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Dishonest Medical Mistakes

Maxwell J. Mehlman

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Dishonest Medical Mistakes

*Maxwell J. Mehlman**

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In the medical liability wars, physicians like to think that they are the ones in the trenches. Yet the true soldiers, of course, are the patients. As patients seek to avoid the barrage of malpractice reforms and the spoliation of managed care, one of their key refuges—the fiduciary duty of health care professionals—is being assailed from a number of directions. This Article describes these attacks and suggests how best to thwart them.

I. THE PATIENT'S PREDICAMENT

Imagine that you are seriously ill and go to a doctor. If you are like most patients these days, you are enrolled in some form of managed care.¹ One consequence of this is that your doctor is a

* The author is Arthur E. Petersilge Professor of Law and Director, The Law-Medicine Center, Case School of Law, and Professor of Bioethics, Case School of Medicine. He thanks Elizabeth Banger, Paola Ortiz, and Matthew Wright for their research assistance, and Jessica Berg, Peter Gerhart, Sharona Hoffman, and Dale Nance for their comments and suggestions.

1. Managed care emerged in the 1980s as the term for efforts by third-party payers to control health care expenditures for enrollees. Third-party payers had always practiced some form of claims management; traditional indemnity health insurers would not simply pay any bill that they received, but would review it for price and appropriateness of care. The term "managed

relative stranger.² Another is that the doctor has a financial interest in providing you with the minimum possible amount of care, for example, foregoing beneficial diagnostic tests and ordering less expensive treatments.³ This can seriously harm you.⁴

How would you feel if the doctor made a mistake that harmed you, not because he was careless or forgetful⁵—what might be called an inadvertent or “honest mistake”—but because the doctor made a “dishonest” mistake—that is, sacrificed your interests in order to benefit himself? In other words, how important is it to you that your doctor be not only competent, but committed to placing your interests ahead of his own?

care” referred to newer approaches that focused on controlling the behavior of the patients’ physicians. These included health maintenance organizations, which employed a number of financial and administrative methods to encourage physicians to limit the services that they provided or recommended to their patients, as well as placing financial and administrative obstacles before patients seeking reimbursement for services obtained outside of their plans. Approximately 80 percent of Americans with health insurance are enrolled in some type of managed plan. Gail B. Agrawal, *Resuscitating Professionalism: Self-Regulation in the Medical Marketplace*, 66 MO. L. REV. 341, 375 (2001).

2. See Thomas Bodenheimer, *The American Health Care System: Physicians and the Changing Medical Marketplace*, 340 NEW ENG. J. MED. 584, 586 (1999) (describing pressure on physicians in the managed care setting to increase productivity, which leads to a decline in the duration of patient office visits, and the consequences this has for the patient-physician relationship, with patients reporting more uncertainty regarding physician instructions after an office visit; reporting results of a survey indicating 75% of physicians in managed care plans in California reported pressure to see more patients per day); Jerome P. Kassirer, *Doctor Discontent*, 339 NEW ENG. J. MED. 1543 (1998) (discussing physicians’ discontent with time constraints that hinder their ability to spend adequate time with patients as one factor in the growing trend of physicians’ discontent with their practice).

3. Managed care plans use a number of techniques to encourage physicians to limit health care spending. They hold back a portion of the doctor’s remuneration, releasing the funds only if the physician, or a group of which the physician is a member, meets certain spending guidelines (“risk-sharing”). Managed care plans often require physicians to obtain permission before providing certain services, like non-emergency hospitalization, to patients (“prospective utilization review”). Plans also sometimes pay physicians a lump sum per patient which must cover the patient’s health care costs, with the physician getting to keep any money left over at the end of the calendar period (“capitation”). Finally, plans will drop doctors from the plan who do not follow plan policies or who exceed spending projections (“de-selection”).

4. Patients also can be harmed when doctors provide too much care. Such care is often referred to as “unnecessary,” but this is misleading. All medical interventions carry with them some risk, and therefore the question for clinical decisionmaking is not whether or not care is “necessary,” but whether the potential risks (and other costs) outweigh the expected benefits. “Too much care” presumably describes situations in which the risks to patients exceed the benefits. Doctors have an incentive to provide too much care when they are paid on a fee-for-service basis and are not constrained by utilization review. Since few patients these days are treated by doctors who are paid according to a pure fee-for-service system—that is, one without external utilization constraints—the bulk of this Article focuses on the latter danger.

5. The doctor is made male here in order to convey the possibility that a female patient may receive care from a male physician, potentially increasing the patient’s sense of vulnerability.

Chances are, it is pretty important to you for three good reasons. First, you have far less power than the doctor. Due to the non-competitive market for general practitioners⁶ and the likelihood that if you are sick you will need care urgently, you are not in a good position to insist upon seeing the most highly qualified and trustworthy physician. Second, the doctor often has to do things that you cannot monitor because you are untutored or oblivious.⁷ Third, your health and well-being are in peril, and most likely you are worried and afraid. (Some experts say you can be so intensely affected by your circumstances that you are no longer the same person.⁸)

No one knows how often doctors take advantage of patients in this situation. Although several research projects have attempted to determine how frequently doctors make mistakes in general,⁹ none have attempted to classify mistakes in terms of whether or not the

6. There is little accurate information available about the costs and benefits of specific health care services, even less about the quality of individual providers of those services, and virtually none correlating quality and price. Even if this information were available, patients often are not in a position to shop around. Finally, as Kenneth Arrow and other economists have pointed out, health care typically is a "credence good." A credence good is one whose quality cannot be detected even after it is experienced. Health care is a credence good because patients typically cannot evaluate from a clinical standpoint whether or not they have received high quality care. A favorable result following an episode of care cannot necessarily be attributed to the care, since the patient's condition might have improved of its own accord. See Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 951–52 (1963) (describing a patient's lack of knowledge regarding the nuances of medical care, treatment, and what actually cured them); David Hemenway, *Thinking About Quality—An Economic Perspective*, 9 QUALITY REV. BULL. 321, 325 (1983) (attributing patients' inability to judge care quality to their lack of information).

7. These factors were cited by the Supreme Court of California in *Tunkl v. Regents of the University of California*, 383 P.2d 441, 444–46 (1963), to explain why it refused to uphold an agreement under which a malpractice victim released a hospital from malpractice liability before being admitted for an urgent condition. In a famous footnote, the court, clearly appalled at the jury's verdict for the defendant, noted that, at the time he signed the release, the patient was "in great pain, under sedation, and probably unable to read." *Id.* at 442 n.1. Patients may be unable to monitor physicians even when the patient is not so obviously compromised. As Gregg Bloche observes, "Discretion, poorly scrutinized, invites opportunism, and for the reasons reviewed above, sick people are singularly ill-situated to monitor the exercise of medical discretion. Health care contractarians have offered no answer to this monitoring problem aside from calls for better-informed patients and medical purchasers." M. Gregg Bloche, *Trust and Betrayal in the Medical Marketplace*, 55 STAN. L. REV. 919, 930 (2002).

8. See *id.* at 927–28 ("Mere apprehension of serious illness transforms us: It makes us afraid and causes us to regress to childlike states of dependence and wishful thinking. Diagnosis of serious illness furthers this transformation, as do disabling symptoms."). Rebecca Dresser argues that this tends to invalidate all living will instructions. Rebecca Dresser, *Life, Death, and Incompetent Patients: Conceptual Infirmities and Hidden Values in the Law*, 28 ARIZ. L. REV. 373, 379–81 (1986). The commonly advocated solution is to execute a durable power of attorney, designating someone the patient trusts to act in the patient's best interests to make decisions for the patient in that eventuality.

9. For a description of the literature, see INSTITUTE OF MEDICINE, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 26–48 (2000) [hereinafter IOM REPORT 2000].

doctor took advantage of the patient, and it is not clear how such a study would be designed. It is probably safe to assume that most medical mistakes are honest mistakes—ones that occur despite the doctor's best intentions. Doctors certainly believe that this is true¹⁰; this is one of the main reasons why they despise the malpractice system, with its "shame and blame" approach.¹¹ In fact, physicians seem to think that, for the most part, they do not deserve to be punished at all. As Lucien Leape observed, most doctors insist that the vast majority of physicians who get sued are not careless or "engaged in foolish behavior."¹² By and large, physicians believe that they are conscientiously trying to do the right thing. "A malpractice suit isn't about being a bad doctor," emphasizes a psychiatrist who conducts medical malpractice education sessions for physicians. "It's about a bad event."¹³ The title of a 2000 report on medical mistakes by the Institute of Medicine says it all: "To Err is Human."¹⁴

Yet there is no question that doctors sometimes do make mistakes by placing their interests ahead of their patients'. For one thing, it is relatively easy for doctors to get away with it. Most of the time, doctors who make any kind of mistake, honest or dishonest, do not get punished. This is because nothing untoward happens; or something does, but the patient does not realize that it was the doctor's fault; or the patient does realize this, but is unable to sanction the doctor for it.¹⁵

10. One reason why doctors are upset at the medical malpractice system is that they believe that it treats them as if they routinely made dishonest mistakes. See Maxwell J. Mehlman, *The Shame of Medical Malpractice*, 27 J. LEGAL MED. 17 (discussing whether physicians ought to be made to feel ashamed for committing medical malpractice).

11. See, e.g., Donald J. Palmisano, *Why Your Doctor Might Quit*, SAT. EVENING POST, Nov. 1, 2004, at 50 ("For example, to improve patient safety, the AMA sees a clear need to stop the shame-and-blame mentality and focus instead on preventing errors.").

12. Mark Crane, *The Godfather of Patient Safety Sees Progress*, MED. ECON., Aug. 8, 2003, at 29, 33, available at <http://www.medicaleconomics.com/memag/article/articleDetail.jsp?id=112473>.

13. Gail Garfinkel Weiss, *You've Been Sued. There's Help.*, MED. ECON., Feb. 7, 2003, at 56, 59, available at <http://www.memag.com/memag/article/articleDetail.jsp?id=111267> (quoting psychiatrist Ronald L. Hofeldt, MD).

14. IOM REPORT 2000, *supra* note 9.

15. The Harvard malpractice study found that only one out of eight victims of hospital malpractice asserted a claim and that only half of those claims ever resulted in compensation. William M. Sage et al., *Enterprise Liability for Medical Malpractice and Health Care Quality Improvement*, 20 AM. J. L. & MED. 1, 2 (1994), referring to HARVARD MEDICAL PRACTICE STUDY, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK 3 (1990). The study lumped all medical errors together, including those that would be considered "dishonest." Given the additional elements that would have to be proved, however, it is safe to assume that patients successfully assert claims for dishonest mistakes with no greater frequency.

It is likely to be even harder for patients to establish that a mistake was dishonest. Conflicts of interest abound within the patient-physician relationship. As mentioned earlier, managed care creates financial incentives for doctors to provide less than optimal care. Managed care largely has replaced fee-for-service medicine (in which doctors are paid for each service they provide), yet fee-for-service also creates a conflict of interest, since it increases rewards to physicians as they provide more services for patients, including providing care that is unnecessary or even harmful. Aside from fortune, physicians may be tempted to sacrifice patient welfare for fame: for example, they may experiment on patients to develop breakthrough techniques. Indeed, it might be argued that any time a doctor makes an unreasonable mistake, that doctor is sacrificing patient welfare for the doctor's benefit, since the doctor could avoid the mistake by taking more time or being better prepared, either of which would come at the doctor's expense.

Yet there is an important difference between a mistake caused by inadvertence and one that results from selfishness. The former may affect patients' estimation of their doctors' degree of skill, but the latter undermines their ability to trust doctors to act in their patients' best interest. As numerous scholars have recognized, trust is essential to the patient-physician relationship because it reduces the resources patients must expend to monitor physician behavior, thereby decreasing the transaction costs of the relationship and increasing net patient benefit.¹⁶ Therefore, as they are faced with conflicts of interests, physicians must consciously avoid compromising patient care.¹⁷ A doctor whose unreasonable mistake can be attributed to a desire to promote his own interests at the patient's expense has committed a different wrong than one who merely makes

16. Mark Hall maintains that trust also produces therapeutic benefits, such as the placebo effect: "[T]he effectiveness of care depends on patients' confidence in its efficacy." Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 479 (2002) [hereinafter Hall, *Law, Medicine*]. In an article attacking Hall, Robert Gatter questions whether there is a true placebo effect, whether—if it exists—it is due to trust in physicians, and why it cannot be produced in patients who are protected by what Gatter calls "trust-as-confidence," as opposed to "trust-as-faith," the former being a result of the law. Robert Gatter, *Faith, Confidence, and Health Care: Fostering Trust in Medicine Through Law*, 39 WAKE FOREST L. REV. 395, 416–17 (2004). Gatter concedes, however, that researchers have established "a positive correlation between medical trust and certain desirable health-related [patient] behaviors," such as obtaining health care, obeying doctors' orders, and perceiving that care was effective. *Id.* at 399–400.

17. It is not even clear that a doctor ethically can protect himself from being injured by the patient—such as by becoming infected with the patient's disease—if this would seriously compromise the patient's care, unless the alternative would be to deprive other patients of life-saving treatment. Cf. Samuel J. Huber & Matthew K. Wynia, *When Pestilence Prevails . . . Physician Responsibilities in Epidemics*, 4 AM. J. BIOETHICS W5 (2004) (citing need for renewed commitment to treating contagious patients).

an unreasonable mistake due to carelessness, even if it is hard to tell the difference.

A. Sometimes Disloyal Doctors are Caught

In *Strauss v. Biggs*, a podiatrist named Strauss, who operated what the trial court called a "podiatric mill,"¹⁸ was held liable for pretending to perform a certain surgical procedure and instead severely injuring the plaintiff's heel. The defendant had not performed the correct procedure because it would have had to take place in a hospital, and he did not have hospital privileges to perform hospital surgical procedures. The doctor's mistake consisted of performing the wrong procedure and doing it badly; his disloyalty consisted of allowing his financial interest in conducting a lucrative, high-volume office practice to interfere with his patient's well-being. This inference was strengthened by evidence that he had billed the plaintiff's insurer for the surgery and other procedures that were either unnecessary or not performed at all.¹⁹

In *Davis v. Superior Court*,²⁰ a plaintiff who injured his hand in a workplace accident alleged that physicians retained by the employer's workers' compensation insurer had treated him negligently by leaving a 2-inch stick embedded in his hand, and then concealed the negligence by referring to the stick as "a splinter." This was more than mere negligence, since the plaintiff demonstrated that the doctors were motivated by the desire to stay in the insurance company's good graces so that they could continue to receive its referrals.²¹

Financial motivations were also involved in *Sweed v. Cigna Health Plan*, in which a patient complained that her primary care provider failed to make a timely surgical referral after finding a lump in her breast because of her health plan's financial incentives to withhold care.²² By the time she did have a biopsy, her cancer was

18. *Strauss v. Biggs*, 525 A.2d 992, 1000 (Del. 1987). The evidence showed that he began work at 9 a.m., made the plaintiff wait for several hours with other patients when she arrived at his office between 9 and 10 p.m. that evening, and eventually operated on her at 1 a.m. *Id.* at 994, 1000.

19. *Id.* at 998.

20. 33 Cal. Rptr. 2d 6, 7 (Cal. Ct. App. 1994).

21. *Id.* at 9. The court held that the plaintiff was not entitled to punitive damages because he had not complied with California statutory requirements. *Id.* at 10.

22. No. 87C-SE-171-1-CV, 1989 Del. Super. LEXIS 51, at *1-2 (Del. Sup. Ct. Feb. 2, 1989). The financial incentives were fee-withhold arrangements in which a portion of the physician's fees would be returned depending on the referral practices of all of the physicians in the managed care network. *Id.* at *4. The court upheld the trial court's refusal to award punitive damages because the patient's own expert refused to attribute her physician's behavior to

inoperable. In another case, an optometrist was successfully sued for allowing his unlicensed, untrained son to examine a patient's eyes, sell her contact lenses, and incorrectly advise her how to care for them, as a result of which she developed an infection that left her with a permanent corneal scar.²³ The optometrist's disloyalty consisted of placing his and his son's financial interests first. And recently, a doctor was accused of diluting the AIDS drugs he prescribed his patients in order to pocket the difference.²⁴

In *Charell v. Gonzalez*,²⁵ the plaintiff became blind and suffered from severe back pain after her uterine cancer metastasized to her spine. She sued an alternative practitioner who had dissuaded her from having chemotherapy and radiation treatments and instead had put her on a special diet and prescribed six coffee enemas a day. After performing bogus "hair tests," he also had informed her erroneously that the number of cancer cells in her body had decreased as the result of the treatment. The court found that the plaintiff proved that the defendant's quackery²⁶ caused her cancer to metastasize.

In the description of *Charell's* given facts, there is no hard evidence that the practitioner placed his interests above the patient's. Some alternative practitioners undoubtedly believe that their services benefit patients. But there was one additional piece of evidence in the case that elevated the practitioner's misconduct above that of simple wrong-headedness: the plaintiff showed that the "defendant's practice of prescribing nutrition as a cure was designed to enable companies in which he had a financial interest to sell product."²⁷

The impetus for disloyal behavior need not be financial, however. It can involve other personal interests of the provider. In *Medvecz v. Choi*, for example, a patient undergoing an elective renal

financial motives, because there was no evidence that the managed care plan had advised the physician that he was making too many referrals, and because the plaintiff did not show that the physician had failed to make other necessary referrals in the past. *Id.* at *11-12, *14-15.

23. *Menaugh v. Resler Optometry Inc.*, No. 56297, 1990 Mo. App. LEXIS 405, at *1-2 (Mo. Ct. App. 1990).

24. David Rosenzweig, *Fraud Case Filed Against Doctor: Operator of Clinics in L.A. and Orange Counties Is Accused of Improperly Treating AIDS Patients, Bilking Insurers and Medicare*, L.A. TIMES, July 21, 2005 at B1. The indictment charged the doctor with cheating Medicare and insurance companies out of \$1.2 million in this way between 1995 and 2001.

25. 660 N.Y.S.2d 665 (N.Y. Sup. Ct. 1997).

26. For a discussion of what can be considered quackery, see Maxwell J. Mehlman, *Quackery*, 31 AM. J. L. & MED. 349 (2005).

27. *Charell*, 660 N.Y.S.2d at 669. On appeal, plaintiff's award of punitive damages was vacated, with the court stating inexplicably that "[d]efendant's conduct was not so wantonly dishonest, grossly indifferent to patient care, or so malicious and/or reckless as to warrant such an award." *Charell v. Gonzalez*, 673 N.Y.S.2d 685, 687 (N.Y. App. Div. 1998) (citations omitted).

arteriography alleged that she was paralyzed from the waist down when the anesthesiologist abandoned her in order to have lunch.²⁸

Given the egregious nature of these behaviors, patients clearly deserve to have all the reassurances they can that, when faced with opportunities to further their own interests at their patients' expense, doctors will do the right thing. What discourages physicians from harming patients for selfish reasons?

II. SOURCES OF PATIENT PROTECTION

There are a number of possible sources of patient reassurance.²⁹ One is medical socialization: medical students must be taught to be loyal to their patients, and practitioners must be reminded of this in continuing medical education classes. Another important source of security for patients is the internalization of professional norms and their enforcement through peer pressure. The Code of Ethics of the American Medical Association provides as one of its nine principles that "a physician shall, while caring for a patient, regard responsibility to the patient as paramount."³⁰ Opinion E-803 of the AMA Code of Ethics states even more unequivocally:

Under no circumstances may physicians place their own financial interests above the welfare of their patients. The primary objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. For a physician to unnecessarily hospitalize a patient, prescribe a drug, or conduct diagnostic tests for the physician's financial benefit is unethical. 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.³¹

A physician who violates these professional rules can be expelled from the AMA, which in turn jeopardizes his hospital privileges and his acceptability to managed care plans.³²

28. 569 F.2d 1221, 1222–24 (3d Cir. 1977).

29. I am focusing on social sources. There is some evidence that we are biologically induced to be altruistic. *See, e.g.,* ELLIOTT SOBER & DAVID SLOAN WILSON, UNTO OTHERS: THE EVOLUTION OF UNSELFISH BEHAVIOR 17–54 (1998).

30. American Medical Association, Principles of Medical Ethics, Principle VIII (2001), <http://www.ama-assn.org/ama/pub/category/2512.html> (last visited May 31, 2006). There are a total of nine principles.

31. American Medical Association, AMA Policies, Opinion E-8.03 (June 1994), http://www.ama-assn.org/apps/pf_new/pf_online (last visited Apr. 16, 2006) (select "Code of Medical Ethics"; then "Opinions on Practice Matters"; then select opinion E-803).

32. It is not surprising that organized medicine endorses the principle that patients come first, since adherence to professional norms in general, and to the norm of loyalty to one's patients in particular, is one of the important ways by which the medical profession—indeed, all professions—distinguish themselves from ordinary trade. In return for their special privileges, such as calling themselves "doctor" and being allowed to dispense prescription drugs and controlled substances, physicians (and other professionals) accept the obligation to act, not only

Health care provider organizations, like hospitals and managed care plans, might also play a role in reassuring patients that their doctors will behave correctly. There is no question that internal organizational sanctions can be severe.³³ The question is whether health care organizations put the welfare of patients ahead of their own self-interest. There is good reason to doubt that these organizations put patients' interests ahead of their own.³⁴

III. LOYALTY THROUGH LAW

Physician loyalty to patients is also enforced through the law.³⁵ The law promotes physician loyalty in several ways. The law performs an "expressive function" of proclaiming and reinforcing professional norms.³⁶ Sometimes criminal law is used. For example, the doctor mentioned earlier who was accused of diluting his AIDS patients' prescriptions³⁷ is being prosecuted for committing a federal

competently, but honorably. But patients come out well in the bargain, too, receiving the succor of physician loyalty. Putting patients first occasionally may seem too burdensome to doctors and overly paternalistic toward patients, but the burden and the presumptiveness is worth it to both sides.

33. They include restriction or loss of hospital privileges, without which it is virtually impossible to maintain a successful practice except in the poorest and most remote locales, and "de-selection" from a managed care network—the euphemism for being terminated as a plan physician—which can cause a fatal reduction in the size of the physician's practice. The severity and limited external oversight of internal organizational sanctions is one reason why organized medicine has resisted calls for "enterprise liability," a regime that would permit patients to sue only provider organizations such as hospitals rather than practitioners. See Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381, 415–26 (1994); William M. Sage & James M. Jorling, *A World That Won't Stand Still: Enterprise Liability By Private Contract*, 43 DEPAUL L. REV. 1007 (1994).

34. As Brad Gray observes about managed care plans, "ethical standards are not well established in the managed care industry and devote little or no attention to the problems addressed by the fiduciary ethic, particularly the conflict-of-interest problem and its resolution in favor of the patient." Bradford H. Gray, *Trust and Trustworthy Care in the Managed Care Era*, 16 HEALTH AFFAIRS 34, 40 (1997), available at <http://content.healthaffairs.org/cgi/reprint/16/1/34.pdf>.

35. Actually, internal organizational sanctions are creatures of the law too, since they are governed by organizational by-laws, which are legally enforceable. See, e.g., *Murdoch v. Knollwood Park Hosp.*, 585 So. 2d 873, 876 (Ala. 1991) (stating that physician's termination from hospital staff followed by-laws).

36. Greg Bloche explains that "progressive" corporate law scholars believe that internalization of fiduciary norms is more important than the threat of legal sanctions to prevent breaches of fiduciary duties. Bloche, *supra* note 7, at 926–27. He adds that "[s]elfishness-suppressing requirements—fiduciary obligation, duties of good faith, and other cooperation-favoring principles—are the law's classic response to such monitoring problems. If the emerging psychological understanding of how these legal requirements shape behavior is correct, they work in large measure by inducing target subjects to internalize selfishness-suppressing norms." *Id.* at 930 (citations omitted).

37. See *supra* note 24 and accompanying text.

felony.³⁸ The law also empowers state medical boards to discipline errant physicians.³⁹ Statutory sources of patient protection include consumer protections laws and RICO.⁴⁰ Another statutory protection is the National Practitioner Data Bank, established by Congress in 1990 to record malpractice payments on behalf of, and disciplinary actions against, physicians and other health care professionals.⁴¹ The common law comes into play with remedies for fraud and misrepresentation.⁴²

38. The doctor has been indicted for committing Medicare and Medicaid fraud by submitting claims to the government for full-strength prescriptions while dispensing diluted medicines to his patients. See 18 U.S.C. §1347 (2006), which states:

Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice—(1) to defraud any health care benefit program; or (2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program, in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title [up to \$250,000 per offense] or imprisoned not more than 10 years, or both.

It is also a federal crime to receive a kickback for ordering services and to refer patients to facilities in which the physician has a financial interest. 42 U.S.C. §1395nn. However, it is not a crime to bill for unnecessary services if there is no attempt at a cover-up, or to breach one's fiduciary duty per se.

39. Critics, however, charge that state boards do not adequately perform their disciplinary function. See, e.g., Atul Gawande, *When Good Doctors Go Bad*, NEW YORKER, Aug. 7, 2000, at 60 (addressing the inherent shortcomings of the system for dealing with incompetent physicians); see also Paul R. Van Grunsven, *Medical Malpractice or Criminal Mistake?—An Analysis of Past and Current Criminal Prosecutions for Clinical Mistakes and Fatal Errors*, 2 DEPAUL J. HEALTH CARE L. 1 (1997) (explaining that the licensing system is inadequate to the point that criminal prosecution of doctors for misconduct becomes necessary).

40. Many states have enacted consumer protection laws, which provide consumers with redress from businesses that commit unfair or deceptive trade practices or engage in unfair methods of competition. These statutes are often modeled after the Federal Trade Commission Act. See Joan H. Krause, *The Role of the States in Combating Managed Care Fraud and Abuse*, 8 ANNALS HEALTH L. 179, 192 (1999); Michael Flynn, *Physician Business (Mal)practice*, 20 HAMLINE L. REV. 333, 337 (1996).

41. The data bank is designed to remedy information failure in both the private and public sectors. Hospitals and managed care plans access the information in order to determine whether a physician should be a member of their staffs or networks, and the information is accessible to state medical boards. However, numerous failings have been noted in the Data Bank system, especially non-reporting by managed care organizations. Department of Health and Human Services, Office of the Inspector General, *Managed Care Organization Nonreporting to the National Practitioner Data Bank*, OEI-01-99-00690 (May 2001), available at <http://oig.hhs.gov/oei/reports/oei-01-99-00690.pdf>.

42. This is frequently framed in terms of a violation of the duty to obtain the patient's informed consent, but states have taken other paths in allowing patients to sue. Some cases alleging fraud and misrepresentation involve a physician's failure to adequately disclose his own experience and competence. In these circumstances, courts have allowed patients to sue based on lack of informed consent, fraud, and lack of consumer protection. Heyward H. Bouknight, *Between the Scalpel and the Lie: Comparing Theories of Physician Accountability for Misrepresentations of Experience and Competence*, 60 WASH. & LEE L. REV 1515, 1530–44 (2003). The patient may also be able to obtain punitive damages. See *Sweed v. Cigna Health Plan*, No. 87C-SE-171-1-CV, 1989 Del. Super. LEXIS 51, at *9 (Del. Sup. Ct. Feb. 2, 1989).

When it comes to protecting patients from physician self-aggrandizement, however, one of the most important legal protections for patients is fiduciary law. Fiduciary doctrine emerged as a response of courts of equity to the absence of a remedy in early common law for beneficiaries injured by the disloyalty of trustees.⁴³ It gradually extended beyond trustees to other relationships in which a party with invariably greater power is entrusted with another's welfare.⁴⁴ Fiduciary rules forbid the stronger party in these

43. See Kim Johnston, *Patient Advocates or Patient Adversaries? Using Fiduciary Law to Compel Disclosure of Managed Care Financial Incentives*, 35 SAN DIEGO L. REV. 951, 958 (1998). The common law was incapable of protecting the beneficiaries because the trustees had title to the property.

44. As D. Gordon Smith puts it, fiduciary doctrine targets opportunism. See D. Gordon Smith, *The Critical Resource Theory of Fiduciary Duty*, 55 VAND. L. REV. 1399, 1410 (2002). There have been numerous attempts to discover a unifying theory in fiduciary law. The problem is that the nature of fiduciary constraints varies depending upon the fiduciary relationship in question. See RESTATEMENT (SECOND) OF TRUSTS § 2 cmt. b (1959) ("The duties of a trustee are more intensive than the duties of some other fiduciaries."); Deborah A. DeMott, *Beyond Metaphor: An Analysis of Fiduciary Obligation*, 1988 DUKE L.J. 879, 908-09 ("The scope of the fiduciary's obligation, as well as the obligation's precise formulation, necessarily varies with the context of the relationship. As the law has developed, trustees are under more stringent restrictions in their dealings with trust property than are corporate directors in their personal transactions with the corporation."); Kenneth B. Davis, Jr., *Judicial Review of Fiduciary Decisionmaking—Some Theoretical Perspectives*, 80 NW. U. L. REV. 1, 23-24 (1985) (describing variability in scope of fiduciary obligations). Scott and Frankel attribute the variation to differences in the fiduciaries' ability to harm the entrustor. See Austin W. Scott, *The Fiduciary Principle*, 37 CAL. L. REV. 539, 541 (1949) ("The greater the independent authority to be exercised by the fiduciary, the greater the scope of his fiduciary duty."); Tamar Frankel, *Fiduciary Law*, 71 CAL. L. REV. 795, 826 (1983):

The extent of the fiduciary duty varies with the degree of potential abuse of power stemming from the relation. Thus, the standard is stricter for trustees than for corporate directors because the beneficiary does not control the trustee and is locked into the relation, whereas shareholders can terminate the directors or sell their shares if they are dissatisfied with the directors' performance.

One of the most recent attempts at unified fiduciary theory is Smith's. He contends that a fiduciary relationship is formed "when one party . . . acts on behalf of another party . . . while exercising discretion with respect to a critical resource belonging to the beneficiary." Smith, *supra*, at 1402 (emphasis omitted). Smith's article also contains a review and critique of main fiduciary theories. *Id.* at 1423-31. He explains that by "discretion" he means "the power to use or work with the critical resource in a manner that exposes the beneficiary to harm that cannot reasonably be evaded through self-help." *Id.* at 1449. But neither Smith nor any other theorist has come up with a convincing theoretical explanation for why some relationships in which a party with invariably greater power is entrusted with another's welfare are made fiduciary and others are not. Frankel, for example, attributes fiduciary requirements to the entrustor's vulnerability to the power that he has delegated to the fiduciary: "The delegated power that enables the fiduciary to benefit the entrustor also enables him to injure the entrustor, because the purpose for which the fiduciary is allowed to use his delegated power is narrower than the purposes for which he is capable of using power." Frankel, *supra*, at 810. Davis points to the potential for a conflict of interest: "The source of the fiduciary problem is the joinder of the fiduciary's discretionary control over some nontrivial portion of the principal's assets and affairs with the unavoidable fact that the interests of the principal and the fiduciary are not perfectly aligned." Davis, *supra*, at 4. Anderson focuses on the value of specialization: "Such conflict-of-

relationships from taking advantage of the weaker. The weaker party thereby is encouraged to trust the other, enabling the weaker party to gain a benefit from the relationship that otherwise would be reduced or eliminated altogether (since the relationship would not exist) by monitoring costs. The law regards a number of relationships as fiduciary, and as numerous courts have recognized, the relationship between physician and patient is among them.⁴⁵

Fiduciary law protects patients and similar parties by providing them with powerful procedural advantages compared with common law plaintiffs. In effect, fiduciary law offsets a weaker interpersonal position in the fiduciary relationship with a stronger legal position in the event of a breach by the fiduciary. Once the patient provides evidence of a breach of fiduciary duty, the burden typically shifts to the physician to disprove the allegation.⁴⁶ In

interest rules attempt to preserve the efficiency gains from specialized exchange while preventing the resulting cheating from being too unfair." Allison Grey Anderson, *Conflicts of Interest: Efficiency, Fairness, and Corporate Structure*, 25 UCLA L. REV. 738, 740 (1978). Recognizing that none of these explanations can account for all fiduciary relationships, DeMott states simply that:

[d]escribed instrumentally, the fiduciary obligation is a device that enables the law to respond to a range of situations in which, for a variety of reasons, one person's discretion ought to be controlled because of characteristics of that person's relationship with another . . . This instrumental description is the only general assertion about fiduciary obligation that can be sustained.

DeMott, *supra*, at 915. None of these theories explains why, for example, a garage mechanic asked to fix the brakes on an automobile—someone to whom injurious power is delegated, who might benefit by doing a poorer job than the owner bargained for, and who is expected to use specialized skills—is not regarded as a fiduciary. Most likely, the answer is that the mechanic historically was regarded as a mere tradesperson and therefore neither imbued with the privileges nor saddled with the responsibilities of the professional.

45. See *Canterbury v. Spence*, 464 F.2d 772, 782 (D.C. Cir. 1972); *United States v. Neufeld*, 908 F. Supp. 491, 500 (S.D. Ohio 1995); *Salis v. United States*, 522 F. Supp. 989, 997 n.10 (M.D. Pa. 1981); *Hammonds v. Aetna Cas. & Sur. Co.*, 237 F. Supp. 96, 102 (N.D. Ohio 1965); *Mull v. String*, 448 So. 2d 952, 953 (Ala. 1984); *Hales v. Pittman*, 576 P.2d 493, 497 (Ariz. 1978); *Cobbs v. Grant*, 104 Cal. Rptr. 505, 516 (Cal. 1972); *Stafford v. Shultz*, 270 P.2d 1, 7 (Cal. 1954); *Berkely v. Anderson*, 82 Cal. Rptr. 67, 77 (Cal. Ct. App. 1969); *Simmons v. Univ. of Chicago Hops. and Clinics*, 642 N.E.2d 107, 111 (Ill. 1994); *Petrillo v. Syntex Labs.*, 499 N.E.2d 952, 960-61 (Ill. App. Ct. 1986); *Henkin, Inc. v. Berea Bank & Trust Co.*, 566 S.W.2d 420, 423 (Ky. Ct. App. 1978) (quoting *Warsofsky v. Sherman*, 93 N.E.2d 612, 615 (Mass. 1950)); *Woolley v. Henderson*, 418 A.2d 1123, 1128 n.3 (Me. 1980); *Hendricks v. James*, 421 So. 2d 1031, 1041 (Miss. 1982), *overruled on other grounds by Mullins v. Ratcliff*, 515 So. 2d 1183 (Miss. 1987); *Brandt v. Med. Def. Assocs.*, 856 S.W.2d 667, 670 (Mo. 1993); *Missouri ex rel. McCloud v. Seier*, 567 S.W.2d 127, 128 (Mo. 1978); *Moore v. Webb*, 345 S.W.2d 239, 243 (Mo. Ct. App. 1961); *Stigliano v. Connaught Lab., Inc.*, 658 A.2d 715, 720 (N.J. 1995); *Demers v. Gerety*, 515 P.2d 645, 649 (N.M. Ct. App. 1973); *Nixdorf v. Hicken*, 612 P.2d 348, 354 (Utah 1980); *Carson v. Fine*, 867 P.2d 610, 611 (Wash. 1994); *Miller v. Kennedy*, 522 P.2d 852, 860 (Wash. Ct. App. 1974).

46. See *Demers*, 515 P.2d at 655 (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 43, 951, n.65: *Knaebel v.*

addition, a patient who prevails is entitled to the equitable remedy of restitution, if appropriate,⁴⁷ and, according to most courts and commentators, punitive damages.⁴⁸

The scope of fiduciary duties varies depending on the context. In some situations, it is sufficient for the fiduciary to disclose a conflict of interest to the beneficiary.⁴⁹ In other contexts, the beneficiary is

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). As Johnston states, some courts take the position that the fiduciary must bear this burden with clear and convincing evidence. In addition, at least in some contexts, the patient need not prove actual injury to recover damages. See Milbank, Tweed, Hadley & McCloy v. Boon, 13 F.3d 537, 543 (2d Cir. 1994); Zackiva Commc'n Corp. v. Horowitz, 826 F. Supp. 86, 88 (S.D.N.Y. 1993); Diamond v. Oreamuno, 248 N.E.2d 910, 912 (N.Y. 1969); Rice v. Perl, 320 N.W.2d 407, 411 (Minn. 1982), cited in Johnston, *supra* note 43, at 962 nn. 62–63.

47. See Smith, *supra* note 44, at 1405–06 (2002). Smith quotes Douglas Laycock's summary of the importance of the restitution remedy:

The restitutionary claim matters in three sets of cases: (1) when unjust enrichment is the only source of liability; (2) when plaintiff prefers to measure recovery by defendant's gain, either because it exceeds plaintiff's loss or because it is easier to measure; and (3) when plaintiff prefers specific restitution, either because defendant is insolvent, because the thing plaintiff lost has changed in value, or because plaintiff values the thing he lost for non-market reasons.

Smith, *supra* note 44, at 1406 n.23 (quoting Douglas Laycock, *The Scope and Significance of Restitution*, 67 TEX. L. REV. 1277, 1284 (1989)). Johnston describes how a constructive trust remedy could apply to class action plaintiffs seeking damages for a health care provider's failure to disclose financial incentives, namely, by distributing the provider's fee withhold fund to the members of the class. Johnston, *supra* note 43, at 981. Although the court did not realize it, restitution was the appropriate remedy for the plaintiff in *Moore v. Regents of the University of California*, in which the plaintiff alleged that his physicians removed cells and attempted to commercialize them without his knowledge or permission. 793 P.2d 479, 480 (Cal. 1990). For a discussion of the case and why the court did not get the remedy right, see Maxwell J. Mehlman, *Moore v. Regents of the University of California*, in PROP. STORIES 41 (Gerald Korngold & Andrew P. Morriss eds., 2004).

48. 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). Lori Andrews also claims that the plaintiff in a breach of fiduciary duty case who alleges constructive fraud need not prove affirmative acts of concealment. Lori Andrews, *Studying Medical Error In Situ: Implications for Malpractice Law and Policy*, 54 DEPAUL L. REV. 357, 376–77 (2005) (discussing a 1986 Iowa decision in which the requirement of affirmative acts was relaxed due to the fiduciary nature of the relationship). The procedural differences between actions for breach of fiduciary duty and mere negligence partly explain the distinction between how the law treats honest and dishonest mistakes. Victims of dishonest mistakes might assert claims for intentional or negligent torts, but these causes of action are not synonymous with breach-of-fiduciary-duty cases, since they focus primarily on the degree of risk created by the defendant's behavior, rather than on the motivation for the harm. See, e.g., RESTATEMENT (SECOND) TORTS § 8A, cmt. B (1959) ("As the probability that the consequences will follow decreases, and becomes less than substantial certainty, the actor's conduct loses the character of intent, and becomes mere recklessness.").

49. This is a central issue for Hall, as it was for the Illinois Supreme Court in *Neade v. Portes*, 739 N.E.2d 496 (Ill. 2000). See notes 82–86, *infra*, and accompanying text. Hall maintains

permitted to challenge the fiduciary's behavior as unfair, even if the fiduciary has made full disclosure of the conflict of interest.⁵⁰ Given that seriously ill patients typically have few options and inferior bargaining power, disclosure is not likely to be an adequate form of protection. Indeed, it may well be counterproductive, serving merely to increase costs and upset patients.⁵¹

In terms of the elements of the patient's fiduciary cause of action, the prima facie case consists of presenting evidence that the physician had a conflict of interest with the patient that caused the physician to injure the patient in order to promote the physician's self-interest. If the plaintiff can show this, the burden of proof shifts to the physician. The physician can prevail by proving, by a preponderance of the evidence, that he did not owe the patient a fiduciary duty (e.g., there was no patient-physician relationship),⁵² that the physician did not make an unreasonable mistake that harmed the patient's health,⁵³

that it is sufficient if patients at the time of enrollment are made aware of their managed care plan's incentives for physicians to limit services. See Mark Hall, *Ideology and Trust: A Reply to Bloche*, 55 STAN. L. REV. 955, 966 (2002) [hereinafter Hall, *Ideology and Trust*]. The plaintiff in *Neade* argued that the physician should have alerted the patient to these incentives during the informed consent process, since this would have motivated him to obtain a second opinion about the need for further tests that could have saved his life. *Neade*, 739 N.E.2d at 503.

50. See 1 AUGUST WAKEMAN SCOTT & WILLIAM FRANKLIN FRATCHER, *THE LAW OF TRUSTS* § 2.5, at 43 (4th ed. 1987) [hereinafter 1 SCOTT ON TRUSTS] ("If the fiduciary enters into a transaction with the beneficiary and fails to make a full disclosure of all circumstances known to him affecting the transaction, or if the transaction is unfair to the beneficiary, it can be set aside by him.") (emphasis added). Elsewhere, Scott states: "Where [the trustee] deals directly with the beneficiaries, the transaction may stand, but only if the trustee makes full disclosure and takes no advantage of his position and the transaction is in all respects fair and reasonable." 2A AUGUST WAKEMAN SCOTT & WILLIAM FRANKLIN FRATCHER, *THE LAW OF TRUSTS* §170.25, at 436 (4th ed. 1987). Scott also states: "In the case of a purchase by a trustee of the trust property with the consent of the beneficiaries, however, it would seem that if the price is not fair the transaction can be set aside even though the trustee made full disclosure." 5 AUGUST WAKEMAN SCOTT & WILLIAM FRANKLIN FRATCHER, *THE LAW OF TRUSTS* § 496, at 501 (4th ed. 1987). See also Anderson, *supra* note 44, at 760 ("Where bargaining power is roughly equal, specific fiduciary duties can be waived by the parties on the basis of full disclosure to and consent by the client. Because informational disparities so often mean that bargaining power is unequal, however, all fiduciaries have an unwaivable obligation of fairness toward the other party.").

51. Imagine you are seriously ill and your doctor tells you: "I have a financial interest in giving you the least amount of care possible. I just thought you'd like to know." Given this information, or even information more specifically detailing the way in which the doctor proposes to sacrifice the patient's interests (e.g., "Some doctors would recommend an angiogram at this point, but I don't think it's necessary, but then of course I have a financial incentive to say so"), the most the patient can do is to get a second opinion from another physician, as the plaintiff in *Neade* alleged the patient would have done. *Neade*, 739 N.E.2d at 499. But if the objective is to reduce health care spending, why add this expense, not to mention cause such anguish to the patient?

52. For example, the physician might have been consulted informally by the patient's actual caregiver.

53. The burden shifting in breach-of-fiduciary-duty cases resembles *res ipsa loquitur* cases, where in some jurisdictions, once the plaintiff shows that the accident ordinarily would not occur

or that the unreasonable mistake was not caused by the physician placing his own self interest before the patient's. The last item could be proven by expert testimony that the mistake was not a breach of fiduciary duty—for example, that it was an honest mistake caused by inadvertence—or that the incentive alleged to have made the physician act dishonorably was not significant enough to have had that effect.⁵⁴

Once the basic elements of the cause of action are identified and we agree that physicians cannot shed their fiduciary obligations by warning their patients that they are about to do so, the next question is how far the physician's fiduciary duty should extend. Clearly physicians are allowed to benefit themselves at the patient's expense. Otherwise, how else would you explain their fee? But as D. Gordon Smith observes,

both contracting parties and fiduciaries may be allowed to engage in self-interested behavior. For this reason, fiduciary duty should not be equated with a duty of selflessness. However, the fiduciary must refrain from self-interested behavior that wrongs the beneficiary, whereas contracting parties may act in a self-interested manner even where the other party is injured, as long as such actions are reasonably contemplated by the contact.⁵⁵

In the *Wickliffe* case, all the experts agreed that a physician who was alleged to have discharged a patient four days too soon because her insurance would not pay for additional care had not committed malpractice even though the early discharge resulted in the need to amputate her leg.⁵⁶ The physician testified that, had he

unless the defendant had been negligent, the burden shifts to the defendant to prove that he did not in fact make an unreasonable mistake. See RESTATEMENT (SECOND) OF TORTS § 328D (1965) (defining *res ipsa loquitur* and noting a presumption of negligence in some jurisdictions, rebuttable by the defendant). It is not surprising that *res ipsa loquitur* is often asserted in medical malpractice cases, given that patients are at an information disadvantage relative to caregivers.

54. In *Neade v. Portes*, for example, the court said that it would allow the plaintiff to cross-examine the physician about his managed care financial incentive arrangement in the event that he testified, since it could demonstrate interest and bias, which would affect his credibility as a witness. 739 N.E.2d at 506. Although this would be in an action for malpractice (since the court disallowed a cause of action for breach of fiduciary duty), similar evidence might be introduced in a fiduciary duty case.

55. Smith, *supra* note 44, at 1410.

56. *Wickliffe v. State*, 239 Cal. Rptr. 810, 819 (Cal. Ct. App. 1986). This reflects the important legal distinction between reasonable and optimal care. It also leaves open the question of whether the doctor was influenced by the insurance company's refusal to pay for the additional days of stay. If the plaintiff had been able to prove that, she would have been entitled to recover for breach of fiduciary duty. But this was never an issue, because the plaintiff did not sue the doctor, but rather the insurance company (MediCal—the California Medicaid program), and, as the Supreme Court was to hold in *Pegram*, the law will not prevent a managed care plan from managing care. *Pegram v. Herdrich*, 530 U.S. 211, 231–37 (2000); see *infra* notes 66–81 and accompanying text. For another example of an important legal distinction, see the discussion of

thought his patient truly needed to stay in the hospital the additional four days, he would have “made some effort to keep her in the hospital . . . even if denied authority by Medi-Cal [her health insurer] and *even if he had to pay her hospital bill himself*.”⁵⁷ To require this is far too extreme.⁵⁸ What is permissible under fiduciary doctrine must lie somewhere in between, but exactly where it lies is uncertain and likely to be highly fact-specific.⁵⁹

Another issue is whether a breach of fiduciary duty by a physician is a dignitary tort, that is, whether a patient can recover damages when a doctor has breached a fiduciary duty but the patient has not suffered any actual injury. Courts have refused to allow patients to recover for the physician’s failure to obtain informed consent—a duty that is often described as fiduciary⁶⁰—when the

reasonable and unreasonable medical mistakes in *Lauro v. Travelers Insurance Co.*, 261 So. 2d 261 (La. App. 1972). In *Lauro*, the patient underwent an unnecessary radical mastectomy because the hasty technique that was employed incorrectly concluded that the biopsy was malignant. The court held that a more leisurely pathological examination would have revealed that a breast biopsy was benign, but that the mastectomy, although clearly a mistake, was not an unreasonable one. *Id.* at 266–67.

57. *Wickline*, 239 Cal. Rptr. at 815 (emphasis added).

58. Another example of potentially excessive zeal on behalf of patients may be the widespread physician practice of misrepresenting their patients’ condition in order to have insurance companies approve coverage of services they believe their patients need. See Victor G. Freeman et al., *Lying for Patients: Physician Deception of Third-Party Payers*, 159 ARCHIVES INTERNAL MED. 2263 (1999) (reporting that physicians surveyed were willing to misrepresent their patients’ conditions over fifty percent of the time in connection with obtaining insurance coverage for certain procedures); Rachel M. Werner et al., *The “Hassle Factor”: What Motivates Physicians to Manipulate Reimbursement Rates?*, 162 ARCHIVES INTERNAL MED. 1134 (2002) (noting that eleven percent of physicians surveyed would misrepresent their patient’s condition); Matthew K. Wynia et al., *Physician Manipulation of Reimbursement Rules for Patients: Between a Rock and a Hard Place*, 283 JAMA 1858, 1861 (2000) (reporting that thirty-nine percent of respondents admitted manipulating information for insurance companies in order to secure coverage for patients).

59. Interestingly, if the physician in *Wickline* had been found to have been negligent, he almost certainly should have been liable not only for malpractice but for breaching his fiduciary duty. He admitted that he knew that, when he discharged the patient, she was “seriously ill and that the danger to her was not over.” 239 Cal. Rptr. at 815. He also knew that his patient’s discharge was not in her best interests:

Dr. Polonsky testified that at the time in issue he felt that Medi-Cal Consultants had the State’s interest more in mind than the patient’s welfare and that that belief influenced his decision not to request a second extension of Wickline’s hospital stay. In addition, he felt that Medi-Cal had the power to tell him, as a treating doctor, when a patient must be discharged from the hospital.

Id. *Wickline* is consistent with fiduciary theory in that the physician demonstrated by the unanimous agreement of the medical experts that he did not act negligently when he discharged the patient after only four additional days of hospitalization. The physician thus amply met the burden of proof of showing that he did not make an unreasonable mistake.

60. See, e.g., Mark A. Hall, *The Theory and Practice of Disclosing HMO Physician Incentives*, LAW & CONTEMP. PROBS., Autumn 2002, at 207, 214–17 (2002) (discussing fiduciary liability as a means of mandating disclosure).

doctor fails to disclose a risk that did not materialize.⁶¹ Similarly, courts might refrain from holding doctors liable under these circumstances, or legislatures may so decree, in return for imposing a stringent set of fiduciary requirements on physicians with regard to harms that do materialize.⁶²

A final question concerns the scope of the patient's remedies. The classic remedies for breach of fiduciary duty were those of chancery courts: injunction and constructive trust. Later they were combined into what became known as the remedy of restitution.⁶³ Accordingly, the remedy for dishonest medical mistake in a managed care setting would be restitution to the patient of the value the physician received from the patient's health plan to jeopardize the plaintiff's care.⁶⁴ Victims also would be entitled to the tort remedies of compensatory damages for both economic and non-economic harm, and in addition, punitive damages, with proof of the defendant's disloyal motive satisfying the latter's *malum in se* requirement.⁶⁵ In contrast, the common law remedy for an honest mistake would remain simply compensatory damages.

61. *Canterbury v. Spence*, 464 F.2d 772, 790 (D.C. Cir. 1972).

62. This raises the question of whether physicians are fiduciaries for their patients' economic well-being as well as for their health interests, and, if so, whether disclosing the economic conflict of interest is a more viable defense in the former case. The distinction may be largely illusory, however: behaviors that jeopardize economic welfare are likely to threaten health status, since they may deprive patients of the resources they need to purchase health care services.

63. In contrast, John Moore, when he sued his physicians for misappropriating his cancerous spleen cells, mistakenly sought the common law remedy of conversion. *Moore v. Regents of the University of California*, 793 P.2d 479 (Cal. 1990). At one time it was important to sort out whether an equity court could award compensatory as well as restitutionary damages, but this is no longer an issue in view of unification. See generally Thomas R. McLean & Edward P. Richards, *Managed Care Liability for Breach of Fiduciary Duty After Pegram v. Herdrich: The End of ERISA Preemption for State Law Liability for Medical Care Decision Making*, 53 FLA. L. REV. 1, 44-46 (2001) (discussing equitable and compensatory relief for breach of fiduciary duty).

64. Value includes the reputational and seniority benefits from being a successful physician, as well as the money the physician actually received from the plan to withhold care from the patient.

65. For breaching the fiduciary duty owed to the plaintiff and her fellow managed care plan enrollees by failing to disclose that physicians stood to gain financially by withholding care, Cynthia Herdrich, the plaintiff in the *Pegram* case, wanted her physicians to repay to the patient's managed care plan the money the plan had paid them to jeopardize their care. *Pegram v. Herdrich*, 530 U.S. 211 (2000); see *infra* notes 66-81 and accompanying text. Herdrich elected to proceed in this quasi-class fashion rather than seeking damages for herself, but she also should have been entitled to recover personal damages plus punitives.

IV. DEVELOPMENTS THAT ARE UNDERMINING FIDUCIARY PROTECTIONS

Given the importance of fiduciary law in protecting patients, it may come as a surprise that it is under severe attack. Some legal scholars and jurists maintain either that there is no such thing as fiduciary duty or that it is unnecessary or even harmful to patients. In addition, a state-of-the-art suggestion for decreasing medical mistakes contemplates denying patients the right to sue. Finally, the Supreme Court has declared that suits for breach of fiduciary duty are nothing other than routine medical malpractice actions.

A. The Supreme Court Weighs In

Cynthia Herdrich was enrolled in a managed care plan called Carle. Carle was owned by doctors, and they received a bonus at the end of the year if the plan was profitable. In other words, the doctors who owned the plan received a bonus if they collectively spent less on enrollee health care than they collected in premiums and other revenues.⁶⁶ Dr. Pegram, one of Carle's owners, examined Herdrich, who was complaining of pain in her groin, and Dr. Pegram claimed she found nothing wrong. However,

[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.⁶⁷

Herdrich sued the doctor, alleging that she had not only committed medical malpractice, but a breach of fiduciary duty:

[Herdrich alleged that] provision of medical services under the terms of the Carle HMO organization, rewarding its physician owners for limiting medical care, entailed an inherent or anticipatory breach of an ERISA fiduciary duty, since these terms created an incentive to make decisions in the physicians' self-interest, rather than the exclusive interests of plan participants.⁶⁸

But there was a quirk. The fiduciary duty Dr. Pegram was alleged to have violated was not the classic fiduciary duty that we have been discussing, but a statutory duty under the federal Employee Retirement Income Security Act ("ERISA").⁶⁹ This law, enacted to

66. *Pegram*, 530 U.S. at 211. Writing for a unanimous Court, Justice Souter observed that, under the "Carle scheme," the "relationship between sparing medical treatment and physician reward is not a subtle one." *Id.* at 220.

67. *Id.* at 215.

68. *Id.* at 216.

69. 29 U.S.C. §§ 1001-1461 (2006).

protect employee pension plans, insulates certain managed care plans, including Carle, from conflicting state laws, a quid pro quo for making it illegal for plan administrators to loot or otherwise mismanage plan assets.⁷⁰ The law fashions this prohibition by borrowing a concept from equity and making the plan administrators trustees who owe a fiduciary duty to the plan. Herdrich contended that this same fiduciary duty prohibited her doctor from acting disloyally to her in order to promote the welfare of the plan as a whole. Noting that some sort of incentive to limit individual access to health care services is at the heart of the concept of managed care, the Court understandably refused to rule that, when it passed ERISA, Congress intended to outlaw managed care.

There were all sorts of ways that the Court could have reached this result. The most obvious would have been to focus on the plain language of the law itself, which states that “a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries.”⁷¹ All the Court had to say was that the statutory references to “*participants*” and “*beneficiaries*” make it obvious that Congress was tackling the problem of firms looting and mismanaging their employee benefit plans to the detriment of *all* plan participants and beneficiaries. The Court could have made clear that Congress did not address the completely different problem of under what circumstances, if any, managed care physicians would breach their fiduciary duty to an individual patient if they sought to maximize the interests of the plan members as a whole by conserving plan assets.⁷² Instead, the Court attempted to parse the various types of decisions that a managed care plan can make and ruled that, in taking the actions that Herdrich alleged, the plan physicians were not acting as fiduciaries under ERISA.⁷³

That would have been, at worst, confusing.⁷⁴ But the Court went on to say this:

[T]he Court of Appeals [tried] to confine the fiduciary breach to cases where “the sole purpose” of delaying or withholding treatment was to increase the physician’s financial

70. For an overview of ERISA, see *Andrews-Clarke v. Travelers Insurance Co.*, 984 F. Supp. 49 (D. Mass. 1997).

71. 29 U.S.C. § 1104(a)(1) (2006).

72. In other words, the Court could have sidestepped the difficult theoretical question of how to reconcile fiduciary obligations, which promote the welfare of individuals, with utilitarian objectives, which may allow individual welfare to be sacrificed to maximize the welfare of others.

73. *Pegram*, 530 U.S. at 231–32.

74. The result, in fact, is nearly incomprehensible. For example, in describing Carle’s actions as “mixed eligibility and treatment decisions,” the Court confuses the term “eligibility,” which refers to whether an individual is qualified to receive any plan benefits, with the term “coverage,” which determines the benefits to which qualified individuals are entitled. *Id.* at 229.

reward. But this attempt to confine mixed decision claims to their most egregious examples entails erroneous corruption of fiduciary obligation and would simply lead to further difficulties that we think fatal. While a mixed decision made solely to benefit the HMO or its physician would violate a fiduciary duty, the fiduciary standard condemns far more than that, in its requirement of “an eye single” toward beneficiaries’ interests. But whether under the Court of Appeal’s rule or a straight standard of undivided loyalty, *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 making a mixed decision would boil down to a malpractice claim, and the fiduciary standard would be nothing but the malpractice standard traditionally applied in actions against physicians.*⁷⁵

The Court thus seems to close the door on *all* actions against physicians for breach of fiduciary duty, not just claims brought under ERISA, on the basis that they are nothing more than medical malpractice claims.

The Court’s motivation in *Pegram* is understandable. It was intent on safeguarding managed care, with its promise of controlling health care spending, against the charge that, by jeopardizing the health of individual patients, managed care is inherently unlawful. Furthermore, the Court was reluctant to allow managed care plaintiffs to circumvent ERISA preemption of state law causes of action.⁷⁶ But the Court’s reasoning in *Pegram* is disappointing. In the first place, the Justices are factually mistaken when they belittle the advantages to the plaintiff of being able to proceed with a claim for breach of fiduciary duty, observing that the only benefits would be (1) the creation of a federal cause of action against managed care plans themselves, as well as their physicians, in states that did not allow patients to sue plans directly under state law, and (2) the possibility of being awarded attorneys’ fees if the plaintiff were successful.⁷⁷ The ability to sue plans directly and receive attorneys’ fees alone would add tens or even hundreds of thousands of dollars to the value of plaintiffs’ lawsuits. More importantly, the Court ignores the other procedural benefits, described earlier,⁷⁸ that accrue to a fiduciary cause of action—especially the shift in the burden of proof to the defendant.

75. *Id.* at 235 (emphasis added) (citations omitted).

76. See generally Karen A. Jordan, *Recent Modifications to the Preemption Doctrine and Their Impact on State HMO Liability Laws*, 1 IND. HEALTH L. REV. 51 (2004); Thomas R. McLean & Edward P. Richards, *Health Care’s “Thirty Years War”: The Origins and Dissolution of Managed Care*, 60 N.Y.U. ANN. SURV. AM. L. 283 (2004) (discussing and analyzing the Supreme Court’s ERISA preemption jurisprudence).

77. *Pegram*, 530 U.S. at 235–36.

78. See *supra* text accompanying notes 46–48.

In any event, the Court's decision begs the question of why Herdrich went to all the trouble to get to the United States Supreme Court if she could have gotten the same remedy in a malpractice action in state court. The answer is simple: she would not have obtained the same remedy. In addition to damages for negligence (for which a jury awarded her \$35,000), she also sought to restore to the plan all the money that the managed care plan had paid its physicians to withhold care.⁷⁹

But more importantly, the Court's main argument—that fiduciary duty “boils down” to malpractice because they have the same defense (“reasonableness”)—is a non sequitur. Saying that reasonableness is a defense to a claim of breach of fiduciary duty—which is by no means clear⁸⁰—does not make unreasonableness claims and breach of fiduciary duty claims the same. Not only are the elements and remedies different, but fiduciary breaches are far more immoral. Indeed, we have seen it argued that a simple malpractice error—an honest medical mistake—is not a moral error at all.⁸¹ By signaling that the law should treat doctors who injure patients dishonorably, compounding both the risks to patients and the wrongdoing, the same as doctors who only act negligently, the Court

79. See *Herdrich v. Pegram*, 154 F.3d 362, 367, 367 n.3 (7th Cir. 1998), *rev'd*, 530 U.S. 211 (2000). Pegram's complaint referred to this as “supplemental medical expense payments,” presumably the euphemism used by the plan. There is no indication of how much money this would have represented. *Herdrich*, 154 F.3d 367 n.3.

80. For example, although it is clear that a doctor cannot sacrifice his patient's interest for his own, it is not clear that a doctor can sacrifice his patient's interests for the good of other patients. As a tort concept, reasonableness is a strictly utilitarian standard that allows the welfare of the individual to be sacrificed for the welfare of others if the total amount of welfare would be increased. See *RESTATEMENT (SECOND) OF TORTS* § 292 cmt. a (1965):

Thus, the idea that the interest of the public as a group can best be served by permitting the utmost freedom of individual initiative is inherent in both legal and popular thought. The irreducible minimum of risk both to employees and outsiders which is inherent in manufacture is not regarded as unreasonable, not so much because manufacture is profitable to those who carry it on, but because it is believed that the whole community benefits by it. The operation of railways and other public utilities, no matter how carefully carried on, produces accidents which kill or harm many people but the risk involved in the operation is more than counterbalanced by the service which they render the public.

Hence, negligence is willing to leave losses on innocent victims if the net result benefits society as a whole—for example, allowing people to injure others by automobile without compensating the victims as long as people follow the traffic rules, because we like having cars. The strongest form of the fiduciary rule is antithetical to strict utilitarianism. It would not permit a doctor to sacrifice the interests of a patient even if doing so would create net benefit for society, rather than for the doctor. For example, a doctor would not be allowed to cause a chronic patient's death (say, by skimping on an expensive medication), even though this would lower health plan premiums for other enrollees and the doctor would receive no direct financial benefit. Weaker forms of the fiduciary rule might allow a doctor to do this so long as the doctor did not obtain any direct benefit.

81. See *supra* text accompanying notes 12–14.

unjustifiably strips the victims of dishonest medical error of their equitable remedy.

Unfortunately, the Court's message was not lost on other courts.⁸² The Supreme Court of Illinois promptly dismissed a suit complaining that a managed care physician had breached his fiduciary duty to a deceased patient by not disclosing the doctor's financial conflict of interest, which the plaintiff alleged would have led the patient to obtain a second opinion about the need for life-saving tests.⁸³ The managed care physician was globally capitated, meaning that he was paid a lump sum per year per patient, and would have to pay for the tests, which would have had to have been administered by an outside physician, out of his own money, leaving the managed care physician less profit at the end of the year.⁸⁴ The court held that the breach-of-fiduciary-duty claim was nothing more than a straightforward medical malpractice claim:

In order to sustain a breach of fiduciary duty claim against Dr. Portes, plaintiff would have to allege, *inter alia*, that: (1) had she known of the Medical Incentive Fund she would have sought an opinion from another physician; (2) that the other physician would have ordered an angiogram for Mr. Neade; (3) that the angiogram would have detected Mr. Neade's heart condition; and (4) that treatment could have prevented his eventual myocardial infarction and subsequent death. In order to prove the second element, plaintiff would have been required to present expert testimony that the expert, after examining Mr. Neade and considering his history, would have ordered an angiogram. This requirement relates to the standard of care consideration—the first prong in a traditional medical negligence claim—under which a physician is held to “the reasonable skill which a physician in good standing in the community would use.” That is precisely what plaintiff must prove to support her breach of fiduciary duty claim. As the Supreme Court stated in *Herdrich*, the breach of fiduciary duty claim “would boil down to a malpractice claim, and the fiduciary standard would be nothing but the malpractice standard traditionally applied in actions against physicians.” Thus, we need not recognize a new cause of action for breach of fiduciary duty when a traditional medical negligence claim sufficiently addresses the same alleged misconduct. The breach of fiduciary duty claim in the case at bar would be duplicative of the medical negligence claim.⁸⁵

If the *Neade* court had correctly applied fiduciary law, it would have shifted the burden to the defendant to prove that the failure to provide the angiogram was not an unreasonable mistake, or that, if it

82. It was also not lost on scholarly opponents of fiduciary principles. See Hall, *Law, Medicine, supra* note 16, at 504 (citing *Pegram* in stating that “under common law fiduciary principles, most courts have declined to allow suits for damages for breach of fiduciary duties based on financial incentives”).

83. *Neade v. Portes*, 739 N.E.2d 496 (Ill. 2000). The patient allegedly died of a heart attack after being denied an angiogram despite complaining of chest pains. *Id.* at 498–99.

84. For a description of capitation and other managed care financial arrangements with physicians, see Stephen R. Latham, *Regulation of Managed Care Incentive Payments to Physicians*, 22 AM. J.L. & MED. 399 (1996).

85. *Neade*, 739 N.E.2d at 503 (citations omitted).

was, the defendant was not motivated by capitation. What is especially striking about *Neade* is that it was not an ERISA case. In other words, the Supreme Court of Illinois eliminated all breach-of-fiduciary-duty actions by patients, not just claims brought against plan administrators as ERISA trustees.⁸⁶

B. Scholarly Opposition to Fiduciary Duties

Some legal scholars, principally of the law-and-economics persuasion, take the position that there is no such thing as fiduciary law, that what is called fiduciary doctrine is only an aspect of contract. Judge Frank Easterbrook and Dean Daniel Fischel, for example, assert that fiduciary relationships are simply “contractual arrangements with unusually high transactions costs.”⁸⁷ This is no mere matter of nomenclature: contractarians would allow patients to opt out of legal protections by cutting deals with doctors. Richard Epstein states:

[I]t seems clear that the most forthright and sensible way to deal with the liability crisis is to remove the minimum constraints on liability set by law and allow the parties to cut

86. One other case, decided before *Pegram*, has ruled that a claim for breach of fiduciary duty is a mere medical malpractice claim. *D.A.B. v. Brown*, 570 N.W.2d 168 (Minn. Ct. App. 1997). That case was a class action brought against a physician for allegedly receiving kickbacks from a drug company to prescribe the company’s drug, synthetic human growth hormone, for use by children. The plaintiffs contended that the doctor breached his fiduciary duty by not disclosing the financial arrangement to patients. The court held that this was just a claim for failure to obtain the patients’ informed consent, which sounded in medical negligence. *Id.* at 171. *Brown* illustrates the adage that bad facts make bad law. The plaintiff was attempting to sue for breach of fiduciary duty, for which she wanted a six-year statute of limitations, because she had failed to file her medical malpractice claim within the two-year statute of limitations. *Id.* at 171–72; Johnston, *supra* note 43, at 976.

87. Gregory S. Alexander, *A Cognitive Theory of Fiduciary Relationships*, 85 CORNELL L. REV. 767, 767 (2000) (citing Frank H. Easterbrook & Daniel R. Fischel, *Contract and Fiduciary Duty*, 36 J.L. & ECON. 425, 427 (1993)). According to Alexander, Easterbrook and Fischel argue that, whether or not there is anything special about fiduciary relationships, courts act as if there is not. Alexander, *supra*. Alexander disagrees, maintaining that courts do decide fiduciary cases differently, using a theory-driven “top-down” approach rather than a data-driven “bottom-up” approach. *Id.* at 768. One difference is that “courts are more likely to hold fiduciaries liable for losses to beneficiaries than they are to hold ordinary contracting parties liable for losses their counterparties may experience.” *Id.* See also Smith, *supra* note 44, at 1410:

Both contracting parties and fiduciaries may be allowed to engage in self-interested behavior. For this reason, fiduciary duty should not be equated with a duty of selflessness. However, the fiduciary must refrain from self-interested behavior that wrongs the beneficiary, whereas contracting parties may act in a self-interested manner even where the other party is injured, as long as such actions are reasonably contemplated by the contact.

For a good general description of the contractarian position on health care and more generally, see Bloche, *supra* note 7, at 922–25; see generally Maxwell J. Mehlman, *Fiduciary Contracting: Limitations on Bargaining Between Patients and Health Care Providers*, 51 U. PITT. L. REV. 365 (1990) (discussing in depth the contractarian position on health care).

their own deals, either directly or through professional intermediaries, such as employer health care groups and the like.⁸⁸

According to the contractarians, this is exactly what people do when they enroll in managed care plans—in effect, agreeing to allow their doctors to exploit them in return for a break on the price.⁸⁹

There are two main problems with the contractarian approach. The first is that patients typically enter into these contracts when they are healthy, yet must be held to them when they are sick. As Gregg Bloche points out, illness transforms us, and the transformation “is more than mere ex post regret after loss of a gamble. The fear and regression it entails create ‘later selves’ with quite different preferences and felt needs—needs not imagined ex ante.”⁹⁰ In other words, healthy people cannot make accurate cost-benefit tradeoffs about future states of health.⁹¹ The transformation produced by illness and other desperate states impacts not only the patient but those, like physicians, who interact with them. Unlike managed care plans that deal with enrollees indirectly as “statistical” lives, physicians encounter patients directly as “identifiable” lives.⁹² This significantly increases their apparent value, and this value is amplified by the patients’ suffering. Enforcing ex ante contracts against patients therefore risks outcomes that are inefficient from the physician’s viewpoint as well as the patient’s.

88. Richard A. Epstein, *Contractual Principle Versus Legislative Fixes: Coming To Closure on the Unending Travails of Medical Malpractice*, 54 DEPAUL L. REV. 503, 509 (2005); see also Bloche, *supra* note 7, at 922, 925 (noting contractarians’ willingness to let patients opt out of common-law protections). Another leading contractarian scholar is Clark Havighurst. See, e.g., Clark C. Havighurst, *Private Reform of Tort-Law Dogma: Market Opportunities and Legal Obstacles*, LAW & CONTEMP. PROBS., Spring 1986, at 143 (“[T]ort law must recede from a dogmatic regulatory role in which it alone specifies rights arising out of the provider/patient relationship and should recognize that private agreements altering its prescriptions may benefit everyone appropriately concerned—everyone, that is, except malpractice lawyers.”); see also James F. Blumstein & Frank A. Sloan, *Redefining Government’s Role in Health Care: Is a Dose of Competition What the Doctor Should Order?*, 34 VAND. L. REV. 849 (1981); Glenn O. Robinson, *Rethinking the Allocation of Medical Malpractice Risks Between Patients and providers*, LAW & CONTEMP. PROBS., Spring 1986, at 173 (1986). Piper urges that patients and physicians negotiate the standard for disclosure for informed consent. August Piper Jr., *Truce on the Battlefield: A Proposal for a Different Approach to Medical Informed Consent*, 22 J.L. MED. & ETHICS 301 (1994).

89. See Bloche, *supra* note 7.

90. *Id.* at 928.

91. Initially, the contractarian position may seem consistent with Rawls’s veil of ignorance. However, the ex post/ex ante problem raises the interesting question of whether any ex ante trade-offs can ever accurately predict ex post value.

92. This explains why people go to such great lengths to rescue identifiable strangers. See Maxwell J. Mehlman, *Rationing Expensive Lifesaving Medical Treatments*, 1985 WIS. L. REV. 239 (1985).

The second problem with the contractarian approach is that it does not adequately protect the weaker party, which is invariably the patient.⁹³ In relationships in which one party is invariably weaker, fiduciary doctrine is designed to reduce transactions costs by realigning the interests of the dominant party to parallel those of the weaker party. An arm's-length contract approach would be unlikely to produce as efficient a result. Regarding systematically imbalanced relationships as governed by arm's-length contracts would systematically produce both inefficiency and injustice.

Another group of commentators takes the position that physicians should not be regarded as fiduciaries for their patients.⁹⁴ Some of these commentators are health care contractarians.⁹⁵ Some are just being historically fussy.⁹⁶ Some give no reason for their position.⁹⁷ Some point to conflicts of interest faced by physicians, such

93. As Alexander states:

Conventional legal doctrine depicts the relationship between fiduciaries and their beneficiaries as vertical, with the fiduciary occupying a dominant position of power and responsibility. By contrast, traditional doctrine describes nonfiduciary contracting parties' relationships as horizontal, where all parties are equal and attend exclusively to their own interests. Admittedly, contract doctrine often distinguishes between different sorts of transactions, but the paradigmatic image of contract is a horizontal relationship. Certainly, no one thinks that contract law systemically or formally assigns contracting parties to dominant and subordinate roles. Yet, that is precisely what fiduciary law does. Fiduciary law always defines the trustee or estate executor as the dominant party, who is systemically empowered over the subordinate beneficiary.

Alexander, *supra* note 87, at 775.

94. See, e.g., RESTATEMENT (SECOND) OF CONTRACTS § 161(d) cmt. f (1981) (stating that the physician-patient relationship "strictly speaking" is not a fiduciary one); 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) (questioning whether physicians should be regarded as fiduciaries for their patients).

95. An example can be found in E. Haavi Morreim, *Conflicts of Interest: Profits and Problems in Physician Referrals*, 262 JAMA 390, 390-94 (1989) (asserting that not all courts and commentators regard physicians as fiduciaries "in the full legal sense of the term").

96. See GEORGE GLEASON BOGERT & GEORGE TAYLOR BOGERT, *THE LAW OF TRUSTS AND TRUSTEES* § 482, at 280 (rev. 2d ed. 1978):

There is no uniform practice among the courts in their use of the phrases "fiduciary relation" and "confidential relation" In most cases, however, the latter phrase is employed to indicate a relationship of a character similar to . . . fiduciary relation, but not falling into any well-defined category of law.

This categorization seems to be more a matter of form than of substance, and cannot be justified given the growth of law in the health care field. Shepherd states that English courts first held the physician-patient relationship to be fiduciary "during a time when doctors, because of their far superior education, had considerable influence over their patients," and questions whether this is still the case. J.C. SHEPHERD, *THE LAW OF FIDUCIARIES* 29 (1981).

97. See Sarah Worthington, *Fiduciaries: When is Self-Denial Obligatory?*, 58 CAMBRIDGE L.J. 500, 507 (1999) (stating simply that "[b]odily integrity [as opposed to economic interests] . . . appear[s] to be [an] inappropriate subject[] for protection via an obligation of loyalty") (emphasis

as the duty to protect third parties and contractual obligations to managed care plans, arguing that these conflicts of interest disqualify the patient-physician relationship from being regarded as fiduciary.⁹⁸ But all fiduciaries face conflicts, if only with their own self-interest. The more conflicted the stronger parties are, the more imperative it is that they be loyal to the weaker parties, individual patients.

Some commentators maintain, without explanation, that the patient-physician relationship should be regarded as one of "confidence," rather than as fiduciary.⁹⁹ The difference is that the burden of showing an abuse of a confidential relationship lies with the person seeking to set aside the transaction,¹⁰⁰ while, as noted earlier,¹⁰¹ in a fiduciary relationship, the fiduciary bears the burden of showing that the relationship has not been abused. It is hard to imagine why patients would accept the loss of such an important procedural benefit, or why they deserve to.

Finally, there are commentators who, focusing on David Mechanic's distinction between "interpersonal" and "social" trust,¹⁰² maintain that the key to protecting patients is to trust in the personal integrity of the physician, rather than relying on the fiduciary rules of the law. The most formidable proponent of this view is Mark Hall, who argues that trust in the law is not only an inefficient means of reducing the costs of physician disloyalty, but that it actually destroys

omitted). Some commentators are just confused. Saul Morse, general counsel for the Illinois State Medical Society, states that:

Breach-of-fiduciary-duty claims usually apply to legal or business situations in which the plaintiff has suffered a financial loss because the defendant breached a contractual obligation. . . . It's still not clear to me that a doctor has such a fiduciary duty to his patients. There's no written contract between them—just a professional relationship.

Berkeley Rice, *Invitation to a Lawsuit: Financial Incentives to Limit Care*, MED. ECON., Nov. 22, 1999, at 144, available at <http://www.memag.com/memag/article/articleDetail.jsp?id=121052>. Clearly, the existence of a fiduciary relationship is not contingent on a written contract.

98. Morreim claims that physicians are not fiduciaries when they are engaged in clinical research because they owe their primary allegiance to the study, not to the subjects. E. Haavi Morreim, *Medical Research Litigation and Malpractice Tort Doctrines: Courts on a Learning Curve*, 4 HOUSTON J. HEALTH L. & POL'Y 1, 41–47 (2003). But in the case of physicians who enroll patients whom they are treating into studies they are conducting, the patients' need for fiduciary protections is transparent.

99. See 1 SCOTT ON TRUSTS, *supra* note 50, § 2.5, at 43 ("A confidential relation may exist although there is no fiduciary relation; it is particularly likely to exist where there is a family relationship or such a relation of confidence as that which arises between physician and patient or priest and penitent."); 1 RESTATEMENT (SECOND) OF TRUSTS § 2 cmt. b (1959).

100. See 1 SCOTT ON TRUSTS, *supra* note 50, § 2.5, at 43.

101. See *supra* text accompanying note 46.

102. See Gatter, *supra* note 16, at 407–08 (discussing David Mechanic, *Changing Medical Organization and the Erosion of Trust*, 74 MILBANK Q. 171, 173–75 (1996)).

interpersonal trust.¹⁰³ Hall's argument is elaborate, but basically he distinguishes between "supportive" and "destructive" functions of the law, contending that, in performing its supportive function, the law overprotects patients by creating unrealistic expectations about the fidelity of physicians, while at the same time, in its destructive mode, the law undermines trust.¹⁰⁴ According to Hall, the need to avoid overprotection explains why the law endorses the fiduciary role of physicians so fitfully—why the law defers to professional custom and why decisions like *Pegram* resist recognizing an action against physicians for breach of fiduciary duty.¹⁰⁵ On the other hand, says Hall, the destructive function of the law must be combated by weakening the regulation of managed care plans.¹⁰⁶

The centerpiece of Hall's argument is the assumption that legal protections weaken trust.¹⁰⁷ Hall claims that his assumption is backed by psychological data.¹⁰⁸ But as Bloche points out, the psychological evidence about whether law promotes or undermines trust is ambiguous.¹⁰⁹ Hall's central thesis, in short, rests on an assumption that not only invalidates the historic function of the law of protecting the weak,¹¹⁰ but lacks empirical proof.

Bloche accuses Hall of having an ulterior motive for wanting to reduce fiduciary constraints on physicians. Hall's ultimate objective, says Bloche, is to allow managed care physicians to engage in covert, bedside health care rationing in order to solve the health care spending crisis. In other words, he thinks physicians should withhold care from patients secretly to save money. For this goal to be achieved, patients must trust their physicians rather than question

103. See Hall, *Law, Medicine*, *supra* note 16, at 509.

104. For a clearer account of Hall's thesis, see generally Bloche, *supra* note 7.

105. See Hall, *Law, Medicine*, *supra* note 16, at 504.

106. Hall states that legal regulation of managed care

can create conditions of distrust without necessarily intending to do so, or even by intending just the opposite. By mandating trustworthy behavior, law can crowd out intrinsic motivation to be trustworthy and convey an attitude of distrust, which can have more global effects than the trust-promoting impact of the regulated behavior.

Id. at 514.

107. For an earlier discussion, see Maxwell J. Mehlman, *The Patient-Physician Relationship in an Era of Scarce Resources: Is There a Duty to Treat?*, 25 CONN. L. REV. 349, 376–77 n.97 (1993).

108. See Hall, *Law, Medicine*, *supra* note 16, at 505–06.

109. Bloche, *supra* note 7, at 934 (citations omitted):

From a lawyer's perspective, a frustrating feature of research in this area is that different study designs often yield conclusions that pull in opposite policy directions. For example, some research suggests that legal requirements suppress people's cooperative inclinations, while other studies support the claim that law's expressive power can nurture cooperation.

110. See 3 WILLIAM BLACKSTONE, COMMENTARIES ON THE LAWS OF ENGLAND 2 (1979).

their actions and motivations. As Bloche puts it, "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."¹¹¹

Although the issue of bedside rationing is beyond the scope of this Article, it suffices to say that it would be impossible to keep such a program secret.¹¹² Moreover, without a concerted public effort to establish the rules of rationing, physicians would have no public guidance about how to proceed.¹¹³ Furthermore, the primary rationale for making the rationing covert is to make it extremely difficult or impossible for patients to hold their physician accountable. From a patient's standpoint, this is terrifying. Finally, those least able to protect themselves are bound to suffer the most.¹¹⁴

111. Bloche, *supra* note 7, at 949. Hall professes surprise at many of Bloche's characterizations of his work:

On first reading, I was taken aback, almost stunned, by Gregg Bloche's response to my article. It opens with a story about betrayal of trust by the physician for his dying mother and it closes with the heart-stopping accusation that I am attempting to "remake health law as a tool for limit-setting by deceit, . . . [which] would lead to downward cycles of anger and distrust, with tragic consequences for medicine's healing potential." I wondered, what had I done to prompt this depth of outrage and outpouring of accusation and analysis?

Hall, *Ideology and Trust*, *supra* note 49, at 955 (alteration in original) (citation omitted). However, he concedes that, so long as patients understand that managed care creates incentives for physicians to withhold care, physicians should be free to do so without specifically notifying the patient:

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 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 decisionmaking. In short, it should be up to each patient whether to trust or whether to verify.

Id. at 966–67 (citation omitted).

112. For an earlier discussion, see Mehlman, *supra* note 92, at 274–78.

113. Public guidance would not be easy to obtain. For a description of how not to do it, see generally Maxwell J. Mehlman, *The Oregon Medicaid Program: Is It Just?*, 1 HEALTH MATRIX 175 (1991). But the Oregon Medicaid experiment at least attempted openly to ration health care services to the poor. Indeed, the plan obligates a physician to notify the Medicaid enrollee when there is a medically necessary service that the state does not cover. See *id.* at 188 n.61.

114. Minorities and the poor already are in the poorest states of health in the United States. See Office of Minority Health, Dep't of Health and Human Services, *Minority Health Disparities at a Glance* (2004), <http://www.omhrc.gov/templates/content.aspx?ID=2139> (last visited May 31, 2006); 1 DEPT OF HEALTH & HUM. SERV., HEALTHY PEOPLE 2010 at 12 (2000), available at <http://www.healthypeople.gov/document/tableofcontents.htm#volumel>.

This makes it doubtful that we could ever test Hall's assumption by conducting an ethical experiment in which some patients were subjected to a greater risk of physician disloyalty in order to see if this increased the total amount of trust. An experiment of this nature would be hard to design, since it is not clear how one could get subjects' informed consent to a covert intervention.¹¹⁵ But even if we got past the design stage, it is unlikely that anyone would enroll in such a study. For who in their right mind,¹¹⁶ with reasonable freedom of choice,¹¹⁷ would agree to see what would happen if we took their doctor, removed his accountability, and paid him to jeopardize their health and even their lives in order to increase the welfare of strangers?¹¹⁸

115. The Common Rule—the regulatory framework governing human subjects research by federal or federally funded research—allows researchers to conduct research on human subjects without initially obtaining their informed consent so long as

the research (1) involves no more than minimal risk to the subjects; (2) [t]he waiver or alteration will not adversely affect the rights and welfare of the subjects; (3) [t]he research could not practicably be carried out without the waiver or alteration; and (4) [w]hen appropriate, the subjects will be provided with additional pertinent information after participation.

45 C.F.R. § 46.116(d) (2006). Marianne Elliott gives the following example of deception research that poses no more than minimal risk:

The researcher plans to determine how mood and perception of one's body image may be related. Initially, student subjects complete a series of written questionnaires and scales about their body image. After the subjects are presented with visual images intended to evoke a negative mood, the subjects are asked to complete the same questionnaires and scales. The effect of evoking a negative mood is evaluated.

Marianne M. Elliott, *Research Without Consent or Documentation Thereof*, in INSTITUTIONAL REVIEW BOARD: MANAGEMENT AND FUNCTION 250, 251 (Robert Amdur & Elizabeth Bankert eds., 2002) (cited in Carl H. Coleman, *Rationalizing Risk Assessment in Human Subject Research*, 46 ARIZ. L. REV. 1, 32 n.184 (2004)). Clearly, putting a patient into a situation in which his or her physician is given a financial incentive to conduct covert bedside rationing exposes the patient to more than minimal risk.

116. This is shorthand for the ethical requirement that experimental subjects must give their informed consent to participate in the experiment, which only mentally competent persons can do. Persons who lack mental competence may be enrolled as experimental subjects only in extremely limited circumstances in which they are given special protections against being exploited. See JESSICA W. BERG ET AL., *INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE* 270–71 (2d ed. 2001).

117. This is shorthand for the ethical requirement that experimental subjects must give their informed consent voluntarily, rather than be unduly pressured into doing so. Undue pressure includes having no reasonable alternative means of obtaining needed health care services.

118. This is what would happen if covert rationing subordinated the welfare of individual patients to the welfare of a broader population, such as a pool of insureds or managed care enrollees. Fiduciary obligations arguably require the physician to further his patients' interests even when doing so seems contrary to the broader interests of society. For example, a physician should not deny a patient expensive care on the premise that it provides only marginal benefit to the patient and thereby wastes scarce societal resources unless society has made that judgment overtly. An example of this is the Oregon Medicaid experiment, which specifically immunizes

C. Systems-Failure Approaches to Reducing Medical Errors

Fiduciary protections for patients may fall prey, not only to misguided jurists and legal scholars, but to the latest trend in quality assurance, the systems-failure approach. The medical malpractice system has come under a lot of criticism lately.¹¹⁹ The United States is said to be in the midst of another malpractice “crisis,”¹²⁰ a phenomenon that has occurred twice in the recent past, marked, among other signs, by sudden, steep increases in malpractice insurance premiums. This time around, one of the loudest criticisms of the malpractice system is that it fails to prevent medical errors.¹²¹ This criticism was fueled by *To Err is Human*, the 2000 report of the Institute of Medicine of the National Academy of Sciences (“IOM”), which claimed that as many as 98,000 people die every year in the United States as the result of medical mistakes.¹²²

The main problem, according to the IOM, is that the medical system does not adequately identify mistakes and take steps to prevent them from occurring.¹²³ Instead of conceiving of errors as the product of individual wrongdoing, errors must be understood as resulting from faulty processes or systems:

Building safety into processes of care is a more effective way to reduce errors than blaming individuals The focus must shift from blaming individuals for past errors to a focus on preventing future errors by designing safety into the system. This does not mean that individuals can be careless. People must still be vigilant and held responsible for their actions. But when an error occurs, blaming an individual does little to make the system safer and prevent someone else from committing the same error.¹²⁴

doctors from legal liability for withholding medical necessary care that the state legislature has decided not to cover. OR. REV. STAT. § 414.745 (2006). While requiring physicians to put their patients’ interests above those of society may seem a recipe for waste, the assumption of fiduciary doctrine is that the reduction in transaction costs resulting from increased trust exceeds the cost of marginal services.

119. Complaints about the medical malpractice system are as old as the system itself, however. See, e.g., Catherine T. Struve, *Doctors, the Adversary System, and Procedural Reform in Medical Liability Litigation*, 72 FORDHAM L. REV. 943, 956–64 (2004) (describing nineteenth-century physician hostility to the malpractice system).

120. See Michelle M. Mello et al., *The New Medical Malpractice Crisis*, 348 NEW ENG. J. MED. 2281 (2003).

121. Critics of the malpractice system have long questioned whether it adequately deters negligent patient injuries. See Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595 (2002). The current debate focuses particularly on why medical errors occur and why the system fails to detect them.

122. IOM REPORT 2000, *supra* note 9, at 26.

123. *Id.* at 4 (“All adverse events resulting in serious injury or death should be evaluated to assess whether improvements in the delivery system can be made to reduce the likelihood of similar events occurring in the future.”).

124. *Id.* at 4–5.

Since the principal cause of errors in the IOM's view is the failure of the system to prevent them, error prevention is a matter of "designing systems that make it hard for people to do the wrong thing and easy for people to do the right thing."¹²⁵ The key to doing this is to identify errors when they occur so that their causes can be evaluated and changes to the system can be made to prevent their recurrence. The problem with the current malpractice approach is that "[l]iability concerns discourage the surfacing of errors and communication about how to correct them."¹²⁶

How can physicians and other health care professionals be encouraged to admit mistakes? In its 2000 report, the IOM recommended adopting a combination of mandatory and confidential voluntary reporting systems, which are unlikely to be effective.¹²⁷ Two years later, the IOM issued another report, *Fostering Rapid Advances in Health Care: Learning from System Demonstrations*.¹²⁸ One of the experiments or "demonstrations" it proposed was a systems-failure approach to medical error called "Provider-Based Early Payments." The proposal adopts a continuous improvement model of quality assurance, which lies at the heart of the systems-failure approach.¹²⁹

125. *Id.* at ix. As the IOM report acknowledges, this approach is familiar as the type of continuous or total quality improvement model developed by Edward Deming in the 1950s. When Deming was unable to interest Detroit in his approach for improving the quality of its automobiles, he exported his ideas to Japan. The result, as they say, is history. See Cait Murphy, *1950: Deming Charts Japan's Remarkable Course*, FORTUNE, June 27, 2005, at 70, 72. The health care system became interested in Deming's approach in the late 1980s. See Donald M. Berwick, *Continuous Improvement as an Ideal in Health Care*, 320 NEW ENG. J. MED. 53, 53–56 (1989). So far, however, the approach has not been accepted and implemented widely enough to reduce patient injuries.

126. IOM REPORT 2000, *supra* note 9, at 22.

127. *Id.* at 87. Confidential reporting systems, modeled in part on aviation industry programs, are intended to encourage finger-pointing by concealing the identity of the informant. In many medical settings, however, the number of people with knowledge of a mistake may be so limited that the informant can be sniffed out or at least confined to a very small group, all of whom may suffer unpleasant repercussions. As for mandatory reporting systems, the IOM conceded that their primary purpose is "to hold providers accountable," adding that "[m]ost mandatory reporting systems are operated by state regulatory programs that have the authority to investigate specific cases and issue penalties or fines for wrong-doing." *Id.* at 86. The report did not explain why health care professionals would be inclined to reveal mistakes when the results might be personally costly via administrative and disciplinary sanctions and malpractice liability. Nor did the IOM explain why its mandatory reporting system would work any better than those that are already in place in a number of states, which are widely acknowledged to be defective. See generally Lucian L. Leape, *Reporting of Adverse Events*, 347 NEW ENG. J. MED. 1633, 1634–35 (2002).

128. BOARD OF HEALTH CARE SERVICES, INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, *FOSTERING RAPID ADVANCES IN HEALTH CARE: LEARNING FROM SYSTEM DEMONSTRATIONS* 81–90 (Janet M. Corrigan et al. eds., 2002) [hereinafter IOM REPORT 2002].

129. See Berwick, *supra* note 125, at 53–56 (1989). The continuous or total quality improvement method stresses that quality improvement must be achieved through

In addition to its systems-failure focus, the IOM plan combines features of a number of other proposals. It recognizes the value of having providers admit and apologize to patients for their mistakes.¹³⁰

accountability of the organization itself, beginning with the highest levels of leadership and filtering down through the organization. The model assumes that health care workers strive to perform to the best of their ability and that when a failure occurs, it is the result of wasteful, complex, or problematic organizational methods or structures, rather than a failure of an individual worker. Improving the quality of health care and eliminating errors requires organizations to engage in a constant, systematic, and cooperative effort to participate in quality monitoring and to shift the quality curve upward, rather than focusing on punishing the poor performance of individual practitioners or institutions. *Concepts of Assessing, Assuring, and Improving Quality*, in I MEDICARE: A STRATEGY FOR QUALITY ASSURANCE 45, 58 (Kathleen N. Lohr ed., 1990).

130. See JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS, HEALTH CARE AT THE CROSSROADS: STRATEGIES FOR IMPROVING THE MEDICAL LIABILITY SYSTEM AND PREVENTING PATIENT INJURY 26–30 (2005), available at http://www.jointcommission.org/NR/rdonlyres/167DD821-A395-48FD-87F9-6AB12BCACB0F/0/Medical_Liability.pdf. At least fifteen states have adopted legislation prohibiting the admission of a health care provider's apology or expression of sympathy as evidence of wrongdoing in a malpractice action: Arizona, California, Colorado, Georgia, Illinois, Maryland, Massachusetts, Missouri, Ohio, Oklahoma, Texas, Virginia, Washington, West Virginia, and Wyoming. A campaign to encourage this type of legislation is being waged by a group called the Sorry Works! Coalition. The Sorry Works! Coalition home page, <http://www.sorryworks.net/> (last visited May 31, 2006). The Veterans Administration has adopted a mandatory disclosure policy that has reduced malpractice litigation. See Albert W. Wu, *Handling Hospital Errors: Is Disclosure the Best Defense?*, 131 ANNALS INTERNAL MED. 970, 971 (1999); Steve S. Kraman & Ginny Hamm, *Risk Management: Extreme Honesty May Be the Best Policy*, 131 ANNALS INTERNAL MED. 963, 964 (1999). As Lori Andrews states:

Physicians might be more inclined to disclose error if they realized that such action will not necessarily lead to a lawsuit. The Veterans Affairs (VA) Hospitals adopted a mandatory error disclosure approach to patients which has met with great success. In Lexington, Kentucky, the VA Medical Center began a policy of full error disclosure to patients in 1987. Rather than observing a spike in litigation and lawsuits, the VA hospital has actually realized savings with regard to legal expenses because of a greater number of settlements.

Lori Andrews, *Studying Medical Error In Situ: Implications for Malpractice Law and Policy*, 54 DEPAUL L. REV. 357, 377 (2005) (citation omitted).

One of the most imaginative explanations for the social role of apology comes from sociobiology. See Erin Ann O'Hara, *Apology and Thick Trust: What Spouse Abusers and Negligent Doctors Might Have in Common*, 79 CHI.-KENT L. REV. 1055, 1061–67 (2004). O'Hara begins by pointing to the prisoner's dilemma, where cooperation is optimal for both players, but cheating benefits one player after both agree to cooperate. The solution is to detect and punish the cheater. In this context, apologies reduce anger, thereby reducing the costs of "moralistic aggression." *Id.* at 1063, 1065. According to O'Hara:

Heartfelt apologies therefore can have the effect of restoring the victim's status, and if accepted, the transgressor's status as well. But to restore the status of the transgressor, the transgressor must first place himself in a very vulnerable position and hope that the victim and/or third parties show the mercy necessary to resurrect his status.

Id. at 1065–66. O'Hara continues: "Individuals who develop the emotional framework necessary for the effective use of apology and forgiveness are thus placed at a competitive advantage relative to those individuals who must incur the full costs of moralistic aggression." *Id.* at 1066–67.

It incorporates a version of the “early-offer” idea suggested years ago by Jeffrey O’Connell. O’Connell proposed to encourage providers to make early settlement offers by giving them a quid pro quo.¹³¹ Under the IOM proposal, the quid pro quo would be immunity from tort liability. The settlement offers would be based on compensation schedules similar to those used by state workers’ compensation programs, but tailored to iatrogenic rather than workplace injuries.¹³² All avoidable injuries would be compensable, not just those caused by fault, thus reflecting aspects of the no-fault approach.¹³³ Finally, all admitted errors would be reported to state officials, who would implement oversight programs that would analyze the reports and develop system-wide measures to prevent the same mistakes from occurring in the future.¹³⁴

But what about “dishonest” medical mistakes? Under systems failure approaches like the IOM’s Provider-Based Early Payments proposal, would physicians who act dishonestly also be shielded from tort liability?¹³⁵ Or would dishonest mistakes be treated differently?

131. Jeffrey O’Connell, *Offers That Can’t Be Refused: Foreclosure of Personal Injury Claims by Defendants’ Prompt Tender of Claimants’ Net Economic Losses*, 77 NW. U. L. REV. 589, 590 (1982). O’Connell’s quid pro quo would have providers offer to pay the victim’s out-of-pocket medical expenses and lost earnings. If the victim rejected this offer, in order to have recourse under the tort system, the victim would have to prove beyond a reasonable doubt that the provider was grossly negligent. Jeffrey O’Connell & Evan Stephenson, *Binding Statutory Early Offers by Defendants, Not Plaintiffs, in Personal Injury Suits*, 54 DEPAUL L. REV. 233, 233 (2005). For a criticism of this approach, see Epstein, *supra* note 88, at 521 (complaining that O’Connell’s approach would take the strongest, rather than the weakest, cases out of the tort system).

132. For a description of such a scheduled compensation approach, see James F. Blumstein et al., *Beyond Tort Reform: Developing Better Tools for Assessing Damages for Personal Injury*, 8 YALE J. ON REG. 171 (1991); Randall R. Bovbjerg et al., *Valuing Life and Limb in Tort: Scheduling “Pain and Suffering,”* 83 NW. U. L. REV. 908 (1989).

133. For a discussion of no-fault approaches to medical injury compensation, see, e.g., David M. Studdert & Troyen A. Brennan, *Toward a Workable Model of “No-Fault” Compensation for Medical Injury in the United States*, 27 AM. J. L. & MED. 225 (2001); William G. Johnson et al., *The Economic Consequences of Medical Injuries: Implications for a No-Fault Insurance Plan*, 267 JAMA 2487 (1992).

134. IOM REPORT 2002, *supra* note 128, at 87.

135. The discussion that follows focuses on physicians and other health care professionals as the targets of concern. The focus on physicians and physician surrogates is justified by the degree to which they control the health care decisionmaking process, and, as discussed below, by the trust reposed in them by their patients. Yet, as the systems-failure approach acknowledges, physicians and other health care professionals typically are part of larger, institutionalized delivery systems, such as hospitals and managed care organizations, and these institutions may pressure practitioners to act dishonestly. Regardless of what should be done about dishonest practitioners, a separate question concerns how the institutions themselves should be treated. Should victims be able to sue them instead of—or in addition to—practitioners? Under classic malpractice doctrine, physicians cannot avoid liability for their misdeeds by blaming the improper conduct of the institutions with which they are associated. See *Wickline v. State*, 239 Cal. Rptr. 810, 820 (Cal. Ct. App. 1986):

And if so, how? The IOM report does not address this point, and the only mention of it in the literature advocating a systems-failure approach to medical error is the admission by Brennan and Studdert that “in rare cases, patients are harmed by physicians who are incompetent, dangerous, or malevolent,” followed by the acknowledgement that “[e]ven a system of compensation that is not focused on fault must have mechanisms in place to deal with such practitioners, either directly or by triaging them to appropriate disciplinary bodies.”¹³⁶ With virtually no attention being paid to dishonest mistakes, the IOM’s Provider-Based Early Payments approach could bar patients who were afforded apologies and offered scheduled payment amounts from suing providers for breaching their fiduciary duty as well as for simple malpractice.¹³⁷

In support of such a result, it might be argued that fiduciary breaches, just like ordinary mistakes, are systems failures. In *Sweed v. Cigna Health Care*, described above,¹³⁸ the reason the physician failed to make a timely surgical referral for a cancer patient was alleged to have been the managed care plan’s risk-sharing arrangement. Any physician, it might be said, might have made the same error of judgment if tempted by such an arrangement. The physician’s behavior then becomes just another honest mistake, and, under the IOM approach, the proper remedy is to fix the system—that is, alter the risk-sharing arrangement—rather than punish the

This court appreciates that what is at issue here is the effect of cost-containment programs upon the professional judgment of physicians to prescribe hospital treatment for patients requiring the same. 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.

Moreover, the institutions themselves would ordinarily also be liable as joint tortfeasors. See *Wilson v. Blue Cross of S. Cal.*, 271 Cal. Rptr. 876, 822–85 (Cal. Ct. App. 1990). The ability to sue managed care plans has been circumscribed, however, by the Employee Retirement Income Security Act, which precludes tort remedies against employer health benefit plans. See M. Greg Bloche, *The Invention of Health Law*, 91 CAL. L. REV. 247, 293 n.156 (2003) (describing ERISA preemption of tort remedies).

136. David M. Studdert & Troyen A. Brennan, *No-Fault Compensation for Medical Injuries: The Prospect for Error Prevention*, 286 JAMA 217, 219 (2001).

137. This may explain why Hall thinks that an IOM-type approach is best for promoting trust:

On balance, the reforms that call for early-offer no-fault compensation are the most consistent with trusting medical relationships. This approach satisfies both the goals of corrective justice and the “restorative justice” desire to maintain effective medical relationships. Other reform approaches continue to address only law’s reactive stance toward trust, but do not attempt to promote trust. In the reactive stance, some reforms might appear to detract materially from law’s ability to respond appropriately to serious violations of trust, but these in part are empirical claims that have not been tested.

Mark A. Hall, *Can You Trust a Doctor You Can’t Sue?*, 54 DEPAUL L. REV. 303, 312 (2005).

138. See *supra* note 22 and accompanying text.

physician. Moreover, the objective of the IOM approach is to encourage providers to admit their mistakes so that they can be prevented in the future. Punishing physicians for breaching their fiduciary obligations to patients would discourage them from admitting that they had done so, hindering efforts to correct the system. Indeed, physicians would be discouraged from admitting *any* mistakes, since victims could then seek to portray their physicians as disloyal in order to qualify for the benefits of a suit for breach of fiduciary duty, including potentially greater damages than the scheduled amounts they were offered and the procedural advantages described earlier.¹³⁹ This could bog the entire process down in costly litigation.

Against these arguments is the fact that disloyalty is not just a systemic failure but a personal failure, representing a specific kind of unprofessional behavior that is particularly reprehensible because it is especially dangerous to patients. If the value of disclosure and apology is deemed important enough, then providers could still be given a quid pro quo for admitting breaches of fiduciary duty—just not as large a quid pro quo as if they had committed merely an honest mistake. For example, victims of breaches of fiduciary duty could still be permitted to bring tort actions, entitling them, if successful, to damages for pain and suffering in excess of scheduled damages, but still be barred from obtaining punitive damages. In this fashion, the IOM's error admission goals could be accomplished at the same time that fiduciary law continued to protect vulnerable patients. As for the concern about being flooded with endless litigation, the same fear was expressed about allowing employees to sue their employers for intentional workplace injuries, thereby bypassing the scheduled damages available under workers' compensation. But courts have carefully delineated the grounds for asserting such causes of actions, and the workers' compensation system continues to operate relatively smoothly.¹⁴⁰ More importantly, Florida has implemented a scheduled damages approach to a class of birth-related injuries, but permits traditional medical malpractice actions to be brought in cases alleging "clear and convincing evidence of bad faith or malicious purpose or willful and wanton disregard of human rights, safety, or property."¹⁴¹

139. See *supra* notes 46–48 and accompanying text.

140. See Melissa F. Ross, Comment, *Ripples in Treacherous Waters: A Consideration of the Effects of North Carolina's Intentional Tort Exception to Workers' Compensation*, 31 WAKE FOREST L. REV. 513, 547–54 (1996).

141. FLA. STAT. ANN. § 766.303(2) (West 2006). For a description of this plan, see generally Randall R. Bovbjerg & Frank A. Sloan, *No-Fault for Medical Injury: Theory and Evidence*, 67 U. CINN. L. REV. 53 (1998).

There is no evidence that this exception has caused any problems.¹⁴² In short, permitting patients to bring civil actions for dishonest medical mistakes is compatible with a systems-failure approach to medical malpractice.

V. WHAT IS TO BE DONE?

Since physician loyalty is essential for patient well-being, the attacks on fiduciary principles must be turned back. Patients must be allowed to sue physicians for dishonest medical mistakes within systems-failure medical error regimes. Scholars must strive to protect the patients from unscrupulous providers at the same time that they try to solve the crisis in health care spending. The Supreme Court must reconsider its dicta in *Pegram* and reaffirm the cause of action against physicians who breach their fiduciary duty. Until then, state and lower federal courts must uphold patients' fiduciary rights. Finally, legislatures must not pass laws that weaken patients' fiduciary protections.¹⁴³

As noted earlier, there are important details of the scope of the physician's fiduciary duty to patients that remain to be worked out.¹⁴⁴ But uncertainty about the details of the fiduciary obligation is certainly no reason to weaken, much less jettison, the physician's fiduciary obligations. In fact, if anything, fiduciary protections for patients need to be increased. This is particularly highlighted by the latest trend in health care financing: "consumer-driven health care," a clever contractarian scheme to make insured patients—rather than employers, managed care plans, or entitlement programs such as Medicare and Medicaid—bear a greater share of their own health insurance risk. The epitome of this scheme is the medical savings account, where patients get fixed, pre-tax amounts of money from their employers or from the government with which to purchase health plans with extremely high deductibles, leaving the patient financially responsible for the first several thousand dollars of annual health care costs. The idea is that, since the patients are free to

142. See Jill Horwitz & Troyen A. Brennan, *No-Fault Compensation for Medical Injury: A Case Study*, 14 HEALTH AFF. 164, 168 (1995).

143. Along this line, Congress should amend ERISA to clarify that physicians employed by or serving patients on behalf of ERISA health plans, including plans that are self-insured by the patients' employers, are under the same fiduciary obligations to their patients as any other physicians.

144. My preference, by the way, is for these issues to be resolved by the judicial process rather than by legislatures, since real cases present decisionmakers with identifiable rather than statistical lives, which better approximates their true social value.

reinvest any money left in their accounts at the end of the year, they will have an incentive to make wise health care spending choices.

But how will patients know what choices to make? How will they, untrained in medicine, not only recognize their options, but identify the pros and cons of each option and how much it costs? They will need to turn to someone else for help, and the natural person is their physician.¹⁴⁵ The same dependence on physicians will result if the nation adopts a national health insurance program: patients will need doctors' help, not only in making good health care decisions, but in navigating an unfamiliar bureaucracy. If patients are likely to rely on their physicians even more in the future than they do now, the law needs to recognize this relationship of trust.

145. The contractarians have an ulterior motive, too. They hope that the law will say that, since patients are now free to contract for their care and make the decisions, they are responsible for any mistakes that happen: if they had wanted more careful or loyal doctors, they could have paid for them.
