

WELCOME, HEALING, AND ETHICS

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Although medical ethics has long shifted its focus from physicians' concerns toward those of patients,¹ prevailing "patient-centered" approaches are often criticized for focusing too much on patient choice and autonomy² and too little on the experience of caring and being cared for,³ on trust,⁴ on shared decision making and communication—that is, on relationships. David Schenck and Larry Churchill write in *Healers: Extraordinary Clinicians at Work* ("Healers") that "[h]ealing . . . always has to do with the quality of relationships."⁵ So too, they write, do the ethics that surround healing; ethics itself is a "healing art" that attends to relationships.⁶

But what is the nature of the relationships that we seek? How can relationships be fostered, and who bears responsibility for them? In the clinical setting, the onus of creating and maintaining good relationships with patients generally lies with the clinician. But it is not solely with the clinician. For if *relationships* are what we

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1. Lois Shepherd & Mark A. Hall, *Patient-Centered Health Law and Ethics*, 45 *WAKE FOREST L. REV.* 1429, 1431 (2010).

2. *Id.*; see also CARL E. SCHNEIDER, *THE PRACTICE OF AUTONOMY: PATIENTS, DOCTORS, AND MEDICAL DECISIONS* 3 (1998); Catriona Mackenzie, *Conceptions of Autonomy and Conceptions of the Body in Bioethics*, in *FEMINIST BIOETHICS: AT THE CENTER, ON THE MARGINS* 71, 72 (Jackie Leach Scully et al. eds., 2010).

3. VIRGINIA HELD, *THE ETHICS OF CARE: PERSONAL, POLITICAL, AND GLOBAL* 82–83 (2006). See generally *MEDICINE AND THE ETHICS OF CARE* (Diana Fritz Cates & Paul Lauritzen eds., 2001) (discussing care, justice, and the community).

4. Mark A. Hall, *Law, Medicine, and Trust*, 55 *STAN. L. REV.* 463, 472 (2002).

5. DAVID SCHENCK & LARRY R. CHURCHILL, *HEALERS: EXTRAORDINARY CLINICIANS AT WORK*, at xiii (2012).

6. *Id.* at xvii.

seek, then patients must also have responsibilities, and physicians must also be vulnerable.

In this Essay, we advance the claim that “welcome”—underappreciated and under-theorized—is a primary obligation of health care professionals.⁷ “In fact, we claim that it is *the* primary obligation.”⁸ Without the orientation of welcome, healing relationships cannot be formed and, as a result, patient care suffers.⁹ It is necessary to be welcoming in order to act responsibly—to identify the “fitting response,” as H. Richard Niebuhr famously described responsibility,¹⁰ to the person and situation in front of us. Without welcome, clinicians cannot see, understand, and appreciate the needs and desires of their patients, or anticipate how their actions could be perceived by patients as disrespectful, harmful, or unjust. Without an orientation of welcome, clinicians are not prepared and willing to stay with and learn from the patient who arrives late, just moments before the clinic is scheduled to close, or the emergency department patient who seeks narcotics in a wake of broken “narcotics contracts,” or the dialysis patient who curses staff and pulls out her own dialysis needle. Welcome calls on clinicians to appreciate each patient as a unique human being, rather than as a generic instance of a type of human being, as in “people like that.” For there to be true welcome, the presence of this particular individual—with his or her stories, past, habits, and beliefs—is wanted, whether he or she comes in with ebola, as a prisoner, as a person chronically ill through personal neglect, or as an abusive spouse or parent. Although the clinician need not welcome or tolerate all the behaviors of the patient, the patient herself is invited. At the first point of contact and every point following, it matters whether clinicians’ responses to patients are grounded in a welcoming orientation—a willing receptiveness to this person and his or her particular experiences that led to the decision to seek medical care.

But in addition to calling attention to a *professional obligation*, we advance an understanding of welcome as an obligation of *all people*, owed by each to each and all to all—meaning that welcome is owed by “housekeepers, security guards, administrators designing and implementing systems for patient care, [and] even patients,” and from each of them to the other.¹¹ The obligation of welcome

7. Margaret E. Mohrmann & Lois Shepherd, *Ready to Listen: Why Welcome Matters*, 43 J. PAIN & SYMPTOM MGMT. 646, 646 (2012).

8. *Id.* at 647.

9. *Id.*

10. H. RICHARD NIEBUHR, *THE RESPONSIBLE SELF: AN ESSAY IN CHRISTIAN MORAL PHILOSOPHY* 60–61, 65 (paperback ed. 1978) (1963).

11. Mohrmann & Shepherd, *supra* note 7, at 648.

applies to everyone's interactions with others, regardless of the reason for the encounter.

In this Essay, we push at the boundaries of our common understandings of welcome and the responsibilities of clinicians. First, we share a story related to us by a medical student that reveals why even a simple welcome sometimes appears difficult for clinicians. We then explore the limits of what may be expected in terms of welcome, particularly when the patient does not appear to welcome the physician. If the responsibility to welcome is mutual, does this mean that clinicians are excused when they encounter the unwelcoming patient? How hard do they really have to try? And at what cost to themselves? How vulnerable must they make themselves?

Finally, we will consider what welcome has to do with ethics; in the process, we will examine a classic bioethics legal case about the duties owed to a patient who is described in ways that make her appear unable to be welcomed.¹² We present the concept of *welcoming responsibility* as the essential prior orientation that not only allows healing relationships to form and thrive but also allows careful bioethical practice to succeed. Our project, like that of Schenck and Churchill in *Healers*¹³ and *What Patients Teach: The Everyday Ethics of Health Care*¹⁴ (with coauthor Joseph B. Fanning), focuses less on deliberation among alternative courses of action and tends to choose topics that are not considered classic ethical dilemmas. We aim instead to advance a preventive approach that we hope will allow people to act in ways that mean true ethical dilemmas—in the sense of “situations in which, on moral grounds, persons ought both to do and not to do something”¹⁵—are less likely to arise.

12. *Payton v. Weaver*, 182 Cal. Rptr. 225 (Ct. App. 1982); see *infra* Part V.

13. SCHENCK & CHURCHILL, *supra* note 5.

14. LARRY R. CHURCHILL, JOSEPH B. FANNING & DAVID SCHENCK, *WHAT PATIENTS TEACH: THE EVERYDAY ETHICS OF HEALTH CARE* (2013).

15. Annette Joy Braunack-Mayer, *What Makes a Problem an Ethical Problem? An Empirical Perspective on the Nature of Ethical Problems in General Practice*, 27 J. MED. ETHICS 98, 99 (2001); see also TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 11 (4th ed. 1994) (“Moral dilemmas occur in at least two forms. (1) Some evidence indicates that act *x* is morally right, and some evidence indicates that act *x* is morally wrong, but the evidence on both sides is inconclusive. . . . (2) An agent believes that, on moral grounds, he or she both ought and ought not to perform act *x*. In a moral dilemma with this form, an agent is obligated by one or more moral norms to do *x* and obligated by one or more moral norms to do *y*, but the agent is precluded in the circumstances from doing both. The reasons behind alternatives *x* and *y* are good and weighty, and neither set of reasons is obviously dominant.” (citation omitted)).

I. THE RETICENT CLINICIAN

Physicians, nurses, social workers, and therapists tend to think that they get to ask all the personal questions.¹⁶ And most of the time, they do.¹⁷ It is the patient who must undress, unveil, and reveal. But when clinicians think that they are the only ones who can ask the questions, they are not welcoming. And that can affect patient care.

Consider, for example, a story shared by a medical student who is now a resident physician.¹⁸ He wrote of his difficulty in getting a medical history from a geriatric patient in a nursing facility, as every question he asked seemed to be met with suspicion. When the student introduced himself, holding out his hand to shake the patient's, she refused it. She asked him how young he was, a question he evaded by saying, "Not too young, I promise." When he began asking questions about her health, she countered that he was asking too much about her bowel movements. "What's wrong with you?" she asked. The physical exam was met with similar resistance. Even the student's intentional effort to build some rapport by asking what she liked to do in her free time was rebuffed: "Why? What do you like to do in yours?" The medical student evaded answering again, saying that he did not have much free time. The patient squinted at him and remained silent. At that point, he gave in. He thought about the past weekend and said that he liked to go to the farmers' market.

This answer changed the course of their encounter. The patient followed up with the question, "Have you ever bought honey there?" When he replied, "Yes," she said, "Good."¹⁹ He thought to ask why, but then, he writes, "I decided to stay quiet instead. It might have been the only correct cue I picked up on in that entire conversation." She began to talk about her honey farming. She spoke at length and passionately about how honey achieves its taste, how long it matures, and how she became a self-taught honey farmer fifteen years earlier, after her husband had died. The medical student was

16. See generally Peter R. Lichstein, *The Medical Interview*, in CLINICAL METHODS: THE HISTORY, PHYSICAL, AND LABORATORY EXAMINATIONS 29 (H. Kenneth Walker et al., eds., 3d ed. 1990) (explaining how clinicians should conduct interviews and directing the clinicians to ask the patients questions in order to recommend a course of treatment).

17. See Amir Khan, *10 Questions Doctors Wish Their Patients Would Ask*, U.S. NEWS & WORLD REP.: HEALTH (Sept. 25, 2014, 11:23 AM), <http://health.usnews.com/health-news/patient-advice/slideshows/10-questions-doctors-wish-their-patients-would-ask/1> (offering several questions that doctors wish their patients would ask and suggesting that patients typically are not engaged in asking questions during a doctor visit).

18. This story is shared with the permission of Andrew Wang, M.D., a 2013 graduate of the University of Virginia School of Medicine.

19. *Id.*

finally allowed to enter her world—not just the world of honey bees and community college classes taken in her seventies, but her world of symptoms and signs—only when he let her enter his through his weekend trip to the farmers' market.

This medical student was able to do a better job at providing care—gathering the patient history and performing the physical exam—by allowing himself to be known, even only minimally, and to be vulnerable by being known.

There are limits, to be sure. One of us, as a new mother, had an encounter with a lactation specialist in the hospital that went too far by any standard. Upon learning that her patient was a law professor, the specialist asked about a currently enrolled law student who, she explained bitterly and in detail (while alternately trying to explain how newborns latch on to the breast), had recently had an affair with her husband and broken up her marriage. On another occasion, a surgeon spent twenty minutes explaining his views of medical malpractice reform (he was in favor of it). A clinician cannot forget why he or she is talking to the patient in the first place. But the boundaries may not be as restrictive as some professionals might imagine. Some clinicians—perhaps you have encountered them—seem to have trouble even sharing their names. The medical student speaking with the former honey farmer knew to avoid that misstep—that much is taught in medical schools—but was hesitant to tell his age and his hobbies. Then he opened up a little and, as Thomas Ogletree explains, her world opened up to him. Ogletree offers that the equal dignity that “the stranger and I enjoy[,] . . . emerges concretely only as our interactions unfold over time.”²⁰

Another example of the power of simple but vulnerable welcome can be found in a story published several years ago by an overworked, fatigued resident who described her feelings of impatience and dismissiveness as she approached the emergency room bed of an eighty-six-year-old, frail man.²¹ She was dreading the middle-of-the-night encounter with one more needy patient.²² She wrote, “I had Mr. B categorized in a split second: He is going to be from a nursing home. He is going to be demented. He will not be able to give me a history.”²³ Instead, she learned, he still lived with his wife, took daily walks, and could answer all of her medical history questions, if “painfully slowly and hesitantly.”²⁴ Then,

20. THOMAS W. OGLETREE, *HOSPITALITY TO THE STRANGER: DIMENSIONS OF MORAL UNDERSTANDING* 3–4 (Westminster John Knox Press 2003) (1985).

21. Lucie Opatrny, *The Healing Touch*, 137 *ANNALS INTERNAL MED.* 1003, 1003 (2002).

22. *Id.*

23. *Id.*

24. *Id.*

before touching the patient, she warned him that her hands were cold and rubbed her hands together briefly so that her touch would be more comfortable.²⁵ Unexpectedly, the man took her hands into his and warmed them.²⁶ He was able to give rather than simply to receive care—he was the one with the “healing touch”²⁷—and, most importantly, she accepted the gift.²⁸ That may have been the deepest welcome she could offer him in that moment: to let the patient know she was tired and could use comfort, to let herself be vulnerable and receive care from a person who probably had few opportunities to provide it anymore.

It can actually be more challenging for us to invite someone into our world than for us to enter theirs. Exposure to literature and the arts prepares us for the latter. As Martha Nussbaum wrote in *Poetic Justice: The Literary Imagination and Public Life*, we practice and gain understanding of actual people when we read literature and allow ourselves to cheer or cry for imaginary characters or “suffer with” them (the literal meaning of the word “compassion”²⁹).³⁰ Successful literary works “requir[e] us to see and to respond to many things that may be difficult to confront . . .”³¹ The recent National Book Award novel *Salvage the Bones* does this with power and grace.³² The author, Jesmyn Ward, brings the reader into a poor Mississippi backwater world in which pit bull fighting is a matter of pride, honor, and loyalty—to the dogs as well as to the people for whom they fight.³³ Against all expectations, a reader who would not have allowed a word of defense for Michael Vick (the NFL player who served time for mistreating fighting

25. *Id.*

26. *Id.*

27. *Id.*

28. *Id.*

29. THE OXFORD ENGLISH DICTIONARY 597 (2d ed. 1989); see also Lawrence Blum, *Compassion*, in THE VIRTUES: CONTEMPORARY ESSAYS ON MORAL CHARACTER 229, 230 (Robert B. Kruschwitz & Robert C. Roberts eds., 1987). Martha Nussbaum tells us that “compassion, in the philosophical tradition, is a central bridge between the individual and the community,” and that as such, we should “understand better how to produce it and how to remove obstacles to it.” Martha Nussbaum, *Compassion: The Basic Social Emotion*, 13 SOC. PHIL. & POL’Y 27, 28 (1996). She advocates a civic, public education in compassion, largely through the study of the humanities and the arts, as a way to train individuals to imagine the pain and experiences of others and to “cross boundaries of class, nationality, race, and gender.” *Id.* at 50–51.

30. See MARTHA C. NUSSBAUM, POETIC JUSTICE: THE LITERARY IMAGINATION AND PUBLIC LIFE 5 (1995) (discussing how literature “summons powerful emotions”).

31. *Id.* at 6.

32. JESMYN WARD, SALVAGE THE BONES (2011).

33. *Id.* at 1–2, 4.

dogs)³⁴ could well find herself with sympathy for Skeetah, the teenage boy who trained and fought a dog he loved in order to defend his sister's honor and pay for his brother's basketball camp.³⁵ Entering the world of the characters created in the book allows the reader to respond differently and with better understanding when he or she meets people with similar experiences.

But we do not have as ready a way to learn how to let people into our own worlds. Patients hesitate to do so, such as when they might be reluctant to open up about their sexual history or reveal symptoms of depression or incidents of domestic violence. But clinicians have even higher impediments to sharing anything of their worlds, given that much of professional education seems to teach them to do just the opposite—to place walls or space between them and patients with the idea that doing so will keep the focus on the patient, will make the patient the priority.³⁶ But walling oneself off completely means that actual relationships cannot be formed.

II. THE UNWELCOMING PATIENT

Sometimes a clinician's commitment to being open enough to be welcoming can be challenged—not simply by professional boundaries or habits, but also by signs that the patient does not welcome the clinician.

Take, for example, Ms. Little, whose story was related by medical students, with details now modified for purposes of confidentiality. Ms. Little, an elderly, white patient of a university medical clinic, had for several years been seen by one of the clinic's attending physicians, a white woman, and the nurse practitioner who worked with her, also a white woman. Ms. Little was especially close to and trusted the nurse practitioner, whom she saw frequently, much more frequently than the doctor. But that doctor had retired, and the new doctor who came to see her, Dr. Wilson, accompanied by three or four medical students, was black, a fact Ms. Little pointed out to the doctor herself. "You're black," she said, following the doctor's introduction. Dr. Wilson did not ignore the comment. Instead, she responded, "Yes," she was "as black as black could be," and moved quickly to asking about the pain the patient

34. Juliet Macur, *Vick Receives 23 Months and a Lecture*, N.Y. TIMES, Dec. 11, 2007, at D1; Tessa Stuart, *Reminder: Michael Vick's Dogs Were Shot, Electrocuted, Hanged and Beaten to Death*, VILLAGE VOICE BLOGS (Mar. 25, 2014, 5:00 AM), http://blogs.villagevoice.com/runninscared/2014/03/michael_vick_new_york_jets.php.

35. WARD, *supra* note 32, at 2, 148, 151, 157, 172.

36. Glen O. Gabbard & Carol Nadelson, *Professional Boundaries in the Physician-Patient Relationship*, 273 JAMA 1445, 1448 (1995); James E. Sabin, *Is Physician Self-Disclosure Ever Appropriate?*, 13 AM. MED. ASS'N J. ETHICS 852, 855 (2011).

was experiencing. During the exam, Ms. Little made no further comment about the doctor, but as Dr. Wilson was finishing up by writing a prescription for pain medication, Ms. Little asked whether she could choose her own doctor in the clinic's practice. Dr. Wilson explained that she could, but that she was the only doctor who worked with the nurse practitioner Ms. Little liked so much. Although Ms. Little could have another doctor (and Dr. Wilson would be happy to refer her to one), she would no longer be able to receive her care from the nurse practitioner. But if that was what she wanted, Dr. Wilson said, she would make the referral that afternoon. Ms. Little said that was what she wanted and so the referral was made immediately upon leaving the examining room.

Recounting this experience later, the medical students reported their shock and dismay that such blatant prejudice still existed. They expressed admiration for how Dr. Wilson treated Ms. Little with respect notwithstanding her attitude toward the doctor. Indeed, they admired Dr. Wilson for treating her at all. Some of them questioned whether if in her shoes they would have been tempted to ignore the patient's report of pain and fail to prescribe medication for it. The students' reaction was so powerful that they appeared willing, at least in theory, either to abandon the patient mid-appointment or to intentionally provide her with poor care—both clear violations of basic professional norms.³⁷

Their perspective seemed to be that of justice. Ms. Little had treated Dr. Wilson unfairly and unequally on account of race, and Dr. Wilson would have been justified in walking out of the room and refusing to treat her at all. If we understand justice to be what is deserved, then that is what they believed Ms. Little deserved. Anything Dr. Wilson did above and beyond that was to be praised as gracious, generous, and charitable.

We are much less sanguine about Dr. Wilson's reaction. Justice is an exceedingly narrow lens through which to view human relationships. It is an especially problematic lens through which to view medical care encounters, in which "what is deserved" is rarely what patients seek to receive or what clinicians strive to provide. It is difficult to know what justice might even look like when patients can find themselves so abjectly dependent on others. "Can I choose

37. LUDWIG EDELSTEIN, *THE HIPPOCRATIC OATH: TEXT, TRANSLATION AND INTERPRETATION* 3 (Henry E. Sigerist ed., 1943) (stating that the physician "will keep [the patient] from harm"—i.e., will not intentionally provide poor care); *Principles of Medical Ethics*, AM. MED. ASS'N, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page> (last visited Mar. 18, 2015); Trisha Torrey, *Can My Doctor Fire or Dismiss Me as a Patient?*, ABOUT HEALTH (Dec. 10, 2014), <http://patients.about.com/od/doctorsandproviders/ff/Can-My-Doctor-Dismiss-Me-As-A-Patient.htm> ("Doctors may not dismiss a patient in the midst of ongoing medical care.").

my own doctor?" Ms. Little asks, because she actually does not know and likely suspects she may not be able to.

Certainly we should expect Ms. Little to do better. As we mentioned above, when we talk about a responsibility to welcome in medical encounters, that responsibility is not limited to health care providers. As a universal obligation, welcome is also owed by patients. Patients have an obligation to welcome their caregivers without regard to their race, religion, and so on. In fact, if we were to construct a list of patient rights and responsibilities, we would consider copying the following statement from a common list of *patient rights*: "You have the right to receive treatment in a safe, abuse-free environment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation, or source of payment"³⁸—and placing it, with modification, on the list of *patient responsibilities*: You have the responsibility to accept quality medical care services without regard to the race, color, religion, sex, national origin, disability, or sexual orientation of the health care provider from whom it is offered. If we look only to Dr. Wilson for welcoming actions and if we expect a welcoming attitude only of the physician and not of her patient, we in effect place Dr. Wilson in a privileged position. We see her as being "at home," in power, and with the most to offer.

But even though Ms. Little had a responsibility to welcome Dr. Wilson, the reality was that she was having a very tough time doing so. Her first reaction to Dr. Wilson was telling. It was simply a statement of fact: you are black. It suggests that she could not, at that moment, really process anything beyond observation of that apparently unexpected fact. She does not say anything negative about black people or black doctors. We infer from her later request to change doctors that she is prejudiced, and the inference seems reasonable. But were her prejudgments about Dr. Wilson subject to

38. This list of patient rights appeared on patient education posters in the University of Virginia Health System in 2009. See, e.g., *Patient Bill of Rights and Responsibilities*, PIEDMONT PREFERRED WOMEN'S HEALTHCARE ASSOCS., http://mypiedmontobgyn.com/forms/PATIENT_BILL_OF_RIGHTS_AND_RESPONSIBILITIES.pdf (last visited Mar. 25, 2015). Similar lists of patient rights, which are updated from time to time, can be found on many hospitals' websites. See, e.g., *New York State Patient's Bill of Rights*, MOUNT SINAI HEALTH SYS., https://www.wehealny.org/services/BI_PatientRep/PatientBOR.pdf (last visited Apr. 8, 2015) (providing the right to "[r]eceive treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation[,] or source of payment"); *Patient Rights*, CARILION CLINIC, <https://www.carilionclinic.org/patient-rights> (last visited Mar. 27, 2015) ("You have the right to receive treatment in a safe, abuse-free environment without discrimination as to age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, gender identity or expression, or source of payment.").

change? We do not know because of the reaction her remark generated from Dr. Wilson.

Although the medical students recounting this story praised Dr. Wilson for the respect she showed Ms. Little, true respect would have understood Ms. Little as also having a responsibility to welcome—and would have expected that of her. More than respect, though, what is owed to Ms. Little is a manifestation of desire to be in a relationship with her, a relationship in which she may be understood. And when that is what we seek, it means that sometimes we have to help others to welcome us, that doing so is in fact a responsibility so that a relationship might be achieved.

We should ask: What might have been the outcome if Dr. Wilson had reacted less hastily; if, instead of informing Ms. Little of her rights (yes, you can choose another doctor if you wish) and quickly honoring them (making the referral that very afternoon), she had explored Ms. Little's hesitation about having a black person as her doctor? At the outset, instead of *reacting* with the statement that she was "black as black could be," which only pushed back Ms. Little's comment, Dr. Wilson could have stopped and actually *responded* to Ms. Little. She might have asked, "Am I the first black physician you've ever seen?" or remarked, "You seem surprised. Tell me more about that." Given Ms. Little's own startled reaction to Dr. Wilson's presence, it may have been that simply by giving her some time, a relationship between the two might have been established. Conversation and a real attempt at understanding might have allowed Dr. Wilson (and even Ms. Little) to discover the causes of Ms. Little's reaction—perhaps in her upbringing in the segregated South in the first half of the twentieth century; in her past experiences with white and black caregivers; or in her ignorance of the fact that black and white doctors today receive the same education, undergo the same licensing, and so on. Indeed, when evaluating Ms. Little's request to change doctors, we have assumed that it was based on her hostility to Dr. Wilson on account of her race. But the only statement we have from Ms. Little about race is a statement of fact and one uttered, it would appear, in surprise. Could it be, we have to wonder, that it was not Dr. Wilson's race that ultimately prompted Ms. Little to change doctors but Dr. Wilson's abrupt reaction to Ms. Little's first, thoughtless comment?

Let us not forget what Ms. Little lost in this encounter. She lost the connection to the now-retired physician she had long trusted, and she also lost the care of the nurse practitioner with whom she had built a close relationship over the years. For any patient, perhaps particularly an elderly patient, such losses are heavy and consequential.

Yet, this is not about blame. We do not blame Dr. Wilson for her reaction, for her failure to help Ms. Little to welcome her as her new doctor. It is entirely understandable. She may well have felt an upsurge of anger, the memory of past humiliations, and an

immediate defensive reaction against the threat of being put, yet again, in a position of assumed inadequacy based solely on her skin color. This discouraging inner turmoil—perhaps made worse by the presence of observing medical students—may have been a distressingly familiar sensation for her, the recurring consequence of being a member of a racial minority in a prejudiced society. She may have promised herself in the past that, although she could not avoid the burden of being sometimes seen as “other” and often as an “inferior other,” she could refuse to invite further humiliation by entering a conversation about race with someone she could not trust. Better to just get the work done and get out.

We are asking a lot of Dr. Wilson. In suggesting that she engage in a conversation about race with Ms. Little, we are asking her to be prepared to hear whatever Ms. Little has to say. And while we have presented a counterfactual scenario, in which all ends well through that discussion, Ms. Little might well have believed and said some awful things. Welcome is costly. Can the price be too high?

III. THE “UNWELCOMABLE” PATIENT

We think in some instances it can be. In his poem “Case History,” physician-poet Dannie Abse makes strikingly clear that the demanding professional obligation to welcome each patient may at times carry a significant cost.³⁹

The poem tells of a physician listening to his patient complain that Welshmen are an “inferior breed” and praise “the architects of the German death-camps.”⁴⁰ The physician in the poem notes the prejudicial remarks, but they do not seem to be aimed at him specifically, and he does not respond to them aloud.⁴¹ He does not inform the patient that he is Welsh and Jewish; he does not challenge the patient’s bigotry.⁴² Although the physician’s angry internal response is clear—he envisions the patient as an avatar of Nazism and contemplates poison—his behavior remains professional, even fraternal.⁴³ Only in the relaxation of sleep does he experience the cost: he writes, “Later that night I must have slept on my arm: momentarily my right hand lost its cunning.”⁴⁴ These words echo the words of Psalm 137—“If I forget thee, O Jerusalem, *let my right hand forget her cunning*”—to articulate the price for

39. Dannie Abse, *Case History*, in *ON DOCTORING: STORIES, POEMS, ESSAYS* 222, 222–23 (Richard Reynolds & John Stone eds., 1995).

40. *Id.*

41. *Id.* at 223.

42. *Id.*

43. *Id.*

44. *Id.*

betraying loyalties so deeply held as to be inseparable from self.⁴⁵ In remaining true to his perceived professional obligations, the physician feels that he has betrayed his identifying allegiances and thereby has betrayed himself.⁴⁶

Is this what welcome asks of physicians and nurses and therapists? No, betrayal of self is *not* one of the requirements of welcome. But a welcoming orientation does ask that the clinician cultivate a clear-eyed awareness of what is at stake and be willing to take some risks.⁴⁷

It is instructive to compare the ways in which Abse's fictional physician (who may or may not be a stand-in for Dr. Abse himself) and Dr. Wilson reacted to their patients and the price each paid or refused to pay, and then to consider what a welcoming orientation might propose instead.

Both physicians remained outwardly professional and efficient. By not responding directly to his patient's explicit and repellent prejudices, Abse's physician sought to uphold some of his *vocational obligations*, but at the cost of betraying *himself*. Dr. Wilson, by making a quick referral to another physician rather than responding to what was not yet, but may have proven to be, a similarly vicious level of intolerance, sought to be true to *herself*, but at the cost of betraying some of her *vocational obligations*. Each physician refused to pay the price that they had good reason to think would be asked of them if they were to respond directly to their patients' challenges.

Is there an alternative, a way to honor both self and vocation without incurring unbearable costs? Obligations to welcome include the responsibility *to be prepared* for the possibility of disturbing patient interactions that challenge one's personal attributes and allegiances.⁴⁸ The practice of welcoming all patients entails, in principle, being open not only to hearing such difficult sentiments but also to responding to them with questions and comments that invite patients to be more welcoming in turn.⁴⁹ What might have happened if the physician in Abse's poem had responded to his patient's bigotry with self-disclosure and a question: "I am both

45. *Psalms* 137:5 (emphasis added).

46. Abse, *supra* note 39.

47. See ADRIAAN PEPPERZAK, *TO THE OTHER: AN INTRODUCTION TO THE PHILOSOPHY OF EMMANUEL LEVINAS* 19–20 (1993) (describing, according to the philosophy of Emmanuel Levinas, the vulnerability created by engagement with the other); Mohrmann & Shepherd, *supra* note 7, at 648 ("[Welcome] signifies an orientation toward the other that involves an utter and complete willingness to let another person—who may be, and in the context of medical care is, a stranger—into our consciousness, our gaze, our care, our lives, even if only temporarily.").

48. Mohrmann & Shepherd, *supra* note 7, at 648.

49. *Id.* at 648–49.

Welsh and Jewish. I strongly disagree with and abhor what you say. Is it possible for us to come to some understanding of each other that would allow me to continue as your physician?" Perhaps the patient would have stormed out of the office and taken himself to another physician. Or he may have unleashed even more venom directly towards the physician, who would then be correct to end the encounter immediately ("It is clear that we cannot work together. Do you wish me to give you names of other physicians in the area?"). If the situation were such that the patient was in need of immediate help and there was no other source of care available, the physician's initial reply would allow him to continue by setting the terms of their continued engagement: "I will treat you to the best of my ability, but I must insist that you stop saying such things." On the other hand, it is also possible that the physician's directness could deflate the patient's bluster and result in, if not an apology, at least the negotiation of a truce that would allow the visit to proceed. In any case, the physician could have remained true both to himself and to his professional obligations.

And what if Dr. Wilson had invited conversation following Ms. Little's blurting, "You're black!?" Ms. Little may indeed have revealed a settled animosity, or she may have said something even more vicious and rejecting, leading Dr. Wilson to rightly end the encounter. On the other hand, she may have admitted that this experience was new to her and that she would try to get used to it, or she may have even apologized and explained that she was finding herself lately blurting out whatever she is thinking.

Welcoming clinicians take risks: the risk of rejection, the risk of having someone's bile sprayed in their face, the risk of being explicitly weighed and found wanting—in sum, the risk of not being welcomed in return, sometimes vehemently and painfully so. The costs are *not* negligible, and in no way do we argue that Dr. Wilson, or any clinician similarly situated, should or must continue to be welcoming once it has become clear that the price will be too steep. Our purpose is not to judge health care professionals who are not willing, for perhaps very good reasons, to continue to welcome certain patients, but rather to explore ways of honoring commitments to self and one's loyalties as well as to one's chosen vocation under conditions of significant conflict. We believe that the potential benefits of this kind of risk taking, of continuing to welcome the apparently unwelcoming and perhaps unwelcomable, include not only the opportunity to forge a therapeutic relationship, formed in honesty and acceptance, but also the growth of both clinician and patient as they learn to look beyond stereotype, ingrained prejudice, and reactive defenses to see the human beings behind those masks.

We understand that there are limits to the obligation of welcome. If the encounter with the other person threatens physical or emotional security, then insisting on welcoming actions in these

situations can actually be irresponsible and can do more harm than good. In order to be a person who generally welcomes others, one must not permit oneself to lose one's senses of security and self. But, importantly, these limits apply to *individuals* and to *individual instances*. They do not admit categorical refusals to provide welcome to certain people or for all times, and they do not justify systematic or group practices that ignore the fundamental obligation of welcome. When the opportunity is right, when welcome can be offered without failure to attend to responsibilities to other persons or one's own personal security, then the obligation persists. On a particularly difficult night in the emergency department, there may be no time for proper recognition and welcome of a new patient when the medical team is desperately responding to the needs of a critically injured patient. Responsibility for one person may place limits on the degree to which another can be welcomed by those present at that moment and in that space. But it should always be a consideration; the possibility of extending welcome should never be automatically excluded. The new patient to the overwhelmed emergency room should be greeted as soon as feasible, and greeted well, and, as a matter of *institutional* obligation and practice, devices and settings that substitute for human warmth should be in place to permit as much of a welcome as possible until an individual can deliver it, such as clear signs directing someone as to what to do or where to go.

IV. WELCOME AND ETHICS

The question of welcome appears then not simply in the intimate encounter of clinician and patient. The orientation of welcome is also essential for ethical practices, systems, and policies and for deliberation about ethical dilemmas and disputes. In order to determine what a situation involves, what one must do, and how one can be prepared to see and do it, one needs a disposition that allows one to see and appreciate the uniqueness of the people involved in the situation and thus their particular concerns, desires, fears, and so on. This is necessary in order first, to recognize that a situation involves ethical considerations and second, to determine how one might best respond.⁵⁰ In other words, the first step towards acting ethically in a given situation or resolving any ethical dilemma is a *welcoming and responsible step towards* all of the people

50. Judith Andre, *Learning to See: Moral Growth During Medical Training*, 18 J. MED. ETHICS 148, 150 (1992) ("The professional with moral understanding sees the patient as a person. . . . Noticing another's subjectivity is a skill that can be learned."). According to Howard Brody, "Andre counters that a good deal of unethical behavior arises, not from poor reasoning, but rather from a perceptual problem, a moral blindness." HOWARD BRODY, *THE FUTURE OF BIOETHICS* 105 (2009).

involved in it. Our approach calls for the development of the disposition to be ready to take that step. As stated above, it calls on everybody—and not just clinicians—to develop that disposition. Everybody matters—not just as participants or “stakeholders” in the situation, but as *moral agents*. Therefore, everybody’s actions are subject to ethical examination—the physician *and* the patient *and the students talking about the physician and the patient*. And just as everybody matters, everything matters too. True “ethical dilemmas” are actually a very small part of the world of biomedical ethics; yet everything we do—in clinical settings and otherwise—has ethical import, from whether we make eye contact and introduce ourselves,⁵¹ to how carefully notes are placed into medical records where other clinicians can find and understand them, to what manner of clinician incentives are adopted to advance “evidence-based medicine.”⁵²

Yet, you do not have to look long around a typical hospital or clinic to realize how little formal and systematic attention is paid to the obligation of welcome, even when the people who work in these places care earnestly about doing their jobs well. In fact, you will see many unwelcoming practices. To return to the emergency room, notice whom the patient or family first encounters there—probably a security guard or a receptionist asking for an insurance card. But there are many other common clinical practices or hospital routines that bear scrutiny in terms of welcome. We should ask: How can a victim of a stroke or a brain injury feel welcomed if awakened on the hour to be asked, in order to assess capacity and clinical progress, whether she knows her name or where she is? How do people using wheelchairs feel when they have to take a circuitous route around a building to reach their appointments?⁵³ With what feelings and fears do chronic pain sufferers approach the clinic or hospital when they know a past physician has noted, unfairly, in their medical record that they have exhibited “drug-seeking behavior?”⁵⁴ What does it mean to respond to the patient with a permanent disability who wishes to starve herself to death only by telling her that it is her right to do so—rather than expressing dismay at her intention

51. SCHENCK & CHURCHILL, *supra* note 5, at 6–8.

52. Howard Brody, in his book *The Future of Bioethics*, excludes some of the “usual suspects” in his discussion of bioethics, such as genetic testing, and includes items such as evidence-based medicine and pay for performance. BRODY, *supra* note 50, at 7, 16–17, 54–55.

53. Elizabeth Pendo, *What Patients with Disabilities Teach Us About the Everyday Ethics of Healthcare*, 50 WAKE FOREST L. REV. 287 (2015).

54. Carlton Haywood, Jr. et al., *A Systematic Review of Barriers and Interventions to Improve Appropriate Use of Therapies for Sickle Cell Disease*, 101 J. NAT'L MED. ASS'N 1022, 1023 (2009).

and attempting to convince her that her presence in the world is of value?⁵⁵

Only with a disposition of welcoming responsibility is one able to see and see well, regardless of whether one then analyzes a given situation using the method of “principlism”—the predominant method of bioethics analysis, involving specification and balancing of the four principles of respect for autonomy, beneficence (doing good), non-maleficence (not doing harm), and justice—or other ethical approaches that instead emphasize care, community, solidarity, or professionalism.⁵⁶ Welcoming responsibility is *prior* to the successful application of any of the common methods of bioethical analysis. We claim, then, that welcoming responsibility is not *just one of many ways of doing ethics, it is essential to and prior to all of the other methods*. All methods, to be truly successful, rely on the presence of individuals who are radically open to the presence of all others and ready, willing, and able to take appropriate responsibility for what is going on.

To illustrate how an orientation of welcome is necessary not only for establishing healing relationships, but also for ethical practice, we return briefly to the situation of Dr. Wilson. Overly simplified considerations of justice, as well as respect for both the patient’s and the physician’s autonomy (understood only as an expression of choice), could justify a quick referral to another physician, even at the cost of the patient losing other clinical relationships that she valued. Someone analyzing that situation from a principlist approach might be willing to say as, indeed, the students reporting the story did, that considerations of justice and respect for autonomy outweighed beneficence, and the doctor was therefore justified in transferring the patient’s care to another doctor shortly after the request was made. Once the students checked off nominal consideration of the principles, they saw no ethical questions left to consider. An orientation of welcoming responsibility would challenge some of these conclusions, even if one were to be guided by the four principles in ethical analysis. For example, one would have to question whether Dr. Wilson’s quick referral could truly be said to honor Ms. Little’s *autonomy* when we know nothing about what influenced the request for the referral—

55. *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 298 (Ct. App. 1986); *Ms. B v. NHS Hosp. Trust*, [2002] EWHC (Fam) 429, 2 All E.R. 449 (Eng.); see Lois Shepherd, *Face to Face: A Call for Radical Responsibility in Place of Compassion*, 77 ST. JOHN’S L. REV. 445, 500–14 (2003) (comparing the cases of *In re Bouvia* and *In re Ms. B*—both cases in which intelligent, articulate women experiencing a severe physical disability sought court orders granting the withdrawal of life-sustaining treatment—where although the courts reached similar legal outcomes, they approached their task in sharply different ways).

56. See generally BEAUCHAMP & CHILDRESS, *supra* note 15 (discussing these four principles in detail).

knowledge that would require understanding more about Ms. Little's particular circumstances. If the principle of *beneficence* is important, how can we simply ignore the fact that moving to another physician would mean that Ms. Little would lose her important relationship with the nurse practitioner? And with respect to considerations of *justice*, in addition to the fundamental difficulty of judging physician-patient encounters and relationships in the language of courts, we would further have to ask whether Ms. Little had been afforded sufficient opportunity to reveal herself as deserving such a dismissal.

The shortcomings we point out here are not just seen in rote application of common methods of bioethical analysis. The students would also have found little in the American Medical Association's ("AMA") Principles of Medical Ethics to help them discover the ethical challenges that existed in the encounter between Dr. Wilson and Ms. Little.⁵⁷ The sixth principle (out of just nine) provides that: "A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care."⁵⁸ This statement sounds much more like a statement of physician *rights* than a statement of physician *responsibilities*. Indeed, it suggests that physicians have more freedom to discriminate than even the law permits. While in general physicians are not legally required to begin to treat or to continue treating patients,⁵⁹ they cannot refuse to take on or to continue to treat patients if their reasons are impermissibly discriminatory.⁶⁰

57. *Principles of Medical Ethics*, *supra* note 37.

58. *Id.*

59. *Hurley v. Eddingfield*, 59 N.E. 1058, 1058 (Ind. 1901) (declaring that a physician's refusal to render aid to the decedent is not actionable because the physician, by obtaining a state license, does not obligate himself to practice medicine on any terms he does not choose to accept); *Childs v. Weis*, 440 S.W.2d 104, 106-07 (Tex. Civ. App. 1969) (stating that the physician-patient relationship is contractual and voluntary and that a physician is under no legal obligation to provide services to anyone upon request); *see also* MARK A. HALL ET AL., *HEALTH CARE LAW AND ETHICS* 111 (6th ed. 2003) (explaining that *Hurley* is still thought to represent "the prevailing law for physicians"). *See generally* Lois Shepherd, *HIV, the ADA, and the Duty to Treat*, 37 HOUS. L. REV. 1055, 1082-84 (2000) (discussing the "no duty" rule).

60. Under the Patient Protection and Affordable Care Act, health care providers are prohibited from discriminating on the basis of race, ethnicity, gender, sex, or disability. Pub. L. No. 111-148, 124 Stat. 260 (2010) (codified as amended in scattered sections of 42 U.S.C.). In 2012, the Office for Civil Rights within the Department of Health and Human Services interpreted the Act as also protecting individuals against discrimination on the basis of sexual orientation or gender identity. Letter from Leon Rodriguez, Dir. of Office for Civil Rights, Dep't of Health & Human Servs., to Maya Rupert, Fed. Policy Dir., Nat'l Ctr. for Lesbian Rights (July 12, 2012), *available at* <http://www.nachc.com/client/OCRLetterJuly2012.pdf>.

They must also give existing patients notice of termination of the doctor-patient relationship and an opportunity to find alternative care.⁶¹

V. BRENDA AND DR. WEAVER

We turn now to *Payton v. Weaver*,⁶² a modern, classic bioethics and health-law case used in many texts to illuminate aspects of the duty to treat or, rather, the duty to not abandon a patient.⁶³ It involves a “disruptive dialysis patient,” a term found in the literature whose very use denotes a generic understanding of the plaintiff and the problem she presents.⁶⁴ In a nutshell, the court denied the plaintiff’s request to order the defendant providers—a physician and the institutions with which he was affiliated—to continue dialyzing her at their outpatient clinics.⁶⁵ The case, as reported, appears fairly straightforward: Ms. Payton is impossible, the doctor is a saint, and the court wishes it could do more, but it cannot.⁶⁶ Viewing the case through a lens of welcoming responsibility, however, reveals a host of other issues.

Brenda Payton began receiving treatment, including regular dialysis, in 1975 from Dr. John C. Weaver, Jr., and continued receiving treatment for three years until Dr. Weaver sent Ms. Payton a letter stating he would no longer permit her to be treated at the outpatient dialysis treatment unit associated with his practice because of her “persistent uncooperative and antisocial behavior over . . . more than . . . three years[;] . . . her persistent refusal to adhere to reasonable constraints of hemodialysis, the dietary schedules[,] and medical prescription[;] . . . the use of barbiturates and other illicit drugs[;] and because all this resulted in disruption of [the clinic’s program].”⁶⁷ She applied for admission to other dialysis treatment programs and was refused.⁶⁸ Dr. Weaver continued to provide Ms. Payton with emergency dialysis, but a few months later he again notified her that he would no longer treat her

61. See *Payton v. Weaver*, 182 Cal. Rptr. 225 (Ct. App. 1982); *infra* Part V (discussing *Payton v. Weaver*); see also Shepherd, *supra* note 59, at 1082–83; *Opinion 8.115—Termination of the Physician-Patient Relationship*, AM. MED. ASS’N, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion8115.page?> (last visited Feb. 26, 2015).

62. 182 Cal. Rptr. 225.

63. See, e.g., JANET L. DOLGIN & LOIS L. SHEPHERD, *BIOETHICS AND THE LAW* 545 (1st ed. 2005) (discussing *Payton v. Weaver*); HALL ET AL., *supra* note 59, at 157.

64. See Stella L. Smetanka, *Who Will Protect the “Disruptive” Dialysis Patient?*, 32 AM. J.L. & MED. 53, 60 (2006).

65. *Payton*, 182 Cal. Rptr. at 228–29, 231.

66. See *id.*

67. *Id.* at 227 (internal quotation marks omitted).

68. *Id.*

on an outpatient basis.⁶⁹ Litigation ensued, resulting in a settlement under which Dr. Weaver, the outpatient dialysis clinic, and the hospital with which it was affiliated agreed to continue to provide dialysis so long as Ms. Payton met certain conditions.⁷⁰ These conditions included “that she keep all appointments at their scheduled time; that she refrain from use of alcohol and drugs; that she maintain prescribed dietary habits; and that she ‘in all respects cooperate with those providing her care and abide by her physician’s prescribed medical regimen.”⁷¹ Later, participation in a regular psychotherapy or counseling program was added as a condition.⁷²

Less than a year later, Dr. Weaver again notified Ms. Payton that he could no longer provide her with care, given that she had violated every part of their bargain.⁷³ He referred her to other providers in the local area and volunteered to work with Ms. Payton’s legal counsel to find her alternative care, but no alternative was found.⁷⁴ This resulted in further involvement by the court, during which it heard undisputed evidence that Ms. Payton, in violation of the stipulated agreement, bought illegal drugs, gained weight, was late or missed appointments (resulting in emergencies that required hospitalization), sometimes appeared for treatment in an intoxicated condition, discontinued counseling, and was grossly noncooperative.⁷⁵ Her behavior in all these respects was, according to the trial court, “knowing and intentional.”⁷⁶

Ms. Payton’s behavior affected not only Dr. Weaver and the staff at the dialysis clinic but also the other patients at the clinic.⁷⁷ The court explained that dialysis treatment typically involves several patients connected to a single dialysis machine, making Ms. Payton’s behavior an imposition on the rights of other patients.⁷⁸ According to the court:

There was evidence that Brenda would frequently appear for treatment late or at unscheduled times in a drugged or alcoholic condition, that she used profane and vulgar language, and that she had on occasion engaged in disruptive behavior, such as bothering other patients, cursing staff members with obscenities, screaming and demanding that the dialysis be turned off and that she be disconnected before her treatment

69. *Id.*

70. *Id.*

71. *Id.* (internal quotation marks omitted).

72. *Id.*

73. *Id.*

74. *Id.* at 227–28.

75. *Id.* at 228.

76. *Id.* (internal quotation marks omitted).

77. *Id.*

78. *Id.*

was finished, pulling the dialysis needle from the connecting shunt in her leg causing blood to spew, and exposing her genitals in a lewd manner.⁷⁹

Ultimately, the court found that Dr. Weaver and the corporate defendants had met their legal obligations because they had given Ms. Payton due notice of termination of their services and an ample opportunity to secure alternative care.⁸⁰ In some ways, the court's opinion might be considered creative and progressive in that it suggested that hospitals and health care facilities—even if private—have deep responsibilities to provide life-preserving care and that sometimes those responsibilities might have to be collectively shared, so that the burden of difficult patients does not fall on one facility alone.⁸¹ Nevertheless, the court declined to impose further responsibility on the defendant providers before it and further determined that “[w]hatever collective responsibility may exist, it is clearly not absolute, or independent of the patient's own responsibility.”⁸² In a later portion of the opinion of no legal effect, the court noted that Ms. Payton's lawyers were trying to convince her to agree to a voluntary conservatorship that would enable “her placement in a private, closed psychiatric facility.”⁸³

The analysis we offer here does not attempt to provide a different legal answer to the general question of the duties providers owe to patients in terms of not abandoning them. In other words, we are not challenging here the idea that providers are legally allowed to terminate treatment relationships as long as they do so with adequate notice, the patient is not in an emergency situation, and the grounds for termination are not impermissible discrimination (such as on the basis of race or disability).

We instead want to use this case to examine the relationship between Ms. Payton and Dr. Weaver and just as important—perhaps more important—the court's understanding of these two individuals and their relationship. The reason for this latter focus is to illustrate that an orientation of welcoming responsibility asks us—the court and those of us reading the court's opinion—to notice different things, to be finely aware of details that suggest welcome or its absence, and to recognize the consequences thereof.

Let us begin with the descriptions of the two primary individuals in this story. Ms. Payton, throughout, is described as “Brenda.”⁸⁴ Dr. Weaver is referred to as “Dr. Weaver.”⁸⁵ This

79. *Id.*

80. *Id.* at 229.

81. *Id.* at 230.

82. *Id.*

83. *Id.* at 231.

84. *See id.*

85. *Id.*

immediately signals a lack of equal consideration of the two parties. The court tells us in the first paragraph that Ms. Payton is black, but it does not anywhere tell us the race of Dr. Weaver, suggesting that Ms. Payton's race is important to understanding the facts of the case, perhaps her behavior or the reaction of others to her, but that Dr. Weaver's race is not important to understanding his behavior or the response of others to him.⁸⁶ The court begins the opinion by describing Ms. Payton's medical condition and her dependence on regular dialysis. But then it tells us:

Brenda has other difficulties. Unable to care for her children, she lives alone in a low-income housing project in West Oakland, subsisting on a \$356 per month Social Security check. She has no family support; one brother is in prison and another is a mental patient. She confesses that she is a drug addict, having been addicted to heroin and barbiturates for over 15 years. She has alcohol problems, weight problems and, not surprisingly, emotional problems as well.⁸⁷

Why is the court telling us these facts? It is not actually clear. Whatever the court's intention, it has painted a picture here of a stereotypically dysfunctional black family: Ms. Payton's children do not live with her because she cannot care for them; one brother is imprisoned and the other "is a mental patient"—whatever that means. Moreover, her poverty suggests she is a charity case, even though Medicare has long covered dialysis treatment for all Americans with end-stage renal disease.⁸⁸ Her alcohol abuse and drug addiction mark her as one kind of "difficult patient"—a term providers often use to distance themselves from certain patients and absolve themselves of a certain level of responsibility in their care.⁸⁹ Taken together, these details present her as a generic "case" rather than as an individual. The court might be telling us about her brother in prison, her government dependency, and so on in order that we have a better understanding of her, but those facts are not

86. *Id.* at 226.

87. *Id.* at 226–27.

88. Steven Ross Johnson, *Dialysis Demand Strong as Kidney Disease Grows*, MODERN HEALTHCARE (Oct. 11, 2014), <http://www.modernhealthcare.com/article/20141011/NEWS/141019999>. Medicare coverage has been provided by the End Stage Renal Disease Program since 1973. *Id.* In 2013, 86% of dialysis facilities were for-profit centers. *Id.*

89. In addition to creating categories of patients for whom responsibility is perceived as somehow lessened, terms such as "difficult patient" can also express, in a medically acceptable way, providers' aversions to certain patients whose behaviors contribute to their illnesses (e.g., substance abuse). When the aversion is couched in medical terms, the fact that it is a *moral* aversion is less obvious to all. In some cases, these labels also allow physicians to distance themselves from patients who remind them of their own substance abuse or other issues.

relevant to the questions before the court—instead what matters is *how she behaves at the clinic*.

After gratuitously listing these details of Ms. Payton's life, the court makes the following positive statement about her: "Despite these difficulties Brenda appears from the record to be a marvelously sympathetic and articulate individual who in her lucid moments possesses a great sense of dignity and is intent upon preserving her independence and her integrity as a human being."⁹⁰ But other than her "articulateness," there is no detail provided in this description that tells us anything positive about Ms. Payton that is *particular to her*.

Compare the way Ms. Payton is described to the way Dr. Weaver is described. The opinion tells us that the trial court judge found Dr. Weaver to be "one of the most sensitive and honest physicians that I have been exposed to either in a courtroom or out of a courtroom," a man with "the patience of Job."⁹¹ The appellate court even uses Ms. Payton's grammatically incorrect description of Dr. Weaver to simultaneously vaunt him and deprecate her; she is quoted as saying, "Dr. Weaver is and was and still is the man between me and death . . . other than God, I don't think of nobody higher than I do Dr. Weaver."⁹²

But how well did Dr. Weaver actually treat Ms. Payton? The appellate court wrote: "It appears that Dr. Weaver has behaved according to the highest standards of the medical profession . . ."⁹³ It recounts that after the second notification of termination following her breach of the settlement agreement, he "volunteered to work with [Ms. Payton's legal] counsel to find [her] alternative care."⁹⁴ There are questions to be asked, however, both in terms of the effort he actually put towards finding her alternative care and in the amount of responsibility he instead transferred to her, with knowledge of her various incapacities, in securing alternative care for herself. It is true, as the court reminds us, that his legal responsibilities were limited to adequate notice and perhaps a referral, and he appears to have met those responsibilities by supplying Ms. Payton "with a list of the names and telephone numbers of all dialysis providers in San Francisco and the East Bay . . ."⁹⁵ But just as justice was a narrow lens through which to view the referral Dr. Wilson hastily made for Ms. Little in the scenario discussed above, a recounting of the legal requirements Dr. Weaver satisfied does not tell us how well he met the ethical

90. *Payton*, 182 Cal. Rptr. at 227.

91. *Id.* at 229 (internal quotation marks omitted).

92. *Id.* at 227 (internal quotation marks omitted).

93. *Id.* at 229.

94. *Id.* at 227.

95. *Id.* at 229.

challenges which faced him.⁹⁶ Nor do those legal standards equate to the highest standards of the medical profession.⁹⁷

Dr. Weaver's apparently minimal effort in finding alternative care, however, is not the aspect of his relationship with Ms. Payton that is most troublesome. What is considerably more problematic is the settlement agreement that was entered into in the first place. Recall that when Ms. Payton received her first notice of termination, she sued Dr. Weaver, along with the institutions with which he was affiliated, and entered into a settlement agreement with them.⁹⁸ That settlement agreement extended well beyond the behaviors that would be unacceptable for any patient in a dialysis clinic. It would be understandable, for example, for the clinic to insist that its patients not scream and curse at staff and other patients and that they not pull out their own dialysis needles and spew blood around the facility. Those are certainly reasonable requests, perhaps even demands. Also understandable would be the requirement that patients keep all appointments at their scheduled time; but to determine whether this requirement was *reasonable*—and whether Ms. Payton's violation of it was "knowing and intentional"⁹⁹—one would need to know something about her access to reliable transportation as well as her ability to manage a schedule without assistance.¹⁰⁰

But the settlement agreement went far beyond setting clear expectations for behavior at the clinic. By insisting that she refrain from alcohol and drug use, manage her weight, "maintain prescribed

96. See *id.*; *supra* Part II.

97. See BEAUCHAMP & CHILDRESS, *supra* note 15, at 487 (explaining that some medical associations "ask health care professionals to set aside substantial self-interest by requiring actions that elsewhere are considered supererogatory").

98. *Payton*, 182 Cal. Rptr. at 227.

99. *Id.* at 228; see PAUL FARMER, *PATHOLOGIES OF POWER: HEALTH, HUMAN RIGHTS, AND THE NEW WAR ON THE POOR* 151 (2005) (describing some of the complicated implications of concluding that a patient's noncompliance is to blame for his or her continuing illness). Questioning assumptions about noncompliance among patients in Haiti, Farmer writes:

Doctors may instruct their patients to eat well. But the patients will "refuse" if they have no food. They may be told to sleep in an open room and away from others, and here again they will be "noncompliant" if they do not expand and remodel their miserable huts. They may be instructed to go to a hospital. But if hospital care must be paid for in cash, as is the case throughout Haiti, and the patients have no cash, they will be deemed "grossly negligent."

Id.

100. Today, some reimbursement for transportation costs for nonemergency outpatient dialysis care is available through Medicare. CTRS. FOR MEDICARE & MEDICAID SERVS., *MEDICARE COVERAGE OF KIDNEY DIALYSIS & KIDNEY TRANSPLANT SERVICES* 21 (2014), available at <http://www.medicare.gov/Pubs/pdf/10128.pdf>.

dietary habits,” and “*in all respects . . . abide by her physician’s prescribed medical regimen,*” it set her up to fail.¹⁰¹ Surely it was clear at the time that there was no way she would be able to comply with all of these conditions. Why did Dr. Weaver insist on them? In what way was that action therapeutic? How could an agreement of this kind foster a healing relationship? Equally important to assessing this arrangement is the question of whether he required such onerous contracts of his other dialysis patients. Did he insist, even in a less formal way, that they too follow *all* orders and manage their weight successfully? Failures in these areas, though troubling, are frequent among patients, generally forgivable, and rarely, if ever, considered absolute barriers to access to dialysis.¹⁰² It seems obvious to us that the settlement agreement was pro forma; it was not a genuine bargained-for understanding between two parties, but more of an ultimatum than a contract. Clearly, Dr. Weaver wanted Ms. Payton out of his practice, and the settlement agreement was one step toward making that outcome inevitable. Its purpose could only have been to set up the structure by which Ms. Payton’s termination from the practice would appear justified and well documented.

But if this is the case, we also have to ask: Where were her lawyers—her *advocates*? Tellingly, her own lawyers agreed to this contract whose ultimate effect was to allow her failures to be piled one on top of the other and thus permit, in the end, her physician to terminate treatment on the basis of weaker evidence of Ms. Payton’s actual disruptive behavior at the clinic. The ultimate outcome was not only predictable—it was predetermined.

And finally, where were the trial and appellate courts? They blurred and combined the reasonable and unreasonable elements of the settlement agreement, just as they blurred and combined Ms. Payton’s personal troubles, stereotypical descriptions of generic patients “like her,” and the actual (and truly problematic) behaviors she engaged in at the clinic.¹⁰³ The appellate court, it is true, tried to appear sensitive.¹⁰⁴ And it did go out on a limb to consider whether there might be a collective responsibility among health care providers to “difficult patients” like “Brenda.”¹⁰⁵ But the court’s imagination was limited by the fact that it—along with her doctors and lawyers—did not know how to see her as more or other than a difficult patient.

101. *Payton*, 182 Cal. Rptr. at 227 (emphasis added) (internal quotation marks omitted).

102. David Orentlicher, *Denying Treatment to the Noncompliant Patient*, 265 JAMA 1579, 1580–81 (1991).

103. *Payton*, 182 Cal. Rptr. at 228.

104. *Id.* at 227.

105. *Id.* at 230.

Other than the court's recounting of Ms. Payton's praise for Dr. Weaver, we do not hear her voice in this case, even indirectly. Did she have any understanding of her disruptiveness or of what she was reacting to in the clinic; what set her off? What was the relation between her psychological symptoms and her chronic renal disease and its treatment? Did her behavior become problematic precisely because she needed or was receiving dialysis?¹⁰⁶ What did she say in those "marvelous [lucid] moments"? Did anyone, clinic professional or officer of the court, ask her how they could help her keep her disruptive behavior from interfering with her care? Did anyone ask her what she needed? A private room in the dialysis clinic? A reminder call and transportation?

Perhaps Ms. Payton was asked these questions, but the fact that we do not know this tells us much about the perspective with which all those involved viewed this case. If questions such as these had been asked, and her answers truly revealed an intentional and knowing decision to behave outside acceptable bounds in the clinic setting, even under the threat of treatment denial, then we would have to consider whether she might be acting so much against her own interests as to be considered suicidal. She may have at that point exhibited such a severe psychiatric condition that a move toward involuntary commitment would have to be considered.

To the court's credit, there is some attention to the question of psychiatric placement at the end of the opinion. After explaining that its reasoning was "analytically sufficient to dispose of Brenda's legal arguments," the court stated that it could not "responsibly avoid confronting the more fundamental question posed by Brenda's challenge . . . [as to] what alternatives exist for assuring that Brenda does not die from lack of treatment as a result of her uncooperative and disruptive behavior."¹⁰⁷ Counsel from both parties had engaged in discussion about the possibility of a conservatorship under which someone else would make medical and placement decisions for Ms. Payton.¹⁰⁸ Some discussion of voluntary versus involuntary conservatorship follows in the opinion, with no real resolution other than the implication that her attorneys would be seeking a voluntary conservatorship for Ms. Payton that might allow for her placement in a private, closed psychiatric facility.¹⁰⁹ During the intervening time before such placement, if it were to occur, the court made clear that Dr. Weaver would not be obligated to provide dialysis, having "already fulfilled his obligations to

106. See generally Paul L. Kimmel et al., *Psychiatric Illness in Patients with End-Stage Renal Disease*, 105 AM. J. MED. 214, 217–20 (1998) (discussing the high rates of psychiatric illness in end-stage renal disease patients).

107. *Payton*, 182 Cal. Rptr. at 231.

108. *Id.*

109. *Id.*

Brenda, and more.”¹¹⁰ The opinion makes a vague reference to the fact that “other resources may be available.”¹¹¹

However, these moves and even the genuine concerns they show about finding a solution to the problem presented by the case remain inadequate largely because they represent an attempt to solve *the problem of Ms. Payton*, rather than to find a solution for *Ms. Payton’s problems*. Far from welcoming Ms. Payton, Dr. Weaver’s and the court’s actions are those that are turned to when there has been a failure to provide welcome. According to the reported facts, each of these players—the clinicians, the lawyers, and the courts—failed to inquire deeply and seriously into the source of, and possible remedies for, the behaviors she exhibited to clinic staff and other patients. They were not seeking to know and understand Ms. Payton well, in order to know how best to help her care for herself. We might have found a turn to the possibility of conservatorship, even involuntary conservatorship, more palatable if it had come after Ms. Payton’s story had been elicited and her engagement expected, encouraged, and supported. For then there would not have been a *failure* to provide welcome, but an *exhaustion of welcome*. Instead, the suggestion of conservatorship appears as little more than a last-ditch effort to shelve the problem as the court appears to have seen it: yet another drug-addicted, government-dependent, overweight member of a racial minority from a dysfunctional family, unable or unwilling to act in her own best interests. Ms. Payton was never welcomed *as* she is long enough to learn *who* she is.

Since this case was decided, Medicare rules have been amended to give patients more rights against being discharged or transferred by dialysis clinics. Today, a terminating facility must (a) “determine that the patient’s behavior is disruptive and abusive to the extent that the delivery of care to the patient or the ability of the facility to operate effectively is seriously impaired,” (b) involve an interdisciplinary team to make efforts to resolve the problems, (c) secure the agreement of the patient’s attending physician, (d) attempt to place the patient at another facility, and (e) notify a state agency about the involuntary discharge or transfer of the patient.¹¹² These rules seem to speak to some of what an orientation of

110. *Id.* at 231 n.4.

111. *Id.*

112. 42 C.F.R. § 494.180(f) (2014). In addition, the rules now give patients the right to be informed by a dialysis facility about policies regarding routine and involuntary transfer. *Id.* § 494.70(b)(1). The Americans with Disabilities Act, adopted in 1990, might also have provided protections of these sorts, as “reasonable accommodations.” American with Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 327 (codified as amended at 42 U.S.C. § 12101–12213 (2012)); see Orentlicher, *supra* note 102 (discussing the ADA and denial of treatment).

welcoming responsibility indicates as needing attention. All to the good. But the effectiveness of these and other rules still depends upon physicians, clinicians, and others on the interdisciplinary team coming *into a relationship* with patients like Brenda Payton. Those relationships cannot lead to effective care of any sort, unless they are established and maintained within a consistent orientation of welcoming responsibility.

CONCLUSION

In selecting the encounters to examine in this Essay, we have not chosen simple ones. We have especially avoided choosing examples of egregious immorality, of completely inept or downright bad performance of ethical duties in medicine. For example, we have not focused on a clinician who refused to treat a patient with HIV in the late 1980s,¹¹³ or who would refuse a patient with ebola today, or who finds a patient objectionable simply because he or she is a lawyer.¹¹⁴ Instead, the actors whose actions and dispositions we have examined appear to be trying hard to meet their professional obligations, and each is admirable in his or her own way. The student is diligent in trying to perform a good physical exam, establish appropriate rapport with the elderly honey bee farmer, and be “professional” as he understands it. He learns much by opening up, even if just a little. Dr. Wilson and the physician in Abse’s poem do not lash out at their apparently unwelcoming patients. They do not intentionally provide poor care or immediately walk away. And Dr. Weaver continued treating Ms. Payton long after he wanted to stop. The lawyers who took her case

113. Despite ethical guidance issued in 1987 by the AMA’s Council on Ethical and Judicial Affairs that physicians could not ethically refuse care to patients who were HIV positive, substantial numbers of physicians (for example, two-thirds of orthopedic surgeons according to one survey) did not believe this to be the case. David Orentlicher, *The Influence of a Professional Organization on Physician Behavior*, 57 ALB. L. REV. 583, 596–97 (1994) (citing Paul M. Arnow et al., *Orthopedic Surgeons’ Attitudes and Practices Concerning Treatment of Patients with HIV Infection*, 104 PUB. HEALTH REP. 121, 124, 127 (1989)).

114. *Hiser v. Randolph*, 617 P.2d 774, 775–76 (Ariz. Ct. App. 1980) (finding that a trier of fact could conclude that refusal of an on-call emergency room physician to see a patient arriving in a semi-comatose condition was due to “personal animosity” toward the patient or to the fact that the patient’s “husband was a lawyer”). At the AMA’s annual meeting in 2004, a delegate introduced a proposal urging the AMA to inform physicians that, except in emergencies, it is not unethical to refuse care to plaintiffs’ attorneys and their spouses. Don Babwin, *Refusing Treatment Makes Malpractice Debate Even Uglier*, CHARLOTTE OBSERVER, June 19, 2004, at 1D. The sponsor of the proposal asked that it be withdrawn prior to consideration, but it still drew passionate speeches denouncing it. *Id.*

were likely poorly compensated, if at all, for doing so. And the court searched for answers, although it did not find any.

Perhaps the demands of welcome are, in some situations, just too much to expect, but we insist that they are not too much to ask. There is too much at stake in these encounters, the power gaps are too wide, and the needs are too urgent, to settle for what only seems to be the best we can do. Each of these professionals—physicians, lawyers, and judges—could have done better, just as the medical student did, if each had approached the person who came to them in need with genuine, responsible welcome.