 MILBANK Q. 613, 629 (2001) [hereinafter Hall et al., *Trust: What Is It?*] (internal citations omitted) (citing to empirical studies in support). David Mechanic identified the correlation between physician trust and effective patient care before this most recent round of empirical research. See David Mechanic, *Public Trust and Initiatives for New Health Care Partnerships*, 76 MILBANK Q. 281, 284-85 (1998).

19. See Elizabeth A. Jacobs et al., *African American Trust and Distrust in Health Care 13-14* (2003) (manuscript on file with author) (finding that, among nine African American focus groups, a common theme was that individuals were less likely to seek medical care unless they trusted their physician).

20. See Hall et al., *Medical Profession*, *supra* note 15, at 1433; Thom et al., *supra* note 3, at 514-16.

21. See Hall et al., *Medical Profession*, *supra* note 15, at 1433; Hall et al., *Primary Care Providers*, *supra* note 13, at 314.

22. See Hall et al., *Medical Profession*, *supra* note 15, at 1433; Hall et al., *Primary Care Providers*, *supra* note 13, at 314; Zheng et al., *supra* note 3, at 200.

23. See Hall et al., *Primary Care Providers*, *supra* note 13, at 314 (concerning physicians); Kao et al., *supra* note 14, at 684 tbl. 4 (showing that the duration of patient-physician relationships tend to be longer among patients with high physician trust scores when compared to patients with comparatively lower physician trust scores); Zheng et al., *supra* note 3, at 200 (concerning health insurers).

24. See Hall et al., *Primary Care Providers*, *supra* note 13, at 314 (noting that high physician trust scores positively correlated with patient satisfaction); Zheng et al., *supra* note 3, at 198 (noting that high insurer trust scores positively correlated to satisfaction with health care received and satisfaction with insurer); see also *infra* notes 40-41.

25. See Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 964-65 (1963), reprinted in 26 J. HEALTH POL. POL'Y & L. 851, 874-75 (2001) (stating that given the uncertainties of illness and medical care and the partial absence of an insurance mechanism to account for the risk of those uncertainties, "there arise institutions which offer some sort of substitute guarantees" including a relationship of trust between patient and physician that allows the patient to believe that the physician will do his or her best to minimize the risk of medical uncertainties for the patient); see also Hall, *Arrow on Trust*, *supra* note 1, at 1133 ("Arrow regards trust strategically, as an adaptive response to uncertainty that serves as a functional alternative to the costs of heightened monitoring or to market failures in

perspective, someone with a high score on a medical trust scale is a dream patient—a satisfied, repeat customer who follows doctors' orders, does not visit competitors or raise a fuss about treatment received, and even drums up new business from time to time.²⁶

In fact, the correlation between measurable trust scores and efficient health-related behaviors may explain why the development of medical trust surveys has become a cottage industry. Provider networks and health plans routinely survey their patients and members to gauge consumer satisfaction with services provided.²⁷ They do so in part because satisfaction surveying is required among health plans²⁸ and in part because it makes good business sense.²⁹ They use the results of satisfaction surveys to determine what, if any, institutional changes are needed in order to remain competitive.³⁰ Because business-oriented consumer surveying is common in the health care market, it is reasonable to assume that provider networks and health plans would be interested in measuring medical trust, especially when trust scores are linked to efficient health-related behaviors among patients. What health plan or hospital network would *not* want to measure and market improvements in "trust" that translate into improvements in efficiency?³¹

insurance.”).

26. One commentary adds,

On balance, these many significant associations indicate that trust is a useful measure or monitor of physician and health plan performance—not only because of its intrinsic importance but because trust affects many important attitudes and behaviors. Trust appears to be good for business, good for effective care, and good for reducing disputes.

Hall et al., *Trust: What Is It?*, *supra* note 18, at 629.

27. See Elizabeth Goldstein et al., *Medicare Managed Care CAHPS: A Tool for Performance Improvement*, 22 HEALTH CARE FIN. REV. 101 (2001); Meryl D. Luallin, *Patient Satisfaction Surveys Vital to Practice Assessment*, 3 PRIMARY CARE WEEKLY 5 (June 23, 1997).

28. See Joint Commission on Accreditation of Healthcare Orgs., *The Official Handbook: Comprehensive Accreditation Manual for Hospitals*, Standard PI.3.1 (Update 2, May 2002) (requiring as a condition of accreditation that health care organizations collect data concerning the expectations, needs and satisfaction of those the organization serves); American Accreditation Healthcare Commission/URAC, *Health Utilization Management Standards*, Standard CORE 36 (version 4.1) (requiring as a condition of accreditation that a health or managed care organization implement “a mechanism to collect or obtain information about consumer satisfaction with services provided by the organization”); National Committee for Quality Assurance, *The State of Health Care Quality: 2002, CAHPS 2.0H: Purpose and Methodology* (stating that, as a condition of accreditation, health care plans must annually complete the “Consumer Assessment of Health Plans Study (CAHPS)”), available at <http://www.ncqa.org>.

29. See Goldstein et al., *supra* note 27, at 104-05; Luallin, *supra* note 27.

30. See Goldstein et al., *supra* note 27, at 104-05; Luallin, *supra* note 27.

31. See Mechanic, *supra* note 18, at 287 (“A hospital or health plan relays

Authors of the newly developed medical trust surveys anticipate commercial interest in measuring medical trust. Some expressly recommend that health plans and institutional providers use the results of medical trust surveys—along with or as a substitute for patient satisfaction surveys—to inform managerial decisions and institutional policy-making.³² They claim that trust scores are more stable than patient satisfaction scores because levels of trust generally do not rise or fall significantly based on a patient's last treatment experience while satisfaction scores do.³³ In other words, the results of trust surveys are more reliable for business planning purposes than are satisfaction survey results.

Even though research on medical trust has had an empirical focus, enthusiasm for trust and its link to health-related behavior exists at the theoretical level as well. Several commentators have recently argued that trust is essential to health care delivery³⁴ and fragile.³⁵ As a result, it is claimed that medical trust should be

as its most powerful advertisement the message that its physicians and nurses are not only competent and accomplished but also caring and committed to patient interests.”)

32. See Hall et al., *Trust: What Is It?*, *supra* note 18, at 617, 629; see also *infra* notes 37-45 and accompanying text.

33. See Hall et al., *Trust: What Is It?*, *supra* note 18, at 617.

34. See, e.g., Hall, *Law, Medicine, & Trust*, *supra* note 3, at 477-80; David Mechanic, *Changing Medical Organization and the Erosion of Trust*, 74 MILBANK Q. 171, 171-73 (1996) (stating trust is necessary to health care delivery and cannot be replaced by aggressive medical consumerism). Others assume that trust is essential to health care without analyzing the claim in significant detail. See, e.g., Audiey C. Kao et al., *The Relationship Between Method of Physician Payment and Patient Trust*, 280 JAMA 1708, 1708 (1998); Pearson & Raeke, *supra* note 8, at 509, 512; David H. Thom et al., *An Intervention to Increase Patients' Trust in Their Physicians*, 74 ACAD. MED. 195, 195 (1999); see also Hall, *Law, Medicine, & Trust*, *supra* note 3, at 472 n.24.

35. See, e.g., Hall et al., *Trust: What Is It*, *supra* note 18, at 618 (explaining the propensity of distrust to create a negative “feedback loop” that generates further distrust); Neil McLaughlin, *Trust, That Valuable, Fragile Asset*, 32 MODERN HEALTHCARE 16 (2002); Mechanic, *supra* note 34, at 173 (“[T]rust is particularly fragile because negative events are more visible, they carry greater psychological weight, they are perceived as more credible, and they inhibit the kinds of experience needed to overcome distrust.”).

The “spiral of distrust” and the difficulty of regaining betrayed trust also have been identified outside of the context of medical trust. See Jeffrey S. Busch & Nicole Hantusch, *I Don't Trust You, But Why Don't You Trust Me? Recognizing the Fragility of Trust and Its Importance to the Partnering Process*, 55 DISP. RESOL. J. 56, 62 (2000) (arguing that one's willingness to perceive others as potentially trustworthy is an initial step towards the kinds of cooperation that can allow a trusting relationship to develop); Russell Hardin, *Distrust*, 81 B.U. L. REV. 495, 499-500 (2001) (positing that where social and reputational indicators suggest your untrustworthiness, others are unlikely to risk the kinds of interactions with you that could reveal your trustworthiness, and thus, distrust of you by others becomes a permanent state); Lawrence E. Mitchell, *Trust and Team Production in Post-Capitalist Society*, 24 J. CORP. L. 869, 870 (1999) (“Trust is fragile; once broken, it is hard to regain. And where

preserved, if not promoted, as a matter of policy.³⁶ A notable example is Professor Mark A. Hall's recent article, *Law, Medicine and Trust*.³⁷ The article is summarized below because it is a comprehensive example of the rationale for preserving, if not promoting, medical trust as a matter of policy.

First and foremost, Hall theorizes that trust is a central guiding theme for health law. He writes, "[T]rust is central to virtually all parts of health care law" and should be treated as part of health law's "core organizing framework."³⁸ The centrality of trust in health law, according to Hall, derives in part from the importance of trust in health care delivery. He writes that trust is an instrument for capturing therapeutic benefits. "Without some minimal level of trust, patients would not seek care, submit to treatment, disclose necessary information, or follow treatment recommendations. Even routine medical care requires a high level of trust in order to expose our bodies and personal histories."³⁹ Similarly, he claims that trust is instrumental in triggering scientifically unexplained healing phenomena, such as the placebo effect.⁴⁰ "Trust is not merely an

trust is gone, self-protection, suspicion, and diminished dedication to the enterprise are sure to ensue.") (citation omitted); Larry E. Ribstein, *Law v. Trust*, 81 B.U. L. REV. 553, 582 (2001) (asserting that "breaches of trust . . . may be difficult to repair . . . [when] they carry emotional weight") (citing Roy J. Lewicki & Barbara Benedict Bunker, *Developing and Maintaining Trust in Work Relationships*, in TRUST IN ORGANIZATIONS: FRONTIERS OF THEORY AND RESEARCH 114, 128-36 (Roderick M. Kramer & Tom R. Tyler eds., 1995)); Paul Slovic, *Trust, Emotion, Sex, Politics, and Science: Surveying the Risk Assessment Battlefield*, 1997 U. CHI. LEGAL F. 59, 88 ("One of the most fundamental qualities of trust has been known for ages. Trust is fragile. It is typically created rather slowly, but it can be destroyed in an instant—by a single mishap or mistake. Thus, once trust is lost, it may take a long time to rebuild it to its former state. In some instances, lost trust may never be regained.").

36. See, e.g., Hall, *Law, Medicine, & Trust*, *supra* note 3, at 472 n.24; Mechanic, *supra* note 34, at 179-86 (arguing that health care institutions must find new ways to promote trust in medical providers in order to promote good medical relationships and healing, and implicitly arguing that trust in medicine must be bolstered so as to weather the challenges to it posed by the managed care movement). I include myself in this group as well. See 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, 1099-1106 (1999) (arguing that "trust is at the ethical core of the physician-patient relationship" and should be preserved).

37. See *supra* note 3.

38. Hall, *Law, Medicine, & Trust*, *supra* note 3, at 526-27.

39. See *id.* at 478 (citation omitted).

40. *Id.* at 479 ("Trust very likely underlies hidden elements of treatment encounters, elements that result in healing through what might be termed charismatic, spiritual, or emotional means. This is seen, for instance, in the powerful placebo effect, which pervades much of medicine. Researchers and physicians have documented countless examples of mundane and miraculous relief caused by a largely nonscientific or 'nonspecific' process of healing.") (citation omitted); see also Mechanic, *supra* note 18, at 283 (noting that the

adjunct to biochemically active treatment; it is essential for activating the charismatic or emotive dimension of healing that is fundamental to effective treatment relationships.⁴¹

Additionally, Hall claims that trust is central to health law because, apart from its instrumental value, trust has intrinsic value in health care. "Trust is a defining aspect of strong caregiver relationships, one that gives them fundamental meaning and value. . . . [I]t is . . . a product of the relationship and is a primary reason why the relationship is valued as much as, or sometimes more than, any other consequence of the relationship."⁴² Hall also finds that trust in health care has intrinsic value because it appears to be the vehicle patients use to cope with the vulnerability they feel as a result of their illnesses and injuries.⁴³

While Hall's thesis is largely descriptive, he nonetheless takes a normative turn. He argues that a complete understanding of trust in medicine "provides tools for taking on the *prescriptive* task of formulating responses to new legal, ethical, and public-policy challenges in health care delivery . . ."⁴⁴ On the surface, Hall appears to take no position on whether medical trust should be promoted, merely preserved, or even diminished. A closer examination, however, reveals his claim that medical trust should be preserved. He writes that, given the importance of trust in medicine and the risk that trust lost may never be regained, health law should presume to preserve, if not increase, trust in medicine and take a skeptical stance toward trust only if it can be proven that such a stance is warranted.⁴⁵ In short, he claims that health policy should be trust-oriented and also presumptively trust-preserving.

In the end, we may be witnessing the emergence of a new medical trust movement in health care management and health policy. It would teach that trust—in physicians, in hospitals, in insurers—is an essential part of health care delivery because it enables the formation of treatment relationships, encourages greater compliance among patients with treatment plans, reduces the likelihood of disputes between patients and providers, unleashes mysterious healing powers, and is an all-around antidote to societal distrust of market-based health care delivery. Additionally, the emerging movement would warn that trust is easily lost and difficult to regain, and thus that, as a matter of policy, trust in medicine must generally be preserved if not promoted.

placebo effect and any similar "therapeutic advantage now is less likely to come from patients' belief in the omnipotence of physicians but is, rather, more apt to be drawn from the ability of clinicians to develop relationships of mutual trust.").

41. Hall, *Law, Medicine, & Trust*, *supra* note 3, at 480.

42. *Id.* at 477.

43. *Id.* at 477-78.

44. *Id.* at 525 (emphasis added).

45. *Id.* at 508-09.

Next, this Article clarifies that the emerging medical trust movement conceives of medical trust as a kind of faith and not as mere confidence. It then challenges the claim that trust-as-faith is necessary in medicine, concluding that it may not be.

III. THE QUESTIONABLE NECESSITY OF TRUST-AS-FAITH IN HEALTH CARE AND THE POTENTIAL SUFFICIENCY OF TRUST-AS-CONFIDENCE

A positive perception among consumers of the health care delivery system and its players is probably necessary to effective and efficient medical care. Without at least some belief in the reliability of the physicians, nurses, technicians, hospitals, and health plans who care for us, individuals are unlikely to seek medical attention at all, except perhaps in the most grave medical circumstances.⁴⁶ This does not necessarily mean, however, that trust in the health care delivery system, or in the professionals and institutions that comprise it, is essential to the public's health—not when trust is defined as an emotionally based faith and not merely a rational confidence. Yet, according to the emerging medical trust movement, trust-as-faith is an irreplaceable ingredient of effective and efficient medical care.

After identifying the importance of trust-as-faith in current scholarship about medical trust and health policy, Part III distinguishes trust-as-faith from trust-as-confidence and challenges the assumption that faith is essential in health care delivery. It does so by examining utilization and institutionalization in the American health care system as well as evidence that patients who have experienced betrayal in the health care system replace their naive faith in medicine with a rational confidence. Accordingly, any claim that trust-as-faith is necessary to health care delivery is, at best, questionable. Part III then hypothesizes that trust-as-confidence may be sufficient to achieve the health benefits associated with medical trust.

A. *Confidence in Health Care and How it Differs from Faith*

Trust is a state of mind, a belief that another will take proper care of something of importance to you.⁴⁷ It derives from the risk that trustees will abuse the power they hold over that which has been entrusted to them.⁴⁸ In other words, trust is associated with the trustor's vulnerability to the care-taking discretion of the trustee.⁴⁹

46. See Gatter, *supra* note 36, at 1099-1103 (describing the minimal degree to which "trust" is essential to medical decision-making).

47. See ANNETTE C. BAIER, *Trust and Antitrust*, in MORAL PREJUDICES: ESSAYS ON ETHICS 95, 95-129 (1994) (giving a philosophical assessment of trust).

48. BAIER, *supra* note 47.

49. See Hall et al., *Trust: What Is It?*, *supra* note 18, at 615 ("[T]rust is inseparable from *vulnerability*, in that there is no need for trust in the absence

While trust can emerge from a rationally based confidence that another is likely to act in the trustor's best interests with respect to an entrusted item, some argue that trust necessarily goes beyond confidence.⁵⁰ A story from the Reagan presidency captures this notion well. "When negotiating with the Russians, during the Cold War, President Reagan used the phrase: '[t]rust, but verify.' This statement drew chuckles because if the other party is trusted, there is no need to verify . . ."⁵¹ Trust, from this perspective, involves a leap of faith beyond a strategic decision to rely on another.⁵² Professor Hall writes:

Trusting attitudes are directed as much to *motivations and intentions* as they are to results. Of course, those who trust also hope or expect a good result, but more than this, they believe that the one they trust has their best interests at heart. Trust, in this conception, differs from confidence or reliance, which also entails the calculated prediction of positive results. Trust has an emotional component that assumes the motivations of the trusted one are benevolent and caring.⁵³

To others, however, trust is an umbrella term that includes both faith and confidence.⁵⁴ For example, Bloche employs the term trust "in a broad sense, encompassing a range from the deeply felt, mutual *faith* experienced by people in loving relationships and close

of vulnerability.").

50. See, e.g., Adam B. Seligman, *Role Complexity, Risk, and the Emergence of Trust*, 81 B.U. L. REV. 619, 619-24 (2001).

51. Tamar Frankel, *Trusting and Non-Trusting on the Internet*, 81 B.U. L. REV. 457, 460-61 (2001) (citation omitted).

52. See, e.g., Seligman, *supra* note 50, at 619-24 (explaining that confidence arises from knowledge about what to expect, while trust goes beyond confidence to situations where one cannot know what to expect).

53. Hall, *Law, Medicine, and Trust*, *supra* note 3, at 474 (citations omitted).

54. See, e.g., Timothy L. Fort & Liu Junhai, *Chinese Business and the Internet: The Infrastructure for Trust*, 35 VAND. J. TRANSNAT'L L. 1545, 1552-53 (2002) (distinguishing between "hard trust" and "real trust" on the grounds that the former is akin to confidence and the latter is a kind of assurance one feels in reliable relationships); Mechanic, *supra* note 34, at 173-74 (delineating between two levels of trust: interpersonal trust, which is intimate and emotional, and social trust, which is cognitive and based on shared interests); Ribstein, *supra* note 35, at 555-76 (distinguishing among strong trust, semi-strong trust, and weak trust, and equating strong trust with altruism, semi-strong trust with reliance, and weak trust with a complete absence of trust).

In reality, there is a substantial degree of confusion in the use of the terms trust, faith, and confidence, including at times even those who attempt to distinguish among them. See, e.g., ADAM B. SELIGMAN, *THE PROBLEM OF TRUST* 16-21 (1997) (distinguishing between trust and confidence, and yet identifying confidence as referring to "trust" in systems).

friendships to the dispassionate, even 'calculative' trust or *confidence* that facilitates business dealings among strangers and casual acquaintances.⁵⁵ Despite differences in how the term "trust" is used, there is widespread agreement that faith and confidence are different concepts, with confidence having a primarily rational basis and faith springing largely from an emotional foundation that goes beyond rationality.^{56,57}

Common wisdom from the emerging medical trust movement is that a faith-like trust is essential to health care delivery. This is obvious from the above summary of Hall's thesis,⁵⁸ which defines trust as an emotional phenomenon distinguishable from confidence⁵⁹ and claims that such trust is fundamental to medicine.⁶⁰ Others appear to agree. For example, Professor David Mechanic, who in 1996 warned about the erosion of trust in medicine as a result of a new emphasis on economic efficiency in health care, was chiefly concerned with the erosion of "interpersonal trust."⁶¹ This version of trust is similar to what I refer to above as *faith* because of its emotional foundation. Mechanic defines interpersonal trust as "an intimate form" of trust "based on emotional bonds" often found among loved ones, and which commonly underlies the doctor-patient relationship.⁶² Moreover, he distinguishes this form of trust from

55. Bloche, *supra* note 8, at 921 n.4 (emphasis added).

56. *E.g.*, compare Bloche, *supra* note 8, at 921 n.4 (distinguishing faith and confidence while using "trust" to encompass both), with Hall, *Law, Medicine, & Trust*, *supra* note 3, at 474 (describing trust in medicine as having an emotional basis that distinguishes it from confidence).

57. Of course, faith is not completely a-rational just as confidence is not entirely emotionless. See, *e.g.*, Mechanic, *supra* note 34, at 173-74 (identifying interpersonal and social trust as "separate" but "correlated" concepts, with interpersonal trust being primarily emotional and social trust being primarily cognitive). Even assuming, however, that faith and confidence each involve some degree of both rationality and emotion, the concepts are nonetheless distinct, with emotion primarily underlying faith and rationality primarily underlying confidence.

58. Although he does not use the terms "confidence" and "faith" to do so, Hall recognizes that medical trust may involve both emotionally based and rationally based forms of trust. See Hall et al., *Trust: What Is It?*, *supra* note 18, at 618-19 (acknowledging that distrust when referring to an attitude of wariness can enhance trust).

59. See Hall, *Law, Medicine, and Trust*, *supra* note 3 and accompanying text.

60. See *supra* notes 37-45 and accompanying text.

61. See Mechanic, *supra* note 34, at 179 (stating, "[s]everal emerging trends suggest that interpersonal trust will be under assault in coming years"). My claim that Mechanic's concern for the erosion of trust is primarily a concern for the erosion of an emotionally based, interpersonal trust is bolstered by his later writing in which he associates the preservation of trust in the new medical marketplace with the development among health care professionals of interpersonal skills. See Mechanic, *supra* note 18, at 287-91.

62. See Mechanic, *supra* note 34, at 173-75 (discussing "two levels of trust: interpersonal and social").

“social trust” on the grounds that social trust is based on a rational assessment of the interests and beliefs of others. He writes: “Social trust, in contrast, is more cognitive and abstract, and typically is based on inferences about shared interests and common norms and values.”⁶³ In the end, he argues that these two forms of trust are mutually supportive⁶⁴ and necessary in medicine, and that interpersonal trust is uniquely at risk for erosion in a new environment of medical commercialism.⁶⁵

Underlying the claim that trust-as-faith is essential in medicine may be an assumption that the doctor-patient relationship and the kind of interpersonal trust often associated with it sets a standard against which to judge the role of trust in all medical relationships.⁶⁶ This assumption is challenged next.

B. Trust-as-Faith in Today's Medical Marketplace

If patients must have an emotional form of trust (i.e., faith) in the health care delivery system and its components in order for the system to effectively provide medical care, then one would expect to see a reduction in the effectiveness of health care in response to the vast corporatization of health care delivery over the last thirty or so years. Presumably, medical care provided through a system that is increasingly concentrated in fewer and larger institutional networks, and that is increasingly steered by free market incentives,⁶⁷ is unlikely to engender the faith that the emerging medical trust movement claims to be essential. This presumption is borne out by the cultural and political backlash to managed care⁶⁸ of which the emerging medical trust movement is arguably a part.⁶⁹ Yet, as described below, Americans continue to rely on the health care delivery system despite its corporatization, which suggests that faith may not be essential to health care delivery despite claims to the contrary from the emerging movement.

Since about 1970, U.S. health care has experienced a dramatic

63. *Id.* at 173.

64. *See id.* at 174 (“Although social and interpersonal trust are separate concepts, they are correlated and mutually supportive.”).

65. *See id.* at 178 (“Activism is not a bad idea, but it is an illusion to believe that it can reasonably substitute for trust.”).

66. *See* Mechanic, *supra* note 34, at 175-77 (explaining the importance of physician-patient interaction in establishing trust in medicine).

67. *See generally* ROBINSON, *supra* note 1, at 228-30, 233-34 (describing at length the trend toward consolidation among health care providers and payors).

68. *See id.* at 213-14 (stating that a “fundamental feature” of past and ongoing evolution in health care delivery “is continued social discontent and political backlash” in response to replacement of physicians with corporations and medical professionalism with marketplace values as the organizational cornerstones of the system); *see also* Bloche, *supra* note 8, at 920-21, 925, 943 and sources cited therein.

69. *See supra* note 8 and accompanying text.

consolidation of power,⁷⁰ and, as a result, it has changed from a system dominated by independent medical professionals and not-for-profit hospitals to one dominated by large health plans and large provider networks.⁷¹ For example, one observer estimates that, from 1980 to 2000, the number of major health insurers decreased from about twenty-five to about five.⁷² Similarly, since 1980 the number of community hospitals that are part of systems has increased from about one-third to about one-half,⁷³ with some corporations owning well over 200 hospitals nationwide.⁷⁴ Likewise, physicians are increasingly practicing medicine in larger collectives, including both multi-specialty group practices and hospitals.⁷⁵

This consolidation is a result of increased market competition among health plans and professional and institutional providers. Insurers that have created health plans in pursuit of economies of

70. See generally ROBINSON, *supra* note 1, at 228-30; see also PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE: THE RISE OF A SOVEREIGN PROFESSION AND THE MAKING OF A VAST INDUSTRY* 420-49 (1982); Roger D. Feldman et al., *HMO Consolidations: How National Mergers Affect Local Markets*, 18 HEALTH AFF. 96, 98-102 (1999) (describing health plan consolidations of mid- and late-1990s); Robert I. Field, *New Ethical Relationships Under Health Care's New Structure: The Need for a New Paradigm*, 43 VILL. L. REV. 467, 473-74 (1998) (summarizing the business rationale for consolidation among physicians and hospitals); John V. Jacobi, *Competition Law's Role in Health Care Quality*, 11 ANNALS HEALTH L. 45, 67 & n.114 (2002); Joan H. Krause, *Reconceptualizing Informed Consent in an Era of Health Care Cost Containment*, 85 IOWA L. REV. 261, 289-91 (1999); William M. Sage, *Enterprise Liability and the Emerging Managed Health Care System*, 60 L. & CONTEMP. PROBS. 159 at 171, 199, 201-02 (1997) (describing trend of health care integration); Joanne Spetz et al., *The Growth of Multihospital Firms in California*, 19 HEALTH AFF. 224 (2000) ("At least half of all hospitals in California are now part of multihospital systems.")

71. See ROBINSON, *supra* note 1, at 8 (referring to changes triggered by the HMO Act of 1973); STARR, *supra* note 70, at 430-36.

72. Spencer Rich, *Health Care: An Era of Consolidation*, 32 NAT'L J. 2296, 2296 (2000).

73. See *id.* at 2297 (stating that, in 1980, the American Hospital Association ("AHA") reported that 1,877 of 5,842 community hospitals nationwide were part of a corporate system, and that, in 1998, the AHA reported that 2,868 of 5,015 community hospitals were part of systems); see also American Hospital Association, *Fast Facts on U.S. Hospitals from HOSPITAL STATISTICS* (reporting that, in 2002, 2,261 of 4,927 community hospitals were part of hospital systems), at http://www.hospitalconnect.com/aha/resource_center/fastfacts/fast_facts_US_hospitals.html (last updated Dec. 10, 2003).

74. See Rich, *supra* note 72, at 2297.

75. See ROBINSON, *supra* note 1, at 90-92 (explaining the trend of physician consolidation in multi-specialty practice groups), 178-79 (summarizing physician consolidation in physician-hospital organizations); see also THOMAS PASKO ET AL., *PHYSICIAN CHARACTERISTICS AND DISTRIBUTION IN THE US: 2001-2002 EDITION* 327-28 & tbl. 19 (Am. Med. Ass'n 2001) (reporting a 178% increase from 1980 to 1999 in the number of physicians that practice in groups larger than two, as well as an 80% increase in the number of physicians employed by private hospitals over the same time period).

scale offer their plans in many different geographic markets.⁷⁶ At the same time, plans must be able to quickly enter and exit geographic markets as conditions affecting profitability in various markets change. Thus, health plans have an incentive to grow through non-exclusive contracting with large provider groups.⁷⁷ Accordingly, there is an incentive among physicians and hospitals to affiliate with each other in order to capture the business of health plans as they enter the geographic market served by those providers. Moreover, provider groups continue to grow in size so as to increase their power to negotiate higher reimbursement rates from large health plans.⁷⁸

Corporatization in health care arguably threatens trust in medicine, particularly trust-as-faith, because it pits the financial interests of providers against the medical interests of patients. Corporate control of health care delivery causes individuals "to question the motives and decisions of these [corporate] organizers and providers of care."⁷⁹ Similarly, health care consumers may doubt the fidelity of physicians to the welfare of their patients because of "incentives [such as capitation] that make professional rewards dependent on withholding care, thereby placing the interests of patients and doctors in direct conflict."⁸⁰ This may explain why some studies find that trust in physicians is higher among patients in fee-for-service systems than among patients in capitated systems.⁸¹

Moreover, the drive for efficiency generally associated with corporate medicine may encourage physicians to spend less time with each patient. This, in turn, limits the opportunity for patient trust to form or be sustained.⁸² Additionally, gatekeeping mechanisms may disrupt the continuity of care, which also can undermine patient trust.⁸³

Given the corporatization of health care delivery and evidence that it undermines faith in physicians, one would expect to find that individuals behave in a less trusting manner in today's health care system than they did in the system that pre-dates such corporatization. For example, Hall claims that, without trust, individuals are less likely to seek care or to comply with physicians' treatment recommendations.⁸⁴ If this is correct, then there should

76. See ROBINSON, *supra* note 1, at 58-61.

77. See *id.* at 71-83.

78. See *id.* at 150-51 (summarizing provider consolidation through physician practice management), 178-79 (summarizing provider consolidation through physician-hospital organizations).

79. Mechanic, *supra* note 34, at 178.

80. *Id.* at 178.

81. See Kao et al., *supra* note 14, at 683.

82. See Mechanic, *supra* note 34, at 179-80.

83. See *id.* at 180.

84. See Hall, *Law, Medicine, & Trust*, *supra* note 3, at 478.

be evidence of a decline in utilization rates that corresponds to a rise in corporate health care delivery and an increased unwillingness of individuals to seek or receive treatment. National utilization data, however, suggest that we visit the doctor today as often, if not more so, than we did prior to the era of corporate health care. In 2000, Americans went to the doctor at an annual rate of 300.4 visits per 100 persons.⁸⁵ This is up from a rate of approximately 280 visits per 100 persons that has held relatively constant from 1975 through 1999.⁸⁶ In addition, two indicators of the utilization of preventive health measures also have increased substantially, suggesting that individuals seek care even when well. The percentage of mothers receiving prenatal care increased from about 70% to about 83% between 1975 and 2000,⁸⁷ and the percentage of individuals age sixty-five receiving flu and pneumonia vaccinations jumped from about 30% to about 65% and from about 15% to about 52%, respectively, between 1989 and 2000.⁸⁸ All of this suggests that faith is not a prerequisite to seeking medical care or complying with treatment recommendations, and thus individuals are willing to seek care and comply with treatment plans despite the more commercial environment in which health care is delivered and despite more limited opportunities for interpersonal trust to develop or be sustained.

Even if we shift our focus from global utilization statistics to behavior among particular groups of individuals who have experienced betrayal in medicine, a pattern of medical utilization without faith is detectable. While the examples described below do not tie feelings of betrayal to the corporatization of health care, they do suggest that, when betrayal occurs and trust-as-faith is lost, individuals continue to seek treatment from physicians.

An observational study of seventy-seven individuals suffering

85. See Donald K. Cherry & David A. Woodwell, *National Ambulatory Medical Care Survey: 2000 Summary*, ADVANCE DATA FROM VITAL AND HEALTH STATISTICS, June 5, 2002, at 2.

86. See *id.* (comparing 2000 rate with those of years 1997 through 1999); see also Donald K. Cherry et al., *National Ambulatory Medical Care Survey: 1999 Summary*, ADVANCE DATA FROM VITAL AND HEALTH STATISTICS, July 10, 2001, at 6 fig. 6 (showing that overall rate of physician visits has remained largely constant since 1985 with significant increases in rates of visits among the elderly being offset by decreasing rates among the population age twenty-five years and younger); James E. DeLozier & Raymond O. Gagnon, *National Ambulatory Medical Care Survey: 1989 Summary*, ADVANCE DATA FROM VITAL AND HEALTH STATISTICS OF THE NAT'L CENTER FOR HEALTH STATISTICS, July 1, 1991, at 2 (reporting a physician visit rate of 2.8 visits per person per year for 1989, and reporting that this rate has not changed significantly since 1985). Summaries of National Ambulatory Medical Care Surveys over the years are available at <http://www.cdc.gov/nchs/about/major/ahcd/adata.htm>.

87. See NAT'L CENTER FOR HEALTH STATISTICS, HEALTH, UNITED STATES, 2002: CHARTBOOK ON TRENDS IN THE HEALTH OF AMERICANS 32 fig. 11 (2002).

88. See *id.* at 44 fig. 13.

from chronic illnesses found that each patient experienced a period of distrust following a perceived betrayal of trust by a physician.⁸⁹ While, in the short run, the betrayal disrupted the individuals' health care relationships, each continued to rely on physicians in the long run and felt satisfied with the care they received.⁹⁰

Other researchers observed more than 2,300 insured and generally healthy adults over a three-year period and measured changes in individuals' responses to the Primary Care Assessment Survey, including changes in trust for one's primary care physician and the continuity of care received by individuals.⁹¹ They found that, while trust decreased slightly over time (about 0.7%), the continuity of care increased slightly (about 1.2%), suggesting that the drop in the perceived trustworthiness of their own physicians did not interfere with patients seeking and receiving medical attention from those physicians over time.⁹²

Medical utilization among African Americans also suggests that faith is not necessary before patients are willing to seek medical care or accept medical recommendations. A recent report by the Institutes of Medicine ("IOM") on racial disparities in health care summarized theories and data suggesting that African Americans are more likely to distrust physicians.⁹³ It also found conflicting evidence about the likelihood that these patients accept or refuse recommended treatments. While acknowledging that some evidence exists suggesting that African Americans are more likely than white patients to refuse recommended medical care, IOM also found several studies concluding that African Americans are just as likely to accept recommended treatments as are white Americans.⁹⁴

C. *The Sufficiency of Trust-as-Confidence: An Initial Hypothesis*

While the evidence outlined above does not conclusively disprove the claim that trust-as-faith is essential in health care delivery, it significantly weakens the claim, which should cause medical trust scholars to rethink the nature and necessity of various forms of trust in medical relationships. More specifically, we must seriously consider that trust-as-confidence is sufficient to achieve the instrumental benefits associated with trust generally and with

89. See Thorne & Robinson, *supra* note 3, at 783-84.

90. See *id.*

91. See Julia Murphy et al., *The Quality of Physician-Patient Relationships: Patients' Experiences 1996-1999*, 50 J. FAM. PRACT. 123, 124-25 (2001).

92. See *id.* at 127 & tbl. 3. Overall, the study found that the quality of physician-patient relationships was eroding as evidenced by lower scores related to communication, trust, and interpersonal treatment.

93. See INST. OF MED., *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE* 131-38, 174-75 (Brian D. Smedley et al. eds., 2003) [hereinafter *UNEQUAL TREATMENT*]; see also *infra* notes 190, 195-201 and accompanying text.

94. See *UNEQUAL TREATMENT*, *supra* note 93, at 131-38.

trust-as-faith particularly. In fact, this hypothesis finds support in some of the same evidence that tends to disprove the necessity of trust-as-faith.

For example, the study described above in which researchers observed seventy-seven chronically ill individuals found that in response to medical betrayal patients abandoned their faith in physicians.⁹⁵ In its place, those patients adopted a new kind of trust based on a more realistic presumption about the motives of physicians generally and based on agreements reached or tests applied to particular physicians.⁹⁶ The researchers write:

While all of the informants experienced a stage of shattered trust that was characterized by dissatisfaction with health care relationships, a measure of satisfaction was eventually attained and could be explained by the various configurations of the reconstructed trust in guarded alliance. None of these configurations, however, resembled the absolute trust of the initial naive stage. Indeed, patients and their families emphatically denied that blind faith was possible once insight into the inner dimensions of the health care world was achieved. . . . Because they were based upon more realistic expectations, all patterns of guarded alliance included numerous qualifiers and conditions that addressed the limitations inherent in health care relationships.⁹⁷

The authors described such reconstructed trust as “confidence”⁹⁸ and associated it with increased responsibility, assertiveness, and satisfaction among patients.⁹⁹

Other studies examining trust and distrust among patients have also found that faith in medicine can give way to confidence, and that medical relationships not only survive this transformation in trust, but prosper.¹⁰⁰ Such findings suggest that trust-as-

95. See Thorne & Robinson, *supra* note 3, at 784-86.

96. See *id.* at 784-86.

97. *Id.* at 784.

98. See *id.* at 786 (“Such trust is no longer characterized by blind faith in the humanity of the system; rather, it is analogous to a confidence expectation as to what the health care professional can offer.”).

99. See *id.* at 784-86.

100. See Mechanic & Meyer, *supra* note 3, at 661-62, 665-67 (describing how patients with Lyme’s disease, breast cancer, and chronic mental illness test the trustworthiness of their physicians, but the Lyme’s disease group was much more likely to test trustworthiness aggressively because of prior experiences of betrayal); Trojan & Yonge, *supra* note 3, 1905-08 (describing interviews with six elderly patients receiving home care and seven home care nurses which revealed that patients commonly exhibited an initial degree of trust, but that

confidence can enable many of the positive behaviors associated with trust-as-faith—compliance among patients with recommended treatments, continuity of care, and satisfaction with care—while also generating more realistic expectations and greater responsibility among patients with respect to their health care. Thus, trust-as-confidence appears to be a more enduring and stable variety of medical trust.

Moreover, the hypothesis that trust-as-confidence is a sufficient form of medical trust can account for other data correlating diminished trust-as-faith with disruptions in medical treatment and increased disputes.¹⁰¹ The trust snapshot taken by such data may reveal only the immediate reactions of patients who have endured a betrayal of trust-as-faith. It may not account for the process by which patients regain confidence in health care providers and systems, which not only sustains treatment relationships but also enables patients to take greater control of their medical care, achieve greater satisfaction, and protect themselves from future abuses of trust.

While trust-as-confidence appears to be a sufficient substitute for trust-as-faith in health care delivery, this does not completely explain why, as a matter of policy, confidence should be preferred over faith. In Part IV, this Article argues that a policy of promoting confidence in medicine, when compared to a policy of promoting faith in medicine, is: (1) less likely to undermine the culture of patient responsibility that has evolved over the last thirty or so years; (2) less likely to ignore consumers who distrust medicine and thereby exacerbate racial and ethnic inequality in medicine; and (3) less likely to inhibit forms of health care regulation that protect patients as consumers by intruding into medical relationships.¹⁰² Before reaching those claims, however, it is necessary to address some likely counter-arguments to the trust-as-confidence thesis as developed to this point.

First, one might object—as Professor Hall does in his reply to this Article—that the distinction between faith and confidence creates a false dichotomy between components of medical trust that, in reality, coexist. It is not necessary, however, to conceive of faith and confidence as mutually exclusive in order to establish the importance of distinguishing between emotional and rational forms of medical trust. As argued throughout this Article, theory and data

establishing a good relationship turned in part on a deliberate negotiation between nurse and patient about patients' expectations of control); *see also* UNEQUAL TREATMENT, *supra* note 93, at 175 (“[D]espite ethnic minority patients' generally higher levels of mistrust of the medical and research establishment, most minority patients appear to be satisfied with and have confidence in their healthcare providers.” (citing Leiyu Shi, *Experience of Primary Care by Racial and Ethnic Groups in the United States*, 37 MED. CARE 1068 (1999))).

101. *See supra* notes 18-19 and accompanying text.

102. *See infra* Parts IV, V.

about medical trust acknowledge, if not prove, the real difference between faith and confidence. Thus, debate about whether and how to preserve or promote medical trust necessarily raises questions about the propriety of preserving or promoting faith or confidence. Even assuming that faith and confidence co-exist, such debates question the "mix" of faith and confidence that should comprise medical trust.

Second, one might argue that trust-as-faith has not diminished sufficiently as a result of corporatization for us to see its utilization effects and that faith in doctors remains high, which masks the real effects of any loss of faith in delivery system as a whole. This claim, however, is inconsistent with findings that trust in physicians diminishes when capitation and gatekeeping are introduced.¹⁰³ Additionally, the claim is inconsistent with anecdotal evidence that, despite short-run disruptions in care, betrayals of faith in physicians do not result in long-term disruption of care or dissatisfaction with care.¹⁰⁴ Thus, even if current losses of faith are *de minimis*, the phenomenon of confidence appears sufficient to overcome any short-run disruptions in treatment that future losses of faith might cause.

Third, one might argue that the utilization data relied on above does not capture the problem of delay in treatment. A lack of faith under this argument may cause delays in seeking treatment which translate into greater health problems when finally treated. Yet, this argument does not account for data from 1970 through 2000 suggesting that, in general, the health of Americans has improved.¹⁰⁵ Also, it disregards evidence that such delays are a short-run phenomenon only until individuals reconstruct a confidence-based trust.¹⁰⁶

Fourth, one might seek to narrow the application of the trust-as-confidence thesis to law related to the more commercial and less personal relationships in medicine. For example, on the theory that relationships between health care consumers and institutions (e.g., managed care organizations and hospitals) tend to be more commercial and more impersonal than relationships between health care consumers and their physicians, one might argue that a policy to pursue trust-as-confidence should be limited to relationships involving health care institutions while a policy of pursuing trust-as-faith should be applied to relationships between patients and physicians.¹⁰⁷ But this argument erroneously assumes that commercialism does not significantly affect all health care

103. See Kao et al., *supra* note 14, at 684-85.

104. See Thorne & Robinson, *supra* note 3.

105. See NAT'L CTR. FOR HEALTH STATISTICS, HEALTH, UNITED STATES, 2002: CHARTBOOK ON TRENDS IN THE HEALTH OF AMERICANS 43 fig. 18 (2002) (showing that life expectancy has risen at a relatively constant rate between 1970 and 2000 whether measured at birth or at age sixty-five).

106. See *supra* notes 95-99 and accompanying text.

107. See *supra* notes 67-83 and accompanying text.

relationships, including patient-physician relationships. Physicians are increasingly dependent on their affiliations with institutional providers and managed care networks.¹⁰⁸ Thus, the very commercialism in medicine that justifies a policy of pursuing trust-as-confidence in relationships between health care consumers and institutions also justifies the same policy in patient-physician relationships. Moreover, as described in detail below, a policy of pursuing trust-as-faith in medicine would undermine the decades-old policy of encouraging patients to act more assertively in their interactions with physicians.¹⁰⁹

Fifth, one might argue that, if health law were to pursue the rationality of confidence rather than the emotion of faith, medicine would lose the healing power of the placebo effect. This argument, however, makes three potentially false assumptions. First, it assumes that the placebo effect is authentic. Despite widespread acceptance of the effect for nearly forty years,¹¹⁰ researchers have recently questioned its validity. Most notably, one analysis published in the *New England Journal of Medicine* in 2001 reviewed and critiqued prior research that appeared to verify the placebo effect, concluding that almost all of this research was scientifically flawed.¹¹¹ At the same time, the National Institute of Health launched a program to fund research (currently ongoing) into the science of the placebo.¹¹² Given that the authenticity of the effect is in doubt, claims that a particular policy can harness it are premature. Second, the concern that a shift from pursuing faith to pursuing confidence in patient-provider relationships will diminish the placebo effect assumes that health care professionals are responsible for triggering the effect. In fact, even among researchers who believe that the effect is real, there is disagreement about how it works.¹¹³ For example, some claim that the placebo effect is triggered by personality characteristics of patients.¹¹⁴ If that assertion is true, then some patients are predisposed to experiencing the effect and others are not, and this would not be significantly affected by the nature of their interaction with a health care professional. Third, the claim that pursuing trust-as-

108. See *supra* notes 70-71, 75 and accompanying text.

109. See *infra* Part IV.A.

110. See Kathleen M. Boozang, *The Therapeutic Placebo: The Case for Patient Deception*, 54 FLA. L. REV. 687, 694-95 (2002) (providing an excellent review of the historical and current thinking about the placebo effect and identifying the publication of an article by Henry Beecher in 1955 as the key event that triggered widespread acceptance of the placebo effect).

111. See *id.* at 715-16 (citing Asbjorn Hrobjartsson & Peter C. Gotzsche, *Is the Placebo Powerless?: An Analysis of Clinical Trials Comparing Placebo with No Treatment*, 344 NEW ENG. J. MED. 1594 (2001)).

112. See <http://placebo.nih.gov> (last visited Mar. 17, 2004).

113. See Boozang, *supra* note 110, at 699-713 (reviewing the variety of theories about how the placebo effect works).

114. See *id.* at 701-02.

confidence in medicine means sacrificing the placebo effect assumes that patients having rationally based expectations of their health care providers lack the kind of optimism about their treatments necessary to experience the effect.¹¹⁵ Yet, this is contradicted by at least some accounts of patient-provider interactions associated with a perceived placebo effect. Some observers conclude that the placebo effect occurs in treatment relationships where the patient “feels heard” and where the health care professional has expressed some certainty that a proposed treatment will work.¹¹⁶ Yet, these characteristics of a positive patient-provider interaction can exist under a policy of pursuing trust-as-confidence in medicine. As indicated by observational studies of patients who have developed confidence in physicians following a betrayal of an emotional form of trust, assertive patients who voice their concerns and interests to physicians, and who seek to understand why treatments will work, can experience optimism about their patient-provider interaction.¹¹⁷

Finally, one might object to the entire trust-as-confidence hypothesis because it fails to account for the intrinsic value of an emotionally based trust in medicine. According to this argument, there is more to trust-as-faith in medicine than its causing individuals to seek medical care, comply with treatment plans, and avoid disputes with their providers. Faith in doctors and hospitals is valuable by itself because it responds to feelings of vulnerability among patients brought on by illness and injury.¹¹⁸ It is, in Hall’s words, “a defining aspect of strong caregiver relationships, one that gives them fundamental meaning and value.”¹¹⁹

Certainly, the claim that trust-as-faith is intrinsically valuable to medicine is appealing because it resonates with traditional views of medicine. Yet, it is difficult to clearly articulate the intrinsic value of trust-as-faith in medicine and to differentiate it from instrumental benefits of such trust. For example, it is argued that trust-as-faith is intrinsically valuable in medicine because it helps patients to cope with feelings of vulnerability.¹²⁰ In reality, however, this articulates an instrumental feature of trust-as-faith, namely, that it is a vehicle for managing feelings of anxiety and helplessness associated with illness and injury. As demonstrated elsewhere in this Article, trust-as-confidence responds to such vulnerability as well by enabling patients to take greater control of their medical care and thereby reduce their feelings of helplessness.¹²¹

115. *See id.* at 703.

116. *See id.*

117. *See supra* notes 95-100 and accompanying text (describing that patients perceive their relationships with their health care professionals as improved when based on confidence rather than faith).

118. *See Hall, Law, Medicine, and Trust, supra* note 3, at 477-78.

119. *See id.* at 477.

120. *See supra* note 118.

121. *See supra* notes 95-100 and accompanying text.

Skepticism about the intrinsic value of faith in medicine, however, goes beyond the semantics of intrinsic and instrumental categories. Trust-as-faith is embedded in our cultural view of medicine.¹²² Thus, as we question its continued relevance, we should expect to feel that something foundational to medicine is being uprooted. Yet, feelings of loyalty to traditional assumptions about trust in medicine cannot substitute for sound reasoning.¹²³ Unless we are prepared to reconceptualize medical trust in light of today's health care delivery system and today's health care consumers, we risk turning trust-as-faith into a sacred cow of health policy and thereby exempting it from criticism, which would not serve the interests of health care professionals, institutions, payers, or consumers.

IV. FAITH, CONFIDENCE, AND HEALTH CARE CONSUMERS

As argued above, trust-as-faith may not be necessary in modern health care. Additionally, it may also undermine efforts to encourage a public perception of medicine among consumers that facilitates medical care without disabling the ability of consumers to protect themselves in today's medical marketplace. Below, Part IV.A claims that a policy of preserving, if not promoting, trust-as-faith in medicine may encourage patients to be docile with respect to their medical care and thereby erode assertiveness among health care consumers. Part IV.B then identifies the risk that a policy of pursuing trust-as-faith in medicine may abandon those who distrust health care providers and systems on the belief that trust lost cannot be regained except at great cost. In comparison, a policy of pursuing trust-as-confidence will encourage assertiveness among health care consumers and thereby create an avenue for managing the distrust of those whose faith in medicine has been betrayed.

A. *Faith, Confidence, and the Assertive Patient*

Although patients who trust their physicians seek needed medical attention, enable diagnosis by revealing private information, consent to and comply with recommended treatment regimes,¹²⁴ and may also benefit from mind-over-body healing

122. See Hall, *Law, Medicine, and Trust*, *supra* note 3, at 469 n.18 (citing seminal writings from 1951 and 1927 claiming trust to be central in medicine), 472 (reviewing academic literature and finding that the importance of trust in medicine is often presumed based on intuition).

123. I have argued similarly with respect to calls for a legislative ban on human cloning. See Robert Gatter, *Yelling Yuck' at Cloning Is Not Rational*, HARRISBURG PATRIOT-NEWS, Jan. 2, 2003, at A9 ("Public disgust with reproductive cloning may reflect a yearning for simpler times when medical progress did not seem so threatening, but such a yearning is not a sufficient basis from which to make public policy . . .").

124. See *supra* notes 18-22, 39 and accompanying text; see also Gatter, *supra* note 36, at 1100-02; Hall et al., *Trust: What Is It?*, *supra* note 18, at 617-18

processes,¹²⁵ medical trust is not an unqualified good. For example, relatively high measures of medical trust also are associated with submissive behavior among patients and consumers of health insurance.¹²⁶ Recent studies establish that, in comparison to those who are less trusting, patients with relatively high medical trust measurements are less likely to enter into disputes with their physicians, less likely to dismiss their physicians, less likely to seek second medical opinions, and more likely to comply with physicians' orders.¹²⁷ Thus, in cases where a physician acts unprofessionally, provides substandard care, or serves his or her own interests rather than the welfare of those he or she treats, patients with high degrees of trust in the offending physician might nonetheless fail to take self-protective action because of an overblown sense of loyalty. Likewise, individuals covered by health insurance who exhibit relatively high degrees of trust in their insurer are, when compared to others, less likely to dispute their insurers' actions or to switch insurers.¹²⁸ This also may indicate that health care consumers placing a high degree of trust in their insurers are less prepared to take a necessary stand against their insurers than are less trusting consumers.

The conclusion that individuals with high degrees of medical trust are docile and thus unduly deferential to medical authority may be challenged by some as inconsistent with empirical evidence about medical trust. For example, Hall et al. argue that "trust levels do not appear strongly related to patients' preference for being involved in making medical decisions. This suggests that trust is consistent with patient roles that are both deferential to physicians and actively involved in decision making."¹²⁹ This claim is undermined, however, by the data to which the authors cite in support. The studies cited by Hall et al. indicate that, as medical trust scores increase, so does the willingness of patients to allow their physicians to exercise primary control over patients' treatment

("High-trusting patients are more likely to forgive a physician's mistake with the observation that the doctor at least meant well or gave a good effort.") (citations omitted).

125. See Hall, *Law, Medicine, and Trust*, *supra* note 3, at 479-82.

126. See Hall et al., *Primary Care Providers*, *supra* note 13, at 314.

127. See Hall et al., *Medical Profession*, *supra* note 15, at 1433 (empirical study demonstrating that "trust exhibits a strong positive association with . . . following doctors' recommendations, and a strong negative association with prior disputes with physicians, having sought second opinions, and having changed physicians."); see also Hall et al., *Primary Care Providers*, *supra* note 13, at 314 ("Physician trust exhibits a strong association with satisfaction, having enough choice in selecting one's physician, willingness to recommend the physician, no desire to switch physicians, no prior dispute with the physician, and not seeking second opinions.").

128. See Zheng et al., *supra* note 3, at 200.

129. Hall et al., *Trust: What Is It?*, *supra* note 18, at 627-28 (citations omitted).

decisions.¹³⁰ Thus, the data suggest that a policy of promoting trust-as-faith may also be a policy of promoting greater deference among patients to medical authority.

First, Hall et al. cite to a seminal study by Anderson and Dedrick, which attempted to measure trust of patients in their physicians.¹³¹ Surprisingly, it contradicts the claim that trust is consistent with active involvement by patients in medical decision-making. Anderson and Dedrick found that trust is *negatively* correlated with patients' desire for personal control in the patient-physician relationship, and *positively* correlated with their desire for the physician to control the relationship.¹³² In fact, Anderson and Dedrick conclude "that, at least within the sample we studied, patients with high trust may express lower desires for personal control in the interaction. This in turn may lead to a more passive role in the medical interaction."¹³³ A second study to which Hall et al. cite comes to a similar conclusion.¹³⁴ Thom et al. found that *lower* levels of medical trust were associated with patients' claims that they prefer to have primary control over their medical decisions,¹³⁵ again suggesting that increases in medical trust are made at the sacrifice of assertiveness among consumers of health care.

The claim by Hall et al. that "trust is consistent with patient[s]"

130. See *infra* notes 131-35 and accompanying text.

131. See Hall et al., *Trust: What Is It?*, *supra* note 18, at 627-28; see also Anderson & Dedrick, *supra* note 3.

132. See Anderson & Dedrick, *supra* note 3, at 1099.

133. See *id.*

134. Mark Hall et al., *Patient Trust in a Primary Care Physician: What Is It and Can It Be Reliably Measured?*, 15 J. GEN. INTERNAL MED. 69 (supp. 1, 2000); see Hall et al., *Trust: What Is It?*, *supra* note 18, at 628. According to Professor Hall, the cite refers to a conference presentation, the contents of which were most closely recreated in Hall et al., *Medical Profession*, *supra* note 15. See email message from Mark Hall to author dated Mar. 28, 2003. Unfortunately, the article to which I was referred does not cover the portion of the conference presentation that addressed the relationship between measurable medical trust and patient assertiveness or passivity with respect to medical authority.

135. See Thom et al., *supra* note 3, at 515 tbl. 3 (on a 0-100 scale, the mean trust score among sixty-two patients expressing a desire for more control over medical decisions was 70.4, which is statistically significant—as indicated by a p-value of less than 0.001—when compared to the mean trust score of 75.3 among the approximately 400 patients surveyed). Interestingly, the data from this study also showed that the fifty-four patients claiming that they desired their physician to primarily control medical treatment decisions for them had a mean trust score of 81.9 (more than six points higher than the mean trust score for all patients), and that the 250 patients expressing a desire to share control over medical treatment decisions equally with their physician had a mean trust score of 75 (almost exactly the mean trust score for all patients surveyed). See *id.* These data were not statistically significant; nonetheless, when combined with the significant finding described above, the study appears consistent with the claim that increases in medical trust are associated with increased passivity in medical decision-making and decreases in medical trust are associated with increased assertiveness among patients.

being] . . . actively involved in decision making”¹³⁶ may be based on empirical evidence that patients who want primary control over their medical treatment decisions appear to have high medical trust scores, even though those scores are significantly lower than patients who prefer less control over their treatment decisions.¹³⁷ Despite such evidence, however, the claim that trust can be associated with assertive patient behavior may be wrong because no distinction has been made between trust-as-confidence and trust-as-faith. It is possible that what researchers have identified as “trust” among assertive patients is a rationally based confidence and not the emotionally based faith associated with the emerging medical trust movement.¹³⁸

Consider, for example, the data from the study conducted by Thom et al. There, patients who prefer that their physicians exercise primary control over treatment decisions had a mean medical trust score of about eighty-two on a 100-point scale; patients preferring to share control over treatment decisions equally with their physicians had a mean medical trust score of seventy-five; and patients who wanted primary control over treatment decisions had a mean medical trust score of about seventy.¹³⁹ While the twelve-point trust gap between the more passive and the more assertive patients seems small on a 100-point scale, it may be a critically important gap—namely, the gap between confidence and faith in one’s physician. In other words, confidence may account for seventy trust points, but only faith can account for an additional twelve points and the corresponding desire to defer to your physician on all treatment decisions. Accordingly, to disprove the claim that high degrees of medical trust are associated with passive behavior among health care consumers, researchers must distinguish between trust-as-confidence and trust-as-faith.

If trust-as-faith in medicine is associated with passive behavior among health care consumers, then a policy of promoting medical trust may result in creating a more docile health care consumer. This, in turn, would undermine a long-established policy of empowering patients to protect themselves from a medical establishment whose loyalty to the welfare of patients is suspect—a policy sprung from consumer activism that is as needed today as when it first arose.

This policy is evidenced most clearly by patients’ rights established under law and institutional policy. By law, patients have rights to access their medical records and to have those records

136. Hall et al, *Trust: What Is It?*, *supra* note 18, at 628.

137. *See supra* note 18.

138. *See supra* notes 58-66 and accompanying text (associating the emerging medical trust movement with an emotionally based trust).

139. *See supra* note 135.

treated confidentially.¹⁴⁰ They have the right to make their own treatment decisions, including decisions to refuse proposed treatments,¹⁴¹ even life-extending treatments,¹⁴² or proposed participation in medical experimentation.¹⁴³ Additionally, physicians have a legal duty to disclose medical information so that patients can exercise their decision-making rights in an informed manner.¹⁴⁴ Likewise, the law provides individuals who come to a hospital's emergency department with the right to receive treatment necessary to stabilize any emergent medical condition.¹⁴⁵ Hospital and other institutional policies provide patients with these rights and more, including a right to be treated respectfully and reasonably without delay, a right to receive visitors and mail, a right to effective pain management, and a right not only to have medical information disclosed, but also explained in layman's terms or, if necessary, in another language.¹⁴⁶

The policy of empowering patients through legal and institutional rights has come under increasing challenge,¹⁴⁷ and the emerging medical trust movement might be a byproduct, if not a part, of that challenge.¹⁴⁸ Some argue that a rights-based conception

140. Although states' laws typically recognize the privacy of medical records as well as the right of patients to access those records, federal law, through the Health Insurance Portability and Accountability Act ("HIPAA"), has largely preempted state law with respect to medical confidentiality. See 45 C.F.R. §§ 160.201-205 (2003) (addressing the pre-emptive effects of HIPAA regulations). Thus, federal law is a—if not the—source for establishing patients' rights to both privacy of and access to patients' medical records. See 45 C.F.R. § 164.502(a) (prohibition against use or disclosure of health information except as specifically permitted by regulation); 45 C.F.R. § 164.524 (right of access for individuals to their otherwise private health information).

141. See Robert Gatter, *Informed Consent Law and the Forgotten Duty of Physician Inquiry*, 31 LOY. U. CHI. L.J. 557, 558-59 (2000) (describing informed consent law).

142. See *Cruzan v. Mo. Dept. of Health*, 497 U.S. 261, 278 (1990) (presuming that the Fourteenth Amendment to the federal constitution protects as a liberty interest the right of competent individuals to refuse life-sustaining medical treatment).

143. See 45 C.F.R. § 46.116 (2003) (prohibiting the involvement of human subjects in medical experimentation without informed consent and describing the elements of such consent).

144. See *id.* (describing the disclosures that must be made as part of seeking the consent of a human subject to experimentation); Gatter, *supra* note 141, at 558-59 (describing disclosure requirements for consent to treatment).

145. See 42 U.S.C. § 1395dd(h) (2000).

146. See AHA MANAGEMENT ADVISORY, *A Patients' Bill of Rights* (Am. Hosp. Assoc. 1992), available at <http://www.hospitalconnect.com/aha/about/pbillofrights.html> (last visited Feb. 29, 2004).

147. See Hall, *Law, Medicine, and Trust*, *supra* note 3, at 472-73 n.26 and accompanying text; see also Sandra H. Johnson, *The Changing Nature of the Bioethics Movement*, 53 MD. L. REV. 1051, 1060-61 (1994).

148. See Hall, *Law, Medicine and Trust*, *supra* note 3, at 469-70 (acknowledging that interest in medical trust has been renewed as a rights-based conception of medical relationships has been challenged); see also *id.* at

of relationships between patients and their health care providers distorts reality by implying that patients and providers are battling for control when, in truth, most patients prefer to share control of their medical care with their providers.¹⁴⁹ Others argue at a conceptual level, claiming that “rights talk” in medicine is unsatisfying because it fails to account for acts of goodwill and caring conduct among close relations.¹⁵⁰ Accordingly, to some, a medical enterprise organized around patients’ rights isolates and abandons patients.¹⁵¹ In the end, some are concerned that, when we conceive of medical relationships from the perspective of rights, we generate an untrusting and otherwise negative public attitude toward the medical establishment.¹⁵²

Nonetheless, most observers concede that a policy of empowering patients through legal rights is necessary and appropriate at least to some extent.¹⁵³ Perhaps they recognize that, apart from conceptual debates about the role of law in medicine, legal rights for patients are a consumer protection mechanism that frees the public from relying exclusively on the good will of the medical establishment to safeguard the welfare of patients. In fact, patients’ rights were first recognized as part of a consumer movement in the late 1960s and early 1970s.¹⁵⁴ From 1966 through 1970, citizens’ groups in Philadelphia, Chicago, Boston, and New York City picketed and staged sit-ins at hospitals, protesting practices that seemed to ignore the health care needs of the poor and disenfranchised.¹⁵⁵ Not only did these consumer activists win

469 (“The language of rights and the language of trust move in opposite directions from one another. The scrupulous insistence on observance of one’s rights is an admission that one does not trust those at hand to care properly for one’s welfare.” (quoting Richard Sherlock, *Reasonable Men and Sick Human Beings*, 80 AM. J. MED. 2, 3 (1986))).

149. See, e.g., CARL E. SCHNEIDER, *THE PRACTICE OF AUTONOMY: PATIENTS, DOCTORS, AND MEDICAL DECISIONS* (1998).

150. See, e.g., John Ladd, *Legalism and Medical Ethics*, in CONTEMPORARY ISSUES IN BIOMEDICAL ETHICS 1, 18–21 (John W. Davis et al., eds., The Humana Press, 1978); Gilbert Meilaender, *Reconciling Rights & Responsibilities: Our Vocabularies, Our Selves*, 24 HASTINGS CENT. REP. 13 (1994); Carl E. Schneider, *Bioethics in the Language of the Law*, 24 HASTINGS CENT. REP. 16 (1994).

151. See, e.g., JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 224–27 (The Free Press, 1984); EDMUND D. PELLEGRINO & DAVID C. THOMASMA, *THE CHRISTIAN VIRTUES IN MEDICAL PRACTICE* 118–21 (1996).

152. See, e.g., KATZ, *supra* note 151, at 224–27.

153. See, e.g., Alexander Morgan Capron & Vicki Michel, *Law and Bioethics*, 27 LOY. L.A. L. REV. 25, 35–37 (1993); Michael L. Gross, *Wagging the Watchdog: Law and the Emergence of Bioethical Norms*, 21 MED. & L. 687, 705–08 (2002); Charity Scott, *Why Law Pervades Medicine: An Essay on Ethics in Health Care*, 14 NOTRE DAME J.L. ETHICS & PUB. POL’Y 245, 271–75 (2000).

154. See RUTH R. FADEN & TOM L. BEAUCHAMP, *A HISTORY AND THEORY OF INFORMED CONSENT* 93–95 (Oxford Univ. Press, 1986); DAVID J. ROTHMAN, *STRANGERS AT THE BEDSIDE: A HISTORY OF HOW LAW AND BIOETHICS TRANSFORMED MEDICAL DECISION MAKING* 145–47 (BasicBooks, 1991).

155. See Robert Gatter, *The Juridification of Medical Decision-Making:*

influence over hospitals' business decisions, they also forced hospitals to assist them in gaining greater control from physicians in medical decision-making. In response to the demands of these citizens' groups, hospitals created complaint tables in their emergency departments and hired patient advocates, ombudsmen, and Spanish language translators who helped assure that patients received understandable medical information from physicians.¹⁵⁶ In addition to these local protests, the consumer movement in health care operated on the national stage through the National Welfare Rights Organization, which confronted the Joint Commission for the Accreditation of Hospitals¹⁵⁷ in 1970 and won adoption of a patients' bill of rights.¹⁵⁸

The assertiveness among health care consumers that gave rise to a policy of patient empowerment is as vital a consumer protection tool in today's medical marketplace as it was more than thirty years ago. As described above, the free market regulates health care delivery more today than ever, steering providers down an entrepreneurial path and exacerbating conflicts between providers' business interests and the medical interests of patients.¹⁵⁹ In such an economic environment, an attitude among consumers to vigilantly protect their own health care interests is an indispensable check on medical authority. This, combined with evidence that evermore trust could breed blind compliance among patients, suggests that a policy of promoting trust-as-faith in medicine is simply a bad idea despite any efficiency it might create or vulnerability it might soothe. In short, a healthy skepticism toward medicine, rather than faith in it, may be the best mechanism for coping with the vulnerability of illness.

Some might claim that arguing against a policy of promoting trust-as-faith in medicine is like knocking down a straw man because nobody has proposed such a policy. Rather, most commentators recognize that, in excessive amounts, trust is harmful.¹⁶⁰ Accordingly, thoughtful observers call for a balance

Towards a Theory of the Role of Law in Bioethics 47-48 (1995) (unpublished thesis, Medical College of Wisconsin) (on file with author) (citing *The Surge of Community Involvement*, 13 MED. WORLD NEWS 51 (May 19, 1972)).

156. *See id.*

157. Today it is known as the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"), available at <http://www.jcaho.org>.

158. *See supra* note 146; *see also* Gatter, *supra* note 155, at 49-52 (citing Laurens H. Silver, *The Legal Accountability of Nonprofit Hospitals*, in REGULATING HEALTH FACILITIES CONSTRUCTION: PROCEEDINGS OF A CONFERENCE ON HEALTH PLANNING, CERTIFICATES OF NEED, AND MARKET ENTRY 183 (Clark C. Havighurst ed., 1974)).

159. *See supra* Part III.B; *see also* Marcia Angell, *The Doctor as Double Agent*, 3 KENNEDY INST. OF ETHICS J. 279 (1993).

160. *See* Hall et al., *Trust: What Is It?*, *supra* note 18, at 617-18 (noting that trust can at once promote greater health and create "overly optimistic expectations" that lead to betrayal); Mechanic, *supra* note 34, at 174-75

between trust and skepticism among health care consumers.¹⁶¹

While true on its face, any claim that the emerging medical trust movement will not pursue evermore trust-as-faith fails to account for the implications of lessons taught by the emerging movement. First, it teaches that medical trust is necessary in health care delivery and that it enhances treatment and healing.¹⁶² Second, it teaches that trust allows for greater efficiency in health care delivery.¹⁶³ Third, medical trust, according to this theory, is primarily an emotional phenomenon.¹⁶⁴ A fourth lesson is that medical trust tends to build in strength or to deteriorate.¹⁶⁵ Fifth, medical trust lost is very difficult if not impossible to regain.¹⁶⁶ Finally, a sixth lesson of the emerging medical trust movement is that one can have too much medical trust.¹⁶⁷ Any policy oriented toward medical trust should account for all of these lessons, which is why such a descriptive account of medical trust will result in a policy to presumptively preserve medical trust. Such a policy pursues the clinical and economic advantages of trust and protects against irretrievable losses of trust. Yet, to account for the concern that trust lost cannot be regained, the policy must presume to preserve trust-as-faith, allowing for a skeptical stance only in exceptional circumstances where there is affirmative evidence of too much trust. In other words, by highlighting the medical benefits of trust and warning that trust lost might never be recovered, the emerging medical trust movement has no choice but to argue for a policy that errs on the side of at least preserving trust-as-faith except when the risk of blind trust actually materializes. Indeed, Hall proposes such a policy following his largely descriptive theory of medical trust and law.¹⁶⁸

(recognizing the necessity and efficiency of trust as well as the dangers of misplaced trust); see also Hardin, *supra* note 35, at 516-18 (recognizing the value of distrust in modern democracies that favor weak governments in which power is limited and distributed over many).

161. See, e.g., Hall, *Law, Medicine, and Trust*, *supra* note 3, at 498-522 (arguing that, as a matter of policy, the law can take a supportive or skeptical stance towards medical trust); Mechanic, *supra* note 34, at 175 (calling for a "proper balance between trust and distrust").

162. See *supra* notes 38-41 and accompanying text.

163. See *supra* notes 18-26 and accompanying text.

164. See *supra* notes 53, 58-65 and accompanying text.

165. See Hall et al., *Trust: What Is It?*, *supra* note 18, at 618.

166. See *supra* note 35.

167. See *supra* notes 126-28 and accompanying text.

168. He writes:

[T]hreats to trust are real and should be taken seriously, for several reasons. First, as noted above, the stronger trust is, the deeper the sense of betrayal that can result when trust is violated. Once this occurs, it may be impossible ever to restore trust. Both trust and distrust have a self-generating or spiraling dynamic in which the starting attitude colors how people interpret particular events and actions, which then further shape the basic attitude that

Furthermore, a policy to *preserve* trust-as-faith in medicine will likely morph into a medical trust-*promoting* policy if the health care marketplace begins measuring trust among its consumers because good medical trust scores, just like good patient satisfaction scores, can be a valuable marketing tool for health care providers and plans. On the theory that a satisfied customer is a loyal customer, health administrators currently use patient and consumer satisfaction¹⁶⁹ surveys to assess the quality and efficiency of its systems and personnel.¹⁷⁰ Moreover, satisfaction survey scores of providers help determine how providers are rewarded by health plans.¹⁷¹ Likewise, hospitals and health plans with relatively high satisfaction survey results use those results to market themselves.¹⁷²

colors subsequent events. Just as a trusting patient tends to forgive mistakes as unavoidable or unintended, a distrusting patient tends to view minor imperfections as symptomatic of an underlying malevolence or incompetence, and may view efforts at improvement as cynical, disingenuous ploys. This makes it extremely difficult to reverse a spiral of distrust. Restoring system or institutional trust can also be difficult, even though the fall from grace may not be as steep, since these more diffused forms of trust cover a much broader range, and so rely on many more inputs, than does trust in a specific person. Finally, all of these points are highly speculative and uncertain, so there is no way to know in advance of any development whether threats to trust will prove to be real or imagined, or what the potential is for maintaining or restoring trust. Therefore, those who advocate supportive legal measures should not have to bear the burden of proving their case empirically.

Hall, *Law, Medicine, and Trust*, *supra* note 3, at 508-09 (citation omitted); *see also supra* note 45 and accompanying text.

169. The term "patient satisfaction" is used among physicians, hospitals, and other health care providers while the term "consumer satisfaction" is used among health plans and other insurers.

170. *See* Clark D. Cunningham, *Evaluating Effective Lawyer-Client Communication: An International Project Moving from Research to Reform*, 67 *FORDHAM L. REV.* 1959, 1960 (1999) ("[V]irtually all hospitals in the United States have some kind of patient satisfaction measurement system in place.") (citation omitted); *see also* Goldstein et al., *supra* note 27; Luallin, *supra* note 27; Elaine Yellen & Gail C. Davis, *Patient Satisfaction in Ambulatory Surgery*, 74 *AORN J.* 483 (2001). For an overview of the development of patient satisfaction as a concept and measurement device, *see generally* Anita L. Comley & Margaret T. Beard, *Toward a Derived Theory of Patient Satisfaction*, 2 *J. THEORY CONSTRUCTION & TESTING* 44 (1998).

171. *See* Russell C. Coile, Jr., *Health Care M & A: How to Structure the Transaction*, in 1045 *PRACTISING LAW INST.: CORPORATE LAW AND PRACTICE COURSE HANDBOOK SERIES* 323, 363-64 (1998) (regarding transactional trends related to managed care service quality).

172. *See, e.g.*, Richard R. Brand et al., *Marketing to Older Patients: Perceptions of Service Quality*, 15 *HEALTH MKTG. Q.* 1 (issue 2 1997) (identifying the importance of patient satisfaction in physicians' retaining patients); P. Mardeen Atkins et al., *Happy Employees Lead to Loyal Patients*, 16 *J. OF HEALTH CARE MKTG. Q.* 14 (1996) (studying the relationship between nurse satisfaction and patient satisfaction and drawing conclusions about its effect on health care marketing).

For example, one health plan took out a full-page advertisement in *The New York Times* "to trumpet their '#1 sweeps' ratings in a consumer satisfaction survey" of New York health plans.¹⁷³

There is reason to believe that health care managers will make similar marketing use of newly developed medical trust surveys. Recent empirical data suggest that medical trust surveys are better predictors of desirable behavior among patients and health plan members.¹⁷⁴ First, developers of medical trust surveys have compared their surveys to patient satisfaction measures and found that those surveys are at least as valuable as satisfaction measures.¹⁷⁵ Patients and insureds with high medical trust scores are unlikely to enter into disputes with their providers or health plans or to switch physicians or health plans.¹⁷⁶ Additionally, they are likely to comply with physicians' treatment plans and to recommend their provider or health plan to others.¹⁷⁷ Second, some developers of medical trust surveys suggest that medical trust is more stable than is patient satisfaction, which is highly variable depending on a patient's most recent experience.¹⁷⁸ In comparison, medical trust instruments appear to measure a more robust sentiment that is less variable,¹⁷⁹ suggesting that medical trust survey scores provide a more reliable basis on which to make managerial decisions.

If health care providers and plans employ medical trust surveys, then we should anticipate that they will pursue ever-higher medical trust scores because of the marketing advantage such scores would bring. It is not hard to imagine the advertising campaign: "*ABC Hospital System: voted by patients as the most trusted hospital*

173. See Coile, Jr., *supra* note 171, at 363.

174. See Hall et al., *Trust: What Is It?*, *supra* note 18, at 617; Thom et al., *supra* note 3, at 515-16 (finding that patients' compliance with their physicians' treatment recommendations were more strongly associated with measures of trust than measures of satisfaction); see also Hall et al., *Medical Profession*, *supra* note 15, at 1433 ("General trust exhibits a strong positive association with satisfaction, trust in one's physician, and following doctors' recommendations, and a strong negative association with prior disputes with physicians, having sought second opinions, and having changed physicians."); Hall et al., *Primary Care Providers*, *supra* note 13, at 314 ("Physician trust exhibits a strong association with satisfaction, having enough choice in selecting one's physician, willingness to recommend the physician, no desire to switch physicians, no prior dispute with the physician, and not seeking second opinions."); Zheng et al., *supra* note 3, at 200.

175. See Hall et al., *Trust: What Is It?*, *supra* note 18, at 617; Thom et al., *supra* note 3, at 515-16.

176. See Hall et al., *Trust: What Is It?*, *supra* note 18, at 617-18; Thom et al., *supra* note 3, at 514-15.

177. See Hall et al., *Trust: What Is It?*, *supra* note 18, at 617; Thom et al., *supra* note 3, at 514-15.

178. See Hall et al., *Trust: What Is It?*, *supra* note 18, at 617; Thom et al., *supra* note 3, at 515-16.

179. See Hall et al., *Trust: What Is It?*, *supra* note 18, at 617.

system in the state!" Given that medical trust surveys were developed on the basis of existing medical trust theory,¹⁸⁰ which conceives of medical trust as an emotional phenomenon distinct from a rationally based confidence,¹⁸¹ market competition for ever-higher medical trust survey scores is, in effect, competition for ever-higher trust-as-faith scores. In the end, the availability and market advantages of new techniques for quantitatively measuring medical trust could undercut the law's decades-long policy of encouraging patients to be informed and independent health care consumers.¹⁸²

Furthermore, a policy to preserve whatever levels of medical trust prevail at a given time is not a check against either a ratcheting-up of trust-as-faith in medicine or a corresponding decline in assertiveness among health care consumers. Instead, such a policy will permit such increases in trust-as-faith and declines in consumer assertiveness absent affirmative proof that prevailing medical trust levels are inappropriate. Thus, a policy of preserving medical trust likely undermines assertiveness among health care consumers.

In comparison, a policy of promoting confidence in medicine strikes a better balance.¹⁸³ On the one hand, it recognizes and accommodates the need for a positive public perception of medicine to sustain the effectiveness of our health care delivery system. On the other hand, it bolsters assertiveness among consumers and thereby prepares them to protect their interests in the modern medical marketplace.¹⁸⁴ It does so by fostering a rationally based perception about the reliability of the medical establishment that both discourages overblown consumer expectations and encourages consumers to take greater responsibility for their own health care.¹⁸⁵ As a result, confidence in medicine is likely to be as stable a consumer attitude as is trust-as-faith, if not more so.¹⁸⁶ Thus,

180. See, e.g., Zheng et al., *supra* note 3, at 189.

181. See *supra* Part III.A.

182. It would be an example of what Brennan and Berwick describe as a substitution of political goals with "technocratic expertise," which erodes the legitimacy of the resulting regulatory system. See TROYEN A. BRENNAN & DONALD M. BERWICK, *NEW RULES: REGULATION, MARKETS, AND THE QUALITY OF AMERICAN HEALTH CARE* 19 (Jossey-Bass Inc., 1996).

183. See Mechanic, *supra* note 34, at 175 (calling for a "proper balance between trust and distrust").

184. See *supra* Part III.C.

185. Indeed, this may explain why a recently published study of how patients choose their physicians found that individuals who have recently had a dissatisfying treatment experience and have switched physicians as a result are almost three times as likely as other patients to choose a new physician based on patient surveys and information received from employers, government, websites or newspapers. See Katherine M. Harris, *How Do Patients Choose Physicians? Evidence from a National Survey of Enrollees in Employment-Related Health Plans*, 38 HEALTH SERVICES RES. 711, 726 (2003); see also *supra* Part III.C.

186. See Harris, *supra* note 185, at 726; see also *supra* Part III.C.

measuring consumer confidence in health care providers would likely provide the same improvement over consumer satisfaction surveying as is currently claimed by the creators of medical trust surveys.

B. Faith, Confidence, and the Distrusting Consumer

Just as a policy of preserving trust-as-faith must account for the problem of too much faith in medicine, it must also account for the problem of too little faith. How does the emerging medical trust movement propose to manage consumers who have lost faith in medicine? While this question has not been answered directly, there is reason to be concerned that a policy of preserving trust-as-faith will not effectively respond to such distrust.

A key tenet of the emerging medical trust movement is that faith once lost generally cannot be regained.¹⁸⁷ Indeed, this explains why commentators have called for a presumption to preserve if not promote trust-as-faith.¹⁸⁸ In other words, because of the perception that faith in medicine that is lost cannot be regained, the exclusive proposal to date has been to prevent such losses in the first place. Thus, there is no plan to regain the trust of those whose faith in medicine is lost. In fact, if we continue to conceive of medical trust as faith in medicine, which, if lost, is unrecoverable, then any effort to restore lost trust would be wasteful. Consequently, a faith-based conception of medical trust appears to require that we abandon those who distrust medicine so as to preserve trust among others.

Given the link between medical trust and certain health-related behaviors,¹⁸⁹ such a policy would be deeply troubling. It would tolerate that the health of distrusting individuals would likely be worse than those who have an emotionally-based faith in health care professionals, institutions, or systems because distrusting individuals are less likely to seek medical care when it is needed.¹⁹⁰ Similarly, such a policy would accept that distrusting individuals who seek medical care will likely have worse treatment outcomes than patients with an emotionally-based faith in medicine because

187. See *supra* note 45.

188. Mark A. Hall articulates this logic. After claiming that trust is both essential to effective health care delivery and emotionally based, see *supra* notes 37-41, he rejects the presumption that regulatory measures designed to sustain or improve medical trust—what he terms “supportive measures”—are *unjustified*. Such a policy is necessary, he reasons, because of our inability to restore trust once it is lost. See Hall, *Law, Medicine, and Trust*, *supra* note 8, at 508-09.

189. See *supra* notes 18-26 and accompanying text.

190. See Vernellia R. Randall, *Slavery, Segregation and Racism: Trusting the Health Care System Ain't Always Easy! An African American Perspective on Bioethics*, 15 ST. LOUIS U. PUB. L. REV. 191, 192 n.2 (1996) (citing to sources claiming that African Americans are less likely to seek medical care or comply with medical recommendations because of their distrust of the health care system); see also Hall, *Law, Medicine, and Trust*, *supra* note 3, at 478.

distrusting patients are more likely to question the propriety of physicians' orders and less likely to comply with them.¹⁹¹ In other words, as a social price for the advantages of preserving trust-as-faith in medicine for some, we would abandon others due to their lack of faith and tolerate the lower standard of health associated with it.

This is all the more troubling when one considers that distrust felt by some towards health care professionals, institutions, and payors is justified in light of a past experience of betrayal within the health care system.¹⁹² Recall the observational study of seventy-seven chronically ill patients.¹⁹³ The loss of faith in medicine found among those patients was triggered by perceived breaches of medical trust experienced by those patients.¹⁹⁴ Consequently, a policy that tolerates the lack of trust-as-faith in medicine among some citizens is a policy that abandons those whose distrust health care professionals, institutions, or systems may have helped to create.¹⁹⁵

Still more troubling is the fact that distrust in medicine may be associated with race and ethnicity.¹⁹⁶ Recent empirical evidence

191. See Hall, *Law, Medicine, and Trust*, *supra* note 3, at 478; see also *supra* note 20.

192. See *supra* notes 8-12 and accompanying text.

193. See Thorne & Robinson, *supra* note 3.

194. See *id.*

195. For example, it is widely reported that African Americans distrust the medical establishment to a greater extent than do white Americans because African Americans have been uniquely subject to abuse by the medical establishment. See Randall, *supra* note 190, at 195-204 (stating that distrust of health care among African Americans is based on experiences of abuse including forced medical experimentation during and after slavery, discrimination related to sickle cell screening, and discriminatory use of family planning and sterilization to reduce the black population); see also Vanessa Northington Gamble, *Under the Shadow of Tuskegee: African Americans and Health Care*, 87 AM. J. PUB. HEALTH 1773 (1997); Barbara A. Noah, *The Participation of Underrepresented Minorities in Clinical Research*, 29 AM. J. L. & MED. 221, 229-30 (2003).

196. There is disagreement about whether minorities distrust health care any differently than do white Americans. For example, compare Bloche, *supra* note 8, at 943-44 (arguing that racial and ethnic minorities have less trust in their physicians than do whites), with Mark A. Hall, *Ideology and Trust: A Reply to Bloche*, 55 STAN. L. REV. 955, 959 n.16 (2002) (claiming that empirical data do not support the conclusion that there is a "strong degree of mistrust by racial minorities of their personal physicians") [hereinafter Hall, *Ideology and Trust*]. While several studies have found that racial and ethnic minorities report significantly less trust or less satisfaction with trust-related aspects of a treatment experience than do their white counterparts, others have concluded that there are no significant differences. See *infra* notes 198-99 and accompanying text. The problem of finding a consensus is compounded by the fact that different studies ask different questions about medical trust, use different trust measures, and observe populations with different degrees of access and different levels of health. Nonetheless, given the number of studies finding that some racial and ethnic minorities have significantly lower trust

suggests that members of some racial and ethnic minority groups are more likely to distrust health care professionals, institutions, and systems than are white Americans.¹⁹⁷ For example, Doescher et al. found that African Americans and Latinos trust their physicians significantly less than do white Americans on a standardized trust-in-physician scale even when potential confounding factors (e.g., health insurance coverage, education, health status) are controlled for.¹⁹⁸ Three other studies have gathered data about individuals'

scores than do whites, *see id.*, the claimed link between diminished trust and race cannot be ignored.

197. *See generally* Carolyn Clancy, *Racial and Ethnic Disparities and Primary Care Experience*, 36 HEALTH SERVICES RES. 979 (2001) (reviewing four studies, all of which find that some racial and ethnic minorities report less satisfaction with care and/or less trust in providers than whites—most notably Asians and Pacific Islanders).

198. *See* Mark P. Doescher et al., *Racial and Ethnic Disparities in Perceptions of Physician Style and Trust*, 9 ARCH. FAM. MED. 1156, 1160-61 (Table 3) (2000) (using a standard trust-in-physician scale to measure the trust of respondents—with varying levels of health, education, and access to medical care—in a personal physician whom the respondent has visited at least once in the preceding year). For other studies finding significantly lower levels of medical trust among African Americans as compared to white Americans, *see* Thomas A. LaVeist et al., *Attitudes About Racism, Medical Mistrust, and Satisfaction with Care Among African American and White Cardiac Patients*, 57 MED. CARE RES. & REV. 146 (2000) (using the authors' own trust questionnaire, researchers measured trust in hospitals generally among 1784 cardiac patients treated at one of three different hospitals in the prior six months, and finding that African Americans were significantly more likely to mistrust hospitals than were white patients), and Vickie L. Shavers et al., *Racial Differences in Factors that Influence the Willingness to Participate in Medical Research Studies*, 12 ANNALS. EPIDEMIOLOG. 248, 252-53 (2002) (finding that, among 200 respondents living in or near Detroit, African Americans were nearly three times as likely as white Americans to report feeling less trust in medical researchers as a result of knowledge of the Tuskegee syphilis study, and African Americans were nearly three times more likely than white Americans to report that they would not participate in medical research as a result of their diminished trust); *see also* David H. Thom & Bruce Campbell, *Patient-Physician Trust: An Exploratory Study*, 44 J. FAM. PRAC. 169, 174 (1997) (noticing a race-based and/or socio-economic-based pattern of experiences with doctors that leads to distrust of physicians). Finally, a recent focus-group study of African American patients found attributes of medical trust and distrust that appear unique, including perceptions about provider racism and fear of experimentation. *See* Jacobs, *supra* note 19, at manuscript pages 9-10, 12-13; *see also* Noah, *supra* note 195, at 229-30 and the studies cited therein.

For historical explanations in support of the anecdotally based claim that African Americans distrust the medical establishment, *see*, for example, Randall, *supra* note 195, and Gamble, *supra* note 195.

For studies in which no significant difference in medical trust was found between African Americans and white Americans, *see* Hall et al., *Medical Profession*, *supra* note 15, at 1424-33 (showing that no statistically significant relationship was found between responses to trust-in-medical-profession survey and race or ethnicity of 502 telephone-survey respondents from throughout the United States who had health insurance or some other method to pay for health care and who had visited the same health care professional at least twice in the

trust in their physicians or their satisfaction with trust-related characteristics of their physicians (e.g., communication skills) and analyzed the data along racial and ethnic lines.¹⁹⁹ While none of them detected statistically significant differences in trust or trust-related satisfaction scores between African Americans and white Americans, each found that Asians/Pacific Islanders had significantly lower scores when compared to white Americans,²⁰⁰ and one also found significantly lower scores among Latinos as well.²⁰¹

Because studies of medical trust, including those examining any potential relationship between medical trust and race or ethnicity, do not distinguish between trust-as-faith and trust-as-confidence, it is impossible to determine whether the racial and ethnic differences reported in these studies reflect differences in faith or differences in confidence. Nonetheless, they highlight the real possibility that members of racial and ethnic minorities are more likely than are white Americans to lose their faith in medicine. If so, then the conception of trust in medicine as faith, and the belief that faith in medicine is both necessary in health care delivery and also incapable of being restored once lost, will result in health policy that discriminates along racial and ethnic lines. Given the link between trust and health, this would also mean that racial and ethnic minorities would have disproportionately poorer health and treatment outcomes than will whites in part because of a disproportionate degree of medical distrust among those minority groups.

prior two years); Leo S. Morales et al., *Differences in CAHPS Adult Survey Reports and Ratings by Race and Ethnicity: An Analysis of the National CAHPS Benchmarking Data 1.0*, 36 HEALTH SERVICES RES. 595, 608-09 (Tables 4 & 5) (2001) (showing no statistically significant difference detected between African Americans and whites regarding satisfaction with access to and communication skills of physicians, based on national patient satisfaction data gathered from approximately 28,000 surveys of adults enrolled in Medicaid and commercial health plans); Jann L. Murray-Garcia et al., *Racial and Ethnic Differences in a Patient Survey: Patients' Values, Ratings, and Reports Regarding Physician Primary Care Performance in a Large Health Maintenance Organization*, 38 MED. CARE 300, 304 (Table 2) (2000) (showing no statistically significant difference detected between African Americans and whites regarding degree of satisfaction with their physicians' competence and communication skills, based on a survey of more than 10,000 members of a large HMO); Deborah A. Taira, et al., *Do Patient Assessments of Primary Care Differ by Patient Ethnicity?* 36 HEALTH SERVICES RES. 1059, 1066 (Table 3) (2001) (explaining that no statistically significant difference was found in the degree of trust in primary care physicians between African Americans and whites, based on a study administering a standard primary care assessment survey to 7,200 state employees in Massachusetts); see also Hall et al., *Trust: What Is It?*, *supra* note 18, at 627 and studies referred to therein.

199. See Morales et al., *supra* note 198; Murray-Garcia et al., *supra* note 198; Taira et al., *supra* note 198.

200. See Morales et al., *supra* note 198; Murray-Garcia et al., *supra* note 198; Taira et al., *supra* note 198.

201. See Taira et al., *supra* note 198.

Moreover, we should expect that a policy of preserving if not promoting trust-as-faith in medicine would only exacerbate distrust among those who have diminished faith in medicine. As described below, a policy of preserving trust-as-faith requires that the law defer to the discretion of health care professionals and institutions to a significantly greater extent than would a policy of pursuing trust-as-confidence.²⁰² By relying on the health care industry to set and police its standards, the law would leave in control of health care delivery those whose conduct has resulted in a loss of faith in medicine for many consumers. Such a policy will only serve to further undermine any faith or confidence those consumers might have in medicine.²⁰³ Moreover, such a policy makes it difficult for regulators to justify new rules that would take direct control of physicians, hospitals, and plans—the kind of control that will protect consumers from abuse and that might help reconstruct trust in the form of confidence.

In comparison, a policy of preserving or pursuing trust-as-confidence in medicine is one that can respond to those who have lost faith in medicine and can help them to reconstruct trust-as-confidence in medicine. As described above, there is anecdotal evidence suggesting that individuals whose faith in medicine is lost as a result of a perceived betrayal can, in time, develop a new kind of trust in medicine, namely trust-as-confidence.²⁰⁴ Thus, a policy of promoting trust-as-confidence enables the pursuit of renewed trust in medicine among those who have lost faith in medicine. Furthermore, there is reason to believe that attempts to promote confidence among the faithless will succeed and that the law can play an important role in achieving that success. Because trust-as-confidence is built on reason rather than emotion,²⁰⁵ it can overcome emotional scars from betrayals of faith by appealing to reasons why one should have confidence in health care professionals, institutions, and systems in the future. A policy of pursuing trust-as-confidence also justifies lawmakers' use of regulatory tools necessary to protect consumers from abuses of discretion by players within the health care industry.²⁰⁶ Moreover, such regulation will help form a rational basis for individuals to have confidence in medicine despite their

202. See *infra* Part V.

203. This is particularly relevant in light of the possibility that members of racial and ethnic minorities are more likely than their white counterparts to distrust medicine because the discretion of health care professionals and institutions in treating racial and ethnic minorities may be the avenue through which bias is translated into unintended discrimination. See Ana I. Balsa et al., *Clinical Uncertainty and Healthcare Disparities*, 29 AM. J. L. & MED. 203, 207 (2003); M. Gregg Bloche, *Race and Discretion in American Medicine*, 1 YALE J. HEALTH POL'Y L. & ETHICS 95, 103-04 (2001).

204. See *supra* notes 95-99 and accompanying text.

205. See *supra* Part III.A.

206. See *infra* Part V.

inability to feel faith towards health care professionals, institutions, or systems.²⁰⁷

V. FAITH, CONFIDENCE, AND THEIR LIMITING EFFECTS ON HEALTH CARE REGULATION

Just as a policy of preserving trust-as-faith in medicine may erode a self-protective attitude among health care consumers and thereby undermine the ability of consumers to protect themselves in the medical marketplace, so too might such a policy hamstring the ability of regulators to protect consumers. As explained below, a goal of preserving trust-as-faith in medicine will have a substantial effect on the style of health care regulation. Regulations designed to preserve trust-as-faith must be primarily procedural and largely deferential to the substantive standards of health care industry insiders. Such a deferential regulatory regime is unlikely to exert the kind of control over the medical marketplace as is commonly associated with consumer protection laws. Stated differently, laws designed to protect consumers from abuses within the health care industry would employ a controlling style of regulation, which would erode trust-as-faith in medicine and thereby conflict with a policy of preserving such trust.²⁰⁸ Thus, preserving trust-as-faith in medicine necessarily takes tools away from lawmakers—namely, the regulatory tools most appropriate for protecting health care consumers. We should be skeptical that preserving trust-as-faith in medicine is worth such a price given that free market principles are increasingly relied upon to organize modern health care delivery.

A. *Trust-as-Faith and Deferential Regulation*

Faith in medicine requires a feeling of optimism among consumers that health care professionals, institutions, and systems are both competent and dedicated to the faithful service of consumers' medical interests.²⁰⁹ If it becomes policy to promote such faith, then regulators must act in ways that are consistent with the

207. See *infra* Part V.

208. See Hall, *Arrow on Trust*, *supra* note 1, at 1141 (stating that detailed regulation can “crowd-out” intrinsically motivated behavior that promotes trust).

209. For a definition of medical trust as optimism, see Hall, *Law, Medicine, and Trust*, *supra* note 3, at 474 (“the optimistic acceptance of a vulnerable situation in which the trustor believes the trustee will care for the trustor’s interests”), and at 494 (“Strong trust [of medicine] entails an optimistic view of physicians’ benevolent motivation, which allows patients to view poor performance in the most positive light, as unintended or unavoidable isolated events that do not undermine patients’ fundamental assumptions about their physician’s intentions and abilities.”). For a description of medical trust as involving trust in both the technical skills and the caring motivation of professionals and institutions, see Hall et al., *Trust: What Is It?*, *supra* note 18, at 620-24; Mechanic, *supra* note 8, at 663-64.

message that health care professionals, institutions, and systems are worthy of such faith.

The need for health care regulators to stay "on message" derives from the law's expressive function.²¹⁰ The law articulates public policy messages,²¹¹ announcing that a social consensus exists to endorse or condemn various behaviors. Moreover, its messages affect public perceptions and conduct.²¹² Consider, for example, findings from an observational study of income tax compliance.²¹³ Data from Minnesota reveals that, when regulators announced their intent to audit a larger proportion of taxpayers and increase the penalties for evasion, the incidence of tax evasion rose.²¹⁴ Meanwhile, when regulators announced that the voluntary compliance rate was high, compliance increased still more.²¹⁵ Thus, taxpayers appear to interpret the law as a signal of the trustworthiness of their fellow taxpayers to voluntarily pay their fair share of tax. Laws increasing audits and penalties signaled that the public cannot be trusted to pay their taxes voluntarily. Taxpayers reciprocated by mimicking the degree of evasive behavior they perceived was being practiced by others, and evasion increased as a result.²¹⁶ This demonstrates a fundamental principle of how law

210. The expressive function of law is a concept that has arisen from scholarship on the relationship between law and norms, which teaches that the law regulates behavior in part by affecting social norms that also steer behavior. For a concise overview of the law and norms movement and its literature, see Richard H. McAdams, *The Origin, Development, and Regulation of Norms*, 96 MICH. L. REV. 338, 343-50 (1997); see also Symposium, *Law and Society & Law and Economics: Common Ground, Irreconcilable Differences, New Directions*, 1997 WIS. L. REV. 375 (1997); Symposium, *Law, Economics & Norms*, 144 U. PA. L. REV. 1643 (1996); Symposium, *The Legal Construction of Norms*, 86 VA. L. REV. 1577 (2000); Symposium, *Social Norms, Social Meaning, and the Economic Analysis of Law*, 27 J. LEGAL STUD. 553 (1998). For an application of law and norms theory to the goal of promoting trust relationships, see Symposium, *Trust Relationships*, 81 B.U. L. REV. 321 (2001). For an explanation of the expressive function of law and its relationship to the law and norms movement, see generally Cass R. Sunstein, *On the Expressive Function of Law*, 144 U. PA. L. REV. 2021 (1996).

211. See McAdams, *supra* note 210, at 398 (stating that "law can strengthen esteem norms by expressing them and, further, that norms help to explain how the 'expressive' function of law works"); Sunstein, *supra* note 210, at 2024-25 (characterizing the expressive function of law as concerning "how legal 'statements' might be designed to change social norms.") (citation omitted).

212. For an explanation of how law affects behavior through norms, see McAdams, *supra* note 210, at 400-08 (explaining how law announces or clarifies social norms, which then motivates individuals to either comply with those norms or suffer a loss of social esteem).

213. Dan Kahan, *Trust, Collective Action, and Law*, 81 B.U. L. REV. 333, 342 (2001) (citing STEPHEN COLEMAN, MINNESOTA DEPARTMENT OF REVENUE, THE MINNESOTA INCOME TAX COMPLIANCE EXPERIMENT: STATE TAX RESULTS 5-6 (1996)).

214. See *id.* at 342-43.

215. See *id.*

216. See Gatter, *supra* note 10, at 364 ("When the law signals that others

affects behavior: “[A]ctors observe and interpret evidence about the motives of others and then reciprocate. The law is one piece of evidence about the motives of others.”²¹⁷

Given the law’s expressive power, it is necessary for lawmakers to account for the message expressed by proposed health care regulations. If we want health care consumers to maintain a belief that health care professionals, institutions, and systems are, by nature and without threats of punishment, dedicated to competent and faithful service of consumers’ medical interests, then health laws must consistently echo this belief. As explained next, this generally requires lawmakers to rely on industry self-regulation to police health care delivery.

There are a variety of mechanisms for regulating health care delivery to assure that expectations for access, quality, and cost are met.^{218,219} For example, lawmakers can choose *not* to regulate health

are complying and thus that there is a consensus in support of paying one’s taxes, the norm is reinforced and compliance increases. In contrast, an increase in penalties and audits signals that there may not be a consensus about paying one’s taxes, and, as a result, the norm weakens and tax evasion increases.”)

217. Gatter, *supra* note 10, at 389 (citation omitted); see also Kahan, *supra* note 213 (providing theoretical and empirical support for the claim that individuals tend to observe the behavior of others and then reciprocate).

218. The literature on health care regulation is rich and growing richer. For analyses of regulating health care quality, see generally BRENNAN & BERWICK, *supra* note 182, and Timothy Stoltzfus Jost, *The Necessary and Proper Role of Regulation to Assure the Quality of Health Care*, 25 HOUS. L. REV. 525 (1988). For analyses contrasting free market and regulatory organizations of health care delivery, see David A. Hyman, *Consumer Protection in a Managed Care World: Should Consumers Call 911?*, 43 VILL. L. REV. 409, 453-57, 466 (1998); David A. Hyman, *Regulating Managed Care: What’s Wrong With a Patient Bill of Rights*, 73 S. CAL. L. REV. 221, 233-37 (2000). For an analysis of the role of professional norms in checking the profit-maximizing incentive of the free market, see generally Gail B. Agrawal, *Resuscitating Professionalism: Self-Regulation in the Medical Marketplace*, 66 MO. L. REV. 341 (2001) (arguing that professional self-regulation is a form of regulation apart from the market); Bloche, *supra* note 1 (identifying a market for professional norms that arises from the economics of health care delivery). For an explanation of industry self-regulation as a form of regulation, see Peter D. Jacobson, *Regulating Health Care: From Self-Regulation to Self-Regulation?*, 26 J. HEALTH POL., POLY & L. 1165, 1174 (2001) (recognizing institutional accreditation as a form of industry self-regulation apart from professional self-regulation). For an analysis of various forms of legal regulation, including legal endorsement of professional and industry standards as well as command and control style regulation, see *id.* at 1170-71 (covering a wide range of regulatory styles); Timothy Stoltzfus Jost, *Oversight of the Quality of Medical Care: Regulation, Management, or the Market?*, 37 ARIZ. L. REV. 825, 858-68 (1995) [hereinafter Jost, *Oversight of Quality*] (identifying a combination of health care quality regulations necessary to correct failures of the market).

219. Commonly, observers suggest that these mechanisms can be located relative to each other along a regulatory continuum. See James F. Blumstein, *The Legal Liability Regime: How Well Is It Doing In Assuring Quality, Accounting for Costs, and Coping With an Evolving Reality in The Health Care Marketplace?*, 11 ANNALS HEALTH L. 125, 125-26 (2002) (arguing that the

care delivery, relying instead on professionals and institutions operating in a free market to create and enforce standards of conduct. These might include codes of medical ethics, clinical guidelines, and standards for professional and institutional accreditation.²²⁰

Alternatively, the law may take a more active stance by creating public mechanisms for overseeing health care delivery, while still deferring to health care professionals and institutions to set standards of conduct that will be enforced through these public mechanisms. Professor Peter D. Jacobson refers to this as a “public-private partnership” in health care regulation.²²¹ In effect, the law claims the field as one that is ripe for public regulatory control, and yet it leaves significant control over substantive standard-setting with the industry. For example, federal law has endorsed the private accreditation standards of the JCAHO by declaring that institutions with JCAHO accreditation necessarily satisfy conditions for participation in Medicare and Medicaid.²²² State medical boards offer another example. By creating and authorizing boards comprised primarily of physicians to set and enforce professional standards for licensed physicians, state law ratifies standards imposed on physicians by other physicians through a state-sanctioned process.²²³ Still other examples include state medical

relevant issue in assessing legal liability and health care quality is not whether to adopt either a professional or an economic model for medicine, but rather “to determine where along a continuum between the competing visions public policy (such as tort law) should be located”); Jacobi, *supra* note 70, at 49 (describing a spectrum of regulatory options with “command and control” regulation at one extreme and the free market at the other); Jacobson, *supra* note 218, at 1166-68, 1170-71 (claiming that a health care regulatory continuum exists running from market-facilitating through market-displacing regulations, and placing specific regulations along that continuum); *see also* Agrawal, *supra* note 218, at 343-44 (criticizing debates over health care regulation that have “degenerated into an ideological dichotomy between free market forces and command-and-control style government regulation” and arguing that professional self-regulation is a third option that mediates between the other two).

220. *See* BRENNAN & BERWICK, *supra* note 182, at 4, 28 (recognizing that market-created prescriptions, such as JCAHO accreditation standards, are a form of regulation); *see also* Bloche, *supra* note 1.

221. *See* Jacobson, *supra* note 218, at 1171; *see also* BRENNAN & BERWICK, *supra* note 182, at 22 (discussing “enforced self-regulation” as private regulatory standards that are publicly ratified); Agrawal, *supra* note 218, at 377-80 (recognizing that self-regulation in the form of code of medical ethics can take on the pedigree of law where law chooses to enforce professional standards as legal rules); Jacobi, *supra* note 70, at 66-70 (recognizing and favoring a trend away from total government control and toward market-enhancing regulation).

222. *See* Jacobson, *supra* note 218, at 1172.

223. *See* Agrawal, *supra* note 218, at 389 (recognizing state medical licensure boards as a legal mechanism for enforcing as law professional norms of behavior); Jost, *Oversight of Quality*, *supra* note 218, at 859-67 (explaining the fundamental importance of medical boards and arguing for an expansion of

malpractice law²²⁴ and the federal Health Care Quality Improvement Act ("HCQIA").²²⁵

Finally, the law may attempt to directly regulate health care delivery by imposing government-created standards on professionals and institutions. Such a style of regulation is often referred to as "command-and-control" regulation.²²⁶ Medicare fraud and abuse law is a modern example of such a style of regulation. To preserve Medicare and Medicaid funds and to protect the clinical objectivity of physicians from financial conflicts of interest, federal law prohibits anyone from offering, paying, soliciting, or receiving "[i]llegal remunerations" to or from another for services or other items paid for by Medicare or Medicaid.²²⁷ This general prohibition is offset by a series of highly detailed safe harbors that remove potentially illegal conduct from the reach of the prohibition.²²⁸ Federal nursing home regulations are another example. They set standards for every conceivable aspect of nursing home life. For

their role in policing medical quality).

224. Medical malpractice law generally does not set substantive standards for the quality of medical care, but rather enforces a broad standard of medical reasonableness and defers to the medical profession to define medically reasonable behavior in any particular case. *See, e.g.*, *Osborn v. Irwin Mem'l Blood Bank*, 7 Cal. Rptr. 2d 101, 121 (Cal. Ct. App. 1992) (noting application of rule to physicians and other professionals); *Doe v. Am. Red Cross Blood Servs.*, 377 S.E.2d 323, 326 (S.C. 1989) (noting application of this rule to professions furnishing skilled services for compensation); *see also* Philip G. Peters, Jr., *The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium*, 57 WASH. & LEE L. REV. 163, 164 (2000) (noting that jurisdictions are split as to whether the formal standard is one of complying with either reasonable medical practice or customary medical practice).

225. Federal law, through HCQIA, takes considerable control of the procedure by which hospital committees assess the quality of medical care provided by physicians practicing at the hospital. *See* 42 U.S.C. §§ 11101-11152 (2000). Despite the degree of procedural control, the statute does not attempt to specify applicable medical standards, and instead authorizes other physicians within the institution to determine what standards of care applied in a particular case and whether those standards were met. *See id.* § 11151. Likewise, courts concentrate on process and otherwise apply a highly deferential standard when reviewing a hospital's decision to suspend a physician's admitting privileges. *See, e.g.*, *Sokol v. Akron Gen. Med. Ctr.*, 173 F.3d 1026, 1030 (6th Cir. 1999) (stating that once it was determined that a hospital's peer review committee had provided a physician under review with adequate notice and an opportunity to present a defense, the court applies only an abuse of discretion standard when reviewing the hospital's decision to limit the physician's privileges to practice in the hospital).

226. *See, e.g.*, *Jacobi*, *supra* note 70, at 49; Marshall B. Kapp, *Quality of Care and Quality of Life in Nursing Facilities: What's Regulation Got To Do With It?*, 31 MCGEORGE L. REV. 707, 707-08 (2000) (describing modern nursing home regulation).

227. 42 U.S.C. § 1320a-7b (2000).

228. For example, safe harbor exceptions exist for investment interests, space and equipment rentals, personal services and management contracts, the sale of a medical practice, and discounts. 42 C.F.R. § 1001.952 (2003).

example, the law establishes standards for residents' nutritional intake based on body weight and protein levels.²²⁹ Additional regulations set standards relating to residents' "vision and hearing, pressure sores, urinary incontinence, range of motion, mental and psychological functioning, naso-gastric tubes, accidents" and more.²³⁰ Indeed, nursing homes are so tightly regulated as to cause at least two commentators to hypothesize that they are over-regulated to the point of diminishing quality of care.²³¹

When it comes to preserving or promoting trust-as-faith in medicine, these styles of regulations are *not* created equal. Some are likely to inspire such faith, and others are likely to erode it. For example, laws that defer to health care professionals and institutions to regulate themselves reinforce, by their example, a perception that those professionals and institutions can be relied upon to competently and faithfully serve the medical interests of consumers.²³² They express to the public that lawmakers trust the health care industry to set standards of conduct that will adequately protect the interests of health care consumers, which, in turn, signals to consumers that they may similarly trust the health care industry. In contrast, laws that override self-regulation suggest that health care professionals and institutions will not assure that the interests of consumers are competently and faithfully served, at least not without governmentally imposed standards of conduct.²³³ Such laws signal consumers to take a similarly skeptical view of the health care industry. As I have written elsewhere, "[a] command-and-control regulatory scheme signals that those subject to regulation cannot be trusted to act responsibly—why else would such heavy regulation be necessary?"²³⁴

Thus, a policy of preserving or promoting trust-as-faith in medicine would necessarily limit the degree of direct regulatory

229. See Alan Meisel, *Barriers to Forgoing Nutrition and Hydration in Nursing Homes*, 21 AM. J.L. & MED. 335, 346 (1995) (citing 42 C.F.R. § 483.25(i)-(j) (1994)).

230. Alexander D. Eremia, *When Self-Regulation, Market Forces, and Private Legal Actions Fail: Appropriate Government Regulation and Oversight is Necessary to Ensure Minimum Standards of Quality in Long-Term Health Care*, 11 ANNALS HEALTH L. 93, 107 (2002) (citing 42 C.F.R. § 483.25 *et seq.*).

231. See Kapp, *supra* note 226, at 720; Meisel, *supra* note 229, at 334.

232. See *infra* notes 234-35 and accompanying text; see also Agrawal, *supra* note 218, at 397 (arguing that self-regulation is more likely than command-and-control regulation to encourage voluntary compliance with rules designed to achieve an appropriate balance between quality of care and cost containment in medicine); Gatter, *supra* note 10, at 384-91 (explaining that, to encourage trustworthy behavior among medical researchers and research institutions, the law must avoid command-and-control regulations that will undermine voluntary compliance with trust-preserving norms, and instead must err on the side of self-regulation).

233. See Agrawal, *supra* note 218, at 397; Gatter, *supra* note 10, at 384-91.

234. Gatter, *supra* note 10, at 389.

control that governments may take over the health care industry. In order to express that health care professionals and institutions are worthy of such trust, regulators must generally defer to the health care industry to set its own standards of conduct either by not regulating or by employing "public-private" regulation, whereby the law assigns government to oversee some aspect of self-regulation or it mandates processes by which the industry regulates itself or both. Similarly, the need for health law to express a message consistent with a policy of pursuing trust-as-faith would largely eliminate the use of command-and-control style regulations because they override the authority of health care professionals, institutions, and systems to regulate themselves.²³⁵

In this way, a policy of preserving or promoting trust-as-faith in medicine hamstringing efforts to protect health care consumers through the law. Consumer protection laws by their very nature attempt to displace market practices and thus take a significant degree of control over those practices by directly regulating them.²³⁶ Because such regulation would undermine faith in medicine, we should expect that a policy of preserving faith will, ironically, result in consumers being at greater risk of harm as they navigate the medical marketplace.²³⁷ This is, of course, all the more concerning

235. The use of even some public-private regulations could be limited in cases where the substantive rules are associated with the government's oversight mechanism, such as in the case of JCAHO accreditation standards. Consider the findings of Brennan and Berwick. As part of their analysis of the role of regulation in improving health care quality, they interviewed administrative and clinical managers at two regional hospital systems, one managed care organization, and eight hospitals about the influence of various forms of regulation on their efforts at quality improvement. See BRENNAN & BERWICK, *supra* note 182, at 297-309 (describing their method and the institutional subjects of their research). They found that interviewees routinely conceived of the private and detailed accreditation standards of JCAHO as regulations and complained that compliance simply tied up valuable human resources for no apparent benefit. See *id.* at 318-21.

236. See *supra* notes 153-61 and accompanying text; see also Gail B. Agrawal & Howard R. Veit, *Back to the Future: The Managed Care Revolution*, 65 LAW & CONTEMP. PROBS., Autumn 2002, at 11, 43-53 (arguing that market-displacing regulations are necessary to assure health care consumers of adequate information and choice); Eremia, *supra* note 230, at 104-06 (discounting the ability of self-regulation in medicine to adequately safeguard consumers, thereby implying that consumer protection in health care requires regulations that override professional and industry self-regulation); Jacobi, *supra* note 70, at 49 (claiming that the goal of assuring consumer safety is associated with a controlling style of health care regulation); Marshall B. Kapp, *Health Care in the Marketplace: Implications for Decisionally Impaired Consumers and Their Surrogates and Advocates*, 24 S. ILL. U. L.J. 1, 21 (1999) (distinguishing market-based and regulatory models of health care delivery and associating regulatory models with consumer protection).

237. While a policy of promoting trust-as-faith in medicine involves a regulatory strategy that tends to be market-facilitating, it does not require a pure market organization of health care delivery. In fact, a self-regulated

given the degree to which U.S. health policy has encouraged players in the health care industry to behave more competitively in the name of controlling medical costs.²³⁸

B. *Trust-as-Confidence and Regulatory Control of Health Care Delivery*

Unlike a policy of pursuing trust-as-faith in medicine, promoting trust-as-confidence does not require a regulatory strategy that primarily relies on the health care industry to police itself. Rather, it has a significantly higher tolerance for command-and-control regulation of health care. This is because trust-as-confidence is rationally based.²³⁹ Under this form of trust, one perceives another as trustworthy only when one has reason to believe that it is in the self-interest of that other person to serve one's own interests.²⁴⁰ It is, therefore, a more skeptical kind of trust when

health care industry is more likely than an unregulated one to promote trust-as-faith in medicine. *See supra* note 219 (citations in support of the claim that professional and industry self-regulation is a form of regulation that can be distinguished from pure market-organization). Consider, for example, the state of American medicine in the mid-to-late nineteenth century. *See STARR, supra* note 70, at 60-144. At that time, medicine was viewed as a commercial endeavor, and government mostly had withdrawn from its regulation. *See id.* at 61-64. As a result medical schools and their graduates grew in great numbers without much control over their quality, and fees were set purely on the basis of what the market would bear. *See id.* Competition among physicians was fierce. They so feared losing patients to competitors that medical consultations between physicians were rare. *See id.* at 80. Likewise, competition was fierce among various medical schools of thought. Disputes among these "sects" of medicine were rampant, and often carried out in public fora. *See id.* at 99-102. In such a competitive environment, where the failures of the market went largely unchecked by both public regulation and professional self-regulation, there was little if any faith in individual physicians and certainly not in medical professionals as a whole. Physicians found that their diagnoses and treatment plans were routinely challenged by those they sought to treat. One physician of the day wrote: "With some exceptions, the rank and file of the profession were—as far as general education went—little, if any, above the level of their *clientele*. And the *clientele* not only felt this, but knew it." *Id.* at 81 (citation omitted) (*italics in original*). Another concluded that "the good effects of mystery, hope, expectation and will-power are of late almost entirely lost to regular physicians; all special confidence is sapped . . ." *Id.* at 88. Thus, it is incorrect to depict the emerging medical trust movement as a veiled attempt to justify a purely market-based health care system. *See generally* Bloche, *supra* note 8; *see also* Hall, *Ideology and Trust, supra* note 196. More accurately, the emerging movement, in its present form, requires discreet regulation of medicine, but not complete de-regulation.

238. *See supra* notes 70-78 and accompanying text for a description of competitive trends in health care delivery.

239. *See supra* Part III.A.

240. *See* RUSSELL HARDIN, TRUST AND TRUSTWORTHINESS ch. 1 (2002) (conceiving of trust as an "encapsulated interest" where the trusting party trusts another because the trusting party believes the other has an incentive to serve the trusting party's interests) (*emphasis omitted*).

compared to trust-as-faith. Faith assumes the fidelity of the entrusted party absent evidence to the contrary, while confidence seeks assurance of fidelity as a prerequisite to trust.

As applied in the context of health care, this means that a policy of pursuing trust-as-confidence in medicine does not depend on bolstering pre-existing notions that health care professionals, institutions, and systems are inherently worthy of public trust. Accordingly, government can more freely and directly regulate health care delivery despite the fact that such regulation will send a message that health care industry insiders cannot adequately police themselves. In fact, such direct government regulation will likely promote trust-as-confidence because it can provide a reason for health care consumers to believe that health care professionals, institutions, and systems have a practical incentive to serve the medical interests of consumers. For example, imagine that the federal government enacts new regulations that prohibit research institutions from conducting human subjects experiments where there was evidence of any prohibited financial relationships involving the institution or its researchers, which were defined in significant detail by the regulations. Further, imagine that these regulations penalized institutions and researchers by making them ineligible for federal research funds for a period of time, and that they gave a private right of action to human subjects allegedly injured as a result of any violation of the regulations. While such a law would likely diminish trust-as-faith because of the control it takes from the health care industry, it would likely bolster trust-as-confidence because it would provide the public with a reason to believe that it is in the self-interest of institutions and researchers to safeguard human subjects from the risks of harm associated with financial conflicts of interest.

Although a policy of promoting trust-as-confidence has greater tolerance for command-and-control regulation, that tolerance is nonetheless limited. There is a point at which confidence in medicine is undermined by the government's taking additional control over health care through regulation. Just as confidence may require assurance that health care professionals, institutions, and systems have an incentive to serve the medical interests of consumers, it also depends on those professionals, institutions, and systems having sufficient regulatory room to meet the unique needs of each consumer. Professor Gail B. Agrawal articulated this idea in the context of physician self-regulation: "Formulating [command-and-control styled] rules for medical conduct is undesirable because they could obscure the need for physicians to respond creatively and flexibly to the particularized clinical and personal needs of individual patients."²⁴¹ Yet, the threat of over-regulation in health

241. Agrawal, *supra* note 218, at 397 (citation omitted).

care is not limited to clinical medicine. As the prescriptiveness of regulations increase, so does the risk that the targets of regulation—whether they are physicians, institutions, or health plans—make compliance with those regulations their primary task even at the expense of providing lower-quality service to consumers. For example, Professors Troyen A. Brennan and Donald M. Berwick, in their interviews with various health care managers, found that managers commonly complained that oversight by federal and state regulators and by private accreditation organizations undermined innovative quality improvement programs by redirecting limited resources from those programs to regulatory compliance programs, and by encouraging a “surveillance mentality” that squelched an institution’s willingness to take the risks necessary to make quality improvements.²⁴² Federal nursing home regulation provides another example. At least two commentators have concluded that the quality of care provided in nursing homes is diminished in part by the institutional drive to comply with onerous regulations.²⁴³ I have described such over-regulation in health care and its consequences as an example of *juridification*.²⁴⁴ Others label it as an example of *crowding out*.²⁴⁵ Both terms, however, refer to the circumstance in which “the task of regulatory compliance becomes so large as to overwhelm any effort to comply with the normative spirit underlying those regulations—like losing sight of the forest for all of the trees.”²⁴⁶

The greater tolerance for command-and-control regulation associated with a policy to promote trust-as-confidence in medicine means that such a policy will better enable lawmakers to protect

242. See BRENNAN & BERWICK, *supra* note 182, at 316-27.

243. See Kapp, *supra* note 226, at 720 (arguing that the administrative burden of compliance draws highly trained nursing home personnel away from providing care); Meisel, *supra* note 229, at 338-40 (asserting that nursing home residents have a more difficult time than hospital patients refusing feeding tubes because of a high degree of regulation and a prevailing attitude among nursing home personnel to avoid citations from inspectors for regulatory violations).

244. See Gatter, *supra* note 10, at 384-91. Juridification is a concept arising from Jürgen Habermas’s theories related to the sociology of law. See 2 JÜRGEN HABERMAS, *THE THEORY OF COMMUNICATIVE ACTION* 356-64 (Thomas McCarthy trans., Beacon Press 1987) (1981); Jürgen Habermas, *Law as Medium and Law as Institution*, in *DILEMMAS OF LAW IN THE WELFARE STATE* 203, 204 (Gunther Teubner ed., 1985); see also Gunther Teubner, *Juridification—Concepts, Aspects, Limits, Solutions*, in *JURIDIFICATION OF SOCIAL SPHERES: A COMPARATIVE ANALYSIS IN THE AREAS OF LABOR, CORPORATE, ANTITRUST AND SOCIAL WELFARE LAW* 3, 3-4 (Gunther Teubner ed., 1987).

245. See, e.g., Hall, *Arrow on Trust*, *supra* note 1, at 1141. The concept of crowding out, in comparison to juridification, has its roots in economic theory. See Bruno S. Frey, *A Constitution for Knaves Crowds Out Civic Virtues*, 107 *ECON. J.* 1043-53 (1997); Bruno S. Frey & Reto Jegen, *Motivation Crowding Theory*, 15 *J. ECON. SURV.* 589-607 (2001).

246. Gatter, *supra* note 10, at 387 (citation omitted).

health care consumers in the medical marketplace. Thus, a primary advantage of pursuing trust-as-confidence in medicine rather than trust-as-faith is that it does not rule out the use of more controlling and less deferential styles of regulation, which is the kind of regulation most likely to protect consumers in an increasingly market-driven system of health care delivery.²⁴⁷

Promoting confidence in medicine not only justifies the use of more controlling forms of regulation, it also de-legitimizes the use of the most deferential forms of health regulation that are nonetheless faith-promoting. For example, there is a point at which regulatory deference to the health care industry renders government oversight toothless and thus meaningless. Such regulation would undermine confidence despite preserving faith in medicine. Accordingly, an advantage of pursuing confidence in medicine rather than faith is *not* that it authorizes the use of all or even more regulatory tools in health care. Instead, it authorizes the use of more *relevant* regulatory tools. In particular, such a policy makes available to lawmakers some forms of relatively deferential regulation as well as moderately controlling government regulations. Thus, while free market principles have increasingly dominated health care delivery, a policy of promoting confidence in medicine brings with it regulatory tools that are capable of both supporting and offsetting that market as needed.

VI. CONCLUSION

The emerging medical trust movement is a reaction to the dominance of free market principles in the organization of health care delivery for the purpose of containing the cost of health care. Its central premise is that, because trust in medicine is clinically and economically valuable, health policy should be designed to presumptively preserve, if not enhance it. To its credit, the emerging movement has resulted in a new empirical and theoretical understanding of trust, its role in producing health, and its pervasive influence in health law. Yet, the conception of medical trust relied upon by the emerging movement is flawed. It describes trust in medicine as a primarily emotional phenomenon—a kind of faith—that is distinguishable from confidence, its more rational counterpart.

The significance of this flaw is great. As described above, if health policy were redesigned to pursue trust-as-faith in medicine, it would likely conflict with long-term efforts to encourage greater assertiveness among health care consumers as well as efforts to end racial inequality in medicine. Moreover, such a policy would limit strategies for regulating health care, favoring all forms of self-regulation and de-legitimizing direct governmental regulation that

247. See *supra* note 236 and accompanying text.

seizes control over health care delivery from industry insiders. This would make it more difficult for lawmakers to protect health care consumers from failures of our market-based health care system, which, ironically, would abandon consumers to the very medical marketplace of which the emerging medical trust movement is deeply suspicious.

Nonetheless, the emerging medical trust movement should not be dismissed. Its instinct that a positive perception of health care professionals, institutions, and systems is vital to health is correct. Thus, this Article proposes a different conception of trust, one based on a rational confidence in medicine, which is more consistent with the realities of our market-based health care delivery system. A policy pursuing rational confidence in medicine permits consumers to rely on the health care delivery system while still viewing it with a critical eye. Such an attitude among consumers will not conflict with the goal of encouraging assertive consumerism in health care, and it enables those who lack faith in medicine to develop a new form of trust in medicine. Finally, a policy of pursuing confidence better equips lawmakers to protect consumers in today's medical marketplace. In the end, by adopting this concept of trust in medicine, the emerging movement would be more responsive to those realities and much less likely to be perceived as reactionary.