Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System

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Owen Barfield, the British solicitor and literary scholar, reminds us that many legal concepts have their origin as metaphors and legal fictions.[1] We often fail to see the nature of legal metaphors, Barfield argues, because over time they ossify and we read them literally rather than figuratively.[2] Look closely at changes in law over time, Barfield advises us, to see how effectively metaphor works in law and language.[3] Many legal categories and procedures we now use had their origin in using a metaphor that revealed a new way of looking at a problem or that helped solve a legal problem.[4] Legal metaphors also help us to identify critical limits and strains in adapting to new facts and circumstances.

George Annas has pointed out that our choice of metaphors for medicine can reframe our debates about health policy reform.[5] And Analee and Thomas Beisecker remind us that patient-physician relations have been viewed through many metaphors.[6] These include parent-child relations (paternalism); seller-purchaser transactions (consumerism); teacher-student learning (education); relations among partners or friends (partnership or friendship); or rational parties entering into negotiations or contracts (negotiation or rational contract). Doctors have also been viewed both as priestly healers and engineers.[7]

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[1] Owen Barfield, *Poetic Diction and Legal Fiction, in* THE IMPORTANCE OF LANGUAGE 51, 58-59 (Max Black ed., 1962).

[2] *Id.* at 58-59.

[3] *Id.* at 64-66.

[4] The illustrations Barfield uses come mostly from forms of action in early English law, the ideas of corporate action and trustee ownership. *Id.* at 59-65.

[5] For a thoughtful discussion of metaphors in medicine, see George J. Annas, *Reframing the Debate on Health Care Reform by Replacing Our Metaphors*, 332 NEW ENG. J. MED. 744 (1995).

[6] Analee E. Beisecker & Thomas D. Beisecker, *Using Metaphors to Characterize Doctor-Patient Relationships: Paternalism Versus Consumerism*, 5 HEALTH COMM. 41 (1993).

[7] *Id.* For examples of various metaphors for viewing doctors and patients, see (educator) A.L. Caplan, *Informed Consent and Provider-Patient Relationships in Rehabilitation Medicine*, 69 ARCHIVES PHYSICAL MED. & REHABILITATION 312 (1988) (engineer, priestly healer); Maxwell J. Mehlman, *Fiduciary Contracting: Limitations on Bargaining Between Patients and Health Care Providers*, 51 U. PITT. L. REV. 365 (1990) (rational contract); Richard A. Epstein, *Medical Malpractice: The Case for Contract*, 1976 AM. B. FOUND. RES. J. 87; Clark C. Havighurst, *Private Reform of Tort-Law Dogma: Market Opportunities and Legal Obstacles*, LAW & CONTEMP. PROBS., Spring 1986, at 143; Robert M. Veatch, *Mod-*

Health law has drawn on each of these metaphors. The idea that physicians are or should be fiduciaries for their patients, however, is a dominant metaphor in medical ethics and law today and is presumed by much of the legal and ethical analysis of physicians' conflicts of interest.[8]

Nevertheless, the fiduciary metaphor is only helpful up to a point. This Article examines the metaphor of physicians as fiduciaries and asks several questions. How far does the law play out this metaphor in the way it treats doctors? What are the limits in this way of conceiving the patient-doctor relationship? What limitations or modifications on its use may be looming in the future?

The thesis is that although doctors perform fiduciary-like roles and hold themselves out as fiduciaries in their ethical codes, the law holds doctors accountable as fiduciaries only in restricted situations. Moreover, private and public groups often expect doctors to work for parties other than patients, and health policy now focuses on the population rather than individual patients. Given the formidable costs of medical care and the increasing dependence of doctors on organizations that employ and pay for their services, physician loyalty is weakened for patients and strengthened for other parties. These facts suggest that the law may consider the interests of these other groups in the future and that other metaphors may more aptly describe patient-physician relationships. Nonetheless, there is reason to think that the law will continue to address strained physician loyalty within a fiduciary framework. It may impose limits on and stretch the fiduciary metaphor to reconcile obligations of doctors to patients with service to groups and society.

I. THE PHYSICIAN'S AMBIGUOUS STATUS AS A FIDUCIARY

How useful is it to view physicians as fiduciaries? To answer this question let us

els for Ethical Medicine in a Revolutionary Age, HASTINGS CENTER REP., June 1972, at 105; James F. Childress & Mark Siegler, *Metaphors and Models of Doctor-Patient Relationships: Their Implications for Autonomy*, 5 THEORETICAL MED. 17 (1984) (partnership or friendship, negotiation); Bernard Barber, *Compassion in Medicine: Toward New Definitions and New Institutions*, 295 NEW ENG. J. MED. 939 (1976) (paternalism); TOM L. BEAUCHAMP & LAURENCE B. MCCULLOUGH, MEDICAL ETHICS: THE MORAL RESPONSIBILITIES OF PHYSICIANS (1984); WADE L. ROBISON & MICHAEL S. PRITCHARD, MEDICAL RESPONSIBILITY: PATERNALISM, INFORMED CONSENT, AND EUTHANASIA 1-42 (1979) (paternalism); L.J. Henderson, *Physician and Patient as a Social System*, 212 NEW ENG. J. MED. 819 (1935); TALCOTT PARSONS, THE SOCIAL SYSTEM (1951); Analee E. Beisecker, *Aging and the Desire for Information and Input in Medical Decisions: Patient Consumerism in Medical Encounters*, 28 GERONTOLOGIST 330 (1988); Leo G. Reeder, *The Patient-Client as a Consumer: Some Observations on the Changing Professional-Client Relationship*, 13 J. HEALTH & SOC. BEHAV. 406 (1972) (consumerism); BOSTON WOMEN'S HEALTH BOOK COLLECTIVE, THE NEW OUR BODIES, OURSELVES: A BOOK BY AND FOR WOMEN (1984); FRANCIS V. CHISARI & ROBERT M. NAKAMURA, THE CONSUMER'S GUIDE TO HEALTH CARE (1976); ARTHUR LEVIN, TALK BACK TO YOUR DOCTOR: HOW TO DEMAND (AND RECOGNIZE) HIGH-QUALITY HEALTH CARE (1975); KEITH W. SEHNERT & HOWARD EISENBERG, HOW TO BE YOUR OWN DOCTOR, SOMETIMES (1975); DONALD M. VICKERY & JAMES F. FRIES, TAKE CARE OF YOURSELF: A CONSUMER'S GUIDE TO MEDICAL CARE (1976); Linda Demkovich, *Fight for Your Rights*, MOD. MATURITY, Apr.-May 1987, at 32; HAROLD J. CORNACCHIA & STEPHEN BARRETT, CONSUMER HEALTH: A GUIDE TO INTELLIGENT DECISIONS (2d ed. 1980); PATRICIA A. HAMILTON, HEALTH CARE CONSUMERISM (1982) (consumerism); ROBERT E. KIME, HEALTH: A CONSUMER'S DILEMMA (1970) (consumerism).

For a thoughtful discussion of metaphors in medicine, see SUSAN SONTAG, AIDS AND ITS METAPHORS (1989); SUSAN SONTAG, ILLNESS AS METAPHOR (1978); Annas, *supra* note 5, at 744-47.

[8] *See generally* MARC A. RODWIN, MEDICINE, MONEY, AND MORALS: PHYSICIANS' CONFLICTS OF INTEREST (1993). For discussions of the fiduciary metaphor from a different perspective, see Deborah A. DeMott, *Beyond Metaphor: An Analysis of Fiduciary Obligation*, 1988 DUKE L.J. 879; Eileen A. Scallen, *Promises Broken vs. Promises Betrayed: Metaphor, Analogy, and the New Fiduciary Principle*, 1993 U. ILL. L. REV. 897.

examine: (1) the legal definition of a fiduciary; (2) the roles physicians perform; (3) the ethical standards the medical profession professes; and (4) the standards to which physicians are legally accountable.

A. What is a Fiduciary?

Austin Scott, the noted scholar of trusts, says that the contemporary idea of a fiduciary is analogous to the concept of stewardship as expressed in the Biblical parable of the unjust steward, in the Gospel according to Saint Luke.[9] The steward squanders his master's funds by paying servants more than they are owed with the expectation that the favor will later be returned to him personally.[10] Saint Luke uses the parable to illustrate divided loyalties and the impossibility of serving both God and Mammon.[11] Austin Scott draws on this parable to explain the fiduciary concept, I believe, because he recognized that it deeply influenced fiduciary law.

The fiduciary concept, so prevalent in American law today, has its origins in the law of trusts and agency.[12] Trustees—through a legal fiction—own property but manage it for beneficiaries. Agents are subject to control by other parties who authorize them to act on their behalf. Both trustees and agents are prohibited from furthering their own interests when performing their work.[13]

Over time, courts made analogies between trustees, agents, and others who performed similar roles and extended legal principles governing trustees and agents to these other relationships. Courts and scholars abstracted from these different examples and spoke of fiduciaries as a class of relationships which resembled each other. Now fiduciary relationships include guardians to wards, lawyers to clients, corporate officers and directors to shareholders, government officials to the public, and financial advisors, brokers, and money managers to clients.[14] In all these relationships, the party who provides service is the fiduciary.[15] But no single word refers to the people on whose behalf the fiduciary acts. Therefore, I have coined the term *fiducie* to refer to the other party in fiduciary relationships.

The law defines a fiduciary as a person entrusted with power or property to be used for the benefit of another and legally held to the highest standard of conduct.[16]

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[9] *Luke* 16:1-8 (King James); Austin W. Scott, *The Fiduciary Principle*, 37 Cal. L. Rev. 539, 539-40 (1949).

[10] Scott, *supra* note 9, at 540.

[11] "No servant can serve two masters: for either he will hate the one, and love the other; or else he will hold to the one, and despise the other." *Luke* 16:13 (King James).

[12] *See generally* 1 Austin W. Scott & William F. Fratcher, The Law of Trusts 42-48 (4th ed. 1987); Warren A. Seavey, Handbook of the Law of Agency (1964).

[13] 1 Scott & Fratcher, *supra* note 12; Seavey, *supra* note 12.

[14] Scott, *supra* note 9, at 541; James E. Holmes, Note, *The Federal Conflicts of Interests Statutes and the Fiduciary Principle*, 14 Vand. L. Rev. 1485, 1499 (1961). *See* Robert C. Clark, Corporate Law 141-57 (1986); Charles W. Wolfram, Modern Legal Ethics 145 (1986). *See generally* 1 Tamar Frankel, The Regulation of Money Managers: The Investment Company Act and the Investment Advisers Act 4-6 (1978); Bayless Manning, Federal Conflict of Interest Law (1964); Kathleen Clark, *Do We Have Enough Ethics in Government Yet? An Answer from Fiduciary Theory*, 1996 U. Ill. L. Rev. (forthcoming 1996).

[15] Scott, *supra* note 9, at 540.

[16] *See* P.D. Finn, Fiduciary Obligations (1977); J.C. Shepherd, The Law of Fiduciaries (1981); Scott, *supra* note 9, at 541 (the greater the fiduciary's authority, the greater the duty); Ernest J. Weinrib, *The Fiduciary Obligation*, 25 U. Toronto L.J. 1, 5-6 (1975). *See generally*, L.S. Sealy, *Some Principles of Fiduciary Obligations*, 1963 Cambridge L.J. 119, 119-22. *Cf.* Tamar Frankel, *Fiduciary Law*, 71 Cal. L. Rev. 795 (1983) (adapting the fiduciary duty to the structure and nature of the fiduciary relationship).

Fiduciaries advise and represent others and manage their affairs. Usually they have specialized knowledge or expertise. Their work requires judgment and discretion. Often the party that the fiduciary serves cannot effectively monitor the fiduciary's performance. The fiduciary relationship is based on dependence, reliance, and trust.[17]

Fiduciaries must be scrupulously honest. With limited exceptions, they must not divulge confidential client information. They may not promote their own interests or those of third parties, although they may receive compensation for their services. Roles, interests, or activities that compromise their loyalty or judgment create a conflict of interest. Such behavior triggers judicial scrutiny and is usually regulated or prohibited. In extending the fiduciary standard from trustees to former business partners Justice Cardozo once said:

> Many forms of conduct permissible in a workaday world for those acting at arm's length, are forbidden to those bound by fiduciary ties. A trustee is held to something stricter than the morals of the marketplace. Not honesty alone, but the punctilio of an honor the most sensitive, is then the standard of behavior .... Only thus has the level of conduct for fiduciaries been kept at a level higher than that trodden by the crowd.[18]

Anything that compromises the fiduciary's loyalty to the fiducie or the fiduciary's exercise of independent judgment on the fiducie's behalf creates a conflict of interest. There are two main kinds: (1) conflicts stemming from financial and other personal interests; and (2) conflicts stemming from divided loyalties of an actor performing competing roles.[19] Conflicts of interest exist prior to any breach of trust. They signal an increased risk that the fiduciary may not act as expected.

Once conflicts of interest are identified, the law can inquire into the kinds of risks that may ensue, the probability of their occurrence, and the seriousness of their consequences. Because fiduciaries have great discretion, there is always a risk that they may abuse their trust. Thus, the law tries to find ways to hold fiduciaries accountable.

Many relationships require one person to trust or depend on another, but not all are fiduciary relationships. Who decides what kind of relation is a fiduciary one, and on what basis?

Courts and legislatures determine who is a fiduciary, not the individual parties in a relationship. Parties can invoke court supervision by engaging in relations that are traditionally subject to fiduciary law. But individuals cannot simply remove themselves from fiduciary obligations.[20] Using their authority to "do justice," courts can refuse to enforce contracts that eliminate fiduciary obligations. Courts can also apply fiduciary principles to novel transactions and relationships.[21]

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[17] RODWIN, *supra* note 8, at 179-211. *See generally* SHEPHERD, *supra* note 16; Frankel, *supra* note 16; Scott, *supra* note 9; Sealy, *supra* note 16; Weinrib, *supra* note 16. For other perspectives, see also Clark, *supra* note 14; DeMott, *supra* note 8; Robert Flannigan, *The Fiduciary Obligation*, 9 OXFORD J. LEGAL STUD. 285 (1989); Scallen, *supra* note 8; J.C. Shepherd, *Towards a Unified Concept of Fiduciary Relationships*, 97 LAW Q. REV. 51 (1981).

[18] Meinhard v. Salmon, 164 N.E. 545, 546 (N.Y. 1928).

[19] *See generally* RANDOM HOUSE DICTIONARY OF THE ENGLISH LANGUAGE 428 (2d ed. 1987) (distinguishing two types of conflict of interest).

[20] However, parties can structure their relations so that they do not engage in activities that are currently subject to fiduciary law.

[21] Over time, courts have developed legal principles in several distinct areas of law and applied these principles to new situations that appeared analogous. In addition, common law fiduciary principles have been the basis for new or more extensive obligations imposed by legislation. For example, Congress en-

Over time, courts have developed the fiduciary concept in several distinct areas of law and extended the metaphor by applying the doctrine to new circumstances that appeared analogous, borrowing rules used in one situation for others.[22] In addition, state and federal legislatures have enacted legislation that imposes fiduciary obligations on certain professionals.[23] The result is a diverse set of rules held together by some broad common principles.

No simple criteria fully explain how courts decide which relationships they will recognize as fiduciary.[24] Courts make the decisions as they resolve individual disputes.[25] The decision is a social and policy choice as well as a legal one. It requires choosing which metaphor to use to view a relationship.

B. THE PHYSICIAN'S ROLE

As clinicians, physicians perform three main kinds of activities: they examine patients and diagnose their medical conditions; they advise patients on health matters and prescribe drugs and treatment; and they perform medical procedures and other medical services. Patients reveal personal information about their physical, social, and psychological conditions so that physicians can help them.

Certain features of patient-physician relations closely resemble classic fiduciary relationships. Physicians have specialized knowledge and expertise. They also control the use of medical resources which patients need: only they can admit patients to hospitals, order diagnostic tests, and prescribe drugs. Patients are often ill or anxious about their health, which increases their dependence. The patient-physician relation-

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acted the Investment Company Act and the Investment Advisers Act to remedy abuses in these fields. *See* 1 FRANKEL, *supra* note 14, at 21-34.

[22] *See* RODWIN, *supra* note 8, at 179-211.

[23] *See* 1 FRANKEL, *supra* note 14, at 21-34.

[24] Many relationships have attributes of those recognized as fiduciary but are not themselves considered fiduciary relationships. For example, automobile mechanics give advice and have special expertise. Customers depend on their judgment and honesty, but auto mechanics are not considered fiduciaries. There are three ways to account for why activities such as these are not covered by fiduciary principles. First and foremost, these activities are different in degree, rather than in kind. Their importance and the degree of the purchaser's vulnerability is generally less than in fiduciary relationships. The market generally does an adequate job of holding the providers accountable. Second, there has been a greater willingness of courts and legislatures to impose fiduciary standards on the classic professions because of tradition, their independence, and self-regulation. Third, the decision to hold any class or individual to fiduciary standards is a social decision. If society, through the action of courts, legislatures, and other means, wishes to extend fiduciary obligations to new groups, it may.

Even activities that are not regulated as "fiduciary" may be held to some similar obligations. Federal and many state consumer protection laws require sellers to make full disclosure of material facts to prospective purchasers and impose penalties for failure to do so and for making misrepresentations. *See, e.g.*, Regulation of Business Practices and Consumer Protection Act, MASS. GEN. L. ch. 93A, §§ 1 *et seq.* (1992); Robert B. Reich, *Toward a New Consumer Protection*, 128 U. PA. L. REV. 1, 9-19 (1979) (government as a similar purchasing agent). *See generally* Slaney v. Westwood Auto, Inc., 322 N.E.2d 768, 775-78 (Mass. 1975) (discussing MASS. GEN. L. ch. 93A); Patricia P. Bailey & Michael Pertschuk, *The Law of Deception: The Past as Prologue*, 33 AM. U. L. REV. 849, 849-97 (1984). These are similar to many disclosure obligations for brokers and others involved in sale of securities regulated by the Securities Exchange Act of 1934, 15 U.S.C. § 78a (1994). *See, e.g.*, Federal Trade Commission Act, 15 U.S.C. §§ 41 *et seq.* (1988).

[25] In recent years, many of the common law rules regarding fiduciaries have been codified in the United States Code. *See* GEORGE G. BOGERT & GEORGE T. BOGERT, THE LAW OF TRUSTS, 15-17 (5th ed. 1983) (notes accompanying text).

ship presupposes patients entrusting physicians to act on their behalf and physicians remaining loyal to their patients.

Since the advent of informed consent litigation in the 1970s, patients have participated more in treatment decisions.[26] Informed consent promotes disclosure as part of a fiduciary ideal.[27] Yet physicians still exercise significant power over patients' medical affairs. Patients rely on physicians to advise them, to execute their choices, and, often, to exercise independent judgment and to make significant decisions for them. Physicians, however, can abuse this trust by advancing their personal interests or those of third parties. Patients are usually in a poor position to monitor physicians, to second-guess their judgment, or to discover and sanction breaches of trust.

C. The Medical Profession's Professed Ethical Standards

Physicians have a powerful ethos that guides their behavior. Since the fifth century B.C., the Hippocratic oath has inspired physicians.[28] It defines a physician's obligations: to heal patients, act on their behalf, maintain confidentiality, and honor their trust.[29] Although medical practice has changed, the prevailing medical ethos still embodies these values. Contemporary medical codes stress that patient welfare should be physicians' prime consideration even when it conflicts with their own financial welfare.[30] The current American Medical Association (AMA) Principles of Medical Ethics state that the medical profession's ethics were "developed primarily for the benefit of the patient."[31] An AMA report on conflicts of interest asserts that "a physician must exercise medical judgment independently of his own or a third party's financial interests."[32] The report states that conflicts between the physician's and the patient's interest "must be resolved to the patient's benefit."[33] These benefits derive, according to the AMA, from the "physician's role as a fiduciary, i.e., a person who, by his undertaking, has a duty to act primarily for another's benefit."[34] The recent AMA report on managed care states that physicians should be advocates for their patients.[35]

The American College of Physicians declares that the physician is "the advocate and champion of his patient, upholding the patient's interest above all others."[36] They add that "[t]he physician must avoid any personal commercial conflict of interest that

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[26] Paul S. Appelbaum et al., Informed Consent: Legal Theory and Clinical Practice 143-46 (1987).

[27] Moore v. Regents of the Univ. of Cal., 793 P.2d 479, 483 (Cal. 1990), *cert. denied*, 499 U.S. 936 (1991); Mehlman, *supra* note 7.

[28] Hippocrates (W.H.S. Jones et al. trans., 1923).

[29] *Id.*

[30] American Medical Ass'n, *First Code of Medical Ethics*, *in* Ethics in Medicine: Historical Perspectives and Contemporary Concerns 26 (Stanley J. Reiser et al. eds., 1977) (reprinting Proceedings of the National Medical Convention 1846-1847, at 83-106 (1847)); World Medical Ass'n, *Declaration of Geneva*, *in* Ethics in Medicine: Historical Perspectives and Contemporary Concerns 37 (Stanley J. Reiser et al. eds., 1977) (reprinting *Declaration of Geneva*, 1 World Med. Ass'n Bull. 109-11 (1949)); American Medical Ass'n, Principles of Medical Ethics, §§ 5-7 (1957) [hereinafter AMA, Medical Ethics].

[31] AMA, Medical Ethics, *supra* note 30, § 1.

[32] American Medical Ass'n, Report of the Council on Ethical and Judicial Affairs, Report A (I-86): Conflicts of Interest 11 (1986).

[33] *Id.* at 2.

[34] *Id.*

[35] American Medical Ass'n, Council on Ethical and Judicial Affairs, *Ethical Issues in Managed Care*, 273 JAMA 330 (1995).

[36] American College of Physicians, Ad Hoc Comm. on Medical Ethics, *American College of Physicians Ethics Manual, Part 1*, 101 Annals of Internal Med. 129, 134 (1984).

might compromise his loyalty and treatment of the patient."[37] Medical specialty groups espouse similar principles. For example, members of the American College of Surgeons pledge "to place the welfare of [their] patients above all else."[38]

Contemporary literature in medicine and medical ethics assumes that physicians are indeed fiduciaries and focuses on how they should fulfill this role. Physicians speak of a "patient-centered ethic," and say that "the doctor's role [is] to serve each individual patient unstintingly."[39] Norman Levinsky captured the spirit when he wrote that although doctors are faced with pressures to serve society as well as patients, "[t]he doctor's master must be the patient."[40] Arnold Relman described the physician's role as "an agent and trustee for the patient."[41] Physicians, he said, should act as "fiduciaries or representatives for their patients in evaluating and selecting the services offered by the health care industry."[42] To perform this role "they should have no economic conflict of interest."[43]

D. Standards to Which Physicians are Legally Accountable

The law uses several ways to hold classic fiduciaries accountable. It reduces fiduciary discretion or prohibits suspect transactions; it regulates or supervises fiduciaries; it imposes penalties when fiduciaries breach their trust and provides remedies for those harmed. The method used depends on the circumstances. Often there are adequate remedies for misbehavior. In cases where monetary damages would be inadequate, however, courts often supervise fiduciaries directly. But when supervision would be too costly or would reduce the value of fiduciary work, the law prohibits certain transactions as a preventive measure.[44]

These options for addressing conflicts of interest of fiduciaries can be displayed along a continuum (see Figure 1). In effect, the law can deal with conflicts of interest *before* they lead to a breach of trust (by prohibiting conduct that poses risks); *during* the patient-physician relationship (by supervising or regulating physician conduct and removing discretion); and *after* a breach of trust has occurred (by imposing penalties for misconduct).[45]

In medicine there is a gap between the fiduciary ideal and practice. Physicians often call themselves fiduciaries and courts sometimes label physicians as fiduciaries, especially in informed consent cases.[46] Still, fiduciary law principles have been applied to physicians only for very limited purposes. These include requiring that physicians not abandon patients, keep information they learn confidential, obtain patients' informed consent to treatment, and in one case, disclose to patients any financial in-

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[37] *Id.*

[38] American College of Surgeons, Statements on Principles 3 (1994) [hereinafter Surgeons, Statements on Principles].

[39] Marcia Angell, *Medicine: The Endangered Patient-Centered Ethic*, Hastings Center Rep., Feb. 1987, at S12, S12.

[40] Norman G. Levinsky, *The Doctor's Master*, 311 New Eng. J. Med. 1573, 1575 (1984).

[41] Arnold S. Relman, *Dealing with Conflicts of Interest*, 313 New Eng. J. Med. 749, 750 (1985).

[42] Arnold S. Relman, *The Future of Medical Practice*, Health Aff., Summer 1983, at 5, 18.

[43] Arnold S. Relman, *The New Medical-Industrial Complex*, 303 New Eng. J. Med. 963, 967 (1980).

[44] *See generally* Rodwin, *supra* note 8, at 207-11.

[45] *Id.*

[46] Canterbury v. Spence, 464 F.2d 772, 780 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Miller v. Kennedy, 522 P.2d 852, 860 (Wash. Ct. App. 1974), *aff'd*, 530 P.2d 334 (1975); Cobbs v. Grant, 502 P.2d 1, 7-8 (Cal. 1972); Lockett v. Goodill, 430 P.2d 589, 591 (Wash. 1967).

terest in clinical research.[47] Aside from these limited circumstances, physicians—as clinicians—are not held to fiduciary standards, especially with respect to financial conflicts of interest.[48] Courts and legislatures have not developed comprehensive fiduciary obligations for physicians and do not consistently hold them accountable as such. One health law scholar has even asked whether fiduciary principles *should* constrain physician behavior.[49]

Traditional fiduciaries are held accountable by federal or state statutes, by courts, and by regulatory agencies. State statutes and common law govern the conduct of trustees and agents. Federal public officials are supervised by the Office of Government Ethics and federal statutes.[50] Lawyers are regulated by extensive court rules and ethical codes.[51] State corporation statutes and common law regulate corporate officers and directors.[52] Financial professionals, like money managers and brokers, are regulated by the Securities and Exchange Commission as well as by several federal statutes.[53] There is no equivalent oversight for physicians. However, some ad hoc measures suggest the direction that law may take in the future. Medicare and Medicaid prohibit physicians from paying or receiving kickbacks.[54] But kickback rules do not prohibit many conflicts of interest, such as self-referral, which is usually restricted for fiduciaries. Recent legislation prohibits physicians from referring Medicare and Medicaid patients to clinical laboratories in which they have an interest.[55] But the statute

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[47] *Canterbury*, 464 F.2d at 780; Hammonds v. Aetna Casualty & Sur. Co., 243 F. Supp. 793, 801-02 (D. Ohio 1965) (confidentiality); Moore v. Regents of the Univ. of Cal., 793 P.2d 479, 483 (Cal. 1990), *cert. denied*, 499 U.S. 936 (1991) (disclosure of financial interest in research); *Miller*, 522 P.2d at 860; *Cobbs*, 502 P.2d at 7-8; *Lockett*, 430 P.2d at 591.

[48] The exception is the *Moore* case, which addressed financial conflicts of interest in research. *Moore*, 793 P.2d 479.

[49] 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).

[50] Ethics in Government Act of 1978, Pub. L. No. 95-521, 92 Stat. 1864 (1978) (codified in relevant parts at 18 U.S.C. § 207, *as amended by* Pub. L. No. 96-28, §§ 1-2, 93 Stat. 76 (1979)); 28 U.S.C. § 591 *et seq.* (1988).

[51] *See, e.g.*, ABA COMM'N ON EVALUATION OF PROFESSIONAL STANDARDS, MODEL RULES OF PROFESSIONAL CONDUCT (1983); ABA SPECIAL COMM. ON EVALUATION OF ETHICAL STANDARDS, CODE OF PROFESSIONAL RESPONSIBILITY (1969).

[52] ABA COMM. ON CORPORATE LAWS, MODEL BUSINESS CORPORATION ACT (2d ed. 1971).

[53] *See* Securities Act of 1933, 15 U.S.C. § 77a (1994); Securities Exchange Act of 1934, 15 U.S.C. § 78a (1994); Investment Company Act of 1940, 15 U.S.C. §§ 80a-1 to 80a-52 (1994); Investment Advisers Act of 1940, 15 U.S.C. §§ 80b-1 to 80b-21 (1994); LOUIS LOSS, SECURITIES REGULATION (2d ed. 1951).

[54] Medicare and Medicaid Patient and Program Protection Act of 1987, Pub. L. No. 100-93, 101 Stat. 680 (1987) (codified at 42 U.S.C. § 1320a-7(b)(7) (1988)).

[55] The Medicare anti-kickback statute has been interpreted to cover certain self-referral. *See* Medicare and Medicaid Patient and Program Protection Act of 1987, Pub. L. No. 100-93, 101 Stat. 680 (1987) (codified at 42 U.S.C. § 1320a-7(b)(7) (1988)); Physician Self-Referral Improvement Act of 1995, H.R. 2173, 104th Cong., 1st Sess. (1995). However, recent court cases have cut back on the interpretive scope of the statute and the ability to enforce it. *See* Hanlester Network v. Shalala, 51 F.3d 1390, 1397 (9th Cir. 1995). Proposed regulations have also carved out certain safe-harbors from prosecution. *See* 42 C.F.R. § 1001.952 (1994).

There have been efforts to restrict physician self-referral, see the Stark I and Stark II statutes, 42 U.S.C. § 1395nn (Supp. V. 1993), and regulations promulgated under these statutes, 42 C.F.R. § 411.350 (1994). However, after the House of Representatives came under Republican control in the 104th Congress, Representative William M. Thomas (R-Cal.) proposed to repeal or weaken the Stark law and has held hearings. *See Hearings on Physician Self-Referral Before the Subcomm. on Health of the House Comm. on Ways and Means*, 104th Cong., 1st Sess. (1995). Representative Stark has subsequently intro-

contains numerous exceptions. A few states explicitly prohibit physicians from splitting fees or dispensing drugs while others prohibit referring patients to medical facilities in which they have an interest or require that this information be disclosed.[56] None of these statutes, however, hold physicians accountable to the full range of fiduciary obligations.

As yet there is no equivalent for physicians of the conflict-of-interest prohibitions that exist for most fiduciaries. If a trustee enters into a financial transaction that violates fiduciary obligations, the beneficiary can object, the transaction will be void, and the beneficiary is reimbursed for any losses. This rule holds even if the trustee acted in good faith, the transaction was fair, and the beneficiary was unharmed.[57] Courts typically deter trustees from entering into conflict-of-interest situations. To invoke preventive measures limiting trustee freedom, beneficiaries need not show harm or unjust enrichment.[58] When a behavior is questionable, courts require fiduciaries to prove that they have not violated trust;[59] such is not the case for physicians.

Malpractice law could hold physicians liable for departing from broad fiduciary standards, if such standards existed; yet they do not. Malpractice law—which holds physicians responsible for their negligence—only adumbrates fiduciary standards. It focuses on physicians' technical clinical competence. It also requires physicians to obtain patients' informed consent, to preserve confidential patient information, and to not abandon patients, which are all traditional fiduciary obligations.[60] But only a small part. Generally malpractice law ignores traditional fiduciary concerns, such as protecting patients from physicians' financial conflicts of interest.

All states have medical licensing boards that establish competency standards, grant and revoke licenses, and discipline physicians.[61] They could hold physicians to fiduciary standards although they do not perform this role now.[62] Some boards sanction physicians for "character unbecoming of a physician," but only where there is fraud, criminal conviction, or other egregious conduct.[63] Typical cases involve kickbacks, fraudulent medical records, false billing, or sexual abuse of patients.[64] Licensing boards do not have conflict-of-interest guidelines.

Hospitals increasingly monitor physician behavior through quality assurance pro-

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duced a bill to take account of some of the Republicans' main concerns in an effort to stave off repeal of the statute. *See* Physician Self-Referral Improvement Act of 1995, H.R. 2173, 104th Cong., 1st Sess. (1995); John K. Iglehart, *Congress Moves to Regulate Self-referral and Physicians' Ownership of Clinical Laboratories*, 322 NEW ENG. J. MED. 1682, 1682 (1990); Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, tit. 6 § 6204, 103 Stat. 2236 to 2243 (1991).

[56] *See, e.g.*, CAL. BUS. & PROF. CODE §§ 650, 654.1 to .2 (West 1990); FLA. STAT. ANN. §§ 455.25, 458.331 (West 1991); MICH. COMP. LAWS ANN. § 333.6221 (West 1992); WASH. REV. CODE ANN. § 19.68 (1989). *See also* OFFICE OF INSPECTOR GEN., DHHS, PHYSICIAN DRUG DISPENSING: AN OVERVIEW OF STATE REGULATION (1988).

[57] *In re* Kline, 59 A.2d 14, 14 (N.J. Ch. 1948).

[58] BOGERT & BOGERT, *supra* note 25.

[59] *Id.*

[60] Alberts v. Devine, 479 N.E.2d 113, 120 (Mass.), *cert. denied, sub nom.* Carroll v. Alberts, 474 U.S. 1013 (1985); Humphers v. First Interstate Bank of Or., 696 P.2d 527, 529-30 (Or. 1985); Horne v. Patton, 287 So. 2d 824, 829 (Ala. 1974); Ricks v. Budge, 64 P.2d 208, 211-12 (Utah 1937).

[61] *See generally* Schware v. Board of Bar Examiners of N.M., 353 U.S. 232, 233 (1957).

[62] WILLIAM O. MORRIS, REVOCATION OF PROFESSIONAL LICENSES BY GOVERNMENTAL AGENCIES (1984); RANDOLPH P. REAVES, THE LAW OF PROFESSIONAL LICENSING AND CERTIFICATION (1984); Joel Brinkley, *State Medical Boards Disciplined Record Number of Doctors in '85*, N.Y. TIMES, Nov. 9, 1986, at A1.

[63] *See generally* REAVES, *supra* note 62.

[64] *See* MORRIS, *supra* note 62, at 204-14; REAVES, *supra* note 62.

grams, ethics committees, and conflict-of-interest policies.[65] However, they have their own financial concerns which can conflict with the interests of patients. Hence hospitals do not hold physicians accountable for fiduciary obligations toward patients. Too often quality assurance programs are used mainly to control use of services that are costly to hospitals under Medicare's prospective payment system.[66] Physicians sometimes consult ethics committees when making difficult clinical choices. But ethics committees lack authority to make clinical decisions or set standards of conduct. They also do not usually deem financial conflicts of interest within their jurisdiction.[67] Hospital conflict-of-interest policies typically prevent physicians from competing with hospitals. They promote physician fidelity to the hospital, not to patients.[68]

The AMA has an ethical code. But AMA membership is pro forma and not required for physicians to practice. Joined by less than one-half of American physicians, the AMA lacks institutions or sanctions to ensure compliance.[69] It also has weak conflict-of-interest guidelines. Until 1991, it only asked physicians to disclose conflicts of interest but called unethical only a few transactions—such as fee splitting and kickbacks—already illegal under Medicare and some state laws.[70] Physicians had to recognize and resolve conflicts of interest themselves because the AMA did not do much in the way of providing advice or a framework for analysis.[71] In 1992, the AMA confirmed ethical guidelines adopted in 1991 by the Council on Ethical and Judicial Affairs but rejected by the AMA House of Delegates. AMA guidelines now state that physician self-referral is presumptively unacceptable, but it allows for exceptions and the organization has no effective way to enforce its ethical code. Medical sub-specialties have ethical codes with similar limitations.[72]

Unlike typical fiduciaries, who cannot accept gifts that may influence their professional decisions, doctors frequently accept gifts from pharmaceutical firms and medical suppliers.[73] Although the AMA has adopted an ethical opinion which re-

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[65] BRIGHAM AND WOMEN'S HOSP., CONFLICT OF INTEREST POLICY (Jan. 1989); MASSACHUSETTS GEN. HOSP., CODE OF CONDUCT AND POLICY ON CONFLICTS OF INTEREST (May 27, 1988) [hereinafter CODE OF CONDUCT AND POLICY].

[66] *See* INSTITUTE OF MEDICINE, MEDICARE: A STRATEGY FOR QUALITY ASSURANCE 107-09 (Kathleen N. Lohr ed., 1990); Kathleen N. Lohr & Steven A. Schroeder, *A Strategy for Quality Assurance in Medicare*, 322 NEW ENG. J. MED. 707, 707-12 (1990).

[67] Gregory A. Jaffe, *Institutional Ethics Committees: Legitimate and Impartial Review of Ethical Health Care Decisions*, 10 J. LEGAL MED. 393, 393-431 (1989).

[68] CODE OF CONDUCT AND POLICY, *supra* note 65, at 6-7.

[69] AMERICAN MEDICAL ASS'N, MEMBERSHIP FACTS (1989).

[70] AMERICAN MEDICAL ASS'N, CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS OF THE AMERICAN MEDICAL ASSOCIATION, Opinion 8.03 (1986). For a discussion of the history of the AMA's stance on conflicts of interest, see RODWIN, *supra* note 8, at 19-45.

[71] Since 1992, the AMA has provided clarifications interpreting its guidelines on gifts and conflicts of interest, in particular cases such clarifications are issued infrequently.

[72] AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, STANDARDS FOR OBSTETRIC-GYNECOLOGIC SERVICES (5th ed. 1982); SURGEONS, STATEMENTS ON PRINCIPLES, *supra* note 38; AMERICAN OCCUPATIONAL MEDICAL ASS'N, CODE OF ETHICAL CONDUCT FOR PHYSICIANS PROVIDING OCCUPATIONAL MEDICAL SERVICES (1976); American Thoracic Soc'y, *The Potential for Conflict of Interest of Members of the American Thoracic Society*, 137 AM. REV. RESPIRATORY DISEASE 489-90 (1988); *Academy Advisory Opinion of the Code of Ethics: Advertising Claims Containing Certain Potentially Misleading Phrases*, 93 OPHTHALMOLOGY 273-75 (1986).

[73] Mary-Margaret Chren et al., *Doctors, Drug Companies, and Gifts*, 262 JAMA 3448, 3448 (1989); Michael A. Jenike, *Relations Between Physicians and Pharmaceutical Companies: Where to Draw the Line*, 322 NEW ENG. J. MED. 557 (1990).

stricts such gifts, it has no adequate way to enforce its guidelines.[74] So compliance is a matter of honor. With fiduciaries, compliance is a matter of law.

When behavior is questionable, courts require fiduciaries to prove that they have not violated their trust.[75] Such is not the case for physicians. Regulatory institutions can penalize doctors for misconduct, and can attempt to stop overuse and underuse of medical services and ensure quality of care. But they are woefully inadequate, and they do not explicitly address physicians' conflicts of interest. The experience of government, business, and the legal profession suggests a need for outside groups to evaluate professional conduct, set standards, and exercise disciplinary control. The fiduciary ideal, implicit in much of medical ethics and some medical law, lacks support from equivalent institutions designed to promote accountability.

The era when doctors relied on their individual clinical judgment alone is passing. The medical profession is now developing criteria to hold physicians to standards of technical performance.[76] Third-party payers and others are developing practice guidelines for diagnosis and treatment. This trend is sometimes called the *outcomes movement.*[77] No such movement, however, has yet emerged for medical ethics, especially for financial conflict-of-interest issues.[78] In ethics, physicians are still relatively unconstrained.

II. PHYSICIANS' OBLIGATION TO PARTIES OTHER THAN THEIR PATIENTS

Physicians have divided loyalties when they perform roles other than patient care or serve two or more patients with diverging interests.[79] In these circumstances, pursuing legitimate roles may cause physicians to act in ways that are not in the best interests of at least some of their patients. In some situations, the law has even required physicians to act for the benefit of parties other than their patients. Although these cases are exceptions, they nonetheless limit the context and manner in which physicians can act as fiduciaries for patients and strain the fiduciary metaphor.

Consider some examples. Psychiatrists owe loyalty to their patients but are also expected to institutionalize dangerous patients in order to protect society.[80] Likewise, leading court decisions have held psychiatrists liable for failing to divulge the confidences of their clients when doing so was necessary to protect an identifiable third

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[74] American Medical Ass'n, Council on Ethical and Judicial Affairs, *Gifts to Physicians from Industry*, 265 JAMA 501, 501 (1991).

[75] BOGERT & BOGERT, *supra* note 25.

[76] The federal Medicare program is now developing institutions to hold physicians to standards of technical performance and quality. *See* Michael Betz & Lenahan O'Connell, *Changing Doctor-Patient Relationships and the Rise in Concern for Accountability*, 31 SOC. PROBS. 84, 84-85 (1983); Arnold S. Relman, *Assessment and Accountability: The Third Revolution in Medical Care*, 319 NEW ENG. J. MED. 1220, 1221 (1988).

[77] Arnold M. Epstein, *The Outcomes Movement–Will It Get Us Where We Want to Go?*, 323 NEW ENG. J. MED. 266, 266 (1990).

[78] *See generally* Susan M. Wolf, *Quality Assessment of Ethics in Health Care: The Accountability Revolution*, 20 AM. J.L. & MED. 105 (1994). *See also* RODWIN, *supra* note 8, at 210-11, 244-47.

[79] For a discussion of conflicting roles, see Mark G. Field, *Structured Strain in the Role of the Soviet Physician*, 58 AM. J. SOC. 493 (1953); Levinsky, *supra* note 40, at 1573-75; Stephen Toulmin, *Divided Loyalties and Ambiguous Relationships*, 23 SOC. SCI. & MED. 783 (1986).

[80] THOMAS S. SZASZ, LAW, LIBERTY, AND PSYCHIATRY: AN INQUIRY INTO THE SOCIAL USES OF MENTAL HEALTH PRACTICES 45-46 (1963); *Developments in the Law: Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190 (1974).

party at risk of serious immediate harm.[81] The physicians' role in promoting public health requires that they report certain contagious diseases, which in turn creates conflicts with the traditional legal and ethical presumption that physicians protect the confidences of their clients.[82] In the case of Human Immunodeficiency Virus infection the law is unresolved, but the AMA and the American Psychiatric Association state that physicians are ethically obligated to divulge a patient's confidences and warn sexual partners known to be at risk of contagion.[83]

Physicians also act as gatekeepers, often rationing medical resources for the benefit of providers, insurers, government, or society at large. Primary care physicians in HMOs and other managed care settings play this role when they control the flow of patients to specialists, or deny marginally beneficial services to patients to promote the institutions' interests.[84] Physicians also work for the government, certifying eligibility for disability income and insurance benefits.[85] Physicians limit beneficial services to patients in disaster triage.[86] They may also consider the needs of other patients in deciding whether to place a patient in an intensive-care unit; and they can consider criteria other than medical need.[87] In all these legitimate roles physicians are expected to act in ways that do not promote the best interests of their patients.

Likewise, occupational physicians who treat workers in a business are subject to pressures from their employers, who often have interests which differ from those of patients.[88] Physicians who work for the armed forces,[89] or for sports teams face similar tensions between serving the needs of the organization which employs them and the best interests of the patient they treat.[90] As participants in hospital management, physicians may act to advance the hospital's financial situation and other goals, which can impair their clinical judgment or loyalty to patients.

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[81] Tarasoff v. Regents of the Univ. of Cal., 551 P.2d 334, 340 (Cal. 1976). In order to preserve his patient's confidences, a psychiatrist did not reveal the patient's intent to kill a named individual. The patient did murder the individual and the deceased person's family brought suit. The California Supreme Court held that a psychiatrist has a duty to warn an individual known to be at risk of imminent harm and that this duty overrides the patient's right to confidentiality. *Id.* at 346-47.

[82] Many states have statutes requiring that physicians report certain sexually transmitted diseases.

[83] *See* American Medical Ass'n, Council on Ethical and Judicial Affairs, *Ethical Issues Involved in the Growing AIDS Crisis*, 259 JAMA 1360, 1360 (1988). *But see* Doe v. Health/Kansas City, Inc., No. 88C-5149 (D. Kan. Oct. 17, 1988) (Chipman, J.) (enjoining physicians in an HMO from notifying a man's former wife of his HIV status).

[84] Norman Daniels, *Why Saying No to Patients in the United States is So Hard: Cost Containment, Justice, and Provider Autonomy*, 314 NEW ENG. J. MED. 1380, 1381-82 (1986); Alexander Leaf, *The Doctor's Dilemma—and Society's Too*, 310 NEW ENG. J. MED. 718, 718-19 (1984).

[85] Michael D. Reagan, *Physicians as Gatekeepers: A Complex Challenge*, 317 NEW ENG. J. MED. 1731, 1731-32 (1987); Anne R. Somers, *And Who Shall Be the Gatekeeper? The Role of the Primary Physician in the Health Care Delivery System*, 20 INQUIRY 301, 310-11 (1983); Deborah A. Stone, *Physicians as Gatekeepers: Illness Certification as a Rationing Device*, 27 PUB. POL'Y 227, 227-29 (1979).

[86] GERALD R. WINSLOW, TRIAGE AND JUSTICE 95-98 (1982).

[87] Bruce E. Zawacki, *ICU Physician's Ethical Role in Distributing Scarce Resources*, 13 CRITICAL CARE MED. 57 (1985).

[88] DIANA CHAPMAN WALSH, CORPORATE PHYSICIANS: BETWEEN MEDICINE AND MANAGEMENT (1987); Diana Chapman Walsh, *Divided Loyalties in Medicine: The Ambivalence of Occupational Medical Practice*, 23 SOC. SCI. & MED. 789, 790-92 (1986).

[89] *See* Arlene K. Daniels, *Military Psychiatry: The Emergence of a Subspecialty*, *in* MEDICAL MEN AND THEIR WORK 145, 145-46 (Eliot Freidson & Judith Lorber eds., 1972); Edmund G. Howe, *Ethical Issues Regarding Mixed Agency of Military Physicians*, 23 SOC. SCI. & MED. 803, 803 (1986).

[90] Thomas H. Murray, *Divided Loyalties in Sports-Medicine*, PHYSICIAN & SPORTSMEDICINE, Aug. 1984, at 134, 134.

Sometimes physicians care for patients whose interests conflict with each other. Physicians who treat a dying patient and a potential transplant recipient of human organs work for two different patients with interests that can conflict.[91] Some writers suggest that physicians who care for a pregnant woman have both the woman and fetus as patients and that their interests can sometimes conflict.[92]

III. CHANGING MEDICAL CARE PRACTICE STRAINS THE FIDUCIARY METAPHOR

Today, the idea that physicians are fiduciaries for the patients whom they treat is being further challenged by changes in medical practice from three sources: (1) a shift in influence over doctors from patients to other groups; (2) a shift in authority from doctors to managed care organizations; and (3) a growing concern with groups rather than individuals. These trends reinforce the idea that physicians *should* serve the interests beyond those of their individual patients.

Groups other than patients now have growing influence over physicians. Integrated health care systems and managed care organizations often control the flow of patients to doctors. Third-party payers and managed care organizations control the flow of payments to physicians and set policies on what services are covered, rates of reimbursement, and the standard of care.[93] Quality reviewers and other parties are establishing protocols which set parameters that define the work of doctors.[94] For-profit hospitals need to promote a return for their shareholders and not-for-profit hospitals which have to compete with for-profit hospitals are often forced to adopt similar financial policies. Both are beginning to use economic criteria to assess the performance of physicians and decide whether to maintain or expand their hospital privileges.[95] These trends make it easier for parties other than patients to hold doctors accountable to their interests and in the process weaken accountability to patients.

Equally critical, the locus of control is shifting from physicians to managed care organizations.[96] With increasing frequency, physicians are part of the array of resources that managed care organizations use, rather than the key decision-makers and

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[91] UNIFORM ANATOMICAL GIFT ACT (1987), 8A U.L.A. § 15 (adopted by fifteen states, establishes procedures for organ donation). *See generally* Susan Martyn et al., *Required Request for Organ Donation: Moral, Clinical, and Legal Problems*, HASTINGS CENTER REP., Apr.-May 1988, at 27, 27-28.

[92] AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, PATIENT CHOICE: MATERNAL-FETAL CONFLICTS (Oct. 1987) (finding that the physicians' primary duty is to the mother). *See generally* SHERMAN ELIAS & GEORGE J. ANNAS, REPRODUCTIVE GENETICS AND THE LAW 253-62 (1987); George J. Annas, *Protecting the Liberty of Pregnant Patients*, 316 NEW ENG. J. MED. 1213 (1987) (arguing against forcing women to follow physicians' advice); Martha A. Field, *Controlling the Woman to Protect the Fetus*, 17 LAW MED. & HEALTH CARE 114 (1989) (arguing against forcing medical choices for women for the sake of the fetus). *But see* JOHN A. ROBERTSON, CHILDREN OF CHOICE: FREEDOM AND THE NEW REPRODUCTIVE TECHNOLOGIES 173-94 (1994) (discussing parents' obligation to take steps to avoid harming the fetus).

[93] Helen Halpin Schauffler & Tracy Rodriguez, *Exercising Purchasing Power for Prevention: Recent Experiences of the Pacific Business Group on Health*, HEALTH AFF. (forthcoming Spring 1996).

[94] Timothy Stoltzfus Jost, *Health System Reform: Forward or Backward with Quality Oversight?*, 271 JAMA 1508 (1994); Jerome P. Kassirer, *The Use and Abuse of Practice Profiles*, 330 NEW ENG. J. MED. 634 (1994); Jerome P. Kassirer, *The Quality of Care and the Quality of Measuring It*, 329 NEW ENG. J. MED. 1263 (1993).

[95] John D. Blum, *Economic Credentialing: A New Twist in Hospital Appraisal Processes*, 12 J. LEGAL MED. 427 (1991); John D. Blum, *Economic Credentialing Moves from the Hospital to Managed Care*, 22 J. HEALTH CARE FIN. 60, 62 (1995).

[96] John K. Iglehart, *The Struggle Between Managed Care and Fee-for-Service Practice*, 331 NEW ENG. J. MED. 63 (1994).

providers of services who draw on and direct resources of medical institutions.

If this trend continues, then doctors will be accorded less discretion and may even be viewed as agents of managed care organizations rather than as independent professionals. What doctors do will then be judged largely in terms of the aims and performance of these organizations. Just as we expect managed care organizations to respond to the legitimate interests of parties other than patients (e.g., consumers, payers, shareholders, the public), the law may oblige doctors to respond to such interests as well. Patients would then be one of the many parties that have a claim on physicians' loyalty, but not one that overrides the claims of other parties.

Furthermore, policy makers, payers, and managed care organizations increasingly promote the health of populations rather than individual patients and they assess physician behavior by how it affects the health status and the finances of groups. Managed care organizations are forced to think about how to allocate resources throughout the system they manage. They are beginning to evaluate the use of physician time, effort, and skill in terms of how it benefits the population served. Specialists who assess quality also focus more on populations than individuals, in part, because when looking at aggregate data it is possible to see significant trends that are not apparent when looking at treatment of one or a few patients. Third-party payers also provide services for groups and consider the collective welfare in making decisions about resource use.

Many scholars note that physicians control a major flow of health care resources by their clinical choices and that it would help society to control health spending if doctors considered the social cost of their clinical decisions.[97] Some scholars have suggested that physicians should take account of scarce resources and society's needs when they make clinical choices.[98] Others suggest that it is impossible for physicians to avoid such a role.[99] Still others argue that our conception of physician morality and the functions doctors serve is broader than serving the interests of patients and that we should also encourage these other roles.[100] These trends and views encourage the idea that rather than strive to promote only the welfare of *individual* patients, doctors and medical organizations must also act in the interests of the populations they serve.[101]

IV. THE FUTURE OF THE METAPHOR

As patients, we would like doctors to work loyally for our individual interest.

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[97] Lester C. Thurow, *Learning to Say "No,"* 311 NEW ENG. J. MED. 1569 (1984); Lester C. Thurow, *Medicine Versus Economics*, 313 NEW ENG. J. MED. 611 (1985).

[98] E. HAAVI MORREIM, BALANCING ACT: THE NEW MEDICAL ETHICS OF MEDICINE'S NEW ECONOMICS 1-2 (1991); E. Haavi Morreim, *Cost Containment and the Standard of Medical Care*, 75 CAL. L. REV. 1719, 1723-24 (1987); E. Haavi Morreim, *Cost Containment: Challenging Fidelity and Justice*, HASTINGS CENTER REP., Dec. 1988, at 20, 20.

[99] Alan Williams, *Medical Ethics Health Service Efficiency and Clinical Freedom, in* NUFFIELD/ YORK PORTFOLIOS 1-8, Folio 2 (A.J. Culyer ed., 1984).

[100] *See* DANIEL CALLAHAN, SETTING LIMITS: MEDICAL GOALS IN AN AGING SOCIETY (1987); DAVID MECHANIC, FROM ADVOCACY TO ALLOCATION: THE EVOLVING AMERICAN HEALTH CARE SYSTEM (1986).

[101] The interests of patients as a group, of course, often coincide with the interests of individual patients. But just as promoting individual civil rights is not always consistent with policies that produce the greatest good for the greatest number, so too can the rights of individual patients clash with the interests of patients as a group. Individual rights are valuable precisely because they can act as a trump card. They prevail in the face of inconsistent policies that may better serve collective welfare. *See* RONALD DWORKIN, TAKING RIGHTS SERIOUSLY (1977). The value of fiduciary obligations is precisely that it will further the interests of patients as individuals in the face of policies that aim to promote the welfare of groups of patients, medical consumers, or society as a whole.

That is the crux of the fiduciary metaphor. Yet the law today goes only a small way in holding doctors to fiduciary standards. There are also significant social and financial demands for doctors to serve interests other than patients.

Serving the interests of several parties strains the fiduciary metaphor. It forces us to ask whether doctors can act as fiduciaries while acting on behalf of parties with different interests and whether it is helpful to consider physicians as fiduciaries.

Thomas Kuhn has observed that "[i]f awareness of anomaly plays a role in the emergence of new sorts of phenomena, it should surprise no one that a similar but more profound awareness is prerequisite to all acceptable changes of theory."[102] He concludes that "[f]ailure of existing rules is the prelude to a search for new ones."[103]

Is that the current position of the fiduciary metaphor in medicine? Probably not. But we can anticipate mounting pressures—both to limit and to stretch the scope of the fiduciary metaphor.

Strains on the fiduciary metaphor may cause the law to adopt other metaphors through which to view physicians. There is already a growing scholarship which advocates dispensing with fiduciary obligations in favor of letting individuals determine their respective obligations by contract.[104] Courts and other legal institutions may cease to consider physicians as fiduciaries or at least let individuals contract out of traditional fiduciary obligations the law imposes as default rules, provided that doctors have properly disclosed relevant information to patients. What are the prospects of this occurring?

It seems unlikely that society will quickly abandon the fiduciary metaphor for physicians for a simple reason. Public policy and market forces are creating pressures for greater physician and provider accountability.[105] And accountability is the core of the fiduciary ideal.

How else, besides abandonment, might the law respond to strains on the fiduciary metaphor? Courts and legislatures may work out ways to resolve the competing demands on physicians within a fiduciary framework. Fiduciaries, by definition, owe loyalty to the parties they serve, but the law can define precisely the limits of a fiduciary obligation or specify the interests of different parties for which the fiduciary works. Such definitions of the scope of fiduciary relationships and specification of how to balance interests the fiduciary must serve can provide a means to resolve or at least ease the strains fiduciaries experience.

There is ample precedent for balancing competing interests within a fiduciary framework. To be sure, the simplest fiduciary relation is one of undivided loyalty to an individual. Many fiduciaries, however, have to balance the interests of competing

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[102] THOMAS S. KUHN, THE STRUCTURE OF SCIENTIFIC REVOLUTIONS 67 (2d ed. 1970).

[103] *Id.* at 68.

[104] Tamar Frankel, Fiduciary Duties as Default Rules (1995) (unpublished manuscript) (on file with the Boston University Law Review). *See generally* Henry N. Butler & Larry E. Ribstein, *Opting Out of Fiduciary Duties: A Response to the Anti-Contractarians*, 65 WASH. L. REV. 1 (1990); John C. Coffee, Jr., *The Mandatory/Enabling Balance in Corporate Law: An Essay on the Judicial Role*, 89 COLUM. L. REV. 1618, 1618-19 (1989); Mark A. Hall, *Rationing Health Care at the Bedside*, 69 N.Y.U. L. REV. 693, 760-64 (1994); Clark C. Havighurst, *Prospective Self-Denial: Can Consumers Contract Today to Accept Health Care Rationing Tomorrow?*, 140 U. PA. L. REV. 1755 (1992).

[105] Marc A. Rodwin, *Patient Accountability and Quality of Care: Lessons from Medical Consumerism and the Patients' Rights, Women's Health and Disability Rights Movements*, 20 AM. J.L. & MED. 147, 166 (1994); Marc A. Rodwin, *The Elusive Quest for Affordable Health Care*, 1 WIDENER L. SYMP. J. (forthcoming 1995); Marc A. Rodwin, *Consumer Protection and Managed Care: Issues, Reform Strategies, Trade-offs*, 32 HOUS. L. REV. (forthcoming 1996).

individuals or groups. Corporate officers must serve the interest of different groups of stockholders. The trustee must serve the interests of the trust beneficiary and remainderman. Lawyers are expected to be zealous advocates for their clients while serve as officers of the court and protect the integrity of the judicial system.[106]

Therefore, the fact that physicians have obligations to third parties does not mean that they cannot be fiduciaries for patients. Obligations to third parties may merely limit the scope of fiduciary obligation or indicate that physicians are fiduciaries for more than one party. It is only when performing as a fiduciary for one party and working for another that creates too great a conflict and there are no adequate ways to resolve these conflicts that the law says performing both roles is incompatible with fiduciary obligations.

In short, the law may hold doctors to fiduciary standards yet also expect physicians to take adequate account of the interests of many patients or even parties other than patients. The law could hold doctors accountable to patients for specific goals while holding doctors accountable to other parties for other goals. As a result, physicians would be subject to greater oversight and more stringent standards of conduct. It is likely that both private and public sector controls will be used to oversee the conduct of physicians, and with institutional mechanics that are not traditionally used to supervise fiduciaries.

V. CONCLUSION

Lawyers typically invoke precedents and legal rules to buttress their arguments. However, precedents can be interpreted loosely or strictly and for nearly every rule of statutory interpretation there is another that proclaims the opposite.[107] The result is that invoking rules and legal categories alone do not resolve most important legal issues. What counts is showing why one rule, category, or metaphor is more appropriate than another.

There are no right or wrong metaphors. The law adopts and uses metaphors, in part, to solve social and legal problems. Over time, the metaphors that lawyers, courts, and society see as most valuable will change. Seeing physicians as fiduciaries is a central metaphor in health law and ethics today. But its use is strained by changes in our health care system. The extent to which the law uses the fiduciary metaphor to understand and govern physician behavior will depend in part on what alternative metaphors are available and how well they resonate.

The crucial issue is not what terms or labels courts, legislatures, and others use to describe doctors, but the standards to which they hold them. In many areas of commerce the law has moved away from a standard of caveat emptor and subjected sellers of services to greater oversight and regulation to protect the consumer even though they have not declared that sellers are fiduciaries.[108] The fiduciary metaphor may guide courts and legislatures in how they treat doctors even if they do not always use the term. Contrariwise, courts may call physicians fiduciaries, but hold them only in limited ways to such standards.

Expect, therefore, a tug-of-war as patients and other groups attempt to hold physicians accountable to their interests. Such are the prospects—for better or worse—until a more serviceable metaphor takes command.

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[106] CLARK, *supra* note 14; 1 SCOTT & FRATCHER, *supra* note 12; WOLFRAM, *supra* note 14.

[107] KARL N. LLEWELLYN, THE BRAMBLE BUSH (1951); Karl N. Llewellyn, *Remarks on the Theory of Appellate Decision and the Rules or Canons About How Statutes Are to Be Construed*, 3 VAND. L. REV. 395, 401-06 (1950).

[108] *See supra* note 24.

Conflicts of Interest: Points of Intervention and Major Policy Approaches		
Before fiduciary acts	*While fiduciary acts*	*After fiduciary acts*
PREVENTION	REGULATION OF THE ACTION	SANCTIONS AND RESTITUTION
Prohibit fiduciaries from entering into situations with conflicts of interest and use other preventive measures.	Supervise the conduct of fiduciaries and limit their discretion.	Penalize fiduciaries for violation of trust. Compensate fiducies for harm caused if fiduciaries abuse their trust.

FIGURE 1.