

# WHY PHYSICIANS ARE FIDUCIARIES FOR THEIR PATIENTS

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## I. INTRODUCTION

That the law should regard physicians as fiduciaries for their patients would seem to be indisputable. Fiduciary obligations are imposed in relationships in which one party, the fiduciary, is in a position to take advantage of the other party, called the beneficiary, principal, or “entrustor,”<sup>1</sup> and in which the interests of the entrustors that are at stake are important to society and sometimes vital to the entrustors’ welfare.<sup>2</sup> If the relationship were at arm’s length, entrustors would be unable to reduce the risk of being taken advantage of except by expending significant resources to monitor the superior party, and those resources would not be available to the entrustors to purchase the welfare-enhancing services or property the securing of which is the reason for the relationship. In order to maximize the utility of the relationship to the entrustor by minimizing monitoring costs, the law therefore imposes on the superior party the status of a fiduciary. Instead of being free to maximize their own self-interest as they would be in an arm’s-length relationship, fiduciaries are required to further the entrustors’ interests and to make restitution<sup>3</sup> and pay punitive damages if they fail to do so.<sup>4</sup>

The relationship between patients and physicians certainly seems to fit these conditions. Good health is essential to patients’ well being and is important to society. Physicians are in a position to take advantage of patients

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<sup>1</sup> There is no generally accepted term for the weaker party in a fiduciary relationship. Frankel coined the term “entrustor.” Tamar Frankel, *Fiduciary Law*, 71 CALIF. L. REV. 795, 800 n. 17 (1983). Rodwin proposes “fiducie.” MARC A. RODWIN, *MEDICINE, MONEY, & MORALS: PHYSICIANS’ CONFLICTS OF INTEREST* 181 (1993). For a thorough exploration of the relationship between fiduciary principles and the early common law, see David J. Seipp, *Trust and Fiduciary Duty in the Early Common Law*, 91 B. U. L. REV. 1011 (2011).

<sup>2</sup> D. Gordon Smith calls these interests “critical resources.” D. Gordon Smith, *The Critical Resource Theory of Fiduciary Law*, 55 VAND. L. REV. 1399, 1402 (2002). Paul Miller calls them “significant practical interests.” Paul B. Miller, *Justifying Fiduciary Duties*, 58 MCGILL L. J. 1014 (2013).

<sup>3</sup> See *infra* note 5, and accompanying text.

<sup>4</sup> See *infra* note 59, and accompanying text.

because they have greater knowledge and experience, and because they often have control over patients, especially when the patients are unconscious or so ill, afraid, or in pain that they cannot adequately fend for themselves. When patients do seek to protect themselves, moreover, the cost of doing so, such as by purchasing “second opinions,” is often very high, consuming resources that otherwise would be available to purchase the health care patients need.

It therefore should come as no surprise that numerous courts<sup>5</sup> and commentators<sup>6</sup> acknowledge the fiduciary

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<sup>5</sup> See *M.A. v. United States*, 951 P.2d 851, 854 (Alaska 1998) (“we have recognized that the unique nature of the physician-patient relationship confers upon physicians a fiduciary responsibility toward their patients.”); *Hales v. Pittman*, 576 P.2d 493, 497 (Ariz. 1978) (“However, because of the fiduciary relationship between physician and patient, the scope of the disclosure required can be expanded by the patient’s instructions to the physician.”); *Hummel v. State*, 196 S.W.2d 594, 595 (Ark. 1946) (“there existed a most confidential relationship—that of physician and patient. Herzog on Medical Jurisprudence, § 96 states: ‘Fiduciary relationship between physician and patient. It is said that the relation of a physician to his patient is one of the highest trust and that the physician must act with the utmost good faith.’”); *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479 (Cal. 1990) (en banc) (“a physician who is seeking a patient’s consent for a medical procedure must, in order to satisfy his fiduciary duty and to obtain the patient’s informed consent, disclose personal interests unrelated to the patient’s health, whether research or economic, that may affect his medical judgment.”); *Smith v. Boyett*, 908 P.2d 508, 513 fn. 10 (Colo.1995) (“we adopt the rule that the plaintiff may establish knowing concealment by showing that the defendant either made an affirmative misrepresentation or failed to disclose material information that he had a fiduciary duty to disclose.”); *Gager v. Mathewson*, 539, 107 A. 1, 2 (Conn. 1919) (“Religious advisers, guardians, attorneys, and physicians . . . occupy a fiduciary relation to the testator, which requires them to use their influence in his service and not in their own.”); *McKnatt v. McKnatt*, 393 Atl. 367, 370 (Del. 1915) (“There is no fixed test to establish a fiduciary relationship. It cannot be defined. It embraces the relation of physician and patient, nurse and patient, and generally all persons who are in any relation of trust and confidence.”); *Emmett v. Eastern Dispensary and Casualty Hosp.*, 396 F.2d 931, 935 (D.C. Cir. 1967) (“We find in the fiducial qualities of that relationship (between physician and patient) the physician’s duty to reveal to the patient that which in his best interests it is important that he should know.”); *Gracey v. Eaker*, 837 So.2d 348, 354 (Fla.2002) (“These cases are also

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persuasive authority and support our conclusion that a psychotherapist who has created a fiduciary relationship with his client owes that client a duty of confidentiality, and that a breach of such duty is actionable in tort.”); *Cox v. Athens Reg'l Med. Ctr., Inc.*, 631 S.E.2d 792, 798 (Ga. Ct. App. 2006) (“We note that, ordinarily, physicians owe a fiduciary duty to their patients with respect to the care given.”); *Billings v. Sisters of Mercy*, 389 P.2d 224, 228 (Idaho 1964) (“it is now generally held that the fiduciary relationship between physician and patient imposes a duty of disclosure, breach of which constitutes fraudulent concealment.”) (internal citation omitted); *Witherell v. Weimer*, 85 Ill.2d 146, 160, 421 N.E.2d 869, 876 (Ill. 1981) (“Numerous cases characterize the relationship as a fiduciary one.”); *Guy v. Schuldt*, 138 N.E.2d 891, 895 (Ind. 1956) (“Usually, there must be some active effort on the part of one to be guilty of concealment but where a fiduciary or confidential relationship exists, such as physician-patient, there exists a duty to disclose material information between the parties and a failure to do so results in concealment.”); *Baines v. Blenderman*, 223 N.W.2d 199, 202 (Iowa 1974) (“A physician owes his patient a fiduciary duty.”); *Natanson v. Kline*, 350 P.2d 1093, 1101-02 (Kan. 1960) (“The courts frequently state that the relation between the physician and his patient is a fiduciary one, and therefore the physician has an obligation to make a full and frank disclosure to the patient of all pertinent facts related to his illness.”); *Wiseman v. Alliant Hospitals, Inc.*, 37 S.W.3d 709, 713 (Ky.2000) (“The fiduciary relationship between the parties grants a patient the right to rely on the physician's knowledge and skill.”); *Rajnowski v. St. Patrick's Hosp.*, 564 So.2d 671, 681 (La.1990) (Barham and Tate, JJ., concurring in writ denial) (“In law the prevailing view is that the relationship between a physician and patient is a fiduciary one . . . .”) *Jacobs v. Painter*, 530 A.2d 231, 239 (Me.1987) (“Dr. Painter's duty to disclose arose, as it always has, from the fiduciary character of the physician-patient relationship.”); *Sard v. Hardy*, 367 A.2d 525, 542 (Md. App. 1977) (“I am convinced that there are fiducial qualities in the doctor-patient relationship which require the application of principles different from those governing arm's length transactions.”); *Alberts v. Devine*, 479 N.E. 2d 113, 120 (Mass. 1985), *cert. denied*, 474 U.S. 1014 (1985) (“This court previously has recognized that the physician-patient relationship possesses fiduciary . . . as well as contractual . . . aspects.”); *Domako v. Rowe*, 475 N.W.2d 30, 34 (Mich. 1991) (“The physician's fiduciary duty to his patient precludes any ex parte conferences with his patient's adversary.”); *Madden v. Rhodes*, 626 So.2d 608, 617 (Miss.1993) (“This Court has for many, many years acknowledged the lawyer/client relationship or doctor/patient relationship as a fiduciary one.”); *State ex rel. McCloud v. Seier*, 567 S.W.2d 127, 128 (Mo. 1978) (en banc) (“Moreover, as this [fiduciary] duty contemplates the physician's undivided loyalty to his patient, such duty necessarily runs contrary to the dual allegiance that would result if the physician were employed and paid by his patient's adversary.”); *Toman v. Creighton*

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Memorial St. Josephs Hosp., Inc., 217 N.W.2d 484, 489 (Neb. 1974) (“Malpractice’ has been defined by the court as the treatment of a case by a surgeon or physician in a manner contrary to the accepted rules and with injurious results to the patient; hence, any professional misconduct or any unreasonable lack of skill or fidelity in the performance of professional or fiduciary duties.”); Hoopes v. Hammargren, 725 P.2d 238, 242 (Nev. 1986) (“This court has recognized that the physician-patient relationship is ‘fiduciary in nature.’”); Stigliano v. Connaught Lab., Inc., 658 A.2d 715, 720 (N.J. 1995) (“The relationship between treating physicians and their patients, sometimes described as fiduciary in nature, gives rise to a duty to testify in judicial proceedings about treatment rendered to the patient.”); Kern *ex rel.* Kern v. St. Joseph Hosp., Inc., 697 P.2d 135, 139 (N.M. 1985) (“Silence may sometimes constitute fraudulent concealment where a physician breaches his fiduciary duty to disclose material information concerning a patient's treatment.”); Miller v. Comm’r of Health for State of N.Y., 270 A.D.2d 584, 585, 703 N.Y.S.2d 830 (3d Dep’t 2000) (“although petitioner was ‘only’ patient B's primary care physician, his treatment of her obviously entailed a fiduciary relationship”); Black v. Littlejohn, 325 S.E.2d 469, 482 (N.C. 1985) (“The relationship of patient and physician is generally considered a fiduciary one, imposing upon the physician the duty of good faith and fair dealing.”); Tehven v. Job Serv. North Dakota, 488 N.W.2d 48, 51 (N.D.1992) (“Courts have generally recognized a patient's right to recover damages from a physician for unauthorized disclosure of medical information as . . . [a] breach of the fiduciary relationship between a physician and a patient.”); Tracy v. Merrell Dow Pharm., Inc., 569 N.E.2d 875, 879 (Ohio 1991) (“The physician-patient relationship is a fiduciary one based on trust and confidence and obligating the physician to exercise good faith.”); Parris v. Limes, 277 P.3d 1259, 1265 n. 3 (Okla. 2012) (“Oklahoma has long recognized that the relationship between a physician and patient is a fiduciary and confidential relationship”); Georgetown Realty v. Home Ins. Co., 831 P.2d 7, 14 (Ore. 1991) (“The form of action for a claim against a fiduciary for breaching a duty of care arising from the relationship is not materially different from a claim against a physician, a lawyer, or an engineer for breaching a duty of care arising from such a relationship.”); Cooper v. Roberts, 286 A.2d 647, 650 (Pa. Super. Ct. 1971) (“[A] physician's duty to disclose is . . . imposed by law which governs his conduct in the same manner as others in a similar fiduciary relationship.”); McCormick v. England, 494 S.E.2d 431, 436-37 (S.C. Ct. App. 1997) (“The jurisdictions that recognize the duty of confidentiality have relied on various theories for the cause of action, including invasion of privacy, breach of implied contract, medical malpractice, and breach of a fiduciary duty or a duty of confidentiality . . . . We find the reasoning of the cases from other jurisdictions persuasive on this issue and today we join the majority and hold that an actionable tort lies for a

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physician's breach of the duty to maintain the confidences of his or her patient in the absence of a compelling public interest or other justification for the disclosure."); *Murfreesboro Med. Clinic, P.A. v. Udom*, 166 S.W.3d 674, 683 (Tenn. 2005) ("In analyzing this issue, we see no practical difference between the practice of law and the practice of medicine . . . . These relationships are consensual, highly fiduciary and peculiarly dependent on the patient's or client's trust and confidence in the physician consulted or attorney retained."); *Nixdorf v. Hicken*, 612 P.2d 348, 354 (Utah 1980) ("The relationship between a doctor and his patient creates a duty in the physician to disclose to his patient any material information concerning the patient's physical condition. This duty to inform stems from the fiduciary nature of the relationship . . . ."); *Stevenson v. Johnson*, 32 Va. Cir. 157, 159 (Va. Cir. Ct.1993) ("It has been held that there is a fiduciary relationship between physician and patient, and that appears to be the general rule."); *Lockett v. Goodill*, 430 P.2d 589, 591 (Wash. 1967) ("The relationship of patient and physician is a fiduciary one of the highest degree."); *State ex rel. Allen v. Bedell*, 454 S.E.2d 77, 85 (W. Va. 1994) ("recently, we added a physician-patient fiduciary relationship to our jurisprudence"); *Steinberg v. Jensen*, 519 N.W.2d 753, 763, 760-61 (Ct.App.1994), *rev'd* on other grounds, 534 N.W.2d 361 (Wis. 1995) ("*Petrillo's* public policy rationale is two-fold and is based on preserving the confidential relationship, as well as the fiduciary relationship existing between a physician and client . . . . We are similarly persuaded, and expressly adopt the rationale of *Petrillo*."); *Wardell v. McMillan*, 844 P.2d 1052, 1066-67 (Wyo. 1992) ("Wardell claims that a physician has a fiduciary duty not to act contrary to his patient's best interests . . . . A contrary position would needlessly pit physician against patient, potentially destroying a mutually beneficial relationship.").

<sup>6</sup> See TAMAR FRANKEL, FIDUCIARY LAW 43 (2011) ("Professionals have expertise that most entrustors do not possess. Their services may involve entrustment of property, and in most cases—[sic] entrustment of power. Thus, surgeons must be entrusted with power over the patient's body."); Dayna Bowen Matthew, *Implementing American Health Care Reform: The Fiduciary Imperative*, 59 BUFF. L. REV. 715, 719 (2011) ("fiduciary law has defined the duties and obligations owed by individuals and institutional health care providers to patients in a wide variety of cases."); Thomas L. Hafemeister and Selina Spinos, *Lean on Me: A Physician's Fiduciary Duty To Disclose an Emergent Medical Risk To the Patient*, 86 WASH. U. L. REV. 1167, 1187 (2009) ("Because patients are so vulnerable and dependent on their physicians, the law imposes a 'trust' on doctors – a fiduciary responsibility stemming from the dependence and vulnerability of the patient, and from the disparity between a patient's and a physician's knowledge and ability to act."); Thomas L. Hafemeister and Richard M. Gulbrandsen, Jr., *The Fiduciary Obligation of Physicians to 'Just Say No' If an 'Informed'*

nature of the patient-physician relationship. So does the American Medical Association (AMA), whose Principles of Medical Ethics, while not explicitly using the term “fiduciary,” states that “a physician shall, while caring for a patient, regard responsibility to the patient as paramount.”<sup>7</sup>

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*Patient Demands Services That Are Not Medically Indicated*, 39 SETON HALL L. REV. 335, 369-370 (2009) (“The physician-patient relationship embodies all three bases [vulnerability, superior knowledge and skills, and trust that physicians will promote their patient’s best interests] routinely cited as the rationale for concluding that a fiduciary duty exists between two parties.”); Charity Scott, *Doctors as Advocates, Lawyers as Healers*, 29 HAMLINE J. PUB. L. & POL’Y 331, 335-342 (2007) (“This concept of the physician as fiduciary has become well accepted both in U.S. law and the ethical tenets of American professional medical associations.”); J. C. Shepherd, *THE LAW OF FIDUCIARIES* 29 (Toronto: Carswell Co., 1981) (classifying physicians as an “advisor” type of fiduciary)

<sup>7</sup> American Med. Ass’n, Council on Ethical and Judicial Affairs, Code of Ethics, *Principles of Medical Ethics* (<http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page>) (last visited Dec. 27, 2013). Other official AMA pronouncements do, however, explicitly use the term “fiduciary” to describe the patient-physician relationship. See American Medical Association, Council on Ethical and Judicial Affairs, CEJA Report 11 – A-98, “Sexual or Romantic Relations Between Physicians and Key Third Parties” ([http://www.ama-assn.org/resources/doc/ethics/ceja\\_11a98.pdf](http://www.ama-assn.org/resources/doc/ethics/ceja_11a98.pdf)) (last visited Dec. 27, 2013) (emphasis added) (“Because of the impact [the decisions of key third parties such as parents] may have on the health and welfare of the patient, such individuals play an important role in *the fiduciary relationship between doctor and patient*, and should therefore be accorded a similar respect that is given to patients.”); Barry Weiss, *Manual for Physicians* 15 (2d ed. American Medical Association 2007) (<http://www.ama-assn.org/resources/doc/ama-foundation/healthlitclinicians.pdf>) (last visited Dec. 27, 2013) (“Our legal system recognizes the patient-physician relationship as a fiduciary relationship, which is the highest standard of duty implied by law.”); American Med. Ass’n, Report of the Council on Medical Service, “Empowering Our Patients: Individually Selected, Purchased and Owned Health Expense Coverage,” CMS Report 9-A-98 at 16 (<http://www.ama-assn.org/resources/doc/cms/a98cms9.doc>) (last visited Dec. 27, 2013) (emphasis added) (“All health benefit plans should be required to clearly and understandably communicate to enrollees and prospective enrollees in a standard disclosure format those services which they will and will not cover and the extent of coverage for the

The AMA's Council on Ethical and Judicial Affairs, which issues "Ethics Opinions" elaborating on the organization's core ethical principles, is even clearer. "Under no circumstances," states Ethics Opinion E-803, "may physicians place their own financial interests above the welfare of their patients. . . . If a conflict develops between the physician's financial interest and the physician's responsibilities to the patient, the conflict must be resolved to the patient's benefit."<sup>8</sup>

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former. The information disclosed should include the proportion of plan income devoted to utilization management, marketing, and other administrative costs, and the existence of any review requirements, financial arrangements or other restrictions that may limit services, referral or treatment options, or negatively affect *the physician's fiduciary responsibility to his or her patients*"); American Med. Ass'n, Report of the Committee on Ethical and Judicial Affairs, "Collective Action and Patient Advocacy," CEJA Report 9-A-98 at 2 ([http://www.ama-assn.org/resources/doc/ethics/ceja\\_9a98.pdf](http://www.ama-assn.org/resources/doc/ethics/ceja_9a98.pdf)) (last visited Dec. 27, 2013) ("Physicians have a fiduciary obligation to hold their patients' interests paramount."). Kim Johnston quotes Plato as stating in *The Republic* that "no . . . physician considers his own good in what he prescribes, but the good of his patient; for the true physician is . . . not a mere moneymaker." Kim Johnston, *Patient Advocates or Patient Adversaries? Using Fiduciary Law to Compel Disclosure of Managed Care Financial Incentives*, 35 SAN DIEGO L. REV. 951 (1998).

<sup>8</sup> AMA Code of Medical Ethics, *Opinion 8.03, Conflicts of Interest: Guidelines*, [http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion803.page?](http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion803.page) (last visited January 5, 2015). Ethical principles adopted by other major physician groups are in accord. See Lois Snyder, *The Physician and the Patient*, 156 ANNALS OF INTERNAL 73, 75-82 (2012), available at <http://annals.org/article.aspx?articleid=1033289#TheEthicsofPractice> ("The patient-physician relationship entails special obligations for the physician to serve the patient's interest because of the specialized knowledge that physicians possess, the confidential nature of the relationship, and the imbalance of power between patient and physician. Physicians publicly profess that they will use their skills for the benefit of patients, not their own benefit. Physicians must uphold this declaration, as should their professional associations as communities of physicians that put patient welfare first. The physician's primary commitment must always be to the patient's welfare and best interests, whether in preventing or treating illness or helping patients to cope with illness, disability, and death. The physician must respect the dignity of all persons and respect their uniqueness. The interests of the patient should always be promoted regardless of financial

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arrangements; the health care setting; or patient characteristics, such as decision-making capacity, behavior, or social status. Although the physician should be fairly compensated for services rendered, a sense of duty to the patient should take precedence over concern about compensation.”); Ad Hoc Committee On Medical Ethics, *American College of Physicians Ethics Manual: Part 1: History of Medical Ethics, The Physician and the Patient, The Physician’s Relationship to Other Physicians, The Physician and Society*, 101 ANNALS INTERNAL MEDICINE 129, 134 (1984) (“Under the covenant of personal medical care the physician is ordinarily the advocate and champion of his patient, upholding the patient’s interest above all others. . . .The physician must avoid any personal commercial conflict of interest that might compromise his loyalty and treatment of the patient.”); American College of Surgeons, *Statements on Principles*, ABOUT ACS (Sept. 1 2008), [http://www.facs.org/fellows\\_info/statements/stonprin.html](http://www.facs.org/fellows_info/statements/stonprin.html) (“I pledge to pursue the practice of surgery with honesty and to place the welfare and the rights of my patient above all else. . . .I will take no part in any arrangement or improper financial dealings that induce referral, treatment, or withholding of treatment for reasons other than the patient’s welfare.”); American College of Occupational and Environmental Medicine, *ACOEM Code of Ethics*, ABOUT ACOEM (last visited January 5, 2015), <http://www.acoem.org/codeofconduct.aspx> (“The first value or belief is that the health professional’s role is primarily to do good for the patient. This is referred to as the “principle of beneficence” in the language of bioethics. . . . Serving the patient’s best interest overrules personal considerations such as business needs, societal expectations, and organizational pressures. This belief dates to ancient codes of medical behavior.”); THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS COMMITTEE ON ETHICS, COMMERCIAL ENTERPRISES IN AMERICA (2007), *available at* [http://www.acog.org/Resources\\_And\\_Publications/Committee\\_Opinions/Committee\\_on\\_Ethics/Commercial\\_Enterprises\\_in\\_Medical\\_Practice](http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Ethics/Commercial_Enterprises_in_Medical_Practice) (“Physicians must not engage in actions that violate or call into question their fiduciary relationship with patients.”); World Medical Association, *Duties of Physicians to patients*, WMA INTERNATIONAL CODE OF MEDICAL ETHICS (last visited January 5, 2015), <http://www.wma.net/en/30publications/10policies/c8/> (“A physician shall owe his/her patients complete loyalty and all the scientific resources available to him/her.”). Some other statements from the AMA are more equivocal, however. *See* American Medical Association Council of Ethical and Judicial Affairs, *Gifts from Patients to Physicians*, CEJA REPORT4-A-03, (2003). (“First, physicians *often* are viewed as holding a fiduciary duty that requires them to be dedicated to the well-being of their patients, irrespective of any advantage or gain to themselves”) (emphasis added); American Medical Association Council of Ethical and Judicial Affairs, *Managing Conflicts of Interest in the Conduct of*

What does come as a surprise are the sources that cast doubt on or reject outright the fiduciary nature of the patient-physician relationship. These include judicial opinions<sup>9</sup> as well as Restatements,<sup>10</sup> legal treatises,<sup>11</sup>

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*Clinical Trials*, CEJA REPORT 3-I-00 (2000) (“*Many aspect* [sic] of the fiduciary relationship exist in the patient-physician relationship, which explains why physicians also have an ethical duty to avoid conflicts between their commitment to heal patients and their economic self-interest”) (emphasis added).

<sup>9</sup> Dayna Matthew states that only Alabama has held that the patient-physician relationship is not fiduciary in nature. Dayna Bowen Matthew, *Implementing American Health Care Reform: The Fiduciary Imperative*, 59 BUFF L. REV. 715, 719 n.18 (2011) (citing *Gunter v. Huddle*, 724 So. 2d 544, 546 (Ala. Civ. App. 1998)). The plaintiff in *Gunter* brought an action for medical malpractice and intentional infliction of emotional distress against a physician for an alleged sexual relationship. The appellate court affirmed the lower court’s dismissal of the malpractice claim on the basis that the sexual relationship was outside the scope of the physician’s professional services. *Gunter*, 724 So. 2d at 546. In the process, it stated that “Alabama caselaw holds that a physician-patient relationship is *not* a fiduciary relationship as a matter of law,” *Id.* at 546 (citing *Mitchell v. Harris*, 246 So. 2d 648, 651 (Ala. 1971)). But two other jurisdictions, Delaware and Minnesota, also have held that the patient-physician relationship is not fiduciary in nature. *McMahon v. New Castle Assocs.*, 532 A.2d 601, 604 (Del. Ch. 1987) (“One may place trust in a workman of any sort and does place trust in one’s physician, but it would hardly be contended that such trust would warrant chancery’s assuming jurisdiction over a claim that a workman or physician caused injury by want of due care—although a claim of that very type against a trustee will be entertained in a court of equity.”); *Carlson v. SALA Architects, Inc.*, 732 N.W.2d 324, 331 (Minn.App.2007) (citing *D.A.B. v. Brown*, 570 N.W.2d 168, 171 Minn. App. 1997) (“Minnesota has declined to classify even the physician-patient relationship as fiduciary.”). In addition, courts in 10 other states have held that, while the patient-physician may be fiduciary, patients have no cause of action against a doctor for breach of that duty, but only a cause of action for medical malpractice. *Hales v. Pittman*, 576 P.2d 493, 497 (Ariz. 1978) (“Additionally, if an undisclosed risk occurs, a patient may pursue a malpractice action premised on a negligence theory. We do not believe that the law in Arizona should be extended to recognize a new cause of action based on breach of trust when an adequate remedy for this case already exists. To do otherwise would ignore the underlying premise that the patient controls his own destiny.”); *Murillo v. Millner*, No. D055984, 2010 WL 4730396, at \*7 (Cal.App. 4 Dist. Nov. 23, 2010) (“Murillo’s claims for breach of fiduciary duty and negligence are based on the same allegation, to wit: Dr.

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Millner failed to obtain Murillo's informed consent prior to the circumcision. . . . Therefore, we likewise conclude Murillo failed to state sufficient facts to constitute a cause of action for breach of fiduciary duty and the trial court properly sustained the demurrer to Murillo's first amended complaint.”); *Spoor v. Serota*, 852 P.2d 1292, 1294-95 (Colo. App. 1992) (Breach of fiduciary duty claim sought to be asserted in amended complaint was merely duplicative of negligence claim in medical malpractice action against plastic surgeon and physician who treated patient's neck ulceration that had allegedly been caused by radiation treatments.); *Kernke v. Menninger Clinic, Inc.*, 172 F.Supp.2d 1347, 1354 (D. Kan. 2001) (“Under Kansas law, a plaintiff who brings a claim against a doctor or hospital for failure to perform the legal duty to exercise reasonable care, skill and diligence in the treatment of a patient may not also maintain other claims against the doctor or hospital for actions that arise from the same series of events as the underlying malpractice claim. . . . Kansas courts will not permit a plaintiff to 'creatively classify' a claim as something other than one for medical malpractice if the substance of the claim concerns the physician-patient relationship.”); *Colton v. Dewey*, 321 N.W.2d 913, 917 (Neb. 1982) (“Therein we stated that any professional misconduct or any unreasonable lack of skill or fidelity in the performance of professional or fiduciary duties is ‘malpractice’ and comes within the professional or malpractice statute of limitations.”); *Garcia v. Coffman*, 946 P.2d 216, 223 (N.M. Ct. App. 1997) (“It is this affirmative duty of full and fair disclosure that is at the heart of Plaintiff's claim of breach of fiduciary duty. However, the failure of a physician to disclose the factors that might influence a patient in his decision is a negligence cause of action that is triable by jury.”); *Jones v. Asheville Radiological Group, P.A.*, 518 S.E.2d 528, 532 (N.C. Ct. App. 1999) (“[I]n the context of a health care provider's unauthorized disclosure of a patient's confidences, claims of medical malpractice, invasion of privacy, breach of implied contract, and breach of fiduciary duty/confidentiality should all be treated as claims for medical malpractice.”); *Lykins v. Miami Valley Hosp.*, 811 N.E.2d 124 (Ohio Ct. App. 2004) (quoting *Ratcliffe v. Univ. Hospitals of Cleveland*, 61791, 1993 WL 69553 (Ohio Ct. App. Mar. 11, 1993)) (“Lykins raised a claim for malpractice in count one of her complaint. '[T]herefore, [Lykins's] claim for breach of fiduciary duty by a physician is a medical claim under R.C. 2305.11(D)(3).”); *Gomez v. Diaz*, 57 S.W.3d 573, 581 (Tex. App. 2001) (“Ms. Gomez contends that this amounts to a breach of fiduciary duty and unconscionable conduct. Again, we hold that these are merely recast health care liability claims.”); *Hansen v. Rogers*, 119 Wash. App. 1064, \*7 (Wash. Ct. App. 2003) (“A physician owes an actionable fiduciary duty toward a patient.... The misrepresentations alleged here by Hansen related directly to Dr. Rogers' care and treatment of Hansen. The alleged

scholarly articles<sup>12</sup> and monographs.<sup>13</sup> Even the Supreme Court has muddied the waters.<sup>14</sup>

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misrepresentations do not support a cause of action independent from RCW 7.70.”).

<sup>10</sup> RESTATEMENT (SECOND) OF CONTRACTS Restatement (Second) of Contracts § 161(d), cmt. f (1981) (“Even where a party is not, strictly speaking, a fiduciary, he may stand in such a relation of trust and confidence to the other as to give the other the right to expect disclosure. Such a relationship normally exists between members of the same family and may arise, in other situations as, for example, between physician and patient); RESTATEMENT (THIRD) OF TRUSTS § 2 cmt. (b)(1) (2003) (“Thus, a confidential relation may exist although there is no fiduciary relation and is particularly likely to arise between family members or close friends or on the basis of the confidence that arises between physician and patient or priest and penitent.”). In contrast, the Reporter’s Notes to the Restatement (Third) of Agency §8.2 suggest that the patient-physician relationship *is* fiduciary when it gives “the case of a layman who trusts a doctor” as an example of a relationship that is subject to “an inherent vulnerability” in its discussion of the agent’s fiduciary duty to the principal. RESTATEMENT (THIRD) OF AGENCY § 8.01, Reporter’s Notes b (2006).

<sup>11</sup> See GEORGE GLEASON BOGERT, ET AL., THE LAW OF TRUSTS AND TRUSTEES § 482 (3d ed. 2009) (hereinafter “Bogert on Trusts”) (“On the other hand, a doctor or nurse has been held to have been in a confidential relationship with a patient. . . .”); Austin Wakeman Scott & William Franklin Fratcher, THE LAW OF TRUSTS §2.5 (4th ed. 1987) (hereinafter “Scott on Trusts”) (“A fiduciary relation is to be distinguished from a merely confidential relation. . . .A confidential relation may exist although there is no fiduciary relation; it is particularly likely to exist where there is . . . such a relation of confidence as that which arises between physician and patient or priest and penitent.”).

<sup>12</sup> See Nan D. Hunter, *Risk Governance and Deliberative Democracy in Health Care*, 97 GEO. L.J. 1, 60 (2008) (“Marc Rodwin has argued that the concept of doctors as fiduciaries for their patients is ‘a dominant metaphor’ in health law, but that courts enforce it in only limited circumstances”); Richard S. Saver, *In Tepid Defense of Population Health: Physicians and Antibiotic Resistance*, 34 AM. J.L. & MED. 431, 455 (2008) (“complicating the fiduciary duty analysis is that courts have clearly applied fiduciary duties only to limited aspects of the physician-patient relationship”); Charity Scott, *Doctors As Advocates, Lawyers As Healers*, 29 HAMLIN J. PUB. L. & POL’Y 331, 399 (2008) (“Although doctors perform fiduciary-like roles and hold themselves out as fiduciaries in their ethical codes, the law holds doctors accountable as fiduciaries only in restricted situations,” (citing Marc. A Rodwin, *Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System*, 21 AM. J. L. & MED. 242, 247-252

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(1995) [hereinafter “Rodwin, Strains”]); Joseph H. King, *The Standard of Care for Residents and Other Medical School Graduates in Training*, 55 AM. U. L. REV. 683, 751 (2006) (“although physicians think of themselves as fiduciaries and courts sometimes label physicians as fiduciaries, ... such legal fiduciary principles have been applied to physicians only in limited instances, such as obtaining patients' informed consent prior to treatment,” (citing Rodwin, Strains, at 241, 242-46); Carl H. Coleman, *Duties to Subjects in Clinical Research*, 58 VAND. L. REV. 387, 449 (2005) (“Rodwin argues that fiduciary law principles have been applied to physicians only for very limited purposes,” (citing Rodwin, Strains at 241)); Mary Crossley, *Infected Judgment: Legal Responses to Physician Bias*, 48 VILL. L. REV. 195, 303 (2003) (quoting Rodwin, Strains at 247-248); D. Gordon Smith, *The Critical Resource Theory of Fiduciary Duty*, 55 VAND. L. REV. 1399, 1462-63 (2002) (quoting Rodwin, Strains at 247-248); E. Haavi Morreim, *Another ERISA Twist: The Mysterious Case of Pegram and the Missing Fiduciary*, 63 U. PITT. L. REV. 235, 239 (2002) (“It is debated whether physicians are fiduciaries in the most technical legal sense,” (citing Rodwin, Strains, at 247)); Michelle Oberman, *Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U. L. REV. 451, 456 (2000) (“In reality, however, although the fiduciary model accurately describes the doctor-patient relationship, doctors have eschewed the legal regulations that are associated with fiduciary relationships.”); *Id.* at 457 (referring to “the limited version of fiduciary duty applicable to doctors.”); *id.* at 458-459 (“As Professor Rodwin concludes in his thorough study of the field, fiduciary law principles have been applied to physicians in only a narrow set of circumstances”); Ken Marcus Gatter, *The Continued Existence and Benefit of Medicine's Autonomous Law in Today's Health Care System*, 24 U. DAYTON L. REV. 215, 282 (1999) (“The fiduciary responsibility physicians have for patients has always been limited compared to other fiduciary relationships,” (citing Rodwin, Strains, at 242-51)); Gregory D. Jones, *Primum Non Nocere: The Expanding "Honest Services" Mail Fraud Statute and the Physician-Patient Fiduciary Relationship*, 51 VAND. L. REV. 139, 182 (1998) (although courts label physicians as fiduciaries, “fiduciary law principles have been applied to physicians for very few purposes,” (citing Rodwin, Strains at 247)); Marc. A. Rodwin, Strains at 242 (“The thesis is that although doctors perform fiduciary-like roles and hold themselves out as fiduciaries in their ethical codes, the law holds doctors accountable as fiduciaries only in restricted circumstances. Moreover, private and public groups often expect doctors to work for parties other than patients, and health policy now focuses on the population rather than individual patients.”); *id.* at 247-248. (“In medicine there is a gap between the fiduciary ideal and practice. Physicians often call themselves fiduciaries and courts sometimes label physicians as

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fiduciaries, especially in informed consent cases. Still, fiduciary law principles have been applied to physicians only for very limited purposes. These include requiring that physicians not abandon patients, keep information they learn confidential, obtain patients' informed consent to treatment, and in one case, disclose to patients any financial interest in clinical research. Aside from these limited circumstances, physicians—as clinicians—are not held to fiduciary standards, especially with respect to financial conflicts of interest. Courts and legislatures have not developed comprehensive fiduciary obligations for physicians and do not consistently hold them accountable as such. One health law scholar has even asked whether fiduciary principles should constrain physician behavior.”); E. Haavi Morreim, *Blessed Be the Tie That Binds? Antitrust Perils of Physician Investment and Self-Referral*, 14 J. LEGAL MED. 359, 375-376 (1993) (“Not all scholars agree that the relationship is strictly fiduciary. Some consider it only a confidential relationship. Still, a number of the courts not explicitly dubbing the relationship fiduciary have nevertheless noted that this relationship does have the ‘fiducial qualities’ of trust and confidence, and that physicians have duties that clearly exceeded those of arms-length transactions. In either case, we can at the least agree that the relationship gives rise to certain obligations of fidelity.”); E. Haavi Morreim, *Conflicts of Interest: Profits and Problems in Physician Referrals*, 262 JAMA 390, 390-94 (1989) (not all courts and commentators regard physicians as fiduciaries “in the full legal sense of the term”).

<sup>13</sup> RODWIN, *supra* note 1. At one point, he states that “fiduciary law for doctors is now all but nonexistent. *Id.*, at 236. Elsewhere in the book he states that the fiduciary role of physicians is “very limited.” *See id.*, at 210 (Although physicians sometimes call themselves fiduciaries, fiduciary law has been applied to physicians only for very limited purposes. These include requiring that physicians not abandon patients, keep information they learn confidential, and obtain patients’ informed consent to treatment. Nevertheless, the roles played by physicians resemble those of professionals considered fiduciaries. They advise patients and act on their behalf. The medical ethos of acting in patients’ interests embodies the fiduciary ideal. The patient-physicians relationship, though unique, poses the same accountability problem as fiduciary relations.”); *id.*, at 184 (“Physicians often act as traditional fiduciaries and espouse a fiduciary ethic. In a few situations, courts apply fiduciary law principles to doctors. But aside from these limited circumstances, physicians—as clinicians—are not held to fiduciary standards, especially with respect to financial conflicts of interest. ...When behavior is questionable, courts require fiduciaries to prove that they have not violated their trust. Such is not the case for physicians. For example, unlike typical fiduciaries, who cannot accept gifts that may influence their professional decisions, doctors frequently accept gifts from pharmaceutical firms and medical suppliers.”).

This article begins by explaining why courts and commentators minimize or reject the fiduciary nature of the patient-physician relationship: a combination of errors; confusions about the difference between common law and equitable remedies; and misguided policy objectives. The article then proposes how physicians should discharge their fiduciary obligations to patients in specific cases. The article concludes by spelling out why reaffirming the fiduciary nature of their relationship is essential for physicians as well as for patients.

## II. WHO GETS IT WRONG AND WHY

### A. Mistakes and Confusions

Errors and misunderstandings about fiduciary doctrine lead some sources to reject or undercut the fiduciary nature of the patient-physician relationship.

#### 1. Restatements and Treatises

The Restatement (Third) of Trusts describes the patient-physician relationship as “confidential” but not fiduciary, while the Restatement (Second) of Contracts agrees that it is not “strictly speaking” fiduciary and instead calls it a relationship of “trust and confidence.”<sup>15</sup> While the Restatement of Trusts gives no support for its position, the Reporter’s Notes to the Restatement of Contracts cites to a 1978 article by Fleming James Jr. and Oscar S. Gray.<sup>16</sup> Not only do the authors of that article say no such thing at the given citation, but elsewhere in the article they state that the patient-physician relationship *is* fiduciary.<sup>17</sup>

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<sup>14</sup> See *Pegram v. Herdrich*, 530 U.S. 211 (2000), discussed *infra* notes 43-48 and accompanying text.

<sup>15</sup> See *supra* note 10.

<sup>16</sup> RESTATEMENT (SECOND) OF CONTRACTS § 161(d) cmt. f, Reporter’s Notes (1981), (citing Fleming James Jr. and Oscar S. Gray, *Misrepresentation—Part II*, 37 MD. L. REV. 488, 524-525 (1978)).

<sup>17</sup> *Id.* at 541 (“Misrepresentation may similarly toll a statute of limitations and, for this purpose, *where there is a fiduciary relationship*,

Both Bogert on Trusts and Scott on Trusts also describe the relationship as “confidential” rather than fiduciary.<sup>18</sup> Like the authors of the Restatement (Third) of Trusts, Scott gives no support for his position.<sup>19</sup> Bogert does cite six court opinions for the proposition,<sup>20</sup> but acknowledges that “there is no uniform practice among courts in their use of the phrases ‘fiduciary relation’ and ‘confidential relation,’ and that the terms are often used as synonyms.”<sup>21</sup> Bogert cites cases from three of the same six jurisdictions in support of this proposition.<sup>22</sup> Yet other decisions in all six of these jurisdictions *have* recognized the patient-physician relationship as “fiduciary.”<sup>23</sup>

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*such as that of physician to patient, ‘fraudulent concealment’ sometimes shades into nondisclosure of relevant facts ‘known to the doctor or readily available to him through efficient diagnosis.’”* (emphasis added).

<sup>18</sup> See *supra* note 11.

<sup>19</sup> See *supra* note 11.

<sup>20</sup> *Faulkner v. Beatty*, 327 P.2d 41 (2d Dist. App. Cal. 1958); *Hendrix v. Schrecengost*, 358 S.E.2d 486 (Ga. App. 1987); *Estate of McRae*, 522 So. 2d 731 (Miss. 1988); *Ostertag v. Donovan*, 331 P.2d 355 (N.M. 1958); *Hewitt v. Bullard*, 128 N.E. 2d 411 (N.C. 1962); *Hodge v. Shea*, 168 S.E. 2d 82 (S.C. 1969), cited at Bogert on Trusts, *supra* note 11 at 306-307.

<sup>21</sup> Bogert on Trusts, *supra* note 11 at 278-279. Shepherd at one point similarly states that “we come across the term ‘confidential relationship,’ which may mean a type of fiduciary relationship, or alternatively, a class of general relationships, some of which are fiduciary in nature.” Shepherd, *supra* note 6, at 7. Later, however, he asserts that “confidential relationships must be a category of fiduciary relationships. *Id.* at 162.

<sup>22</sup> *Id.* at n.1.

<sup>23</sup> *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479 (Cal. 1990) (en banc) (“a physician who is seeking a patient’s consent for a medical procedure must, in order to satisfy his fiduciary duty and to obtain the patient’s informed consent, disclose personal interests unrelated to the patient’s health, whether research or economic, that may affect his medical judgment.”); *Cox v. Athens Reg’l Med. Ctr., Inc.*, 631 S.E.2d 792, 79 n.14 (Ga. Ct. App. 2006) (“We note that, ordinarily, physicians owe a fiduciary duty to their patients with respect to the care given.”); *Madden v. Rhodes*, 626 So.2d 608, 618 (Miss.1993) (“This Court has for many, many years acknowledged the lawyer/client relationship or doctor/patient relationship as a fiduciary one.”); *Kern ex rel. Kern v. St. Joseph Hosp., Inc.*, 697 P.2d 135, 139 (N.M. 1985) (“Silence may sometimes constitute fraudulent concealment where a physician breaches his fiduciary duty to disclose material information concerning

The reasons for denominating the patient-physician relationship as “confidential” or one of “trust and confidence” rather than as fiduciary are unclear.<sup>24</sup> However, many sources recognize that the former differs from the latter in the burden of proof placed on plaintiffs. As Shepherd states:

[A] transaction in which a fiduciary self-deals will, almost without exception, be voidable at the option of the beneficiary. ...Once the beneficiary determines to avoid the transaction, it is only in the very rare case that the fiduciary will be able to meet the very heavy onus on him to demonstrate that there was no abuse of power.”<sup>25</sup>

On the other hand, as Scott on Trusts observes:

[I]f one person is in a confidential, but not a fiduciary, relation to another, a transaction between them will not be set aside at the instance of one of them unless he in fact reposed confidence in the other, and the other, by fraud or undue influence or otherwise,

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a patient's treatment.”); *Black v. Littlejohn*, 325 S.E.2d 469, 482 (N.C. 1985) (“The relationship of patient and physician is generally considered a fiduciary one, imposing upon the physician the duty of good faith and fair dealing.”); *McCormick v. England*, 494 S.E.2d 431, 436-37 (S.C. Ct. App. 1997) (“The jurisdictions that recognize the duty of confidentiality have relied on various theories for the cause of action, including invasion of privacy, breach of implied contract, medical malpractice, and breach of a fiduciary duty or a duty of confidentiality. ...We find the reasoning of the cases from other jurisdictions persuasive on this issue and today we join the majority and hold that an actionable tort lies for a physician's breach of the duty to maintain the confidences of his or her patient in the absence of a compelling public interest or other justification for the disclosure.”).

<sup>24</sup> They may relate to the fact that the patient-physician relationship was not actually called “fiduciary” until the mid-19th century, while English courts had earlier recognized certain relationships as “confidential.”

<sup>25</sup> Shepherd, *supra* note 6, at 159.

abused the confidence placed in him. . . . The burden of showing an abuse of a confidential relation is on the person seeking to set aside the transaction.<sup>26</sup>

In short, designating the patient-physician relationship as merely one of confidence significantly weakens the legal protections for patients, and is unjustified in view of the absence of a good reason for doing so.

## 2. *Scholarly Articles and Monographs*

In an influential 1993 book, Professor Mark Rodwin stated that “fiduciary law for doctors is all but nonexistent,”<sup>27</sup> and that “physicians--as clinicians--are not held to any fiduciary standards, especially with respect to

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<sup>26</sup> Scott on Trusts, *supra* note 11, at §2.5. See E. Haavi Morreim, *Medicine Meets Resource Limits: Restructuring the Legal Standard of Care*, 59 U. PITT. L. REV. 1, 72, 71 n.245 (1997) (citing scholarship, cases, and treatises in support of this contention); *Demers v. Gerety*, 515 P.2d 645, 655 (N.M. Ct. App. 1973) (Sutin, J., concurring) (“In a fiduciary relationship, the burden is on the defendant to show scrupulous good faith in obtaining an express written authority to operate or to extend the operation when it conflicts with the unequivocal beliefs of the patient.”). See also the following cases, cited in Johnston, *supra* note 7, at 951, n.65: *Knaebel v. Heiner*, 663 P.2d 551, 553 (Alaska 1983); *Smith v. Tele-Comm’n, Inc.*, 184 Cal. Rptr. 571, 575 (Cal. Ct. App. 1982); *Konover Dev. Corp. v. Zeller*, 635 A.2d 798, 810 (Conn. 1994); *Labovitz v. Dolan*, 545 N.E.2d 304, 311 (Ill. App. Ct. 1989); *Sampson v. Hunt*, 665 P.2d 743, 754 (Kan. 1983); *Gaynier v. Ginsberg*, 715 S.W.2d 749, 754 (Tex. App. 1986); *Wilkins v. Lasater*, 733 P.2d 221, 228 (Wash. Ct. App. 1987). An illustration of the difference between a relation of confidence and a fiduciary relationship is illustrated in the debate in employment law over which status more aptly describes the relationship of employee to employer. See Michael Sharp, *A Norm-Based Analysis of Employment Obligations of Confidence and Trust*, 18 N. ZEAL. BUS. L. Q. 341, 346 (2012) (discussing *Univ. of Nottingham v. Fishel* [2000] ICR 1462 (QB) “confidence and trust principles only require a party to take the other party’s interests into account rather than have regard to them completely”; V. Sims, *Is Employment a Fiduciary Relationship? Univ. of Nottingham v. Fishel* [2000] IRLR 471; [2000] ICR 1462 (QB), 30 INDUSTRIAL L. J. 101-110 (2001).

<sup>27</sup> RODWIN, *supra* note 1, at 236.

financial conflicts of interest.”<sup>28</sup> The first assertion had no supporting references, while the reference he gave for the second was, in his words, “an exception” that did not support his point.<sup>29</sup> Elsewhere in the book Rodwin was slightly more nuanced, asserting that “although physicians sometimes call themselves fiduciaries, fiduciary law has been applied to physicians only for very limited purposes.”<sup>30</sup> The footnote accompanying this statement also gives no references, but merely says that “one health law scholar has even asked whether fiduciary principles *should* constrain physicians’ behavior,”<sup>31</sup> citing a 1983 book chapter by Boston University law professor Fran Miller. Miller, however, says no such thing. On the contrary, she states that:

[I]t is generally recognized that the parties to a *physician-patient relationship* are frequently on unequal footing. . . . The law redresses this kind of imbalance in certain relationships by requiring people who occupy positions of trust, such as physicians, to subordinate self-interest

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<sup>28</sup> *Id.* at 210.

<sup>29</sup> *Id.* at 210 and n.140 (citing *Moore v. Regents of the Univ. of Cal.*, 792 P.2d 479 (Cal. 1990)).

<sup>30</sup> *Id.* at 184. Later in the book, he states: “Physicians often act as traditional fiduciaries and espouse a fiduciary ethic. In a few situations, courts apply fiduciary law principles to doctors. But aside from these limited circumstances, physicians—as clinicians—are not held to fiduciary standards, especially with respect to financial conflicts of interest. . . . When behavior is questionable, courts require fiduciaries to prove that they have not violated their trust. Such is not the case for physicians. For example, unlike typical fiduciaries, who cannot accept gifts that may influence their professional decisions, doctors frequently accept gifts from pharmaceutical firms and medical suppliers.” *Id.* at 210. Again, none of the references he cites supports his claims.

<sup>31</sup> *Id.* at 356, n. 37, citing Frances H. Miller, *Secondary Income from Recommended Treatment: Should Fiduciary Principles Constrain Physician Behavior?*, in *The New Health Care for Profit: Doctors and Hospitals in a Competitive Environment* 153, 153–69 (Bradford H. Gray ed., 1983) (emphasis in Rodwin).

to the well being of their charges. Such a relationship *is called a fiduciary relationship*.<sup>32</sup>

Unfortunately, Rodwin's unsupported claim that the fiduciary role of physicians was limited was accepted uncritically by many health law scholars.<sup>33</sup>

One reason that Rodwin believes that the law regards physicians as fiduciaries at most in a limited sense is that physicians have conflicts of interest with their patients.<sup>34</sup>

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<sup>32</sup> *Id.* at 356, n. 37 (citing Frances H. Miller, *Secondary Income from Recommended Treatment: Should Fiduciary Principles Constrain Physician Behavior?*, in *THE NEW HEALTH CARE FOR PROFIT: DOCTORS AND HOSPITALS IN A COMPETITIVE ENVIRONMENT* 153, 153-69 (Bradford H. Gray ed., 1983)) (emphasis in Rodwin).

<sup>33</sup> See *supra* note 12.

<sup>34</sup> See Rodwin, *Strains*, *supra* note 12, at 252-253. Rodwin describes the following conflicts: obligations to more than one patient, such as when engaging in triage, considering the needs of other patients in deciding whether to place a patient in intensive care, treating both a dying patient and a patient in need of a transplant organ from that patient, and considering the interests of the fetus when caring for a pregnant woman; an obligation to protect persons who are not their patients, such as physicians' duty to institutionalize dangerous patients and warn identified third parties of a risk of harm from a patient and their duty to breach patient confidentiality to alert public health officials to a patient's contagious disease; owing loyalty to certain organizations as well as to patients, such as sports teams, the military, hospital management, and employers; rationing medical resources on behalf of "providers, insurers, government, or society at large"; and "financial conflicts of interest." *Id.* at 248. These financial conflicts include accepting gifts from pharmaceutical firms and medical suppliers. *Id.*, at 250. Rodwin ultimately says that the law should hold physicians to a more expansive fiduciary duty to patients, but that this is a task for legislatures rather than courts; he acknowledges that having conflicts does not preclude physicians from being fiduciaries for patients: "There is ample precedent for balancing competing interests within a fiduciary framework [and] . . . [m]any fiduciaries . . . have to balance the interests of competing individuals or groups. Corporate officers must serve the interest of different groups of stockholders . . . . Lawyers are expected to be zealous advocates for their clients while serve as officers of the court and protect the integrity of the judicial system." *Id.* at 255-56. "Therefore, the fact that physicians have obligations to third parties does not mean that they cannot be fiduciaries for patients." *Id.* at 256.

But while fiduciary duties may preclude some conflicts,<sup>35</sup> they do not necessarily rule out all; as Shepherd observes, “the mainstream of the law of fiduciaries does not punish a fiduciary for having a conflict of interest, but finds him liable only if he actually chooses interests other than those of his beneficiaries.”<sup>36</sup> Even in the most paradigmatic fiduciary relationship, that between trustees and trust beneficiaries, trustees often face the conflicting interests of different beneficiaries or conflicts between a grantor’s life interest in income-production and a remainderman’s interest in growth assets. This is no less true in the patient-physician relationship than in other fiduciary relationships. Haavi Morreim, a scholar who has written some of the most thoughtful legal scholarship about the fiduciary aspects of the patient-physician relationship, observes, for example, that physicians “have long faced conflicts of interest, as fee-for-service reimbursement rewarded excessive care.”<sup>37</sup> Indeed, if the stronger party in a service relationship did not have conflicts of interest with the weaker party, there would be no reason for the law to make the stronger party a fiduciary to begin with.<sup>38</sup>

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<sup>35</sup> See Julian Velasco, *Fiduciary Duties and Fiduciary Outs*, 21 GEO. MASON L. REV. 157, 162 (2013) (“fiduciaries must avoid conflicts of interest that might tempt them to act against the interests of the beneficiary”); See, e.g., RESTATEMENT (THIRD) OF AGENCY, §§ 801-05 (2006).

<sup>36</sup> J. C. SHEPHERD, *THE LAW OF FIDUCIARIES* 41 (1981), accord Kim Johnston, *Patient Advocates or Patient Adversaries? Using Fiduciary Law to Compel Disclosure of Managed Care Financial Incentives*, 35 SAN DIEGO L. REV. 951, 961 (1998) (“It is sometimes said that a fiduciary may not even enter a situation where a conflict of interest could arise. However, it is probably more accurate to say that, when faced with a conflict between duty and self-interest, the fiduciary must act according to the duty.”)

<sup>37</sup> E. Haavi Morreim, *Cost Containment Challenging Fidelity and Justice*, HASTINGS CENT. REP., Dec. 1988, at 20-25.

<sup>38</sup> However, Morreim argues that physicians who enroll their patients in clinical trials in which the physicians are investigators are no longer fiduciaries for the patients. See E. Haavi Morreim, *The Clinical Investigator As Fiduciary: Discarding A Misguided Idea*, 33 J. L., MED. & ETHICS 586 (2005). One reason she gives is that investigators owe their primary loyalty to the research protocol and the future

### 3. Cases

Courts in three states, Alabama, Delaware, and Minnesota, have declared that the patient-physician relationship is not fiduciary in nature.<sup>39</sup> The Alabama cases do not give a reason. Delaware, unique among United States jurisdictions in retaining the distinction between courts of common law and courts of equity, is concerned that recognizing the relationship as fiduciary and allowing patients to bring actions in equity for breaches of physicians' fiduciary duty would reduce the ability of its Court of Chancery to carry out its primary function of resolving corporate disputes.<sup>40</sup> Minnesota is concerned that

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patients who may benefit from the results of the investigation, rather than to the subjects. *Id.* at 599. Morreim also points out that investigators expose subjects in clinical trials to risks that would be unacceptable in the relationship between physicians and patients, such as the risk of receiving a placebo rather than a potentially beneficial experimental intervention and the risk of harm from experimental procedures. *Id.* at 590. However, fiduciary doctrine does not preclude fiduciaries, including physicians, from subordinating patient welfare to the welfare of third parties in certain carefully circumscribed circumstances. Moreover, physicians routinely expose patients to risks from unproven interventions when they prescribe drugs or medical devices "off-label," that is, in a manner that is not approved by the Food and Drug Administration, and this does not necessarily violate their fiduciary duty to the patients. Curiously, Morreim does not discuss the core aspect of a physician's fiduciary duty, namely, the prohibition against sacrificing patient welfare for doctors' own self-interest. As applied to physician-investigators, the prohibition might seem to preclude physicians from obtaining financial or reputational benefits from enrolling patients as subjects, both of which are standard practice. *See, e.g.*, CTR. FOR HEALTH & PHARM. LAW & POLICY, SETON HALL UNIV. SCH. OF LAW, *A White Paper on Conflicts of Interest in Clinical Trial Recruitment & Enrollment: A Call for Increased Oversight* 1 (2009), available at [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=1515762](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1515762) (last visited January 5, 2015).

<sup>39</sup> *See supra* note 9.

<sup>40</sup> *See McMahon v. New Castle Assocs.*, 532 A.2d 601, 604 (Del. Ch.1987) ("Among the most ancient of headings under which chancery's jurisdiction falls is that of fiduciary relationships . . . . Chancery takes jurisdiction over 'fiduciary' relationships because equity, not law, is the source of the right asserted. Thus, when this court, for example, said 'A fiduciary relationship is a situation where one person reposes special

patients could assert a cause of action for breach of fiduciary duty to avoid the statute of limitations for medical malpractice and the need to prove actual injury.<sup>41</sup>

Similarly, the United States Supreme Court and courts in ten other states, while acknowledging or at least not rejecting the fiduciary nature of the relationship, have held that a patient has no cause of action for breach of a physician's fiduciary duties that is distinct from an action for medical malpractice.<sup>42</sup> The Supreme Court case,

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trust in and reliance on the judgment of another or where a special duty exists on the part of one person to protect the interests of another,' [citation omitted], attention must be paid to the word 'special' lest the statement be thought to describe too broadly chancery's concerns with relationships where an element of trust, as commonly understood, is present. One may place trust in a workman of any sort and does place trust in one's physician, but it would hardly be contended that such trust would warrant chancery's assuming jurisdiction over a claim that a workman or physician caused injury by want of due care—although a claim of that very type against a trustee will be entertained in a court of equity.”); Delaware Court of Chancery (<http://courts.delaware.gov/chancery/>) (last visited Feb. 13, 2014) (“The Delaware Court of Chancery is widely recognized as the nation's preeminent forum for the determination of disputes involving the internal affairs of the thousands upon thousands of Delaware corporations and other business entities through which a vast amount of the world's commercial affairs is conducted.”).

<sup>41</sup> See *D.A.B. v. Brown*, 570 N.W. 2d 168, 171 (Minn. Ct. App. 1997). (“We decline to create a new cause of action [for breach of doctors' fiduciary duty to patients] simply to permit the putative class to avoid showing injury or to circumvent the legislatively mandated statute of limitations.”); E. Haavi Morreim, *High-Deductible Health Plans: New Twists on Old Challenges from Tort and Contract*, 59 VAND. L. REV. 1207, 1242 (2006) (discussing courts' concern about the need for patients to prove actual damages).

<sup>42</sup> See *Hales v. Pittman*, 576 P.2d 493, 497 (Ariz. 1978) (“Additionally, if an undisclosed risk occurs, a patient may pursue a malpractice action premised on a negligence theory. We do not believe that the law in Arizona should be extended to recognize a new cause of action based on breach of trust when an adequate remedy for this case already exists. To do otherwise would ignore the underlying premise that the patient controls his own destiny.”); *Murillo v. Millner*, No. D055984, 2010 WL 4730396, at \*7 (Cal. App. 4 Dist. Nov. 23, 2010) (“Murillo's claims for breach of fiduciary duty and negligence are based on the same allegation, to wit: Dr. Millner failed to obtain Murillo's informed consent prior to the circumcision . . . . Therefore, we likewise

*Pegram v. Herdrich*, involved an employer-sponsored health plan called “Carle,” which was a qualified employee health benefit plan under the Employee Retirement Income

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conclude Murillo failed to state sufficient facts to constitute a cause of action for breach of fiduciary duty.”); *Spoor v. Serota*, 852 P.2d 1292, 1294-95 (Colo.App.1992) (“Breach of fiduciary duty claim sought to be asserted in amended complaint was merely duplicative of negligence claim in medical malpractice action against plastic surgeon and physician who treated patient's neck ulceration that had allegedly been caused by radiation treatments.”); *Kernke v. Menninger Clinic, Inc.*, 172 F.Supp.2d 1347, 1354 (D. Kan. 2001) (“Under Kansas law, a plaintiff who brings a claim against a doctor or hospital for failure to perform the legal duty to exercise reasonable care, skill and diligence in the treatment of a patient may not also maintain other claims against the doctor or hospital for actions that arise from the same series of events as the underlying malpractice claim . . . . Kansas courts will not permit a plaintiff to 'creatively classify' a claim as something other than one for medical malpractice if the substance of the claim concerns the physician-patient relationship.”); *Colton v. Dewey*, 321 N.W.2d 913, 917 (Neb. 1982) (“Therein we stated that any professional misconduct or any unreasonable lack of skill or fidelity in the performance of professional or fiduciary duties is ‘malpractice’ and comes within the professional or malpractice statute of limitations.”) (internal citation omitted.); *Garcia v. Coffman*, 946 P.2d 216, 223 (N.M. Ct. App. 1997) (“It is this affirmative duty of full and fair disclosure that is at the heart of Plaintiff's claim of breach of fiduciary duty. However, the failure of a physician to disclose the factors that might influence a patient in his decision is a negligence cause of action that is triable by jury.”); *Jones v. Asheville Radiological Group, P.A.*, 518 S.E.2d 528, 532 (N.C. Ct. App. 1999) (“in the context of a health care provider's unauthorized disclosure of a patient's confidences, claims of medical malpractice, invasion of privacy, breach of implied contract, and breach of fiduciary duty/confidentiality should all be treated as claims for medical malpractice”); *Lykins v. Miami Valley Hosp.*, 811 N.E.2d 124, 141 (2d Dist. Montgomery County 2004) (“Lykins raised a claim for malpractice in count one of her complaint. '[T]herefore, [Lykins's] claim for breach of fiduciary duty by a physician is a medical claim under R.C. 2305.11(D)(3).”); *Gomez v. Diaz*, 57 S.W.3d 573, 581 (Tex. App.-Corpus Christi 2001, no pet.) (“Ms. Gomez contends that this amounts to a breach of fiduciary duty and unconscionable conduct. Again, we hold that these are merely recast health care liability claims.”); *Hansen v. Rogers*, No. 50259-0-I, 2003 WL 23019948, at \*7 (Wash. App. Ct. Dec. 29, 2003) (“A physician owes an actionable fiduciary duty toward a patient . . . . The misrepresentations alleged here by Hansen related directly to Dr. Rogers' care and treatment of Hansen. The alleged misrepresentations do not support a cause of action independent from RCW 7.70.”).

Security Act (ERISA).<sup>43</sup> Carle was owned by physicians who received a bonus at the end of the year if the plan was profitable—in other words, if they collectively spent less on enrollee health care than they collected in premiums and payments. One way to help the bottom line of the plan was to provide medical care only at those hospitals and other facilities that were affiliated with the plan. Dr. Pegram, one of Carle’s owners, examined Herdrich, who was complaining of pain in her groin, and found nothing wrong. According to the complaint, “[s]ix days later, Dr. Pegram discovered a six by eight centimeter inflamed mass in Herdrich’s abdomen. Despite the noticeable inflammation, Dr. Pegram did not order an ultrasound diagnostic procedure at a local hospital, but decided that Herdrich would have to wait eight more days for an ultrasound, to be performed at a facility staffed by Carle more than 50 miles away. Before the eight days were over, Herdrich’s appendix ruptured, causing peritonitis.”<sup>44</sup>

Herdrich sued Dr. Pegram alleging that the doctor not only had committed medical malpractice, but also had breached his fiduciary duty to her under ERISA, since the bonus feature created an incentive “to make decisions in the physicians’ self-interest, rather than the exclusive interests of plan participants.”<sup>45</sup>

In a unanimous decision, the Court rejected Herdrich’s claim on the basis that her allegations did not show that the defendant physicians had been acting as fiduciaries under ERISA.<sup>46</sup> Furthermore, the Justices went on to explain in

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<sup>43</sup> Pegram v. Herdrich, 530 U.S. 211 (2000).

<sup>44</sup> *Id.* at 215.

<sup>45</sup> *Id.* at 216.

<sup>46</sup> The Court’s reasoning, that the physicians were making “mixed eligibility and treatment decisions” and, as such, were not acting as fiduciaries under ERISA, 530 U.S. at 229-232, is confused. The Court is describing doctors’ decisions about whether a treatment approach was both medically necessary and covered under the ERISA health plan. (The Court misuses the term “eligibility,” which technically refers to whether the patient was entitled to any benefits from a health plan, to describe a coverage decision, which concerns the specific services that a patient is entitled to.) Since the treatment in question, an ultrasound to detect appendicitis, clearly was covered under the plan if it was

dicta that, if the physicians who owned the plan *had* been acting as fiduciaries, Herdrich still would not be entitled to the relief that she sought:

The defense of any HMO would be that its physician did not act out of financial interest but for good medical reasons, the plausibility of which would require reference to standards of reasonable and customary medical practice in like circumstances. That, of course, is the traditional standard of the common law. . . . Thus, for all practical purposes, every claim of fiduciary breach by an HMO physician . . . would boil down to a malpractice claim, and the fiduciary standard would be nothing but the malpractice standard traditionally applied in actions against physicians.<sup>47</sup>

In other words, the Court seemed to be saying, physicians acting in their own self-interest at a patient's expense could be sued only for malpractice and not for a breach of fiduciary duty.

Since the *Pegram* case involved the fiduciary duties of health benefit plan trustees under ERISA,<sup>48</sup> the foregoing dicta might not be deemed to extend to the equitable duties generally owed by physicians to their patients. However, a number of other courts have echoed the Court's reasoning in rejecting breach of fiduciary claims in non-ERISA cases as duplicating malpractice claims. The same year as *Pegram*, for example, the Supreme Court of Illinois decided *Neade v. Portes*,<sup>49</sup> in which the plaintiff alleged that her spouse, who had been complaining of chest pain, had died from a heart

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medically necessary, the only decision the doctors were making was whether or not the ultrasound was medically necessary, which is what the Court calls a "treatment" decision, and there was no "mix" about it. *See Id.* at 229-232.

<sup>47</sup> *Id.* at 235.

<sup>48</sup> ERISA states, for example, "a fiduciary with respect to a plan shall not deal with the assets of the plan in his own interest or for his own account." 29 U.S. Code § 1106 (b)(1).

<sup>49</sup> 739 N.E.2d 496 (Ill. 2000).

attack because his physician had refused to order an angiogram. The physician belonged to a group practice that contracted with a health maintenance organization (HMO) to provide care to plan enrollees. The physicians were “globally-capitated,” in that they received a lump sum of \$75,000 a year to cover the costs of all referrals and tests by non-plan providers; if costs for these services exceeded that amount, the group would have to pay for them out of its own revenues, but if the costs were less, the group would pocket the difference. The plaintiff alleged that the doctor should have disclosed this financial arrangement, which would have prompted her and her husband to seek a second opinion about the need for an angiogram, and that his failure to make this disclosure was a breach of his fiduciary duty as well as malpractice.<sup>50</sup> The court held that, although physicians were fiduciaries for their patients, “Illinois courts have never recognized a cause of action for breach of fiduciary duty against a physician”<sup>51</sup> and that in any event, citing *Pegram*, “plaintiff’s breach of fiduciary duty claim is a re-presentment of her medical negligence claim.”<sup>52</sup> Courts in ten other states have taken the same approach and refused to recognize breach of fiduciary claims against physicians as distinct from medical malpractice claims.<sup>53</sup>

Of course, a claim that a physician breached a fiduciary duty is *not* the same as a claim that the physician committed medical malpractice. The former deals with whether or not the physician acted loyally, while the latter deals with whether the physician acted with due care.<sup>54</sup>

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<sup>50</sup> *Id.* at 499.

<sup>51</sup> *Id.* at 500.

<sup>52</sup> *Id.* at 501-502.

<sup>53</sup> See cases cited *supra* in note 42.

<sup>54</sup> See Shepherd, *supra* note 6, at 49 (“[T]he duty of care has absolutely no necessary connection with fiduciary relationships. In the instances in which fiduciary relationships have a duty of care attached, we posit that that duty of care rests either in contract (e.g. most agents) or in tort (e.g. some types of advisers).”). There is some overlap between a physician’s fiduciary duty and the duty to provide reasonable care. One aspect of reasonable care, for example, is to continue to care for a patient until care is no longer needed or further care would be futile, known as the “continuous treatment rule,” or until the patient or the

Furthermore, as noted earlier,<sup>55</sup> in an action for breach of fiduciary duty, once a plaintiff establishes that a fiduciary had a conflict of interest with the entrustor, the burden shifts to the fiduciary to prove that he or she nevertheless acted loyally;<sup>56</sup> in a malpractice action, on the other hand, the plaintiff bears the burden of proving that the defendant failed to meet the applicable standard of care.

In addition, the remedies are different. A successful plaintiff in a malpractice action is entitled to the common law remedy of restoration, namely, money damages designed to place the plaintiff as much as possible in the position in which the plaintiff would have been had there been no malpractice. The successful plaintiff in an action

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physician properly terminates the relationship. A physician can terminate the relationship unilaterally by giving the patient notice and a reasonable opportunity to obtain care elsewhere. Improperly terminating the relationship is a type of medical malpractice called abandonment. *See* Payton v. Weaver, 131 Cal. App. 3d 38, 182 Cal. Rptr. 225 (1st Dist. 1982). In that case, a physician wanted to terminate a relationship with a dialysis patient who was noncompliant and whose bad behavior disrupted treatment for other patients. If the physician had not given the patient adequate notice and an opportunity to find treatment from another dialysis center, the physician would have been liable for abandonment; if another reason for improperly terminating the relationship was the physician's own self-interest, the physician also would be liable for a breach of fiduciary duty.

<sup>55</sup> *See Shepherd, supra* notes 6 and 36 and accompanying text.

<sup>56</sup> *See* E. Haavi Morreim, *The Clinical Investigator As Fiduciary: Discarding A Misguided Idea*, 33 J.L. MED & ETHICS 586, 589 (2005) (“[I]f the entrustor can prove that his fiduciary is in a conflict of interest, the law will presume that the fiduciary abused his power or exploited the entrustor, and thereby will place on the fiduciary the burden of proving he did not.”). *See also* Johnston, *supra* note 7, at 962-963 (“In light of fiduciary law's protective function, many courts have also created special rules to help plaintiffs in these cases. These special rules recognize the fact that the ‘law watches with the greatest jealousy transactions and dealings between persons occupying a fiduciary relationship.’ For example, courts often reverse the normal rule that the plaintiff has the burden of proof in a civil case and hold that, once the plaintiff has shown that a fiduciary relationship exists, the defendant has the burden of disproving its breach. Many courts also hold that the existence of a fiduciary relationship gives rise to a presumption of fraud or undue influence that can only be rebutted by clear and convincing evidence.”).

for breach of fiduciary duty, on the other hand, is entitled to an accounting for profits or a constructive trust, designed to place the plaintiff in the position the plaintiff would have been in if the fiduciary had acted loyally.<sup>57</sup> In addition, a successful plaintiff may obtain specific performance<sup>58</sup> and punitive damages.<sup>59</sup> In *Pegram*, for example, the plaintiff asked the court to order the defendants to refund to the plan any profits that they made by acting in their own self-interest rather than in the interests of their patients, in other words, the remedy of an accounting for profits or constructive trust.<sup>60</sup> Such a remedy would not be available in a malpractice action; instead, the plaintiff in *Pegram* only would have been entitled to compensation for the losses she sustained as a result of rupturing her appendix.<sup>61</sup>

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<sup>57</sup> See FRANKEL, *supra* note 6, at 249-251 (describing accounting for profits and constructive trusts). See also Shepherd, *supra* note 6, at 116 (“[T]he constructive trust is one of the major remedies in the law of fiduciaries.”).

<sup>58</sup> See FRANKEL, *supra* note 6, at 249-251 (discussing the availability of injunctive relief).

<sup>59</sup> See *id.* at 258-260 (discussing the availability of punitive damages). Punitive damages are usually not available for mere medical malpractice. See Theodore Eisenberg et. al., *Juries, Judges, and Punitive Damages: An Empirical Study*, 87 CORNELL L. REV. 743, 745 (2002) (“Misperceptions about juries and punitive damages are especially strong. Contrary to popular belief, juries rarely award such damages, and award them especially rarely in products liability and medical malpractice cases.”).

<sup>60</sup> *Pegram*, 530 U.S. at 233.

<sup>61</sup> Indeed, one reason the court in *Neade v. Portes* gave for rejecting the plaintiff’s fiduciary cause of action was that her lawyers had not asked for any remedy specifically for breach of fiduciary duty: “Plaintiff requests \$50,000 in addition to costs of the lawsuit in damages under count I [for negligence]. Count II of plaintiff’s amended complaint attempts to state a cause of action for Dr. Portes’ breach of fiduciary duty. The damages alleged in count II are identical to those alleged in count I. Here, though attempting to couch the claim in different terms, plaintiff is essentially pleading the same cause of action which caused the same damages.” 739 N.E.2d 496, at 503 (Ill. 2000). The patient’s lawyers in *Moore vs. Regents of the University of California*, 793 P.2d 479 (Cal. 1990), similarly did not correctly appreciate the remedy for a breach of fiduciary duty, and instead brought an action for conversion against physicians who allegedly failed to inform the plaintiff that they intended to transform cancer cells that they were going to remove from

Finally, although patients alleging breaches of fiduciary duty are likely to have a stronger case if they can show that the physician's disloyalty was accompanied by malpractice, physicians technically can breach their fiduciary duty even if the care that they provided meets the standard of care for negligence. For example, the physician may have made a mistake that was reasonable but that could have been avoided had the physician not acted out of self-interest.<sup>62</sup> Alternatively, the physician may have deprived the patient of care that, while reasonable, would have been of even higher quality had the physician not acted self-interestedly.<sup>63</sup>

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his spleen into a lucrative cell line for use by researchers. In an action for conversion, the plaintiff is entitled to be restored to his property, namely, the handful of cancer cells removed from his spleen, while in an action for breach of fiduciary duty, the plaintiff would have been entitled to the enormous monetary value of the cell line.

<sup>62</sup> In *Lauro v. Travelers Ins. Co.*, a patient who underwent an unnecessary radical mastectomy brought a malpractice action against the pathologist who misdiagnosed a benign tumor as cancerous. 261 So.2d 261 (La. Ct. App. 1972). The majority of the court held that the mistake, although it might have been avoided had the pathologist used state-of-the-art equipment, was nevertheless reasonable. *Id.* at 266. The patient did not allege that the pathologist had used older equipment out of economic self-interest (in fact, the equipment was owned by the hospital where the surgery was performed), but if the patient could show that that in fact was the reason, the plaintiff might have a cause of action against the pathologist for breach of fiduciary duty even though use of the older equipment was still acceptable according to the standard of care at the time.

<sup>63</sup> In a 2001 Pennsylvania Supreme Court case, *Duttry v. Patterson*, 771 A.2d 1255 (Pa. 2001), the plaintiff needed a surgical procedure to remove part of her esophagus and stomach and alleged that the surgeon botched the operation. The plaintiff also alleged that, prior to the operation, she had asked the surgeon how often he had performed the procedure, to which he replied that he did it once a month, but she found out later that he had only done it nine times in the past five years. The plaintiff sued the physician for failing to obtain her informed consent, which in Pennsylvania is a battery action. *Id.* at 1258. After dismissing the plaintiff's cause of action on the ground that Pennsylvania law does not require physicians to disclose their experience when they obtain a patient's informed consent, the court noted that "other causes of action provide avenues for redress to the injured patient. For example, it is conceivable that a physician's lack of experience in performing an operation would support a plaintiff's case in

### *B. Deliberate Attacks*

The previous section described how sources that have rejected the fiduciary nature of the patient-physician relationship have misunderstood fiduciary doctrine. Far more troubling, however, are the sources that deliberately subvert the fiduciary nature of the relationship because they believe that physicians should not be loyal to their patients.

According to these commentators, it is necessary for doctors covertly to withhold care for their patients in order to reduce health care costs. Morreim, for example, states that “it is time to dispose of the naive notion that physicians can offer patients untainted loyalty, unlimited altruism, and boundless professional self-effacement” adding:

Physicians retain some control over resources because only they are licensed to prescribe medical interventions. Therefore, third parties who want to limit their expenditures must either control physicians' decisions (and thereby abridge their clinical autonomy), or influence physicians by placing them under powerful incentives. ... Loyalty remains an important value in this fiduciary relationship,

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negligence.” *Id.* at 1259. But in inquiring about the surgeon’s experience, the plaintiff might have been trying not only to avoid being operated on by a surgeon who was incompetent, but to have the surgery performed by the best surgeon in the area. Similarly, in *Moore vs. Regents of the University of California*, 792 P.2d 479 ( Cal. 1990), the California Supreme Court characterized the duty to obtain a patient’s informed consent as in part fiduciary because the physicians’ failure to obtain informed consent was their failure to disclose “personal interests unrelated to the patient's health, whether research or economic, that may affect his medical judgment.” 792 P. 2d at 485. By subordinating the plaintiff’s well being to the physicians’ personal interests, the physicians breached their fiduciary duty to the patient as well as their duty of care.

but it can no longer be a simplistic mandate always to serve the patient above oneself.<sup>64</sup>

The “third parties” to which Morreim is referring are government health programs such as Medicare and Medicaid and private health plans. In order to control spending, these organizations have adopted various forms of “managed care” aimed at physician decision-making. These include the capitation arrangement for the physicians in the *Pegram* case, a requirement that physicians obtain prior authorization from the plan before it will pay for what they order,<sup>65</sup> and financial rewards for physicians who limit hospital admissions and other expensive services for their patients.

Similarly, when Justice Souter, writing for the unanimous Court in *Pegram*, suggested in dicta that patients could sue physicians only for malpractice and not for acting disloyally, he did so out of concern that allowing patients to sue for disloyal behavior effectively would outlaw efforts by managed care to limit health care spending:

[T]he Judiciary has no warrant to precipitate the upheaval that would follow a refusal to dismiss Herdrich's ERISA claim. The fact is that for over 27 years the Congress of the United States has promoted the formation of HMO practices. ... If Congress wishes to restrict its approval of HMO practice to certain preferred forms, it may choose to do so. But the Federal Judiciary would be acting contrary to the congressional policy of allowing HMO organizations if it were to entertain an ERISA fiduciary claim portending wholesale attacks on existing HMOs solely because of their

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<sup>64</sup> E. Haavi Morreim, *Redefining Quality by Reassigning Responsibility*, 20 AM. J. L. & MED. 79, 92 (1994).

<sup>65</sup> See *Murray v. UNMC Physicians*, 806 N.W.2d 118 (Neb. 2011), discussed *infra* notes 111-115 and accompanying text.

structure, untethered to claims of concrete harm.<sup>66</sup>

Another highly respected health law scholar, Mark Hall, is also concerned that allowing patients to sue doctors for violating their fiduciary duty to patients would interfere with efforts to control health care costs. Hall wants patients to trust their physicians, acknowledging that trust aids the healing process.<sup>67</sup> But he does not want patients to be able to hold doctors legally accountable for breaching that trust, arguing that this would undermine trust by substituting trust in the law for what David Mechanic calls “interpersonal trust” in the physicians’ personal integrity. In a commentary accompanying Hall’s article, law professor Greg Bloche claims that Hall’s real motive is to enable physicians to withhold costly services from trusting patients who do not suspect that this is happening, and, if they find out, to give them no legal recourse.<sup>68</sup>

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<sup>66</sup> *Pegram*, 530 U.S. at 233-234. The last sentence is perplexing since the plaintiff alleged that the physicians’ disloyalty caused her concrete harm in the form of a ruptured appendix and peritonitis. Moreover, as Hafemiester & Bryan observe, “many states do not have either a causation requirement or an actual harm requirement associated with their fiduciary causes of action. This is in part because . . . the breach of loyalty is the harm . . . .”, Thomas L. Hafemiester & Sarah P. Bryan, *Beware Those Bearing Gifts: Physicians’ Fiduciary Duty to Avoid Pharmaceutical Marketing*, 57 U. KAN. L. REV. 491, 524 (2009).

<sup>67</sup> See Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 479 (2002) (“the effectiveness of care depends on patients’ confidence in its efficacy”).

<sup>68</sup> M. Gregg Bloche, *Trust and Betrayal in the Medical Marketplace*, 55 Stan. L. Rev. 919, 949 (2002) (Hall “wants physicians to do the heavy lifting of cost control by drawing upon the trust they have accrued through the profession’s commitment to fidelity to patients”). Hall professed astonishment at Bloche’s accusation, but acknowledged that patients merely need to be informed about managed care incentives for withholding care when they enroll in the plan. Mark Hall, *Ideology and Trust: A Reply to Bloche*, 55 Stan. L. Rev. 955, 966-967 (2002) (“The only respect in which I favor hidden rationing is the following: If patients are properly informed when they join and renew with an insurance plan, and perhaps also when they select a physician group, I would not require physicians to remind patients about financial

The practice that Hall, the Court in *Pegram*, and Morreim are advocating is called “bedside rationing.” It is a response to the need to control health care spending based on the recognition that much of the increase in spending is attributable to physician behavior; as the saying goes, the most expensive piece of medical equipment is the physician’s pen.<sup>69</sup> The objective of bedside rationing is for doctors, acting in response to economic incentives created by their patients’ health plans, to decline to provide patients with expensive interventions, thereby saving scarce health care resources for other members of the plan and for society in general.<sup>70</sup>

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considerations or resource-based constraints each time the physician makes a treatment decision. I don’t disagree with physicians who want to practice medicine this way, but I argue that failing to adhere to such an ethic should not be the basis for tort liability. Instead, I think it is sufficient for legal purposes that physicians be candid about financial considerations when duly informed patients ask questions or express concern about the financial dimension of medical decision making. In short, it should be up to each patient whether to trust or whether to verify.”). The Illinois Supreme Court in *Neade* similarly held that a patient only has the right to receive information about a physician’s conflicts of interest from the plan, and then only if the patient makes a written request. 739 N.E.2d at 503-504.

<sup>69</sup> Much of the blame has been placed on “fee-for-service” payment systems (“FFS”) that reward physicians economically the more care that they give to their patients. Historically, third party payers could withhold payment for services that they considered to be medically unnecessary, but they did so only after the patient had received the service; managed care, on the other hand, has sought to resolve the necessity question before the patient receives the care, so that a refusal to cover the service typically deprives the patient of the health benefit that the physician is seeking to provide.

<sup>70</sup> See E. Haavi Morreim, *Benefits Decisions in Erisa Plans: Diminishing Deference to Fiduciaries and an Emerging Problem for Provider-Sponsored Organizations*, 65 TENN. L. REV. 511, 524 (1998) (distinguishing between conflicts of interest, involving “a conflict between a fiduciary’s duties to beneficiaries and his own personal welfare,” and conflicts of obligation, which “pit the fiduciary’s duties to an individual beneficiary against his duties to various other parties.”); *id.* at 527-528 (“The fiduciary for a health plan cannot literally have ‘undivided loyalty,’ because his loyalty is necessarily divided among the many beneficiaries whose conflicting needs command his attention. The fiduciary can at most be ‘disinterested’ and ‘impartial,’ in the sense that he looks out for beneficiaries’ interests rather than his own, and does

Bedside rationing is problematic, however. Ideally, the interventions that the doctor withheld would provide only marginal health benefits to the patient, and the doctor deems the benefits to be outweighed by the cost. But as suggested by *Neade*, where the patient allegedly died for lack of a timely diagnostic test, the foregone health benefits may be significant, in that case spelling the difference between life and death. Another critical aspect of bedside rationing, as mentioned, is that the patients do not realize that it is taking place. The point is to reduce the social cost of rationing by avoiding contentious public decision-making, such as by the “death panels” excoriated by Republicans during the debate over the Affordable Care Act.<sup>71</sup> But as the cases seeking to hold the physician liable for breach of fiduciary duty demonstrate, the patients or their families may discover the ruse, in which case they and the physician bear the social costs, and unlike rationing by public rulemaking, the patient now is an expensive “identifiable” rather than a less-expensive “statistical” life.<sup>72</sup> Moreover, people who are aware of the practice of bedside rationing by word of mouth or from press and internet accounts will try to protect themselves against it by attempting to research

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not exploit their dependence to promote his personal advantage.”). *But see* E. Haavi Morreim, *The Clinical Investigator As Fiduciary: Discarding A Misguided Idea*, 33 J. L., MED. & ETHICS 586, 589 (2005) (“The fiduciary also must not compromise the entrustor's welfare for the benefit of third parties. As noted by Finn, the fiduciary's duty in the ‘service of his beneficiaries' interests’ includes ‘a duty not to act for his own benefit, or for the benefit of any third person.’ Of course sometimes it may be impossible to avoid such conflicts of obligation. Nevertheless, the fiduciary's presumption is that the entrustor's interests are generally to take priority over third parties' interests as well as the fiduciary's personal benefit.”) (quoting P. D. FINN, FIDUCIARY OBLIGATIONS 3 (1977))

<sup>71</sup> See Bernard W. Corn, *Ending End-of-Life Phobia—A prescription for Enlightened Health Care Reform*, 361 N. ENG. J. MED. e63 (2009) (“The term—introduced on Sarah Palin's Facebook page and subsequently ranked as a finalist on many word-of-the-year lists—has come to connote a theoretical body that determines which patients deserve to live when health care is rationed.”).

<sup>72</sup> See Lisa Heinzerling, *The Rights of Statistical People*, 24 HARV. ENVTL. L. REV. 189-207 (2000).

the medical options themselves, questioning doctors' recommendations, and seeking second opinions, all of which entail monitoring and other transactions costs that fiduciary relationships are created to minimize. Finally, studies of bedside rationing show that physicians are prone to discriminate against poor and minority patients.<sup>73</sup>

So physicians should not sacrifice the welfare of their patients in order to conserve economic resources for others,<sup>74</sup> and doing so should be regarded as a breach of

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<sup>73</sup> See Elizabeth N. Chapman et. al., *Physicians and Implicit Bias: How Doctors May Unwittingly Perpetuate Health Care Disparities*, 28 J. GEN. INT. MED. 1504 (2013) (describing research showing how implicit biases affect clinical decision-making).

<sup>74</sup> The AMA appeared to endorse the notion that physicians have a duty to conserve scarce health resources for the benefit of patients and society in general. See AMA COUNCIL OF ETHICAL AND JUDICIAL AFFAIRS, *Physician Stewardship of Health Care Resources Report 1-A-12*, 1 (2012) (<http://www.ama-assn.org/resources/doc/ethics/ceja-1a12.pdf>) (last visited January 22, 2014) (describing report as providing “ethical guidance to support physicians in making fair, prudent, cost-conscious decisions for care that meets the needs of individual patients *and to help ensure availability of health care for others.*”) (emphasis added). The report went on to state that “Physicians’ primary ethical obligation is to promote the well-being of individual patients. Physicians also have a long-recognized obligation to patients in general to promote public health and access to care. This obligation requires physicians to be prudent stewards of the shared societal resources with which they are entrusted. Managing health care resources responsibly for the benefit of all patients is compatible with physicians’ primary obligation to serve the interests of individual patients.” *Id.* at 5. The report also stated: “Arguments that physicians should never allow considerations other than the welfare of the patient before them to influence their professional recommendations and treatment do not mesh with the reality of clinical practice. Physicians regularly work with a variety of limits on care: clinical practice guidelines, patient preferences, availability of certain services, the benefits covered by a patient’s insurance plan, and the time physicians and nurses can spend caring for a patient all influence what interventions physicians recommend and what care they provide.” *Id.* at 2. Similarly, another CEJA report in 2013 stated that “not to be lost in the quest for innovative payment models is the fundamental expectation that physicians have a fiduciary and ethical obligation to their patient and society to use precious health care resources efficiently.” AMA, *Physician Payment Reform: Early Innovators Share What they Have Learned* at 5 (July 2012) (

their fiduciary duty. Decisions to withhold potentially beneficial interventions for reasons of cost should be made instead through an open and public process, the same way these decisions are made in the British National Health System.<sup>75</sup> Precedent for this approach in the United States exists in the form of the system for allocating transplant organs, which is not left to individual physicians or hospitals but governed by a set of rules established by a

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reform-white-paper.pdf) (last visited Dec. 27, 2013). These statements are misleading, however. The first report went on to explain that “the focus of the report is on physicians’ recommendations and decisions in everyday situations that are often overlooked, in which physicians’ choice of one among several reasonable alternatives can affect the availability of resources across the community of patients or the aggregate cost of care in the community. . . . Everyday choices are also distinct from “high stakes” decisions about interventions that can mean life or death for patients or forestall extremely poor outcomes, such as decisions to initiate mechanical ventilation in emergent circumstances when the patient’s prognosis is uncertain. Arguably, in situations when there is significant risk of harm, cost considerations, if they play a role at all, are better addressed through collectively designed policy than left to individual decisions physicians must grapple with at the bedside.” CEJA Report 1-A-12, *supra*, at 1. Moreover, in terms of withholding care from patient to preserve resources for others, the report merely advises physicians to “choose the course of action that requires fewer resources when alternative courses of action offer similar likelihood and degree of anticipated benefit compared to anticipated harm for the individual patient, but require different levels of resources . . . .” *Id.* at 7. In other words, physicians should not waste resources, but only in the sense that they should provide patients with the cheaper of two equally beneficial alternatives, which is not bedside rationing.

<sup>75</sup> See Lestyn Williams, *Institutions, Cost-Effectiveness Analysis and Healthcare Rationing: The Example of Healthcare Coverage in the English National Health Service*, 41 POLICY & POLITICS 223 (2013). Oregon in the early 1990s attempted to employ a quasi-public rationing process to decide what services should be provided to Medicaid patients. The effort ran into numerous roadblocks, but also differs fundamentally from what is being advocated here, in that the Oregon decision-makers and public participants were asked what they thought should be covered for others, namely, persons on Medicaid, rather than what they thought everyone, including themselves, should be entitled to receive. For an analysis of the Oregon program, see Maxwell J. Mehlman, *The Oregon Medicaid Program: Is It Just?*, 1 HEALTH MATRIX 175 (1991).

national body, the United Network for Organ Sharing.<sup>76</sup> These rules exist not in order to save money but because of the shortage of organs.

The incompatibility of the physician's fiduciary duty with bedside rationing, however, does not mean physicians must never place the interests of others above those of their patients. The law recognizes three well-established situations in which this is permissible. One is triage, when there are not enough resources physically available to provide treatment to everyone in immediate need, and where physicians are allowed to bypass certain patients in order to give priority to patients who can be treated most efficiently with what is at hand.<sup>77</sup> A second well-recognized exception to the duty of loyalty is when a physician is required to breach patient confidentiality in order to warn an identifiable victim whom the patient is placing in immediate, serious peril.<sup>78</sup> The third exception is to protect the public health, when physicians are authorized to act in ways that may be contrary to the interests of the patient, such as breaching confidentiality by reporting them to public health officials, who in turn may order the patient to be quarantined or forcibly treated.<sup>79</sup>

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<sup>76</sup> Note that the approach to allocating transplant organs, unlike the Oregon Medicaid approach described in the preceding footnote, determines the allocation rules for everyone, not just patients on Medicaid.

<sup>77</sup> David G. C. McCann, *Preparing for the Worst: A Disaster Medicine Primer for Health Care*, 30 J. LEGAL MED. 329, 342 (2009) (describing triage).

<sup>78</sup> See W. Jonathan Cardi, *A Pluralistic Analysis of the Therapist/Physician Duty To Warn Third Parties*, 44 WAKE FOREST L. REV. 877 (2009) (discussing physicians' duty to warn third parties).

<sup>79</sup> See *Physician Stewardship of Health Care Resources*, AMA COUNCIL OF ETHICAL AND JUDICIAL AFFAIRS, 2 (2012) <http://www.ama-assn.org/resources/doc/ethics/ceja-1a12.pdf> (last visited January 22, 2014) ("Historically, medicine as a learned profession has been understood to have a social responsibility to use knowledge and skills to enhance the common good, including obligations to protect public health and safety, even if this might require restricting the liberties of individual patients (Opinion E-2.25, 'The Use of Quarantine and Isolation as Public Health Measures'; Opinion E-2.24, 'Impaired Drivers and Their Physicians')."); See LAWRENCE O. GOSTIN, PUBLIC HEALTH

While the physician's fiduciary duty precludes the physician from subordinating the interests of the patient to the interests of third parties, except in the limited circumstances just discussed, the crux of physicians' fiduciary duty is to avoid acting in their own self-interest at the patient's expense. How far must physicians go in sacrificing their own welfare in order to fulfill their fiduciary duty to their patients?

### III. SELF-INTEREST AND THE BOUNDS OF PHYSICIAN LOYALTY

Scholars of fiduciary relationships cite Justice Cardozo's statement that the degree of loyalty that fiduciaries owe is "not honesty alone, but the punctilio of an honor the most sensitive,"<sup>80</sup> and claim that "with respect to the fiduciary relationship, a fiduciary may not act counter to the interests of the beneficiary"<sup>81</sup> and that "fiduciaries are not allowed to promote the interests of third parties or themselves."<sup>82</sup> These statements suggest that physicians would violate their fiduciary duty to patients anytime they acted in their own self-interest. But this is misleading, since fiduciaries are entitled to reasonable compensation for their efforts on behalf of entrustors, even though the compensation comes at the entrustors' expense, as in the form of a charge on the assets of a trust. Similarly, a physician clearly is entitled to be paid a reasonable fee by the patient or on the patient's behalf.<sup>83</sup> This makes sense, of course, even in the context of a fiduciary relationship; although patients might prefer if physician's services were free, patients would not be better off if this were the case because there would be few if any

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LAW: POWER, DUTY, RESTRAINT, 371-460 (2d ed., 2008) (discussing public health interventions).

<sup>80</sup> *Meinhard v. Salmon*, 164 N.E. 545, 546 (N.Y. 1928).

<sup>81</sup> Velasco, *supra* note 35, at 162.

<sup>82</sup> RODWIN, *supra* note 1, at 183.

<sup>83</sup> The AMA Code of Ethics thus only prohibits fees that are "illegal or excessive." *Ethics Opinion E-605-Fees for Medical Services*, AMA CODE OF ETHICS, (1994 update) (<http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion605.page?>) (last visited Oct. 13, 2014).

patient-physician relationships to begin with. As Morreim observes:

[P]rofessional altruism is the physician's promise to seek the benefit of the patient and refrain from exploiting his vulnerability to enhance the physician's own interests. It is a presumption to hold the patient's interests paramount, but with the caveat that this presumption is sometimes defeasible by powerful overriding considerations. It is self-denial, even if not self-sacrifice or high devotion."<sup>84</sup>

Moreover, a physician is only obliged to care for a patient at a reasonable time and in a reasonable place; while an earlier age saw doctors expected to make house calls, even in the middle of the night, this is no longer required and is one of the reasons that some patients pay extra for 24/7 access to doctors in so-called concierge practices.<sup>85</sup>

At the other extreme, some sources argue that physicians ought to be able to place their own interests ahead of patients' so long as patients are made aware that

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<sup>84</sup> E. Haavi Morreim, *Cost Containment Challenging Fidelity and Justice*, 18 HASTINGS CTR. REP., 20, 25 (Dec. 1988). Shepherd similarly states that "in some cases the rigidity of the fiduciary concept must be tempered by a social policy against restraint of trade." Shepherd, *supra* note 6, at 136.

<sup>85</sup> See James Stathopoulos, *Concierge Medicine: Quality Care for a Price*, 19 ANNALS HEALTH L. 155 (2010) (discussing concierge practices). A disturbing possibility is that a similar sort of concierge practice will emerge in which better-off patients will pay extra to ensure that their physicians will act as fiduciaries for them. See also M. Gregg Bloche & Peter D. Jacobson, *The Supreme Court and Bedside Rationing*, 284 JAMA 2776, 2779 (2000) ("Unless Congress or the states limit rewards to physicians for withholding care, we may witness not a wholesale abandonment of [fidelity to individual patients], but the socioeconomic stratification of access to professionals who sustain their commitment to it. Wealthy Americans who insist on their physicians' loyalty at the bedside will be able to afford health plans that do not undermine it. Other consumers may be limited by their buying power to physicians with a conflict of interest.").

this might happen.<sup>86</sup> These sources take a page from the fiduciary relationship between corporate directors and shareholders, in which directors are permitted to self-deal so long as they disclose their intention and receive permission from the rest of the board.<sup>87</sup> In fact, most proponents of disclosure as a remedy for physicians acting in their own self-interest do not even propose to give patients that much protection, since they do not want physicians to have to alert patients to an imminent breach of fiduciary duty in the course of providing care.<sup>88</sup> Instead,

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<sup>86</sup> In relation to fiduciary doctrine generally, Shepherd states, for example, that “if the fiduciary provides effective disclosure, he may reduce his influence over the other party enough to prevent the presumption of undue influence from arising.” Shepherd, *supra* note 6, at 204.

<sup>87</sup> See Victor Brudney, *Contract and Fiduciary Duty in Corporate Law*, 38 B.C. L. REV. 595, 665 (1997) (“Evolving corporate fiduciary obligations appear to be narrowing the disclosure requirements imposed on directors seeking stockholder consent to depart from the prohibition against self-dealing, but developing conceptions of adhesion, unconscionability or good faith appear to be expanding disclosure requirements for contracting parties seeking comparable consent.”).

<sup>88</sup> See Johnston, *supra* note 7, at 986 (“Another problem with disclosure is its potential to weaken the doctor-patient relationship.”). But Johnston in the end opts for physician disclosure: “Even if HMO disclosure were required, there is still a need for physician disclosure.” *Id.* at 988. Johnston cites as a benefit of physician disclosure that it would “encourage patients to challenge their doctors” (*Id.* at 989) and “would also encourage patients to take a more proactive approach to their health. For example, knowledge of financial incentives might make patients question or challenge their doctors' recommendations or insist on getting more information about their diagnosis.” *Id.* at 988. In short, Johnston supports “consumer-driven” health care, which expects patients to limit health care spending by making prudent health care choices. She states, for example, that “disclosure would help patients become more meaningfully involved in the debate over managed care by making them more aware of how much health care costs.” *Id.* at 990. Morreim also seems to think that physician disclosure is sufficient in some cases to discharge the physician’s fiduciary duty. See E. Haavi Morreim, *The Clinical Investigator As Fiduciary: Discarding A Misguided Idea*, 33 J. L., MED. & ETHICS 586, 589 (2005) (“The fiduciary must not exploit the entrustor to promote his own gain. He must not enter into avoidable conflicts of interest that would pit his own welfare against the entrustor's or, when unavoidable, he must disclose such

they only want patients to be warned of the possibility that their physicians may act disloyally when the patient enrolls in a health plan. Mark Hall, for example, states that “if patients are properly informed when they join and renew with an insurance plan, and perhaps also when they select a physician group, I would not require physicians to remind patients about financial considerations or resource-based constraints each time the physician makes a treatment decision.”<sup>89</sup> By the same token, in *Neade vs. Portes*, discussed earlier,<sup>90</sup> the Supreme Court of Illinois noted that the Illinois “legislature has chosen to put the burden of disclosing any financial incentive plans on the HMO, rather than on the physician.”<sup>91</sup>

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conflicts and permit the entrustor to decide whether and how he may handle this transaction, or indeed, continue as fiduciary.”); E. Haavi Morreim, *Blessed Be the Tie That Binds? Antitrust Perils of Physician Investment and Self-Referral*, 14 J. LEGAL MED. 359, 376 (1993) (“A fiduciary ... must try to avoid conflicts of interest, but when they cannot be avoided, the fiduciary must make full disclosure and invite the beneficiary to decide what should be done.”).

<sup>89</sup> Mark Hall, *Ideology and Trust: A Reply to Bloche*, 55 STAN. L. REV. 955, 966-967 (2002).

<sup>90</sup> See the discussion *supra* notes 50 and 71 and accompany text.

<sup>91</sup> 739 N.E.2d at 504. Ironically, the plaintiff in *Neade* had merely wanted her husband’s physician to disclose that he had a conflict of interest in not recommending a life-saving angiogram. *Id.* at 499. One reason that the court gave for not requiring disclosure by the physician was the burden that this would impose on physicians “to remain cognizant at all times of every patient’s particular HMO and that HMO’s policies and procedures.” *Id.* at 504 (citing M. Hall, *A Theory of Economic Informed Consent*, 31 GA. L. REV. 511, 525-26 (1997) (“[A] typical primary care physician in a metropolitan city may have a dozen or more contracts with managed care networks, while specialists may have several dozen or even a hundred. It is not feasible to ask physicians to keep track of the payment incentives and treatment rules for each of these many different plans, nor is this necessarily good public policy”).). The dissent in *Neade* effectively dismissed this concern: “Doctors share generously in the bounty provided by modern medicine, and there is no reason to believe that they cannot manage or afford the administrative tools necessary to keep them fully apprised of the payment incentives affecting a particular patient’s care. Indeed, there is every reason to believe that payment incentives are one aspect of health care plans that physicians such as Dr. Portes will have no trouble at all keeping track of. According to the allegations in plaintiff’s complaint, which must be taken as true, Dr. Portes was well aware that the

Disclosure of conflicted behavior may be sufficient for corporate directors in view of the knowledge and sophistication of the other members of the board and the shareholders whom they represent. Furthermore, disclosure by physicians before they take a specific action, as opposed to by a health plan at the beginning of the patient's enrollment, is better than giving patients no fiduciary protection at all since they can avoid having to monitor their physician's behavior until they receive the warning. But physician disclosure is not adequate. It still requires patients to expend resources that could be devoted instead to the purchase of health care if the patient could trust physician's to forego taking advantage of the patient's weaker position. Moreover, patients generally can be expected to be far less sophisticated than corporate directors or shareholders and therefore may have more difficulty anticipating the consequences of a physician's self-interested behavior, leading the patients to over- or under-protect themselves. But the main objection to relying on disclosure to enable patients to protect themselves is simply

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referral recommended by his associates and needed by plaintiff's husband would reduce the profit he would receive from the health plan. That is exactly why he refused to make the referral, and it is why plaintiff's husband is now dead." *Id.* at 508 (Harrison, C.J., dissenting). *See also* *Shea v. Esenstein*, 107 F.3d 625, 629 (8th Cir. 1997), *cert. denied*, 522 U.S. 914 (1997) ("When an HMO's financial incentives discourage a treating doctor from providing essential health care referrals for conditions covered under the plan benefit structure, the incentives must be disclosed and the failure to do so is a breach of ERISA's fiduciary duties."). The California Supreme Court's decision in *Moore vs. Regents of the University of California*, 792 P.2d 479, 483 (Cal. 1990), similarly supported the notion that disclosure fulfills a physician's duty to avoid acting out of self-interest at the patient's expense in holding that the physicians failed to obtain the patient's informed consent to their actions in furtherance of a plan to commercialize cancer cells that they had removed from the patient's spleen: "(1) a physician must disclose personal interests unrelated to the patient's health, whether research or economic, that may affect the physician's professional judgment; and (2) a physician's failure to disclose such interests may give rise to a cause of action for performing medical procedures without informed consent or breach of fiduciary duty."

that many patients will be unable to do so: they may not have sufficient time due to the seriousness of their condition; lack sufficient resources, say, to pay for a second opinion; have inadequate education or sophistication; or be mentally incompetent or in too much pain or fear. For these patients, and undoubtedly there would be many of them, disclosing physician disloyalty would merely cause them needless mental suffering. And even patients who were able to protect themselves would be likely to be emotionally harmed by disclosure when they realized that they were not able to trust their doctors.<sup>92</sup>

Another question is whether there are some conflicts of interest that are so toxic that physicians must avoid them altogether. As Shepherd states:

[S]ome conflicts of interest presented to the fiduciary may be so dangerous that the fiduciary should not be allowed to make the choice. This may be because the fiduciary would be too tempted by the size of the type of self-interest existing. Alternatively, it may be because the fiduciary would not know when his

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<sup>92</sup> A related issue is whether patients should be able to waive their physician's fiduciary duties. There is a vigorous debate about this in corporate fiduciary scholarship. *See, e.g.*, Larry E. Ribstein, *Are Partners Fiduciaries?*, 2005 U. ILL. L. REV. 209, 211, n.11 (2005). Assuming that the conditions that cause the patient-physician relationship to be deemed fiduciary in the first place are obtained, it is difficult to understand why waiver would be permitted, or indeed why a patient would ever freely choose to do so. One possibility is that the patient is sufficiently knowledgeable and sophisticated that they do not need fiduciary protections and can obtain some net benefit by a waiver, such as being able to enter into a relationship with a more exclusive physician. An example might be patients who themselves are physicians. *But see* FRANKEL, *supra* note 6, at 29 ("The fact that the entrustor is an expert who chooses another expert in the same area does not reduce the entire risk of the relationship. Such an expert can choose a better fiduciary, but like all others he must entrust property or power to the fiduciary, or else lose the entire benefit from the relationship."). Frankel gives as an example Bernie Madoff's fleecing of sophisticated investors.

self-interest had influenced the use of his fiduciary powers.<sup>93</sup>

Examples of conflicts that have been deemed impermissible for physicians include accepting gifts from drug companies;<sup>94</sup> federal laws against referring patients to physician-owned ancillary facilities and accepting kickbacks from non-physician-owned facilities;<sup>95</sup> conditioning too great a proportion of physician income on bedside rationing;<sup>96</sup> and “gag clauses,” which prohibit physicians from giving patients information that might be adverse to the patient’s health plan.<sup>97</sup>

With these ground rules in mind, the next section will examine several key cases to determine how physicians should discharge their fiduciary duty to place the patients’ welfare above their own self-interest.

#### *A. Managed Care Refusals to Pay for Medically Necessary Care*

In *Wickline vs. State of California*,<sup>98</sup> a physician caring for a post-operative patient wanted the patient to remain in the hospital for eight days, but the patient’s health insurer only approved an additional four days. The doctor duly discharged the patient after only four days, following which complications ensued and the patient eventually lost her leg. She thereupon sued the health insurer for negligence. Both the plaintiff’s and defendants’ experts agreed that,

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<sup>93</sup> Shepherd, *supra* note 6, at 151.

<sup>94</sup> See Hafemeister & Bryan, *supra* note 66.

<sup>95</sup> See Tim Drake, Alexandra Kanu, & Nick Silverman, *Health Care Fraud*, 50 AM. CRIM. L. REV. 1131 (2013) (describing federal fraud-and-abuse laws).

<sup>96</sup> See 42 C.F.R. § 417.479 (2014) (limiting Medicare physician incentive plans to no more than 25% of physician fees).

<sup>97</sup> See Kristin L. Jensen, *Releasing Managed Care’s Chokehold on Healthcare Providers*, 16 ANNALS HEALTH L. 141, 149-53 (2007) (discussing efforts to prohibit gag clauses).

<sup>98</sup> 192 Cal. App. 3d 1630 (2d Cir. 1986). The patient was on Medicaid, but the issues raised in the case do not differ substantially depending on whether the patient is publicly or privately insured.

while the patient's leg would have been saved had she remained the full eight days in the hospital, the discharge after only four days was not negligent, and therefore the health plan was not liable.<sup>99</sup> But the appellate court proceeded to consider in dicta what the physician should have done if he had believed that he should not have discharged the patient after only four days, and stated: "The physician who complies without protest with the limitations imposed by a third party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care. He cannot point to the health care payor as the liability scapegoat when the consequences of his own determinative medical decisions go sour."<sup>100</sup>

The dicta in *Wickline* prescribe a key aspect of what physicians must do to be loyal to their patients: they must advocate for them by seeking to persuade managed care plans to pay for the care the physicians think is required. It is important to understand that, in doing so, physicians are placing their patients' interests ahead of their own. Not only does protesting take time and effort, but managed care risk-sharing arrangements may dock a portion of physicians' remuneration if plans believe that patients are being kept too long in the hospital, and physicians who advocate too aggressively for their patients may find themselves excluded altogether from receiving payment for caring for plan enrollees.<sup>101</sup>

How much must physicians jeopardize their own self-interest to fulfill their fiduciary duty to act on behalf of their patients? The physician in the *Wickline* case testified that, "had Wickline's condition, in his medical judgment, been critical or in a deteriorating condition on [the fourth day], he would have made some effort to keep her in the hospital

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<sup>99</sup> The facts of the case provide a good illustration of the distinction between reasonable and optimal care discussed earlier. See *supra* notes 5, 9, 42, 54 and accompanying text.

<sup>100</sup> *Wickline*, 192 Ca. App. 3d at 1645. The court proceeded to observe that, "while we recognize, realistically, that cost consciousness has become a permanent feature of the health care system, it is essential that cost limitation programs not be permitted to corrupt medical judgment." *Id.* at 1647.

<sup>101</sup> The euphemism is called being "de-selected."

beyond that day even if denied authority by Medi-Cal and *even if he had to pay her hospital bill himself*.<sup>102</sup> However laudable the sentiment, it clearly exceeds the physician's fiduciary duty since, as stated earlier, they are entitled to receive a reasonable fee for their services. Beyond that, however, there can be no bright-line rule; other than avoiding certain impermissible conflicts as discussed earlier,<sup>103</sup> all that can be said is that the more that physicians sacrifice their own self-interest, the less vulnerable they will be to being found liable for acting disloyally.

A "the more the better" standard such as this may seem like an unsatisfactory answer, and no doubt physicians may find it disquieting. But the law often must resort to such indefinite rules when, as here, the scope of duty is highly fact-specific. For example, physicians unilaterally may terminate their relationship with patients so long as they give them notice and a reasonable opportunity to obtain care elsewhere,<sup>104</sup> but what constitutes a "reasonable opportunity" will vary depending on how sick the patient is, the availability of other caregivers, and so forth. As with fiduciary duties, the most that can be said is that the longer the notice and the greater the assistance in finding alternative providers that physicians give, the less vulnerable they are to being liable for the tort of "abandoning" their patients.

A variable rule such as this also is particularly apt when physicians are trying to avoid liability for being unfaithful to their patients. As Lawrence Mitchell argues, this type of rule "is aspirational and studiously imprecise. The very ambiguity of the language conveys its moral content as the court's refusal to set lines is designed to discourage marginal conduct by making it difficult for a fiduciary to determine the point at which self-serving conduct will be

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<sup>102</sup> 192 Ca. App. 3d at 1640 (emphasis added).

<sup>103</sup> See the discussion at *supra* notes 78-80 and accompanying text.

<sup>104</sup> See, e.g., *Payton v. Weaver*, 131 Cal. App. 3d 38 (1st Cir. 1982) (discussing how doctors may terminate relationships with patients).

prohibited, and thus to encourage conduct well within the borders.”<sup>105</sup>

It is also important to appreciate that fiduciary law gives doctors a powerful weapon against managed care plans and other entities seeking to prevent them from acting on behalf of their patients. A later California case, *Wilson v. Blue Cross of California*,<sup>106</sup> clarified the dicta in *Wickline* to emphasize that, while a physician who does not protest a managed care plan’s denial of payment would be liable for a premature hospital discharge, so too would a managed care plan that unreasonably refused to approve a medically necessary hospital stay.<sup>107</sup> In addition, patients may be able to hold managed care plans liable for tortious interference with the physician’s fiduciary duties<sup>108</sup> or aiding and abetting a physician’s infidelity.<sup>109</sup> So by advocating for the patient, doctors can claim to be protecting these entities from liability as well as themselves.

Consider now another case, *Murray v. UNMC Physicians*,<sup>110</sup> decided in 2011 by the Supreme Court of Nebraska. According to the plaintiff’s allegations, his wife was a patient hospitalized with pulmonary arterial hypertension. She was catheterized to confirm her

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<sup>105</sup> Lawrence E. Mitchell, *The Death of Fiduciary Duty in Close Corporations*, 138 U. PA. L. REV. 1675, 1701 (1990).

<sup>106</sup> 222 Cal. App.3d 660, 271 Cal. Rptr. 876.

<sup>107</sup> *Id.* at 671-674.

<sup>108</sup> *See Rome Indus., Inc. v. Jonsson et al.*, 415 S.E.2d 651, 652 (Ga. Ct. App. 1992) (“In this case, Rome alleged appellees induced one of its officers to breach his fiduciary duty to Rome. In essence, the claim is one for tortious interference with contractual rights. The trial court erred in granting summary judgment to appellees on the ground the allegation fails to state a claim.”).

<sup>109</sup> *See Halo Tech Holdings, Inc. v. Cooper*, 2008 WL 877156, at \*20 (D. Conn. Mar. 26, 2008) (“To sustain a claim for aiding and abetting a breach of fiduciary duty, a plaintiff must allege that: ‘(1) the party whom the defendant aids must perform a wrongful act that causes an injury; (2) the defendant must be generally aware of his role as part of an overall illegal or tortious activity at the time that he provides the assistance; (3) the defendant must knowingly and substantially assist the principal violation.’”).

<sup>110</sup> 806 N.W.2d 118 (Neb. 2011).

diagnosis and eligibility for treatment with Flolan, a vasodilator that, once begun, cannot be stopped without life-threatening consequences. The doctors confirmed the diagnosis, but since the drug cost approximately \$100,000 a year, they delayed the start of treatment while waiting for the patient's health insurer to agree to pay for it. Before they received word back from the insurer, the patient died.

The patient's husband sued the doctors and the hospital for medical malpractice. (He was unable to sue for breach of fiduciary duty because Nebraska is one of the ten states that follows the *Pegram* decision and recognizes no cause of action for a fiduciary breach aside from medical malpractice.<sup>111</sup>) But consider what the outcome should be if the plaintiff had been able to sue for breach of fiduciary duty. The trial judge ruled that delaying care pending assurance of payment was impermissible; the notion that "the standard of care is different for those with money than for those without," the judge stated, "is neither moral nor just. It is wrong."<sup>112</sup> The Supreme Court of Nebraska overruled the trial judge, however, stating that the physicians did not delay the treatment for economic reasons but because they made a medical determination in the patient's best interests:

This case does not involve a conflict of interest between the physician and patient—there was no evidence, for instance, of a financial incentive for UNMC's physicians to control costs. As explained by UNMC's witnesses, the decision to defer Flolan treatment was not based on its financial effect on UNMC, or

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<sup>111</sup> See discussion *supra* notes 40-48 and accompanying text.

<sup>112</sup> Murray, 806 N.W.2d at 121. The trial judge also stated: "This Court is of the opinion that, as a matter of law, a medical standard of care cannot be tied to or controlled by an insurance company or the need for payment. The 'bean counters' in an insurance office are not physicians. Medicine cannot reach the point where an insurance company determines the medical standard of care for the treatment of a patient. Nor, can we live in a society where the medical care required is not controlled by the physicians treating the patient." *Id.*

subordinating Mary's well being to the interests of other patients, or even considering Mary's own financial interest. Instead, when making its initial value judgment regarding Mary's treatment, UNMC's physicians were not weighing the risk to Mary's health against the risk to her pocketbook, or UNMC's budget, or even a general social interest in controlling health care costs. UNMC's physicians were weighing the *risk to Mary's health* of delaying treatment against the *risk to Mary's health* of potentially interrupted treatment. Stated another way, this was not a case in which a physician refused to provide beneficial care—it was a case in which the physicians determined that the care *would not be beneficial* if it was later interrupted. In fact, it could be deadly.<sup>113</sup>

The court's reasoning is questionable to say the least in assuming that the physicians would have stopped the treatment later if the insurer had refused to pay and in presuming that they could have done so without being liable for the patient's wrongful death.<sup>114</sup> But the case nevertheless raises the question of what the doctors should have done to fulfill their fiduciary duty to the patient.

Based on the previous discussion of the *Wickline* decision, the doctors in *Murray* clearly were not required to start the patient on the expensive drug and then pay for it out of their own pockets if the patient's insurer later refused. Moreover, as stated earlier, decisions about whether patients in the plaintiff's circumstances are entitled to such an expensive and potentially only

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<sup>113</sup> *Id.* at 126 (emphasis in original) (footnotes omitted).

<sup>114</sup> The physicians might be able to show that they did not breach their fiduciary duty to the patient if they could prove that they withheld the drug to spare the patient the cost of paying for it out-of-pocket if the insurer declined, especially if they also had been willing to discount their own fee for the service, but there was no indication that this was the case.

marginally effective treatment<sup>115</sup> ideally should be made by a public body rather than by physicians at the proverbial bedside. But since the nation has not yet come to accept such an enlightened approach, what should doctors do in the meantime? The answer based on *Wickline* is that the doctors must not just sit back passively and wait for the health insurer to make its coverage determination, but must advocate for the patient. There were a number of ways for them to do this: they could “protest,” in this case making an effort to persuade the insurer to make an especially rapid decision; approach the hospital where the patient was being treated to see if it would agree to cover the cost of the drug as “charitable care”; and appeal to the drug manufacturer to provide the drug at a discount, as the defendants’ own expert testified he would have done.<sup>116</sup> There is no indication in the case that her doctors took any of these steps, much less that, pursuant to the “more is better” standard, they did so with sufficient vigor to avoid liability.

The lessons from the *Wickline* and *Murray* cases provide guidance for physicians when managed care plans refuse to cover the patient’s care. But plans can create incentives for doctors to take these decisions out of the hands of the plan, that is, to engage in bedside rationing. How should doctors behave under those circumstances in order to discharge their fiduciary duty to their patients?

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<sup>115</sup> See Cheng-Huai Ruan et al., *Prostacyclin Therapy for Pulmonary Arterial Hypertension*, 37 TEX. HEART INST. J. 391, 396 (2010) (“Although this therapy improves physical function and survival, it has significant drawbacks and results in limited improvements in quality of life.”).

<sup>116</sup> *Murray*, 806 N.W.2d at 121 (“[A]nother of UNMC’s experts, William Johnson, M.D., explained that the standard of care required finding some source of payment for a patient, but that if insurance was unavailable, it was still usually possible to find some other payment on a ‘compassionate need basis’ within the 12-week timeframe that Johnson opined was appropriate for treatment of chronic pulmonary arterial hypertension.”).

*B. Physician Behavior Under Managed Care  
Risk-Sharing Arrangements*

The facts in the *Neade* case discussed earlier provide a context for considering how physicians ought to discharge their fiduciary duty to the patients when the physicians are given financial incentives to withhold care.<sup>117</sup> Recall that the physicians in *Neade* were alleged to be globally-capitated by the patient's managed care plan, meaning that they had to pay for any tests provided by non-plan providers out of a \$75,000 annual allotment, and that, according to the plaintiff, they declined to order an out-of-plan angiogram for the patient and did not disclose their financial arrangement with the plan to the patient, which would have prompted him to obtain a second opinion about the need for the life-saving test. The court, it will be recalled, followed the dicta in the *Pegram* case and refused to allow the plaintiff to assert a cause of action for breach of fiduciary duty, but what if it had? What should the physicians have done to avoid liability?

As the Supreme Court in *Pegram* demonstrated, courts are not likely to rule that incentive plans that reward physicians for limiting spending are per se violations of their fiduciary duty to their patients. However, given the procedural advantages enjoyed by plaintiffs in breach-of-fiduciary-duty cases discussed earlier,<sup>118</sup> once plaintiffs present evidence demonstrating the existence of such an incentive arrangement, the burden should shift to physicians to prove that they did not act improperly. For example, the physician could show lack of causation, in that any harm or lack of benefit suffered by the patient was unavoidable; that the amount at stake for the physician by virtue of the incentive plan was within the limits of the physicians "reasonable fee" or too small to have affected the doctor's behavior<sup>119</sup>; or, per *Wickline*, that the physician had

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<sup>117</sup> See *supra* Part I(A)(3).

<sup>118</sup> *Id.*

<sup>119</sup> See E. Haavi Morreim, *Benefits Decisions in ERISA Plans: Diminishing Deference to Fiduciaries and an Emerging Problem for Provider-Sponsored Organizations*, 65 TENN. L. REV. 511, 551-552

vigorously advocated for the patient against the plan despite the financial consequences for the physician.<sup>120</sup>

The cases discussed so far describe a number of ways in which the structure and function of the health care system challenges the fulfillment of physicians' fiduciary duties. But the health care system is undergoing a period of rapid change. The next section considers whether these changes increase or reduce the patient's need for physician loyalty.

#### IV. WHY IT IS ESPECIALLY IMPORTANT FOR PATIENTS AT THIS TIME FOR PHYSICIANS TO BE FIDUCIARIES

As described earlier, the patient-physician relationship easily fulfills the conditions that justify making one party a fiduciary for another. What is important to understand is how changes taking place in medical practice, delivery, and financing are making fiduciary protections for patients all the more important.

Medical science is becoming increasingly complex and harder for laypersons to comprehend, making it more imperative for patients to be able to obtain disinterested information from physicians.<sup>121</sup> The availability of medical

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(1998) ("One approach asks the court simply to review the merits of the interpretation to determine whether it is consistent with an exercise of discretion by a fiduciary acting free of the interests that conflict with those of the beneficiaries . . . . If a given decision under a particular contract would be acceptable in the absence of any conflict, then that same decision within that same contract should be acceptable, even if a conflict is present.").

<sup>120</sup> Moreover, although as noted earlier it is theoretically possible to establish a breach even if the physician's actions do not constitute malpractice, the strongest case would be if the physician's behavior was negligent as well as disloyal.

<sup>121</sup> See Isaac S. Kohane et al., *A Glimpse of the Next 100 Years in Medicine*, 367 NEW ENG. J. MED. 2538, 2538 (2012) ("In the decades ahead, the pace of biomedical discovery will accelerate . . . . The size and complexity of this multidimensional characterization of patients will lead to far more complex diagnostic and prognostic categories than are currently in use . . . . The high-technology, information-rich medicine of the future will provide powerful and useful tools for clinical medicine."); Diane Swanbrow, *U.S. Public's Knowledge of Science Still Has a Long Way to Go*, PHYS ORG (Feb. 16, 2011), (<http://phys.org/news/2011-02->

knowledge on the web is only partially offsetting, since the data may be inaccurate, conflicting, or difficult for readers to evaluate.<sup>122</sup> The more vulnerable patients are due to poverty or lack of education, moreover, the less likely they are to have access to the Internet or to be able to understand the information that it contains.<sup>123</sup> The

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knowledge-science.html, *archived at* <http://perma.cc/6LV6-RACF>) (“In 1988, just 10 percent of U.S. adults had sufficient understanding of basic scientific ideas to be able to read the Tuesday Science section of The New York Times, according to Jon Miller, a researcher at the U-M Institute for Social Research (ISR). By 2008, 28 percent of adults scored high enough to understand scientific ideas at that level. Despite the improvement, the American public has a long way to go . . .”).

<sup>122</sup> See Shawna L McNally et al., *Can Consumers Trust Web-Based Information About Celiac Disease? Accuracy, Comprehensiveness, Transparency, and Readability of Information on the Internet*, 1 INTERACTIVE J. MED. RESEARCH e1 (2012) (*archived at* <http://perma.cc/P34H-66F4>) (“The information on many websites addressing celiac disease was not sufficiently accurate, comprehensive, and transparent, or presented at an appropriate reading grade level, to be considered sufficiently trustworthy and reliable for patients, health care providers, celiac disease support groups, and the general public.”); Gretchen K. Berland et al., *Health Information on the Internet Accessibility, Quality, and Readability in English and Spanish*, 285 JAMA 2612 (2001) (“Accessing health information using search engines and simple search terms is not efficient. Coverage of key information on English- and Spanish-language Web sites is poor and inconsistent, although the accuracy of the information provided is generally good. High reading levels are required to comprehend Web-based health information.”).

<sup>123</sup> See Namkee G Choi & Diana M DiNitto, *The Digital Divide Among Low-Income Homebound Older Adults: Internet Use Patterns, eHealth Literacy, and Attitudes Toward Computer/Internet Use*, 15 J. MED. INTERNET RESEARCH e93 (2013) *archived at* <http://perma.cc/42QD-R4YR> (“This study is the first to describe in detail low-income disabled and homebound adults' and older adults' Internet use. It shows very low rates of Internet use compared to the US population . . .”); Emily Z Kontos et al., *Barriers and Facilitators to Home Computer and Internet Use among Urban Computer Users of Low Socioeconomic Position*, 9 J. MED. INTERNET RESEARCH e31 (2009): e31, *archived at* <http://perma.cc/5RLC-SKCS> (“Despite the increasing penetration of the Internet and amount of online health information, there are significant barriers that limit its widespread adoption as a source of health information. One is the ‘digital divide,’ with people of higher socioeconomic position (SEP) demonstrating greater access and usage compared to those from lower SEP groups.”).

conversion from paper to electronic medical records also can complicate patients' ability to know and understand their health states, since information that once was available more or less in chronological order in one place may now be arranged in a more confusing manner, and key pieces of data may be available only through links to other records in the provider's electronic database, which is not likely to be readily accessible to patients.<sup>124</sup>

In addition, the classic primary care relationship that lasted over time and in which patient visits often were quite lengthy is giving way to fleeting encounters with random clinicians and multiple specialists who may give patients fragmentary or inconsistent information.<sup>125</sup> At the same

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<sup>124</sup> See Am. Hosp. Ass'n, *Hospitals Face Challenges Using Electronic Health Records to Generate Clinical Quality Measures 5-6*, available at <http://www.aha.org/research/policy/ecqm.shtml> ("EHRs are not designed to capture information from other department information systems at the level of detail needed for eCQM reporting . . . EHRs and certification requirements are not designed to support effective and efficient patient care workflows or draw data from them."); Oladimeji Farri et al., *A Qualitative Analysis of EHR Clinical Document Synthesis by Clinicians*, AM. MEDICAL INFORMATICS ASS'N ANNUAL SYMPOSIUM PROCEEDINGS ARCHIVE 1217 (2012) archived at <http://perma.cc/DZH4-MG2X> ("Trending of past medical diagnoses, medications, and laboratory values were particularly difficult due to poor alignment of dates or incongruent organization of relevant patient information . . .").

<sup>125</sup> See Susan Okie, *The Evolving Primary Care Physician*, 366 NEW ENG. J. MED. 1849, 1849, 1850 (2012) ("[I]n recent years, the pressure on physicians to move quickly and accomplish multiple goals during a visit has intensified, Mechanic said. In surveys, many patients describe their doctors as hurried and unresponsive."); Ateev Mehrotra et al., *Dropping the Baton: Specialty Referrals in the United States*, 89 MILBANK Q. 39, 39 (2011) ("Many referrals do not include a transfer of information, either to or from the specialist; and when they do, it often contains insufficient data for medical decision making. Care across the primary-specialty interface is poorly integrated . . ."); Peter K. Lindenauer et al., *Outcomes of Care by Hospitalists, General Internists, and Family Physicians*, 357 NEW ENG. J. MED. 2589, 2589 (2007) ("[T]he hospitalist model introduces handoffs at the time of admission and at discharge, transitions during which the risk of errors and adverse events is high."). Efforts to establish "accountable care organizations" and "medical homes" to enable greater coordination of care and centralization of responsibility are a partial response to this fragmentation, but it remains to be seen how effective or widespread they will be.

time, changes occurring in how medical care is delivered make patients more vulnerable to being harmed by physician disloyalty. Increasing numbers of physicians are being employed by hospitals and other health care institutions, for example, creating new conflicts of interest with their patients.<sup>126</sup> Finally, the push for patients to assume a greater share of the cost of care through higher deductibles, coinsurance, and copayments gives them more at stake and places a greater burden on them to make wise health care decisions.<sup>127</sup>

In sum, current trends in the delivery of health care make the fiduciary nature of the patient-physician relationship all the more important for patients. Patients need to be able to depend on their physicians to act in their interest and give them trustworthy advice in order to try to navigate the increasingly challenging health care environment that they face. But the preceding sections admittedly show that acting loyally toward patients imposes burdens on physicians, some of which can be quite

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<sup>126</sup> See Robert A. Berenson et al., *Hospital-Physicians Relations: Cooperation, Competition, Or Separation?*, 26 HEALTH AFF. w31, w31-w33 (2007) (“Hospitals and medical staff physicians face growing tensions as a result of physicians’ growing reluctance to take emergency department call and the consequences of hospitalists replacing physicians in the care of inpatients . . . . Hospital-physician relations were perceived to be under greater strain in 2005 than in 2000–01.”).

<sup>127</sup> See Sheila R. Reddy et al., *Impact of a High-deductible Health Plan on Outpatient Visits and Associated Diagnostic Tests*, 52 MED. CARE 86, 86 (2014) (“The rapid expansion of high-deductible health plans (HDHPs) over the last decade is transforming the US insurance marketplace, yet understanding of their impact on access to care remains limited. From 2006 to 2012, the percentage of covered employees enrolled in a plan with at least a \$1000 deductible more than tripled from 10% to 34%. Among small firms, nearly 50% of workers were enrolled in HDHPs in 2012 . . . . HDHPs shift costs to members by requiring full out-of-pocket payments for many services until an annual deductible has been met.”) (footnotes omitted); Robert S. Huckman & Mark A. Kelley, *Public Reporting, Consumerism, and Patient Empowerment*, 369 NEW ENG. J. MED. 1875, 1876 (2013) (“Once shielded from health care costs, consumers are now seeing those bills eat further into their family budgets. That new awareness may explain why the number of physician visits among privately insured patients fell 17% nationally between 2009 and 2011.”).

significant, which may lead physicians to demur. As the next and final section explains, however, reaffirming the fiduciary nature of the relationship is as critical for physicians as it is for patients.

## V. WHY REAFFIRMING THEIR FIDUCIARY STATUS IS NECESSARY FOR PHYSICIANS

Regarding physicians as fiduciaries for their patients is essential not only for patients but for physicians. In order to appreciate why, it is necessary to know the history of the American medical profession.

Prior to the nineteenth century, medical care was delivered by a highly fragmented and contentious group of providers.<sup>128</sup> Beginning in the twelfth and thirteenth centuries, a small number of physicians obtained positions at the emerging universities and were regarded, along with university-based men of the law and the clergy who governed the universities, as “learned professionals.”<sup>129</sup> But these physicians exclusively treated the aristocracy, on whose patronage they depended.<sup>130</sup> “The vast bulk of the population,” explains Toby Gelfand, “constituted by the rural masses and urban poor, had little access to physicians.”<sup>131</sup> Instead, their medical care was furnished by a hodge-podge of barber-surgeons, apothecaries, surgeon-apothecaries (the forerunners to the modern English “general practitioner”<sup>132</sup>), midwives, and “specialists” such

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<sup>128</sup> The discussion that follows pertains to the medical profession in Western society.

<sup>129</sup> See Toby Gelfand, *The History of the Medical Profession*, in COMPANION ENCYCLOPEDIA OF THE HISTORY OF MEDICINE, VOL. 2, at 1121 (W. F. Bynum & Roy Porter, eds. 1993) (describing early history of university-based physicians).

<sup>130</sup> *Id.* at 1122 (“Learned medical professionals drew their clients from among the only members of society who could afford their fees, the narrow segment of upper classes.”).

<sup>131</sup> *Id.*

<sup>132</sup> Edward Shorter, *The History of the Doctor-Patient Relationship*, in COMPANION ENCYCLOPEDIA OF THE HISTORY OF MEDICINE, VOL. 1, at 784 (W.F. Bynum and Roy Porter, eds. 1993).

as tooth-drawers.<sup>133</sup> Some organized themselves into medieval craft guilds,<sup>134</sup> which owed their allegiance to the state rather than to their patients.<sup>135</sup> Another class of healers, the members of “colleges” of physicians, developed in some non-university cities in response to the absence of university-based practitioners.<sup>136</sup>

With the exception of the university-based and some urban physicians, medical practitioners generally enjoyed relatively low social and economic status. Well into the nineteenth century in Britain, for example, they were socially inferior to lawyers, clergymen, and the military.<sup>137</sup> Patients avoided medical providers as much as possible. “For the traditional patient,” explains one historian of medicine, “access to medicine meant really procuring a prescription for some complex purgative the patient could not compound or as a last desperate resort in terminal illness.”<sup>138</sup>

In the American colonies, the role of physician and surgeon had been merged, but doctors still enjoyed relatively low socio-economic status. As bioethicist and physician Edmund Pellegrino observes, medicine was characterized by “venal physicians, charlatans, and internecine dissension.”<sup>139</sup>

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<sup>133</sup> Gelfand, *supra* note 130, at 1122.

<sup>134</sup> *Id.*

<sup>135</sup> *Id.* at 1128. In the 18th century, the influence of laissez-faire economics encouraged a more entrepreneurial approach to medicine that undermined the power of the guilds. *Id.* at 1130.

<sup>136</sup> *Id.* at 1124. The London College of Physicians, for example, was chartered by Henry VIII in 1518. *Id.* at 1125. Baker notes that the colleges were not academic institutions “but rather licensing organizations.” ROBERT BAKER, BEFORE BIOETHICS: A HISTORY OF AMERICAN MEDICAL ETHICS FROM THE COLONIAL PERIOD TO THE BIOETHICS REVOLUTION 95 (2013) [hereinafter BAKER, BEFORE BIOETHICS]

<sup>137</sup> *Id.* at 1135

<sup>138</sup> Shorter, *supra* note 132, at 787.

<sup>139</sup> Edmund D. Pellegrino, *One Hundred Fifty Years Later: The Moral Status and Relevance of the AMA Code of Ethics*, in THE AMERICAN MEDICAL ETHICS REVOLUTION: HOW THE AMA'S CODE OF ETHICS HAS TRANSFORMED PHYSICIANS' RELATIONSHIPS TO PATIENTS, PROFESSIONALS, AND SOCIETY 107 (Robert B. Baker et al. eds. 1999) [hereinafter *Baker*].

It was only when the AMA was formed and adopted its first Code of Ethics in 1847 that we see the birth of a new conceptualization of the physician: as a professional.<sup>140</sup> The Code sought to dispel the popular perception that physicians were interested primarily in their own welfare. “The central moral commitment of the Code,” states Edmund Pellegrino, “was its dedication to something other than the physician’s self-interest, that something being the primacy of the welfare of the patient. This was a necessary reaffirmation given the self-serving conduct of the physician at this time.”<sup>141</sup> Although the Code did not use the term “fiduciary” to describe the patient-physician relationship, there was no mistaking its emphasis: the first section states that “physicians should . . . minister to the sick with due impressions of the importance of their office; reflecting that the ease, the health, and the lives of those committed to

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<sup>140</sup> See BAKER, BEFORE BIOETHICS, *supra* note 136, at 17 (the AMA made a series of decisions “by which it introduced content into the yet-to-be-defined concepts of ‘professionalism’ and ‘professional ethics’”). During the eighteenth century, John Gregory and Thomas Percival, professors at Edinburgh University, wrote tracts on physician ethics, but they were grounded on gentlemanly virtues rather than professionalism. See Chester R. Burns, *Setting the Stage: Moral Philosophy, Benjamin Rush, and Medical Ethics in the United States Before 1846*, in Baker, *supra* note 139, at 7. (“For both Gregory and Percival, the character of a gentleman determined a physician’s moral propriety.”). Baker similarly states that the gentlemanly ethic held sway in the United States until the middle of the nineteenth century. BAKER, BEFORE BIOETHICS, *supra* note 136 at 53. Lawrence McCullough traces the emergence of medical professionalism to Gregory, however: “Gregory also forged the ethical concept of a professional, i.e., someone who lives primarily according to fiduciary obligations of service to patients rather than primarily according to the dictates of self-interest. Gregory thus helped to invent medicine as a fiduciary profession, a legacy that persists into our time. Gregory did so in response to the state of disarray in the medicine of his day, a disarray that he meant to set to rights by using the tools of moral philosophy and philosophy of medicine.” Lawrence B. McCullough, *Introduction*, in JOHN GREGORY’S WRITINGS ON MEDICAL ETHICS AND PHILOSOPHY OF MEDICINE 1 (Lawrence B. McCullough ed., 1998). McCullough’s argument is repeated by Charity Scott. See Scott, *supra* note 6, at 335-337.

<sup>141</sup> Pellegrino, *supra* note 139, at 110.

their charge, depend on their skill, attention *and fidelity*.”<sup>142</sup> As a result of its embrace of professionalism, by the second decade of the twentieth century, the medical profession in the United States had become the most powerful profession in the country.<sup>143</sup> The AMA controlled medical education and licensure.<sup>144</sup> Physicians had become highly respected and their earnings began to increase.

Now consider that the legal concept of a fiduciary has a long pedigree, going back to Roman law.<sup>145</sup> The term was first used by English authors to describe a trustee in 1640.<sup>146</sup> But the first time that a legal opinion used the term “fiduciary” to describe a physician was an American case in 1848, *one year after the AMA adopted its new code*.<sup>147</sup> (The first case in Britain was in 1858.<sup>148</sup>) This is

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<sup>142</sup> Code of Medical Ethics of the American Medical Association, Ch. 1, Art. 1, §1 (1847) *available at* <http://www.ama-assn.org/resources/doc/ethics/1847code.pdf> (emphasis added). Much of the Code was a revival of Hippocratic principles. *See* Pellegrino, *supra* note 139, at 109.

<sup>143</sup> *See* Gelfand, *supra* note 129, at 1142.

<sup>144</sup> *Id.* at 1142; *see* Maxwell J. Mehlman, *Professional Power and the Standard of Care in Medicine*, 44 ARIZ. ST. L. J. 1165, 1169-1175 (2012) (provides description of the developments in self-regulation). A considerable degree of professional prestige came from the embrace of scientific medicine. Shorter, *supra* note 132, at 789-791.

<sup>145</sup> *See* Susan Atherton, Mark Blodgett & Charles Atherton, 2 J. RELIGION & BUSINESS ETHICS Art. 5 (2011) *archived at* <http://perma.cc/PTN6-CK78> (describing the Roman concept of *fiducia*).

<sup>146</sup> 3 William Blackstone, Commentaries on the Laws of England \*122 (“the neglect or unskillful management of his physician . . . breaks the trust which the party has placed in his physician . . .”).

<sup>147</sup> *Crispell v. Dubois*, 4 Barb. 393, 395-96, 1848 WL 5096 (N.Y. Gen. Term 1848) (“as in this case, the alleged will was prepared by an individual standing in a fiduciary relation to the deceased, and who took a large benefit under the will, more was required than bare proof of the execution . . . that as the plaintiff had long acted as the agent and confidential adviser of the deceased, and as her physician, and was attending her in that capacity . . .”). Michelle Oberman incorrectly asserts that “[w]idespread adoption of fiduciary terminology in reference to doctors and patients began in the 1980s.” Michelle Oberman, *Mothers and Doctors’ Orders: Unmasking the Doctor’s Fiduciary Role in Maternal-Fetal Conflicts*, 94 Nw. U. L. Rev. 451, 455 (2000). However, she then acknowledges that “courts have termed the physician-patient relationship a ‘fiduciary’ one since at least the mid-1960s.” *Id.* at 456

not a coincidence. The law conferred the status of a fiduciary on doctors at the very same time that they had begun refashioning themselves into a true profession. In other words, the law was saying that, if physicians want to be professionals, they had to act as fiduciaries for their patients. Arguably this works both ways: If doctors are no longer fiduciaries, they are no longer professionals.

Towards the end of the previous century, there began a substantial erosion of physician power that continues to this day, due in large part to society's distress at an enormous increase in health care spending attributed in no small part to the economic incentives for physicians created by the traditional fee-for-service payment system. In response, health care increasingly has come to be dominated by non-physicians. The result for physicians is a loss of independence and self-regulatory authority. A renowned scholar of the professions, Eliot Freidson, describes current developments that challenge medical professionalism, including that:

[P]hysicians now depend for their income on government agencies, large corporate employers, and health insurance companies, and must usually accept the economic terms offered by those organizations; an increasing number of physicians work for a salary or on a

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(citing *Hammonds v. Aetna Cas. & Sur. Co.*, 243 F.Supp. 793, 799 (N.D. Ohio 1965). Frankel similarly seems to think that regarding physicians as fiduciaries for their patients is a recent development: "The twentieth century is witnessing an unprecedented expansion and development of the fiduciary law. For example, physicians and psychiatrists have recently become members of the fiduciary group . . ." Frankel, *supra* note 1, at 796.

<sup>148</sup> *Hoghton v. Hoghton* (1852) 15 Beav. 278, 287-88 (Ch.), 51 Eng. Reprint, 545 ("The rule in cases of fiduciary relations as between trustee and *cestui que trust*, solicitor and client, guardian and ward, priest and penitent, physician and patient, which throws on the party receiving a benefit the *onus* of proving the fairness of the transaction, has no application to the present case.").

capitation basis in circumstances organized and financed by large for-profit organizations; [and] physicians are being divided into clinical practitioners, on the one hand, and managers or owners of practice organizations, on the other.<sup>149</sup>

Freidson fears that these changes “have the potential to destroy professionalism in medicine and to reduce physicians to technicians.”<sup>150</sup>

The message then is clear: If physicians want to regain and sustain their status as professionals, it is imperative for them to reaffirm their status as fiduciaries for their patients. As Pellegrino states, the challenge is to reassert “the primacy of the patient’s welfare”:

Together we must insist that no public policy, no practice arrangement, no professional prerogative, no definition of roles that weakens our primary loyalty to the patient can be allowed to dilute that commitment. . . . Fidelity to the moral center of medicine is the only antidote to the moral malaise that afflicts our professional today. We do not need a “new” ethic of accommodation to economics, commerce, or the idolatry of the marketplace. Even less do our patients need such an ethic.<sup>151</sup>

Physicians may not like being subject to potential legal liability for breaching their fiduciary duties to patients, viewing it as just another attempt by meddlesome lawyers to complicate their lives. But in doing so, they would be making a grave mistake by not appreciating the connection between fiduciary duty and the benefits that accrue to being professionals, especially the professional prerogative of self-regulation.

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<sup>149</sup> Eliot Freidson, *Professionalism and Institutional Ethics*, in *Baker*, *supra* note 139, at 132.

<sup>150</sup> *Id.*

<sup>151</sup> Pellegrino, in *Baker*, *supra* note 139, at 120.)

A recommitment to their role as fiduciaries, moreover, would help physicians shield themselves from current efforts to transform medicine from a calling into a mere business enterprise: Physicians could point to the threat of legal liability as a reason to avoid arrangements that would pit their interests against those of patients. Of particular importance is the suggestion mentioned earlier that entities such as managed care plans and hospitals that placed physicians into and enforced such arrangements might be liable independently for interfering with the physician's fiduciary duties.<sup>152</sup> By reaffirming their fiduciary duty to patients, physicians therefore can point to the fact that they are protecting these entities as well as themselves from potential liability.

## VI. CONCLUSION

If physicians are going to be able to hold onto their hard-won status as professionals, they need to begin acting now to remake the American health care system so that it is compatible with their fiduciary duties to their patients. Success will not come easily. The restructuring of medicine according to a business rather than a professional model may have gone too far to be turned back. Physicians may have trouble dissuading the public from the impression that they are asserting their fiduciary obligations merely as an excuse to enhance their own self-interest. To save both their patients and their profession, however, physicians have no choice but to try.

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<sup>152</sup> *See supra* Part II(A).

