

Implementing American Health Care Reform: The Fiduciary Imperative

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INTRODUCTION

In the spring of 2010, the United States joined the rest of the developed world in extending access to basic health care to all its citizens. Yet, while the American government has affirmatively answered one fundamental question—should health care be universal?—it has done so by creating a myriad of new entities and obligations that are fundamental to the success and survival of the health reform itself. Each and every one of these new entities will need to be defined; their responsibilities will have to be articulated and their roles explained. Not since “the man gave names to all the livestock, the birds of the air and all the beasts of the field”¹ has there been such a massive creative challenge.

To implement the Patient Protection and Affordable Care Act of 2010 (“ACA”),² the Department of Health and Human Services and other agencies must now generate volumes of regulations to define what qualifies as a “qualified health plan”;³ to explain what care constitutes “essential health benefits”;⁴ and to populate a new “Physician Compare Internet” website with physician

1. *Genesis* 2:20 (New International Version).

2. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Health Care Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (codified as amended in scattered sections of 42 U.S.C.).

3. 42 U.S.C.A. § 18021(a) (West Supp. 2010).

4. *Id.* § 18022.

performance and patient experience information that does not violate new patient privacy protections.⁵ Providers and regulators will determine how to construct an “Accountable Care Organization”⁶ and where to build “patient-centered medical homes.”⁷ State legislators must create new insurance “exchanges,”⁸ establish “high-risk pools,”⁹ and develop infrastructure to accommodate vastly expanded rolls of “newly eligible”¹⁰ Medicaid patients while meeting new “benchmarks”¹¹ or “benchmark equivalents” for evaluating the adequacy of coverage.¹² The legislative and regulatory task ahead is huge. However, not only is the work of health reform implementation dauntingly enormous like the biblical nomenclature assignment, but just as in the ancient account, giving names to all the new creatures is the easy part of the task. The harder work will be saving them from the flood of ACA litigation which has already begun.

Twenty-six states have filed suit to challenge the constitutionality of the ACA. They have asked a Florida court to conclude that the ACA’s individual mandate (which is neither a mandate nor does it apply to all individuals) is unconstitutional.¹³ Four states have enacted nullification laws intended to block federal reforms, and voters in three more states will face anti-reform measures during the upcoming mid-election cycle.¹⁴ Courts will soon be called upon to construe the volumes of regulatory and legislative language that ACA implementation will generate. Yet, the

5. *Id.* §§ 1395w-5(a),(c).

6. *Id.* § 1395jj(a)(1).

7. *Id.* § 256a-1(c)(2).

8. *Id.* § 18041(a)(1).

9. *Id.* § 18001(c).

10. *Id.* § 1396d(y).

11. *Id.* §§ 1396a(k)(1), 1396u-7(b)(1).

12. *Id.* §§ 1396a(k)(1), 1396u-7(b)(2).

13. Florida *ex rel.* Bondi v. U.S. Dep’t of Health and Human Servs., No. 3:10-cv-91-RV/EMT, 2011 WL 285683 (N.D. Fla. Jan. 31, 2011) (granting summary judgment to plaintiffs on grounds that the individual mandate exceeds Congressional commerce clause powers).

14. One such measure has already passed in Missouri. See Monica Davey, *In Missouri, Health Law is Rejected by Voters*, N.Y. TIMES, Aug. 3, 2010, at A11.

ACA has no preamble and contains no title dedicated to rules of construction or general findings and purposes. Thus courts, lawmakers, and all others seeking to implement the ACA will be navigating uncharted waters.

This Article argues that the legal and ethical foundations of fiduciary law—primarily of agency theory—provide an organizational model for describing this nation's emerging health care system and supply the legal framework for analyzing the inevitable challenges to the ACA's implementation. Existing contract and tort law rules governing health care entities will not suffice. For example, the laws that previously prohibited the corporate practice of medicine or required clinical integration to approve provider networks will have to be re-thought. This Article argues that a refined look at the fiduciary law already governing some aspects of medical relationships provides an overarching legal paradigm for analyzing, approving, or correcting steps taken to implement the ACA. The contribution this Article makes is to present a body of legal principles that I call the "fiduciary medicine model." This model is the legal paradigm that can best guide legislators, regulators, courts, and the health care industry in implementing and achieving the goals of the ACA. The importance of this contribution is that without such a model, the implementation of America's health reform could fall far short of Congress's ambitious goal—to universalize access to health care, while simultaneously reshaping both the private and public markets that finance health care and the organizational entities that deliver and control the quality of health care in America.

Part I begins with the bold and undoubtedly controversial claim that all health care actors, including the state itself, create, finance, and distribute health care in the context of their fiduciary relationships with patients. This proposition provides contextual understanding for the legal roles new and existing entities will play as health care reform is implemented. It is supported by an analysis of the well-established common law and ethical foundations of the fiduciary relationship between a physician and a patient. The main idea of this section is to build a firm doctrinal foundation from which to extend established fiduciary obligations, already applied elsewhere in the health care field, to all major participants in the health care industry.

This idea is not without precedent. Indeed, the American law of fiduciary relationships was first espoused

to protect patients in relationships with physician providers in 1760,¹⁵ and in 1819 Chief Justice John Marshall affirmed that the agency relationship between the government and the nation is one of “common sense.”¹⁶ Since then, fiduciary law has defined the duties and obligations owed by individual and institutional health care providers to patients in a wide variety of cases.¹⁷ This is a sizeable body of common law, as all American jurisdictions except one¹⁸ have recognized that the provider-patient relationship is one of trust and confidence, obligating the physician to remain loyal and to act in accord with fiduciary standards. However, these standards are only generally defined and the fiduciary duties owed by individual physicians are haphazardly applied to institutional health care providers and payers. Moreover, jurists, policy makers, and legal scholars have thus far ignored the compelling fiduciary obligations owed by the most pervasive actor in American health care: the United States government. This section concludes with a review of the legal literature to demonstrate widespread dissatisfaction with existing fiduciary doctrines. Health law scholars have observed for twenty-five years that the way in which courts and lawmakers currently apply fiduciary rules to health care is obtuse and limited. The time is ripe for a new understanding of fiduciary law in the health care context.

Part II presents the new fiduciary medicine model and serves as the core of this Article. This section constructs the model based on four principles that sharpen and expand the fiduciary rules that should apply to all existing and emerging health care relationships. I begin by disabusing the reader of two erroneous, though long-standing, notions that seem to have confounded jurists in medical law: first, that one-size fiduciary law fits all fiduciary relationships; and second, that medical relationships are fiduciary because they are trusts. Neither premise is true. In fact, most health

15. See 3 WILLIAM BLACKSTONE, COMMENTARIES *122.

16. See John Marshall, *A Friend of the Constitution*, ALEXANDRIA GAZETTE (July 15, 1819), reprinted in JOHN MARSHALL'S DEFENSE OF *MCCULLOCH V. MARYLAND* 207, 211 (Gerald Gunther ed., 1969).

17. See *infra* Section II.A.

18. Alabama is the only state to have held that physician-patient relationships are not fiduciary. *Gunter v. Huddle*, 724 So. 2d 544, 546 (Ala. Civ. App. 1998).

care interactions are fiduciary in nature because they are agency relationships. This is the first principle of the fiduciary medicine model. While trust law is largely inappropriate to describe (much less regulate) most of these relationships, agency law provides a comprehensive and organized body of law that courts, legislators, and policy makers may access to bring order and predictability to health care relationships throughout the reformed American health care delivery system. However, a narrowly defined group of health care relationships that involve the disposition of property are accurately described as trusts.

The second principle of the fiduciary medicine model identifies which health transactions and relationships are agencies and which are trusts, in order to accurately determine which body of fiduciary law applies to each. The model's third principle addresses the possibility that fiduciary law can align conflicting patient interests with the complex network of those who act on their behalf to purchase, deliver, and reimburse the cost of health care goods and services. Finally, the fourth principle of the fiduciary medicine model acknowledges that the state owes the fiduciary duties of good faith, loyalty, and care when acting as a payer and regulator in the health care marketplace.

This section demonstrates the pervasiveness of agency relationships that exist throughout the American health care delivery system and how they will grow when key ACA-created entities are implemented. Also, because the network of agency relationships in health care is well-described in health economics literature, I use these principles of agency theory to describe how the fiduciary medicine model might reach beyond physicians and individual patients to require skill, competency, loyalty, and good faith from hospitals, home health agencies, pharmaceutical companies, nursing homes, employers, and a host of other agents.

This analysis of fiduciary principles is important and timely. First, because the most recent, precedent-setting Supreme Court decision on health care providers' fiduciary obligations¹⁹ wrongly refers to the fiduciary rules belonging

19. In *Pegram v. Herdrich*, the Supreme Court cited the seminal treatise on trust law to explain its decision not to allow the defendant HMO to be held liable for medical error as a fiduciary. *Pegram v. Herdrich*, 530 U.S. 211, 224-25,

to trust law in its holding, the potential for replicating this mistake in lower courts is great, especially as further ACA enabling rules are enacted. Second, the lack of clarity and precision has artificially hindered courts from imposing the full breadth of available fiduciary doctrine to guide and protect health care actors. As a result, the system of legal rules with perhaps the most potential to help courts address conflicts in health care relationships and policy is vastly underutilized. We can no longer afford this misunderstanding now that the ACA has been passed.

Part III offers concrete steps that courts and legislators may employ to implement the fiduciary medicine model. Courts can take advantage of the model's benefits by referencing a concrete body of fiduciary law and applying it to appropriate disputes as a standard for judicial review. To demonstrate, this section applies these fiduciary rules to two dilemmas in health law that predated the current reform movement: the problem of limiting the influence that financial incentives have on health care providers' medical judgments, and the question of how to restructure informed consent law to encourage shared decision making. This section concludes by offering a proposed enabling statute, modeled after the Uniform Prudent Investor Act, which a state legislature wishing to implement the fiduciary medicine model might enact. I conclude by making observations about the impact this Article's model can have on the long-term sustainability and success of the ACA's new organizational structure and ideals for American health care reform.

I. CURRENT FIDUCIARY HEALTH LAW

Fiduciary relationships describe a variety of interactions between health care providers and patients, in which patients rely upon those more knowledgeable, skillful, and powerful than themselves to act in their best

231 (2000). My argument here is not that the outcome of *Pegram* would or should have been different if this misunderstanding were corrected, but that the decision has unfortunately constrained subsequent courts and commentators from applying fiduciary law as the important and useful tool it is in addressing health care policy dilemmas.

interest.²⁰ Fiduciary law requires an expert to exercise prudent judgment and selfless discretion to protect the weaker party who is dependent upon, but lacks sufficient information or influence to effectively monitor, the expert's choices.²¹ In America, we apply the doctrine to protect the values of trust accounts, bank accounts, and corporate shares, as well as to compel fairness towards employees, shareholders, depositors, patients and others who we regard as vulnerable to the superior knowledge and control of employers, directors, doctors, and guardians.²² Therefore, it is not surprising that courts have developed a nearly unanimous consensus on applying the fiduciary doctrine to protect at least some interests of individual patients in their relationships with physicians and other health care providers.²³ But the courts' failure to plainly extend the doctrine to cover more complex provider-patient and payer relationships is surprising indeed.

Fiduciary principles appear only haphazardly in opinions resolving a variety of medically-related disputes. Courts have yet to articulate a clear set of legal duties that flow from fiduciary principles or specify the parties to whom they apply. Before the 2010 health care reforms, invoking the vague and unpredictable body of common law on fiduciary health care relationships would have meant perpetuating this disarray. It is unclear whether the dramatically increased number of new entities envisioned by the ACA could have survived this confusion. However, the ACA also introduces a paradigm shift that compels a fresh look at fiduciary law and how it applies to American health care. President Barack Obama made reference to

20. See, e.g., 49 A.L.R. 3d 501 § 2(a) (1973) ("The relationship of physician and patient is one of trust and confidence imposing on the physician a fiduciary duty to reveal to the patient that which in his best interest he should know.").

21. See Peter J. Jacobson & Michael T. Cahill, *Applying Fiduciary Responsibilities in the Managed Care Context*, 26 AM. J.L. & MED. 155, 160 (2000); E. Haavi Morreim, *High-Deductible Health Plans: New Twists in Old Challenges From Tort and Contract*, 59 VAND. L. REV. 1207, 1234-35 (2006).

22. Robert Cooter & Bradley J. Freedman, *The Fiduciary Relationship: Its Economic Character and Legal Consequences*, 66 N.Y.U. L. REV. 1045, 1055-56 (1991).

23. See *Mitchell v. Harris*, 246 So. 2d 648, 651-52 (Ala. 1971) (stating that there is no fiduciary relationship between physician and patient as a matter of law); *Gunter*, 724 So. 2d at 546.

this paradigm shift when he spoke on March 23, 2010, when he signed the ACA:

Tonight after nearly 100 years of talk and frustration, after decades of trying, and a year of sustained effort and debate, the United States Congress finally declared that America's workers and America's families and America's small businesses deserve the security of knowing that here, in this country, neither illness nor accident should endanger the dreams they've worked a lifetime to achieve. . . . We didn't give in to mistrust or to cynicism or to fear. Instead, we proved that we are still a people capable of doing big things and tackling our biggest challenges. We proved that this government—a government of the people and by the people—still works for the people.²⁴

The President spoke accurately when he stated that the ACA does “big things” and tackles “our biggest challenges” in health care policy. Moreover, the President's executive proclamation highlighted the importance the reform places on the government's role in fundamentally reorganizing the public and private markets that deliver and pay for health care in a competitive environment.²⁵ Unquestionably, Congress has rejected a public payer or central government controlled health care system.²⁶ Yet the participant chiefly responsible for stabilizing the health care markets envisioned by the Act is the government. The ACA increases state and federal government responsibilities to manage competitive health care markets to unprecedented levels. Expanding the role of fiduciary law in health policy will, I assert, determine the extent to which the government's reform will, in fact, “still work for the people.”

24. Barack Obama, President of the United States, Address to the American People Following the Signing of the Affordable Care Act (Mar. 23, 2010) (transcript available at <http://www.whitehouse.gov/blog/2010/03/22/what-change-looks>).

25. *Health Insurance Exchanges*, CENTERS FOR MEDICARE & MEDICAID SERVICES—CENTER FOR CONSUMER INFORMATION, <http://cciio.cms.gov/programs/exchanges/index.html> (last visited Apr. 10, 2011) (“The Affordable Care Act helps create a competitive private health insurance market through the creation of health insurance Exchanges. These state-run, transparent marketplaces, which launch in 2014, will provide millions of Americans and small businesses with “one-stop shopping” for affordable coverage.”).

26. Robert Pear & Jackie Calmes, *Senators Reject Pair of Public Option Proposals*, N.Y. TIMES, Sept. 29, 2009, <http://www.nytimes.com/2009/09/30/health/policy/30health.html>.

The ACA will expand access to health care to cover approximately thirty-two million previously uninsured Americans by 2019,²⁷ with substantial financial help from the federal government. Individuals who require but are unable to pay for private insurance coverage will be subsidized by means-tested federal tax credits to help cover the cost of their premiums.²⁸ Under Medicaid and the Children's Health Insurance Program, the federal government will finance the largest extension of coverage to newly eligible categories of low-income Americans since the program's inception.²⁹ The government will pay premium assistance and increases in the Federal Medical Assistance Percentage to cover 100% of the expansion's cost from 2014 to 2016, and the percentage will decrease to 90% of the cost by 2020.³⁰

The ACA also appropriates funding to finance states' demonstration programs designed to test alternatives to the tort liability system³¹ and introduces payment bundling cost controls.³² Throughout the ACA, Congress has approved federal grants to finance more than thirty-five pilots, demonstration projects, and studies aimed at testing reforms to delivery and payment systems that the Secretary

27. Letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to Nancy Pelosi, Speaker, U.S. House of Representatives (March 20, 2010), *available at* <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf> [hereinafter Congressional Budget Office Letter]. *But see* RAND RESEARCH BRIEF, ANALYSIS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT 3 (H.R. 3590) (2010), *available at* http://www.rand.org/pubs/research_briefs/RB9514.html (finding that number to be 28 million).

28. 26 U.S.C.A. §36B (West Supp. 2011).

29. Under ACA Title II, Congress extended Medicaid coverage to childless adults earning up to 133% of the federal poverty level, 42 U.S.C.A. § 1396a(a)(10)(A)(i)(VIII) (West Supp. 2010); former foster children, Pub. L. No. 111-148, § 2004, 124 Stat. 283 (2010); and to freestanding birth centers, 42 U.S.C.A. § 1396d(a)(28) (West Supp. 2010).

30. 42 U.S.C.A. § 1396a (West Supp. 2010); *see also* Alec MacGillis, *Study of Health-Care Law Rebuts State Protests on Medicaid Costs*, WASH. POST, May 26, 2010, <http://www.washingtonpost.com/wp-dyn/content/article/2010/05/26/AR2010052603216.html> (summarizing a Kaiser Family Foundation study finding that state spending for increased Medicaid coverage will be mitigated by federal expenditures).

31. 42 U.S.C.A. § 280g-15.

32. *Id.* § 1395cc-4(c)(3)(C)(i).

of Health and Human Services may make law if she finds them effective.³³ In order to direct health care professionals to underserved areas and populations, Congress has authorized funding to enhance training programs and forgive education loans to nursing students,³⁴ specialists in pediatrics³⁵ and primary care,³⁶ and public health professionals.³⁷ Additionally, the ACA appropriates new funding to finance research and development of medical innovations³⁸ and collect data in connection with Patient-Centered Outcomes Research³⁹ to enhance anti-fraud enforcement.⁴⁰

Indeed, the comprehensiveness of these interdependent provisions represents one of the ACA's primary strengths. The ACA's ten titles simultaneously address improvements in the quality of health care delivery, greatly increase access to health care, and modify payment systems to contain health care costs. Health reform analysts have long recognized and agreed that only a coordinated attack on cost containment, quality improvement, and expanding access will work to meaningfully reform and universalize American health care.⁴¹ This act does that. Yet, such a coordinated and comprehensive reform is costly.

The Congressional Budget Office estimates that the cost of implementing the final ACA, including the Manager's Amendment and Reconciliation Bill, is likely to require

33. For a summary of all pilot and demonstration projects under the ACA prepared by the Capital Health Group, see *Pilot Programs and Demonstration Projects*, available at http://www.caphg.com/media/CHG%20Summary_%20Pilot%20Programs%20and%20Demonstration%20Projects.pdf.

34. 42 U.S.C.A. § 297b(a) (West Supp. 2010).

35. *Id.* § 295f(a).

36. *Id.* § 292s(a)(1).

37. *Id.* § 295f-1(a).

38. *Id.* § 1315a(a)(1).

39. *Id.* § 1320e(b).

40. *Id.* § 1395(i).

41. See, e.g., John V. Jacobi, *The Present and Future of Government-Funded Reinsurance*, 51 ST. LOUIS U. L.J. 369, 377 (2007) (favoring a universal coverage system as opposed to an incrementalist approach); Eleanor D. Kinney, *Rule and Policy Making Under Health Care Reform*, 47 ADMIN. L. REV. 403, 404 (1995); David Pratt, *The Past, Present and Future of Health Care Reform: Can It Happen?*, 40 J. MARSHALL L. REV. 767, 796 (2007).

\$788 billion in new government spending, which will be offset by savings and spending reductions, thus resulting in an increase in overall spending of \$114 billion over the nine-year period from 2010 to 2019.⁴² The magnitude of the government's spending and regulatory role under the newly-reformed health care regime is unprecedented, and must be viewed through an entirely new legal lens. In other words, the fiduciary role of the state itself, acting through legislators and regulators, can no longer be ignored. Fiduciary law can clearly give effect to the government's obligations under the ACA that Congress contemplated in organizing the new health care landscape. This Article explores the entire range of fiduciary relationships that characterize the new health care landscape and the legal rules that should apply to them. I include the relationship between the state and its citizens in this analysis, but begin with the most fundamental fiduciary relationship in the health care delivery system—the relationship between doctor and patient.

A. *The Physician-Patient Fiduciary Relationship*

Some courts have a long-established history of acknowledging the fiduciary nature of the physician-patient relationship in medical malpractice cases,⁴³ holding that the provider's fiduciary duty arises from the trust and confidence patients place in physicians to operate in good faith, remain loyal to their patients, and subordinate their own self-interest and the interests of others. Based on the recognition that the physician-patient interaction is a relationship of confidence and trust,⁴⁴ these courts readily apply fiduciary principles to enforce duties involving

42. Congressional Budget Office Letter, *supra* note 27.

43. *See, e.g.*, *Walk v. Ring*, 44 P.3d 990, 999 (Ariz. 2002) (“We long ago held that a patient and a doctor were in a fiduciary relationship ‘calling for frank and truthful information from’ doctor to patient.”) (quoting *Acton v. Morrison*, 155 P.2d 782, 784 (Ariz. 1945)). *See also* *Moore v. Regents of Univ. of Cal.*, 793 P.2d 479, 483 (Cal. 1990) (asserting a physician's fiduciary duty to disclose personal financial interest in a procedure and citing California case law in support dating back to 1947); *Stafford v. Schultz*, 270 P.2d 1, 7-8 (Cal. 1954). *But cf.* *Gunter v. Huddle*, 724 So. 2d 544, 546 (Ala. Civ. App. 1998) (uniquely holding that the physician-patient relationship is not fiduciary).

44. *See, e.g.*, *Tracy v. Merrell Dow Pharm., Inc.*, 569 N.E.2d 875, 879 (Ohio 1991).

disclosure and informed consent,⁴⁵ patient confidences, and not withholding or fraudulently concealing⁴⁶ information patients or related third parties are entitled to receive.⁴⁷ The fiduciary duty obligates physicians to refrain from ex parte communication with lawyers in adversarial proceedings⁴⁸ and provides the basis upon which physician-patient communications are privileged.⁴⁹ A court may rely on the

45. *Hales v. Pittman*, 576 P.2d 493 (Ariz. 1978) (“[B]ecause of the fiduciary relationship between physician and patient, the scope of the disclosure required can be expanded by the patient’s instructions to the physician.”); *Demers v. Gerety*, 515 P.2d 645, 648, 650 (N.M. Ct. App. 1973) (approving an instruction on the fiduciary relationship in an action where the patient had not consented to an operation that had been performed).

46. *See Nardone v. Reynolds*, 538 F.2d 1131, 1136 (5th Cir. 1976) (holding that breach of fiduciary duty occurs when a doctor fails to disclose a known condition, and that such duty does not expire when the consensual-contractual relationship ends); *Batty v. Ariz. State Dental Bd.*, 112 P.2d 870, 876-77 (Ariz. 1941) (noting that in all such dealings, a physician’s relationship with a patient is one of trust and confidence and that a provider must use the utmost good faith or he is guilty of fraud).

47. *See, e.g., Davis v. Rodman*, 227 S.W. 612, 614 (Ark. 1921) (“The relation of a physician to his patient and the immediate family is one of the highest trust.”). *But see Lemon v. Stewart*, 682 A.2d 1177, 1183 (Md. Ct. Spec. App. 1996) (recognizing that the relationship between a health care provider and a patient is based on trust and confidence, giving a patient the right to assume his HIV-positive status will not be voluntarily disclosed to relatives without consent); *Morris v. Consol. Coal Co.*, 446 S.E.2d 648, 657 (W. Va. 1994) (holding that a patient has a cause of action against a physician disclosing information to an employer for breach of the duty of confidentiality and against an employer who induced the physician to breach his fiduciary relationship by disclosing confidential information).

48. *See e.g., Petrillo v. Syntex Lab., Inc.*, 499 N.E.2d 952, 962 (Ill. App. Ct. 1986) (finding that public policy favoring physician-patient confidentiality and the fiduciary nature of the physician-patient relationship justifies prohibition against ex parte communication); *Sorensen v. Barbuto*, 2008 UT 8, 177 P.3d 614, 619-20 (2008) (holding that the health care fiduciary duty of confidentiality prohibits ex parte communications between a tort plaintiff’s treating physician and defense counsel in the underlying tort action).

49. *See, e.g., State ex rel. Dean v. Cunningham*, 182 S.W.3d 561, 566 (Mo. 2006) (holding that the fiduciary duty of confidentiality between patients and doctors is part of the foundation of the doctor-patient evidentiary privilege). *But cf. Stigliano v. Connaught Lab., Inc.*, 658 A.2d 715, 721 (N.J. 1995) (bringing a medical malpractice suit waived the physician-patient privilege concerning the patient’s treatment because it put the plaintiff’s medical condition in issue).

fiduciary relationship to preclude a treating physician from providing expert testimony against a patient.⁵⁰

Moreover, courts also have extended fiduciary law to protect the vulnerable status of patients where physicians may exercise discretionary power over them. Physicians may not exercise undue influence over their patients. For example, courts are suspicious of financial transactions between providers and patients outside the treatment context.⁵¹ Regularly, courts place the burden upon providers to show the fairness of transactions entered into with and conveyances received from their patients.⁵² And many courts, though not all, will find fiduciary obligations breached where a physician takes sexual advantage of a patient.⁵³ Finally, courts impose the fiduciary duty on providers to act in their patients' best interest,⁵⁴ to act in

50. *Piller v. Kovarsky*, 476 A.2d 1279, 1282 (N.J. Super. Ct. Law Div. 1984) (“[T]he fiduciary nature of the [physician-patient] relationship should preclude a physician from testifying against his patient as a liability expert, at least in a medical malpractice action involving the very condition for which the physician has treated the patient.”).

51. *See Houghton v. West*, 305 S.W.2d 407, 411-12 (Mo. 1957) (the defendant physician had a fiduciary relationship which carried into the parties' dealings beyond the medical treatment rendered); *see also Mattingly v. Sisler*, 175 P.2d 796 (Okla. 1957):

It is contended that the relation of physician and patient constitutes a confidential relationship and it is further contended that where the evidence shows the existence of such relationship and the party in whom confidence is reposed obtains an apparent advantage over the other in a transaction between them such transaction is presumed to be void and the burden of proof is upon the party who seeks to support it to show by clear proof that he has taken no advantage over the other party and that the transaction is fair, free from fraud and is conscientious. This is a correct statement of the law.

Id. at 799.

52. *See, e.g., Unruh v. Lukens*, 31 A. 110, 113 (Pa. 1895).

53. *Hoopes v. Hammargren*, 725 P.2d 238, 242 (Nev. 1986) (stating that a physician who takes advantage of a vulnerable patient would “fall below the acceptable standard for a fiduciary”). *But cf. Korper v. Weinstein*, 783 N.E.2d 877, 881-82 (Mass. App. Ct. 2003) (finding that a physician did not breach the fiduciary duty owed to the patient by engaging in a consensual sexual relationship with her, because a fiduciary relationship does not encompass all interaction between parties measured by fiduciary standards).

54. *Ison v. McFall*, 400 S.W.2d 243, 258 (Tenn. Ct. App. 1964) (providing that any physician, chiropractor, or M.D. who has a fiduciary relationship with his

good faith, and to deal fairly with their patients, while eschewing kickbacks,⁵⁵ excessive services,⁵⁶ and improper referrals.⁵⁷

In addition to physicians, institutional providers also have been found to owe a fiduciary duty to their patients. A nursing home may breach its fiduciary duty to an elderly resident by failing to provide suitable care.⁵⁸ The fiduciary duty obligates nursing homes and pharmaceutical companies to collect only reasonable fees.⁵⁹ A public hospital and its physicians owe a fiduciary duty to use their best judgment and employ their skills to provide the same attention and care that would be due from a private health care facility and its doctors.⁶⁰ Thus fiduciary law already serves as a regulator of multiple aspects of the relationship

patient and who knows or should know that a treatment will not benefit his patient must advise his patient of that fact).

55. See *Forziati v. Bd. of Registration in Med.*, 128 N.E.2d 789, 791-92 (Mass. 1955).

56. See, e.g., *Garcia v. Coffman*, 946 P.2d 216, 218, 223 (N.M. Ct. App. 1997) (affirming the trial court's finding of breach of fiduciary duty in a case where a doctor's protocol included "unnecessary computerized muscle testing" performed by "incompetent personnel," on grounds that there was not full and fair disclosure).

57. See, e.g., *Agency for Health Care Admin. v. Wingo*, 697 So. 2d 1231, 1232-33 (Fla. Dist. Ct. App. 1997).

58. In *Petre v. Living Centers-East, Inc.*, 935 F. Supp. 808 (E.D. La. 1996), the court stated that "fiduciary relationships are most often found in financial dealings," and that it could "think of no relationship which better fits the . . . description [of fiduciary duty] than that which exists between a nursing home and its residents." *Id.* at 812.

59. See *Rohlfing v. Manor Care, Inc.*, 172 F.R.D. 330, 350-51 (N.D. Ill. 1997) (upholding a breach of fiduciary duty action against a nursing home and a related pharmaceutical company to recover excessive fees where a resident had confidence in the nursing home and the nursing home was found to be in a position of "superiority and influence"); *Greenfield v. Manor Care, Inc.*, 705 So. 2d 926, 931-32 (Fla. Dist. Ct. App. 1997) (finding a fiduciary duty between a nursing home and its residents that was rooted in a special relationship independent of any contract).

60. *Jackson v. Okla. Mem'l Hosp.*, 909 P.2d 767, 773 (Okla. 1995) ("A licensed attending faculty physician—who, as a member of a state medical school faculty, is charged with delivery of medical care to patients—performs much the same function as an attending physician at a private health-care facility."). *But cf.* *Nutty v. Jewish Hosp.*, 571 F. Supp. 1050, 1052-53 (S.D. Ill. 1983) (explaining the difficulty of deeming a patient's relationship with a hospital a fiduciary one).

between health care providers and individual patients. Current applications of fiduciary law are pervasive in the medical context and are firmly based on the well-established ethical responsibilities that providers historically owed to their patients.

1. *Ethical Roots.* The law of fiduciary relationships rises directly from the ancient, oft-repeated, self-proclaimed ethical duties physicians owe to patients in treatment relationships. Physicians in Ancient Greece organized themselves into a professional guild, in which members shared professional principles most famously articulated sometime during the fourth century B.C. by the Greek medical philosopher Hippocrates.⁶¹ Hippocrates wrote the oath which required new physicians to swear upon Apollo and a number of healing gods to uphold the ethical principles of their profession: "I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous."⁶² One translation continues: "I will keep them from harm and injustice."⁶³ Today's modern version of the oath, still ceremonially recited by medical school students across the nation, declares: "I will treat without exception all who seek my ministrations, so long as the treatment of others is not compromised thereby."⁶⁴

Many legal scholars have traced how these historic pronouncements of physicians' ethical commitments to beneficence and justice have evolved into today's modern declarations by the American Medical Association.⁶⁵ The

61. See HIPPOCRATES, THE OATH OF HIPPOCRATES, *reprinted in* THE HARVARD CLASSICS VOLUME 38: SCIENTIFIC PAPERS (PHYSIOLOGY, MEDICINE, SURGERY, GEOLOGY) 11 (2006).

62. *Id.*

63. Translation from the Greek, *in* LUDWIG EDELSTEIN, THE HIPPOCRATIC OATH: TEXT, TRANSLATION, AND INTERPRETATION 3 (1943).

64. *The Hippocratic Oath*, NAT'L KIDNEY AND TRANSPLANT DIV. OF UROLOGY (March 1, 2009), <http://members.tripod.com/nktiuro/hippocra.htm>.

65. See, e.g., Charity Scott, *Doctors As Advocates, Lawyers as Healers*, 29 HAMLIN J. PUB. L. & POL'Y 331, 335-37 (2008). Referencing the "long and honorable history" of physicians as fiduciaries flowing from medical ethicists such as doctors Laurence B. McCullough, John Gregory, and Thomas Pervical, Professor Scott explains how the physician's ethical obligations to be competent and loyal, to act for the benefit of their patients, to refrain from self-interested

purpose here is not to rehearse that history. My limited objective is to review the way in which these ethical messages and commitments have been incorporated into current medical fiduciary law.

Legal efforts to enforce a physician's pledge to benefit and not harm patients were first introduced in the 1760s by *Blackstone's Commentaries on the Laws of England*. There, the legal action for medical malpractice—the failure to avoid what is deleterious or to act for the benefit of the sick—was described as “[i]njuries . . . by the neglect or unskilful [sic] management of [a person's] physician, surgeon, or apothecary . . . [condemned] because it breaks the trust with the party had placed in his physician and tends to the patient's destruction.”⁶⁶ Around the same time, in New York State, medical societies were given the right to hold physicians and surgeons accountable to professional standards under a 1760 law which was upheld as constitutional in 1833:

[W]ith a view to the moral character, as well as the learning and skill of the members of this most useful and responsible profession, it gives to the county medical societies the right to try any of their members against whom specific charges of gross ignorance or misconduct in his profession, or of immoral conduct or habits, may be brought.⁶⁷

In that state's first reported negligence action against a physician, the Supreme Court of New York County reversed a trial court's evidentiary ruling in favor of the defendant physician in an action alleging “maltreatment of a leg, broken below the knee.”⁶⁸ Thus, from the eighteenth century, American jurisprudence analogized the nature of the physician-patient relationship to that of an employer and a laborer.⁶⁹ The relationship was one in which the

behavior, and to keep patient confidences while disclosing relevant information parallel a physician's legal duties as a fiduciary. *Id.*

66. Emily Chow, Note, *Health Courts: An Extreme Makeover of Medical Malpractice with Potentially Fatal Complications*, 7 YALE J. OF HEALTH POL'Y, L. & ETHICS 387, 404 (2007) (quoting 3 WILLIAM BLACKSTONE, COMMENTARIES *122).

67. *In re Smith*, 10 Wend. 449, 456 (N.Y. Sup. Ct. 1833).

68. *Edwards v. Stewart*, 15 Barb. 67, 68 (N.Y. Gen. Term 1853).

69. *See id.* at 68-69.

patient entrusted her health to the physician, depending upon the latter's exercise of skill and expertise, to benefit the patient in a way that caused neither harm nor injustice. The legal fiduciary standards that governed this relationship emanated from ethical obligations that encompassed the professional, intellectual, and moral performance of providers.

2. *Distinguishing Negligence.* It is important to distinguish the fiduciary obligation recognized in law from the duty imposed on providers to act non-negligently. According to one commentator, negligence law "only adumbrates fiduciary law."⁷⁰ Malpractice occurs when a professionally-defined standard of care is breached, while fiduciary violations may also offend standards of trust defined outside of the profession.⁷¹ Procedurally, fiduciary law places a reduced burden of proof upon plaintiffs making out a prima facie case.⁷² Plaintiffs can access equitable remedies by merely showing that a fiduciary obligation existed and was breached.⁷³ Many jurisdictions allow a fiduciary cause of action with or without proof of actual injury.⁷⁴ Courts enforcing fiduciary rights have the power to

When a party undertakes a work of skill and labor and performs it so unskillfully that his employer derives no benefit from the work, he is not entitled to recover any thing [sic], for his labor. This is an elementary principle; and if the employer not only derived no benefit from the services, but sustained a positive injury, entitling him to compensation for damages, the case is still stronger against the laborer or professional man.

Id.

70. See Marc A. Rodwin, *Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System*, 21 AM. J.L. & MED. 241, 249 (1995).

71. See, e.g., Caroline Forell and Anna Sortun, *The Tort of Betrayal of Trust*, 42 U. MICH. J.L. REFORM 557, 565 (2009) ("Trust and loyalty are what distinguish fiduciary from non-fiduciary relationships."); see also Brian M. Serafin, *Comparative Fault and Contributory Negligence as Defenses in Attorney Breach of Fiduciary Duty Cases*, 21 GEO. J. LEGAL ETHICS 993, 995 (2008) ("The factor which most distinguishes negligence from breach of fiduciary duty is what constitutes duty.").

72. See Serafin, *supra* note 71, at 994-95.

73. RESTATEMENT (THIRD) OF AGENCY § 8.01 cmt. d(1) (2006).

74. For a discussion of the differences between negligence and breach of fiduciary duty causes of action, see generally Serafin, *supra* note 72.

award restitutionary damages and punitive damages and to enjoin future misconduct.⁷⁵ It is unclear why courts chose negligence over the fiduciary standard in malpractice actions,⁷⁶ especially in light of the mounting evidence that physicians themselves are unable to reach consensus about the most effective way to provide beneficial treatment,⁷⁷ and in light of the failure of customary standards of care to account for the complexity of financial incentives on physicians' and other providers' judgment.⁷⁸

The fiduciary duty operates apart from and in addition to the duty under tort law to meet the customary standard of care.⁷⁹ Beyond the duty to provide non-negligent care, fiduciary law requires a physician to do more than meet the standard of care or produce a certain outcome—say finding a cure for the complained-of disease. Fiduciary law focuses on the extent, quality, and integrity of the expert's effort, dedication, and decision making on behalf of a patient.⁸⁰ In *Pegram v. Herdrich*,⁸¹ the United States Supreme Court

75. RESTATEMENT (THIRD) OF AGENCY § 8.01 cmt. d(1) (2006).

76. See Jonathan J. Frankel, *Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures*, 103 YALE L.J. 1297, 1315-16 (1994); Joseph H. King, Jr., *In Search of a Standard of Care for the Medical Profession: The "Accepted Practice" Formula*, 28 VAND. L. REV. 1213, 1234-36 (1975); Allan H. McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 558-59 (1959).

77. See, e.g., M. Gregg Bloche, *The Emergent Logic of Health Law*, 82 S. CAL. L. REV. 389, 462 (2009) ("The malpractice system's greatest failing, from a quality and value perspective, is its reliance on clinical practitioners to specify standards of care.").

78. See, e.g., E. Haavi Morreim, *Medicine Meets Resource Limits: Restructuring the Legal Standard of Care*, 59 U. PITT. L. REV. 1, 3-5 (1997).

79. See, e.g., *Lownsbury v. VanBuren*, 762 N.E.2d 354, 357-58 (Ohio 2002) (emphasizing that the physician-patient relationship is a fiduciary one based on the patient's trust and confidence (meaning that the patient will rely on the judgment and expertise of the physician), and based on the fact that the patient obtained the physician's services because of special knowledge and skill held by the physician); *Hunter v. Brown*, 484 P.2d 1162, 1166 (Wash. 1971) ("We agree with appellant that a physician's duty to disclose is not governed by the standard practice of the physicians' community, but it is a duty imposed by law which governs his conduct in the same manner as others in a similar fiduciary relationship") (quoting *Berkey v. Anderson*, 82 Cal. Rptr. 67, 78 (1969)).

80. See generally Paul B. Miller & Charles Weijer, *Fiduciary Obligation in Clinical Research*, 34 J.L. MED. & ETHICS 424 (2006).

81. 530 U.S. 211 (2000).

distinguished fiduciary duty from negligence actions and precluded plaintiffs from recasting ordinary medical malpractice actions as actions for breach of a fiduciary duty.⁸² Yet, at the same time, the *Pegram* decision may be read to preserve and even extend the breadth of fiduciary obligations that compel providers to act in their patients' best interests in other contexts.⁸³

The power of fiduciary law lies in the fact that it is an equitable doctrine, rooted in the tradition of the English chancery courts before whom citizens came to seek royal justice and "let right be done."⁸⁴ However, despite the ancient roots of the fiduciary obligations that American courts now recognize in the physician-patient relationship, legal commentators have found the current doctrine wanting.

B. *Critiquing the Current Law*

For at least twenty-five years, legal scholars have sought to expand the influence of fiduciary law to regulate health care relationships. Until now, the direction and reasons for that expansion have only been discussed in a piecemeal fashion, to address a discrete doctrinal deficiency in the individual physician-patient relationship. A systematic review of the legal scholarship on fiduciary law

82. See Maxwell J. Mehlman, *Dishonest Medical Mistakes*, 59 VAND. L. REV. 1137, 1156 ("The [Supreme] Court 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.").

83. In criticism of the Circuit Court of Appeals decision to limit fiduciary actions to those involving a financial conflict of interest, the Supreme Court reasoned:

[T]his attempt to confine mixed decision claims to their most egregious examples entails erroneous corruption of fiduciary obligation and would simply lead to further difficulties we think fatal. When a mixed [treatment and eligibility] 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.

Pegram, 530 U.S. at 235 (emphasis added).

84. Paul F. Figley & Jay Tidmarsh, *The Appropriations Power and Sovereign Immunity*, 107 MICH. L. REV. 1207, 1213 (2009) (quoting Ludwik Ehrlich, *Proceedings Against the Crown (1216-1377)*, in OXFORD STUDIES IN SOCIAL AND LEGAL HISTORY 97 (Paul Vinogradoff ed., Octagon Books 1974) (1921)).

and its application to health care reveals an unexpected consensus. Legal scholars have collectively identified two significant defects in the current applications of the doctrine. First, the current fiduciary law focuses too narrowly on selected obligations that flow between provider and patient, ignoring the larger systemic duties that are squarely within the influence and discretion of medical providers and vitally important to expanding access to health care. Second, the application of fiduciary law to medicine has not been updated to reflect the complexity of modern health care delivery systems that now exist in the United States, thus limiting the reach of the law's influence and excluding other actors in the network of relationships that comprise health care delivery today. This second omission will be compounded as health care reform implementation adds new health care entities to the health care market.

In 1983, Francis Miller laid the groundwork for an understanding of the reach of fiduciary law in medicine. She was concerned with the fiduciary responsibility that physicians bear when they receive secondary income from ownership and investment interests in facilities that provide their patients' treatment.⁸⁵ Miller identified not only the predictable fiduciary obligations—to avoid self-dealing, to exercise of undue influence, and to act in a patient's best interest—but also foreshadowed a fourth category that could flow from the fiduciary duty of loyalty arising because physicians are actors in what he called “the medical-industrial complex.”⁸⁶

Though virtually untested in courts, Miller saw then that the rising cost of delivering medical care must mean that the physician's fiduciary responsibility includes the duty to protect patients' financial resources by abstaining from unnecessary care and by providing the least expensive (but still effective) treatment.⁸⁷ Further, she suggested physicians might hold a systemic fiduciary obligation to

85. Frances H. Miller, *Secondary Income from Recommended Treatment: Should Fiduciary Principles Constrain Physician Behavior?*, in *NEW HEALTH CARE FOR PROFIT: DOCTORS AND HOSPITALS IN A COMPETITIVE ENVIRONMENT* 155 (Bradford H. Gray ed., 1983).

86. *See id.* at 153, 166.

87. *Id.* at 159.

minimize cross-subsidization.⁸⁸ However, Miller also saw that the trust analogy between physician and patient was insufficient to support the breadth of the fiduciary doctrine she proposed.⁸⁹ If physicians were held as trustees of patient finances as well as trustees of their health, then any medical advice or treatment they gave would be self-dealing.⁹⁰ Yet Miller's identification of the need for a systemic view of the fiduciary doctrine that addressed health care cost-containment was prescient.

In 2002, Professor Marc Rodwin further explained that the changed health care environment has left the physician's status as a fiduciary "ambiguous," and the current fiduciary metaphor as "only helpful up to a point."⁹¹ Rodwin examined the fiduciary relationship between guardians and wards, lawyers and clients, and corporate officers or directors and shareholders, and identified similarities they share with the patient-physician relationship.⁹² His chief complaint with the fiduciary metaphor for the physician-patient relationship was its inability to constrain financial conflicts of interest in medicine despite its ability to do so for other fiduciaries.⁹³ Rodwin argued that neither licensing boards, hospitals, professional organizations, regulators, nor courts hold physicians accountable to a full range of fiduciary obligations, and so concluded that systemic realities strain

88. *See id.* (referring to the "Robin Hood method of prices" which the author thought ended with the advent of Medicare and Medicaid).

89. *See id.* at 154-55.

90. *See id.* at 157.

91. Rodwin, *supra* note 70, at 242. *But cf. infra* Section II.A.1 (discussing Rodwin's error in analyzing physicians as trustees).

92. *See* Rodwin, *supra* note 70, at 242-45. Rodwin stated that these groups are "entrusted with power and property to be used for the benefit of another," are "held to the highest standard of conduct," are repositories for specialized knowledge and expertise, are given latitude to exercise discretion, and are expected to work on behalf of those who are dependent and reliant on them. *Id.* at 243-44. They must be "scrupulously honest," may not divulge confidences, and cannot promote their own self-interest or the interest of a third party over the best interest of their beneficiary (or "fiducie," as Rodwin suggests). *Id.* They owe loyalty and are subject to judicial scrutiny holding them to "something stricter than the morals of the market place." *Id.* at 244 (quoting *Meinhard v. Salmon*, 249 N.Y. 458, 464 (1928) (Cardozo, J.)).

93. *See id.* at 249.

fiduciary principles.⁹⁴ Rodwin accurately pointed to the lack of a “simple criteria [to] fully explain how courts decide which relationships they will recognize as fiduciary,”⁹⁵ but he incorrectly blamed limitations on fiduciary law itself for failing to adequately supervise physicians.⁹⁶ Professor Rodwin’s unmatched contribution to a right understanding of the fiduciary medicine model, however, is that he identified a “gap” between the fiduciary doctrine and the economic and structural reality of the health care industry.⁹⁷

The solution Marc Rodwin proposed was much smaller than the problem he outlined. Rodwin’s remedy was to incorporate competing interests into the fiduciary loyalties that physicians might owe.⁹⁸ Nevertheless, Rodwin, like Miller, must be credited with seeing that the existing use of fiduciary law to regulate health care relationships is, as yet, too limited for medicine as it is practiced in this new era. In his words, the metaphor was “strain[ed]” by physicians’ loyalties that extend beyond a single patient beneficiary.⁹⁹ Moreover, we owe Rodwin a debt of thanks for the insight that imposing fiduciary law is a decision of social policy and choice.¹⁰⁰ Rodwin gave not only the impetus to expand the fiduciary model to encompass a broader, more complex range of medical relationships, but he pointed to the public, population, and aggregational pressures that would inform later scholars. Rodwin explained, “[i]t 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. And accountability is the core of the fiduciary ideal.”¹⁰¹

94. *See id.* at 249-51.

95. *Id.* at 245.

96. *See infra* Section II.A.1 for an explanation on how the mistake of choosing trust rather than agency law to define medical fiduciary obligations, as Rodwin has done here, has resulted in a fiduciary doctrine that is ill-fitting and therefore prompts jurist to resist applying fiduciary law to health care.

97. *See* Rodwin, *supra* note 70, at 247.

98. *Id.* at 255-56.

99. *Id.* at 255.

100. *See id.*

101. *Id.* at 255 (footnote omitted).

While M. Gregg Bloche and Mark Hall put forth differing perspectives on the role of fiduciary law in medicine, both scholars found the doctrine could do more. Professor Hall's comprehensive discussion offered a phenomenological perspective on the entire body of health law—one that flowed from the understanding that "therapeutic goals should be primary considerations in a body of law that arises from and governs a common enterprise whose central objective is individual health and well-being."¹⁰² Hall views law as having three possible stances toward trust: predicated, supportive, or skeptical.¹⁰³ Fiduciary law syllogistically concerns itself with maintaining institutions' intrinsic and presumed trustworthiness, thus falling into the law's predicated stance where law can either arise "axiomatically from the existence of trust" or provide the rules that vindicate existing trust and punish its violation.¹⁰⁴

The example Hall uses to fix fiduciary law within this schema is informed consent.¹⁰⁵ But he soon finds that the fiduciary doctrine runs out of steam. Hall says, after highlighting two consent cases as examples of syllogistic reasoning used to proclaim the fiduciary characteristics of the physician-patient relationship, "[s]yllogistic reasoning extends only so far."¹⁰⁶ He states:

102. Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 468 (2002). Professor Hall proffers trust as an organizing principle for health law based upon the empirical evidence that patients trust physicians, patients want to trust physicians, relationships between physicians and patients where trust is absent are dysfunctional, and the deep emotional content of trust in its essence has an instrumentalist therapeutic effect on patients, helping them to heal. *See id.* at 478-79. Hall says that this therapeutic paradigm also encompasses institutional relationships between hospitals and insurers, for example, and the component relationship between government and the profession. *See id.* at 467. But I argue that the shortcoming in this analysis lies in considering all these relationships with reference only to the patient's individual experience in the delivery of care. *See infra* Section II.B.2 for a discussion of the application of the fiduciary model to patient populations.

103. *See* Hall, *supra* note 102, at 470.

104. *Id.* at 487.

105. *See id.*

106. *Id.* at 490.

To give further shape and content to informed consent law, we must turn to one of the two consequentialist stances [supportive and skeptical] toward trust discussed below.

The predicated stance is highly indeterminate, despite its syllogistic mode, because fiduciary law does not consist of an integrated body of concrete rules or precise doctrine that applies uniformly to all forms of fiduciary relationships. . . . Fiduciary rules developed in one setting do not necessarily apply in all other settings that have fiduciary characteristics. Instead, general principles of fiduciary obligation give rise to various sets of rules in many different settings in which the rules share only broad, familial resemblance.¹⁰⁷

Of course, the object of Hall's trust article was not to elucidate fiduciary law. But the point of note here is that Hall found fiduciary law offered only general principles that were broad and loosely related, but understood this law was flexible enough to apply differently across different medical settings. Yet, in the end, it seems, Professor Hall could rely upon current conceptualizations of fiduciary law in medicine to do very little work in his trust paradigm.

Professor Bloche, in contrast, relies on fiduciary law to do heavy lifting of a much grander scope. He applies the doctrine to constrain physician selfishness, inspire collective action, and even undergird the normative "rightness" of the fiduciary duties themselves for medical actors to internalize.¹⁰⁸ The conversation between Hall and Bloche swirls around the competing views regarding the interplay between trust and law. Hall's application of the trust perspective proceeds from the ethical view that "[t]he language of rights and the language of trust move in opposite directions from one another."¹⁰⁹ Bloche, on the other hand, sees the law as a response to the trust problem created by the inability of the infirm to monitor their providers despite the fact that "[d]iscretion, poorly scrutinized, invites opportunism."¹¹⁰ Thus in Bloche's view,

107. *Id.* at 490-91.

108. See M. Gregg Bloche, Comment, *Trust and Betrayal in the Medical Marketplace*, 55 STAN. L. REV. 919, 927, 930-31 (2002).

109. Hall, *supra* note 102, at 469 (quoting Richard Sherlock, *Reasonable Men and Sick Human Beings*, 80 AM. J. MED. 2, 3 (1986)).

110. Bloche, *supra* note 108, at 930 (citing Cooter & Freedman, *supra* note 22, at 1046-47).

the work of fiduciary law is expansive.¹¹¹ Bloche concludes that the “legal persistence, let alone *strengthening*, of physicians’ fiduciary obligations to patients” may serve as the chief obstacle to the contractarian agenda in medicine of which he disapproves.¹¹² Bloche’s analysis then sees room for an expanded role for fiduciary law in regulatory health care relationships.

Perhaps the most ardent apologetic on behalf of applying fiduciary law to medicine has been Professor Max Mehlman’s.¹¹³ For Mehlman, the power of fiduciary law derives from its capacity to reach a category of physician misdeeds to which patients are particularly vulnerable and that only fiduciary law can reach.¹¹⁴ Furthermore, dishonest mistakes—those instances where doctors cause patient harm not because they are careless or hyper-efficient, but because they are in pursuit of their own interests at the expense of the patient’s—are the most egregious of all.¹¹⁵ For these offenses, only fiduciary law will do. Mehlman cites the procedural and doctrinal advantages of fiduciary protections for patients over contract law and tort—the burden-shifting presumptions, access to punitive damages and injunctive relief, and presumed asymmetries—to conclude that “[w]hen it comes to protecting patients from physician self-aggrandizement, however, one of the most important legal protections for patients is fiduciary law.”¹¹⁶ Mehlman turns next to combating a four-fold attack on the availability of

111. This is illustrated by the fact that he begins his critique by citing the ethical catastrophes of Enron and WorldCom, then condemns the notion of allowing fiduciaries to contract out of their obligations. *Id.* at 921, 925. Bloche, in his critique of Hall’s trust article, evinces the tension between individualist and communal tendencies in the law. Speaking of the cost control objective, Bloche admits by his own personal testimonial that “[a]s taxpayers, health insurance purchasers, and price-conscious shoppers for goods and services, we demand medical cost control—from government, our own health plans, and the businesses we patronize. That we resist these controls when we and our loved ones face life-threatening or life-changing illness is, for contractarians, the central dilemma of health care policy.” *Id.* at 953.

112. *Id.* at 932-33 (emphasis added).

113. Maxwell J. Mehlman, *Dishonest Medical Mistakes*, 59 VAND. L. REV. 1137 (2006).

114. *See id.* at 1147.

115. *Id.* at 1138, 1141-42.

116. *Id.* at 1147.

fiduciary protections for patients. He sees the Supreme Court's decision in *Pegram*—contractarian scholars' dismissive view that fiduciary law is merely an aspect of contract, the emerging emphasis on trust rather than rights to organize legal relationships in health, and the focus on system-wide approaches to reducing medical error—as a virtually war-like attack on the fiduciary foundations of medical relationships.¹¹⁷ Mehlman calls for courts and law makers to protect what he characterizes as “one of [patients'] key refuges” against the “barrage of malpractice reforms and the spoliation of managed care.”¹¹⁸ Mehlman asks the Supreme Court to reaffirm patients' fiduciary rights contracted by *Pegram*; he proposes that lower state and federal courts uphold patient fiduciary rights, and he calls upon legislatures to cease weakening fiduciary protections.¹¹⁹ Finally, Mehlman quite compellingly calls upon scholars to advocate for imposing fiduciary obligations on medical providers:

[T]here are important details of the scope of the physician's fiduciary duty to patients that remain to be worked out. 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.*¹²⁰

Many other health law scholars have tried to expand the application of fiduciary law. Some have attempted to stretch the doctrine to add circumstances when fiduciary duties are owed by the doctor to a patient. These scholars have proposed expanding fiduciary disclosure obligations to protect pregnant mothers¹²¹ or to apologize for medical

117. *Id.* at 1154.

118. *Id.* at 1137.

119. *Id.* at 1172.

120. *Id.* at 1172 (emphasis added) (citation omitted).

121. Professor Michelle Oberman found the fiduciary construct limited and indeed “hollow” as it applies to doctors treating pregnant patients. See Michelle Oberman, *Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U. L. REV. 451, 457 (2000). Oberman advocated expressly augmenting physicians' fiduciary duties to disclose their bifurcated loyalty to patients *in utero* so that pregnant patients could be warned that their trust in physicians may be compromised. See *id.* at 464-66.

error.¹²² Others have sought to extend the law to create affirmative duties for physicians in new contexts beyond the treatment relationship¹²³ or to impose negative obligations when interacting with third parties.¹²⁴ Our struggle in the health law academy against the constraints of an already broad and flexible doctrine cannot be read as a wholesale outcry for the enlargement of the fiduciary doctrine in health care.¹²⁵ However, where there has been near unanimity for a quarter of a century that the doctrine that has described the primary health care delivery relationship since the eighteenth century is falling short, we have to ask why. I believe Miller and Rodwin pointed us toward the answer years ago.

Both observed the pressure that radical changes in the delivery of health care in the American “medical industrial complex” have placed on the fiduciary medicine rules, as they are currently understood.¹²⁶ The pressure is exacerbated by the advent of the new, larger, and more interdependent actors in that medical complex that will appear as the ACA is implemented.

122. Professor Scott sought to add to fiduciary duty the obligation to disclose and apologize for medical error, and further suggested there might be a fiduciary duty of continuing care owed to patients who seek futile treatments. See Scott, *supra* note 65, at 368; see also Richard W. Bourne, *Medical Malpractice: Should Courts Force Doctors to Confess Their Own Negligence to Their Patients?*, 61 ARK. L. REV. 621, 623 (2009).

123. Professors Miller and Weijer argued to add clinical physician-researchers to the list of physicians who owe a fiduciary duty to protect patient-subjects. See Paul B. Miller & Charles Weijer, *Fiduciary Obligation in Clinical Research*, 34 J.L. MED. & ETHICS 424, 428-31 (2006).

124. Professors Hafemeister and Bryan posited that doctors have a negative fiduciary duty to shun pharmaceutical gifts. See generally Thomas L. Hafemeister & Sarah P. Bryan, *Beware Those Bearing Gifts: Physicians' Fiduciary Duty to Avoid Pharmaceutical Marketing*, 57 U. KAN. L. REV. 491 (2009).

125. By “our struggle,” I mean that I count myself among those who have argued for expanding fiduciary rules. I argued that racial, ethnic, and religious disparities in informed consent law and practice could be addressed by a broader concept of doctors' fiduciary responsibilities. See Dayna Bowen Matthew, *Race, Religion, and Informed Consent—Lessons from Social Science*, 36 J.L. MED. & ETHICS 150, 167 (2008).

126. Miller, *supra* note 85, at 154-55; Rodwin, *supra* note 70, at 242.

First, health care reform will shift influence over physicians' medical decisions towards group-based decision-making, and away from considerations that focus solely on an individual patient. The ACA rewards use of "quality measures"¹²⁷ and "clinical practice guidelines,"¹²⁸ and establishes new centers to research, disseminate, and train practitioners to use innovative methodologies, technologies, and best practices that have been proven effective over time with diverse patient populations.¹²⁹ Therefore, a fiduciary doctrine that does not accommodate duties owed to a group of patients and their representatives as principals does not have application in this new economy.

Second, the authority to control costs, quality, and access to health care has shifted away from individual physicians and towards organizations. The ACA introduces new delivery forms such as the Accountable Care Organization ("ACO"), which is a group of providers and suppliers formed to operate collaboratively to manage and coordinate fee-for-service care for Medicare beneficiaries.¹³⁰ Thus, if the fiduciary law is to have continued relevance to medicine, it must reach beyond physicians and other organizations in the delivery network to include health plans, insurers, employers and newly created participants in the delivery network.

127. Quality measures are "a standard for measuring the performance and improvement of population health or of health plans, providers of services, and other clinicians in the delivery of health care services." 42 U.S.C.A. § 299b-31 (West Supp. 2010).

128. The ACA requires the Secretary of the Department of Health and Human Services to identify and disseminate the results of effectiveness research showing the best practices identified across diverse patient groups. *Id.* § 18022; *see also id.* § 1320e.

129. *See e.g., id.* § 1320(e) (creating the "Patient Centered Outcomes Research Institute," a non-profit corporation); *id.* §§ 299b-31 & 299b-33 (creating the "Center for Quality Improvement and Patient Safety," an agency that will be part of the existing Agency for Healthcare Research and Quality according to ACA Title III, Section 3501 and ACA Title X, Section 10303); *id.* § 1315(a) (creating the "Center for Medicare and Medicaid Innovation" which will operate within the existing Centers for Medicare and Medicaid Services).

130. Title III of the ACA creates the ACO program with the intent that it "promote[] accountability for a patient population and coordinate[] items and services under [Medicare] parts A and B, and encourage[] investment in infrastructure and redesigned care processes for high quality and efficient service delivery." *Id.* § 1395jjj.

Third, because the ACA reflects a socio-political shift towards focusing on the health of populations rather than only on the health of individual patients, fiduciary law must speak to the public health concerns of populations, not just individual patients.¹³¹

In order to serve these three radical changes in America's new health care landscape, the current fiduciary rules must first correctly identify the stakeholders who exercise fiduciary decisional discretion, then establish the most appropriate body of fiduciary law to apply to each stakeholder, and finally define an internally consistent paradigm for applying these fiduciary rules to the majority of health care relationships that will appear under the ACA's implementation. Understandably, courts and scholars have not been willing to extend an imprecise legal regime to any but the most obvious cases where its application has been historically accepted. As a result, I assert that the single most powerful body of law that might help to organize relational obligations between parties in the medical industrial complex is vastly underutilized. This omission will only be compounded as the ACA provisions take effect.

To avoid this outcome, the next section develops a robust version of the fiduciary doctrine that is suited to help organize the health care industry. In it I introduce the core theoretical contribution of this article—I call it the fiduciary medicine model. The model is comprised of four principles or elements that together bring the applications of fiduciary law into sharper focus, and facilitate a broader understanding of the role fiduciary law plays in addressing health care policy conflicts that predated and will arise as a result of the ACA.¹³²

131. See, for example, *id.* § 300u-10, which establishes the National Prevention, Health Promotion and Public Health Council, increasing funding for school-based health centers and appropriating funds for community-based prevention efforts, immunization and wellness programs, and a host of other public health initiatives.

132. See Bloche, *supra* note 77, at 445-46.

II. THE FIDUCIARY MEDICINE MODEL

To say that a physician is a fiduciary “only begins analysis; it gives direction to further inquiry.”¹³³ This section undertakes that further inquiry by thoroughly examining the principles of fiduciary law that apply to physicians. I begin by dismantling one of the greatest misunderstandings about fiduciary law that currently applies to health care—the notion that health providers are fiduciaries only to the extent that they resemble financial trustees. This misunderstanding has directed even the United States Supreme Court to the wrong set of fiduciary rules when applying fiduciary law to health care relationships.¹³⁴ The consequence of this error is grave. Seeing few clear analogies between the law of trusts and health care providers, lower courts and other analysts have settled for applying only the broad values of fiduciary law—honesty, trust, integrity, and loyalty to health relationships—but have shunned the more concrete fiduciary rules that could best help to order health care relationships and inform health care policy.¹³⁵

This section identifies agency, rather than trusts, as the correct form of fiduciary relationship that characterizes the basic physician and patient interaction. The power of this understanding cannot be understated. Agency principles delineate the full range of fiduciary relationships among providers, payers, administrators, health plans, employers, insurers, and patients in the health care market—not just between providers and individual patients. Most importantly, this analysis opens the door to a concrete body

133. *SEC v. Chenery Corp.*, 318 U.S. 80, 85-86 (1943).

134. In *Pegram v. Herdrich*, 530 U.S. 211, 224 (2000), the Supreme Court cited the seminal treatise on trust law to explain its decision not to allow the defendant HMO to be held liable for medical error as a fiduciary. My argument here is not that the outcome of *Pegram* would or should have been different if this misunderstanding were corrected, but that the decision has unfortunately constrained subsequent courts and commentators from applying fiduciary law as the important and useful tool it is in addressing health care conflicts and policy dilemmas.

135. See, e.g., *Allison v. Blewett*, 348 S.W.2d 182,184 (Tex. Civ. App. 1961) (noting that “[t]he relationship between doctor and patient is one of trust and confidence” rather than explicitly applying fiduciary duties to the relationship); Rodwin, *supra* note 70, at 242 (referring to the “fiduciary metaphor” rather than concrete fiduciary rules).

of fiduciary principles that may be usefully applied to health care. This corrected understanding will guide courts in applying the new health reform laws to existing and emerging organizations, networks, and relationships in the health care market.

A. *Physician Fiduciaries*

The physician-patient relationship is characterized by the trust and confidence that patients place in their physicians. The resulting vulnerability the patient accepts by placing herself at the mercy of the physicians' exercise of discretion and power contrasts sharply with the superiority of medical knowledge and information the physician has. Analogously, these characteristics liken the physician-patient interaction to a wide variety of fiduciary relationships, each with distinctive implications: depositors and borrowers trust banks and are subject to their discretion; members of a general partnership are vulnerable to one another's exercise of discretion; corporate directors' knowledge about the business they run is superior to investors'; employees and beneficiaries both place themselves at the mercy of employers' and trustees' exercise of discretion. The list continues—executors, guardians, parents, and union leaders have all been held to be fiduciaries.¹³⁶ And yet the structure of these fiduciary relationships and the obligations that flow from them are not all alike. Nor are they all analogous to the fiduciary relationship between physician and patient. The task then is to identify what type of fiduciaries physicians are with respect to their patients. I start where the United States Supreme Court did in *Pegram v. Herdrich*, by considering whether the oldest form of fiduciaries—trusts—fits the physician's role.¹³⁷

136. See *Airline Pilots Assoc., Int'l v. O'Neill*, 499 U.S. 65, 74-75 (1991) (unions); *Eagan v. Jackson*, 855 F. Supp. 765, 799-80 (E.D. Pa. 1994) (guardians); *Ginsburg ex rel. Palace Mgmt.*, 720 N.Y.S.2d 123, 124 (App. Div. 2001) (executors).

137. *Pegram*, 530 U.S. at 223-24 (repeatedly citing principles, cases, and treatises on the law of trusts to support a holding that defendant the Carle Clinic HMO did not violate its fiduciary duty to an injured patient by not immediately referring her to a specialist for an ultrasound to diagnose abdominal pain, in response to financial incentives that rewarded limited referrals).

1. *Physicians as Trustees*. The law of trusts that defines the rights and responsibilities between trustees and their beneficiaries is the starting point for any discussion of fiduciary law.¹³⁸ However, the analysis of any fiduciary arrangement must proceed further because not all fiduciary relationships are trusts. Moreover, fiduciary law is not a homogenous body of legal rules that apply to trusts as well as to all other fiduciary relationships whether or not they are trusts. Since trusts are a general form of fiduciaries, not all duties imposed on trustees apply to non-trustee fiduciaries. Therefore, before applying fiduciary law to health care relationships, it is important to do what the United States Supreme Court did not do in *Pegram v. Herdrich*.¹³⁹ The *Pegram* Court did not precisely identify the types of fiduciary relationships that operate in the health care industry and did not apply the body of fiduciary law that fit the specific fiduciary relationship presented by the facts of the case. Here, by carefully identifying the type of fiduciary relationships that characterize health care, I will correct the mistake that the Supreme Court and other courts have made in their fiduciary analyses, and will remove the conceptual roadblocks to an accurate application of fiduciary law to regulate health care organizations.

In *Scott and Ascher on Trusts*, Professor Austin Scott highlights the English origins of trust law.¹⁴⁰ Scott quotes Professor Maitland on the topic, who called the development of the trust “the greatest and most distinctive achievement performed by Englishmen in the field of jurisprudence.”¹⁴¹ Structurally, a trust is a relationship between parties with respect to property. It is the method by which a person may transfer legal title to property into the hands of a trustee, while retaining equitable ownership of the same property.¹⁴²

138. For a chronological summary of the evolution of fiduciary law from trusts to agency to corporate contexts and beyond, see generally Tamar Frankel, *Fiduciary Law*, 71 CALIF. L. REV. 795 (1983).

139. 530 U.S. at 223-24.

140. AUSTIN W. SCOTT ET AL., *SCOTT AND ASCHER ON TRUSTS* § 1.1 at 3 (5th ed. 2006).

141. *Id.* (quoting MAITLAND, *SELECTED ESSAYS* 129 (1936)). *But see* Frankel, *supra* note 138, at 795 n.1 (stating that the law of trusts originated in thirteenth century French and German law).

142. *See* RESTATEMENT (THIRD) OF TRUSTS § 2 (2003); pt. 3, ch. 8, intro. note (2010).

The result is a relationship that subjects the trustee as owner of title to the property to a well-developed list of duties—to deal with the property solely for the benefit of one or more beneficiaries or for charity, accompanied by a clear remedial rule that applies in the instance of failure to fulfill those duties.¹⁴³ The list of fiduciary duties that governs trustees provides an inviting body of law to apply to physicians with respect to their patients. Consider the appeal of holding physicians liable as trustees on behalf of their patients as beneficiaries of a medical trust.

Trustees owe a duty of *undivided* loyalty to their beneficiaries, not because of the contract between them, but simply because of the relationship.¹⁴⁴ Therefore, it is legally immaterial that a trustee acted in good faith, entered into a fair transaction, and reaped no personal benefit if the trustee breached the duty of loyalty by, for example, purchasing the trust property for himself. The trustee must act solely in the best interest of the beneficiary, and never for his own benefit, for the benefit of those with whom he is closely related, or for the benefit of third parties where the transaction creates a reasonably foreseeable conflict of interest.¹⁴⁵ Moreover, courts penalize self-interested behavior as a violation of the high standard of conduct expressed in the duty of loyalty, except where the trustee has made full disclosure and takes no unfair advantage.¹⁴⁶ Courts have been said to do so with “[u]ncompromising rigidity . . . when petitioned to undermine the rule of undivided loyalty Only thus has the level of conduct for fiduciaries been kept at a level higher than that trodden by the crowd.”¹⁴⁷

Trustees have a fiduciary duty to give full and accurate information to beneficiaries upon request,¹⁴⁸ and this duty is a continuing one, obligating the trustee to keep beneficiaries reasonably informed of changes and significant developments affecting the administration of the trust.¹⁴⁹

143. See RESTATEMENT (THIRD) OF TRUSTS § 2 (2003).

144. SCOTT ET AL., *supra* note 140, § 17.2 at 1077-78.

145. RESTATEMENT (THIRD) OF TRUSTS § 78 (2007).

146. See, e.g., *Meinhard v. Salmon*, 164 N.E. 545 (N.Y. 1928).

147. *Id.* at 546.

148. SCOTT ET AL., *supra* note 140, §17.5 at 1196.

149. *Id.* at 1198-99.

Trustees are obligated to exercise the care and skill of an ordinary “prudent person.”¹⁵⁰ This common law duty has been codified as the “Prudent Investor Rule”¹⁵¹ and incorporates the obligation to exercise reasonable care, skill, and caution, but is distinguishable from the negligence standard of reasonable care.¹⁵² Thus, where negligence will hold an actor liable only for injury caused by failure to act as others in like circumstances would act, the Prudent Investor Rule holds a fiduciary liable for simply failing to employ careful procedures, make use of his superior skills in decision-making, or seek the advice of others who are more skilled regardless of the eventual outcome.¹⁵³ Trustees furthermore have a duty to incur only reasonable costs, preserve trust property, act prudently in the delegation of authority, supervise trust strategy, and minimize the risk of loss.¹⁵⁴

Each of these would appear initially as attractive duties to ascribe to the physician acting on behalf of the patient. Applying a legally enforceable obligation to physicians to act as a loyal trustee might settle Miller’s question of secondary income, and would generally provide direction in addressing the legal effect of financial incentives on physician medical judgment. The trust paradigm would wipe away proof problems faced by prosecutors who enforce the Stark Law’s gnarly prohibitions against self-referral, perhaps even simplifying the myriad of exceptions under those rules.¹⁵⁵ Similarly, anti-kickback provisions and the attendant safe harbors would be greatly simplified, and plaintiffs would be relieved of the burden to prove injury where they could provide evidence of self-interested relationships. The duty to act in a patient’s best interest would more easily encompass an obligation to implement proven, evidence-based protocols. Legislatures seeking to craft laws restricting physicians’ receipt of gifts from pharmaceutical companies

150. UNIFORM PROBATE CODE § 804 (2001).

151. UNIFORM TRUST CODE § 804 (2000).

152. See SCOTT ET AL., *supra* note 142, § 17.6 at 1209.

153. See RESTATEMENT (THIRD) OF TRUSTS, § 77 at 82 (2007).

154. See *generally* SCOTT ET AL., *supra* note 140, § 19.

155. For a summary of Stark Law history and exceptions, see Andrew B. Wachler & Adrienne Dresevic, *Stark II Phase III—The Full Picture*, 20 HEALTH LAW., Sept. 2007, at 1, 3.

would have an established statute and accompanying body of judicial interpretations to access rather than having to re-invent the wheel. If a physician's legally enforceable obligation included the duty to incur only reasonable costs on behalf of her patient, then the judicial review applying trust law could become a useful tool in enforcing cost containment goals. The trustee's duty to act prudently in delegating authority could be useful in addressing the referral patterns to costly specialists. And the continuing duty to supervise a trust strategy might give rise to a physician's analogous duty to practice comprehensive preventative care rather than the episodic, acute level care that costs the American health care system so dearly.

So why then has trust law not been used to resolve these health law problems? The answer is because the physician-patient relationship is not ordinarily considered a trust.¹⁵⁶ Many duties commonly ascribed to trustees simply make no sense in the physician-patient context. The duties concerning the trustee's use or purchase of trust property, keeping accounts, enforcing claims, defending actions against the property, keeping trust property separate, and making distributions from trust income and principle are all central to the trustee's obligations, but have no application to a relationship between a provider and consumer of health care services.

Though all trusts are fiduciary relationships, all fiduciary relationships are not trusts; specifically, the physician-patient relationship is a fiduciary relationship that is not a trust. Core to the concept of a trust is that the trust is, above all, "most frequently a method of disposing of property."¹⁵⁷ Patients dispose of no property when they place themselves in a physician's care. Physicians treating

156. While the relationship for medical treatment between a physician and patient is not ordinarily a trust, a patient can enter into a transaction with a physician to create a standard trust agreement. These transfers come under close scrutiny by the courts. In *Unruh v. Lukens*, 31 A. 110 (Pa. 1895), for example, a patient transferred property in trust to a physician who asserted the transfer was valid consideration for medical services rendered. However, the court cited the confidential relationship between the physician and patient and set aside the elderly woman's conveyance of real estate to doctor as trustee. *Id.* at 113-14. See also *Macaulay v. Booth*, 128 P.2d 386 (1942) (finding trust ultimately not set aside because defendant doctor overcame the presumption of undue influence).

157. RESTATEMENT (THIRD) OF TRUSTS §1 (2003).

patients do not take ownership interest in any property belonging to patients, whether the property is regarded as tangible or relational.¹⁵⁸ It is vital to put an end to any speculation that the physician is a fiduciary because the physician acts as a patient's trustee; in doing so, it puts an end to applying the law of trusts to the medical treatment relationships that arise between a physician and her patient. Simply put, trust law does not fit.¹⁵⁹

Indeed, some courts, including the United States Supreme Court, have mistakenly imported duties that pertain to trusts in order to guide their decision making about non-trust, medical fiduciary relationships.¹⁶⁰ This error causes confusion.¹⁶¹ For example, a Missouri court concluded that fiduciary law prohibited a plaintiff's treating physician from becoming the defendant's examining doctor in a personal injury trial.¹⁶² This conclusion may be correct on its face, but the underlying reasoning is faulty. The Missouri court rested its view on the assertion that a physician may not create a "dual allegiance" that violates

158. *Id.* § 40. Because no law limits the form or type of property interest that may be held in trust, one might reason abstractly that a patient's health and body are a form of property but it would be very difficult to find any support for this abstraction in the scholarly literature much less in reality.

159. "Although an agent has a fiduciary relationship with the principal, just as a trustee has with the trust beneficiaries, the two relationships have a different history, and different consequences flow from them." SCOTT ET AL., *supra* note 140, §2.3.4.

160. *See, e.g.*, *Pegram v. Herdrich*, 530 U.S. 211, 224 (2000) (referencing the common law of trusts to define the scope of authority and responsibility of fiduciaries, including the medical fiduciary in *Pegram*) (citing *Cent. States, Se. & Sw. Areas Pension Fund v. Cent. Transp., Inc.*, 472 U.S. 559, 570 (1985)); *id.* (listing the stricter "morals of the market place" and general duties owed by trustees to describe duties owed by medical fiduciaries) (quoting *Meinhard v. Salmon*, 249 N.Y. 458, 464 (1928)).

161. Following the *Pegram* decision, several lower courts have had difficulty trying to follow the Supreme Court's erroneous reliance on trust law in health care cases. In *Batas v. Prudential Ins. Co. of Am.*, 281 A.D.2d 260 (2001), for example, the court tried to make sense of the error by substituting the term "duty of good faith" for the term "fiduciary duty," in order to describe situations where ERISA insurers and HMO's have disclosure obligations to patients. *Id.* at 262.

162. *State ex rel. McCloud v. Seier*, 567 S.W.2d 127 (Mo. 1978).

the duty of “undivided loyalty to his patient.”¹⁶³ In today’s health care market, this simply cannot be right. Physicians reimbursed by third-party payers necessarily encounter a dual allegiance to patients and insurers. The magnitude of the legal error that results from misunderstanding this fact is huge considering the overwhelming prevalence of third-party payers in the American health care market. In 2008, for example, 88% of all Americans’ health expenditures were paid by third-party sources.¹⁶⁴ Simply put, any fiduciary law model that does not allow for divided loyalty by providers who care for patients, but are paid by their third party insurers, has no application whatsoever to modern health care delivery in America.

Beyond the confusion caused by the erroneous reliance on trust law in health care cases, this mistake also prevents a full, accurate application of the appropriate fiduciary rules that apply to acknowledged fiduciary relationships in health care. This problem is illustrated in *Pegram v. Herdrich*, where the Supreme Court brought its fiduciary analysis of the defendant HMO’s duties to a screeching halt after wrongly citing the law of trusts:

Beyond the threshold statement of responsibility, however, the analogy between ERISA fiduciary and common law trustee becomes problematic. This is so because the trustee at common law characteristically wears only his fiduciary hat when he takes action to affect a beneficiary, whereas the trustee under ERISA may wear different hats.¹⁶⁵

In addition to truncating its analysis and creating confusing precedent, the most harmful fallout from the *Pegram* Court’s incorrect reliance on trust law is the impediment this mistake erects to clearly understanding

163. *Id.* at 128; see also *Hammonds v. Aetna Cas. & Sur. Co.*, 237 F. Supp. 96 (D.C. Ohio 1965) (explaining that confidences in the trust of a physician are entitled to the same consideration as a *res* in the control of a trustee).

164. See *The Nation’s Health Dollar, Calendar Year 2009: Where it Came From*, CENTERS FOR MEDICARE & MEDICAID SERVICES, NAT’L HEALTH EXPENDITURE DATA, <https://www.cms.gov/NationalHealthExpendData/downloads/PieChartSourcesExpenditures2009.pdf> (last visited Aug. 14, 2010). See also *Health, United States, 2009*, NAT’L CENTER FOR HEALTH STATISTICS, 55 fig.21, 132 tbl.132, <http://www.cdc.gov/nchs/data/hus/hus09.pdf> (last visited Apr. 28, 2011) [hereinafter *Health, United States, 2009*].

165. *Pegram*, 530 U.S. at 225.

the full range of health care interactions beyond the physician-patient relationship that are accurately described and controlled by fiduciary law.¹⁶⁶

The *Pegram* case is too complex and implicates too many policy considerations to simply conclude from the Supreme Court's analytical error that the outcome in that case would or should have been different had the Court applied the appropriate body of fiduciary law. However, it is clear that fiduciary law may only be useful to organize American health care relationships if courts, legislators, and other analysts realize that a one size body of fiduciary law does not fit all fiduciary relationships.

2. *Physicians as Agents.* Just as the trust is the paradigmatic fiduciary arrangement, the physician-patient medical treatment interaction is the prototypical agency relationship. The principal-agent relationship is another fiduciary relationship; it is also the form of fiduciary relationship that correctly defines the transaction that results when a patient entrusts her health care to a

166. Ironically, when the *Pegram* Court cited the role of the "traditional trustee" to discard its application of fiduciary obligations to the defendant HMO, the Court favorably made comparison to a fiduciary relationship in agency law. *Id.* at 225. The Court compared the role of employers as fiduciaries who could act in their own interests even when acting as fiduciaries for employees. But not once did the *Pegram* Court consider that agency law was the proper body of fiduciary law to apply to health care organizations even though the law of agency in fact controls employers and employees even in the very example the Court used:

Speaking of the traditional trustee, Professor Scott's treatise admonishes that the trustee "is not permitted to place himself in a position where it would be for his own benefit to violate his duty to the beneficiaries." 2A Scott § 170, at 311. Under ERISA, however, a fiduciary may have financial interests adverse to beneficiaries. Employers, for example, can be ERISA fiduciaries and still take actions to the disadvantage of employee beneficiaries, when they act as employers (e.g., firing a beneficiary for reasons unrelated to the ERISA plan), or even as plan sponsors (e.g., modifying the terms of a plan as allowed by ERISA to provide less generous benefits). Nor is there any apparent reason in the ERISA provisions to conclude, as Herdrich argues, that this tension is permissible only for the employer or plan sponsor, to the exclusion of persons who provide services to an ERISA plan.

Id. at 225.

physician. In other words, the physician becomes the patient's agent. This is confirmed in the opening pages of Pratt and Zeckhauser's seminal work on agency law where the authors lay the foundation for what I call the fiduciary medicine model: "Whenever one individual depends on the action of another, an agency relationship arises. The individual taking the action is called the agent. The affected part is the principal. In common parlance, the doctor is the agent, the patient is the principal."¹⁶⁷

The agency relationship appeared in American law near the end of the eighteenth century and continues to be omnipresent in the business context. It explains and regulates relationships between corporate directors and shareholders, employees and employers, and unions and laborers.¹⁶⁸ But agency law only began to be applied regularly to physicians and patients in the twentieth century.¹⁶⁹ The first principle of the fiduciary medicine model is that it is the agency form of the fiduciary relationship that primarily should guide the analysis of health care treatment interactions between all forms of medical providers and patients.

Agency is a form of fiduciary relation. It results when one person consents to act on behalf of another, subject to her control.¹⁷⁰ To create an agency relationship, parties must agree to an arrangement under which one—the agent—will act as a representative of the other—the principal—and the latter will agree to entrust his affairs to the former. There need be no contract. However, the principal must have the right to control the agent's conduct with respect to the matters entrusted to her.¹⁷¹ Conversely, the agent has a duty to act.

167. John W. Pratt & Richard J. Zeckhauser, *Principals and Agents: An Overview*, in *PRINCIPALS AND AGENTS: THE STRUCTURE OF BUSINESS* 2 (John W. Pratt & Richard J. Zeckhauser eds., 1985).

168. Frankel, *supra* note 138, at 795.

169. *See id.* at 795-96.

170. RESTATEMENT (THIRD) OF AGENCY §1.01 (2006).

171. *Id.* § 14. But compare principals and agents to masters and servants. Both appear in the health care context. In some agency relationships, the principal may not have direct control over the agent outside of the matter in which the agent is acting on his behalf, as when an independent salesman serves as an agent for a store owner or an emergency room physician who is an independent contractor acts as an agent of the hospital under a contract to staff

Both trusts and agencies are fiduciary relationships. However, they are distinguishable in four fundamental ways.¹⁷² First, in agency the fiduciary agent is subject to the principal's control, while in a trust, the fiduciary trustee is not subject to the beneficiary's control but only to the obligation to deal with the trust property in accordance with the terms of the trust.¹⁷³

Second, an agent usually does not have title to the principal's property although he may be entrusted with the job of passing title to the principal's property as in a sale.¹⁷⁴ However, a trustee holds legal title to the property that is the subject of the trust as a result of a transfer of property that creates the trust in the first place.

Third, the law imposes different liabilities on fiduciary agents than it places on fiduciary trustees.¹⁷⁵ For example, agents may bind principals to liability in contract and tort while acting within the scope of their agency, while trustees have no power to bind beneficiaries.¹⁷⁶ However, agents do not bear the burden of liabilities imposed by law on property owned by their principals, while trustees, not beneficiaries, do have the legal liability of property owners.¹⁷⁷ Thus, it is the trustee, not the beneficiary, who must bring action to recompense injuries to trust property, while in contrast the principal, not the agent, must bring an action for injuries against the principal's property.¹⁷⁸

Finally, an agency relationship is terminable at will by either the principal or agent, and generally ends upon the death of either party.¹⁷⁹ The trust relationship usually is not terminable at will by the beneficiaries or the trustee; this relationship survives the death of any of these parties

the emergency department. However, where the principal has direct control over every aspect of the agent's work, the principal is a master and the agent is a servant. *See* RESTATEMENT (THIRD) OF AGENCY §1, cmts. d, e (2006).

172. *See generally* SCOTT ET AL., *supra* note 140, §2.3.4 at 62-67.

173. *Id.* at 62.

174. *Id.*

175. *Id.* at 62-63.

176. *Id.*

177. *Id.* at 63.

178. *Id.*

179. *Id.*

unless the terms of the trust provide otherwise.¹⁸⁰ Notwithstanding the fact that the law will allow a settlor to reserve the right to revoke a trust, even this revocation will not serve to make the relationship “a mere agency.”¹⁸¹

Agents and trustees share several fiduciary duties and obligations that are directly applicable to the physician-patient relationship. The law imposes on agents a similar fiduciary duty “to act loyally for the principal’s benefit” in all matters connected with the agency relationship.¹⁸² Agents are responsible to subordinate their own interests and the interests of third parties to the interests of their principals.¹⁸³ The agent may not acquire “a material benefit” for himself in an action taken on behalf of the principal, may not compete with the principal himself, and may not assist others in competing with the principal.¹⁸⁴ Where there is property as the subject of the agency, the principal’s property may not be used for the benefit of either the agent or third parties.¹⁸⁵ Agents do not hold title to the principal’s property; thus, the agent has a duty to handle the property so that it is apparent that the property owner is the principal and not the agent.¹⁸⁶ The agent must segregate and not commingle the principal’s property, and must keep accounts to report all transactions involving the property.¹⁸⁷ However, these duties are subject to any agreement the principal and agent reach together.¹⁸⁸

The agent, like the trustee, owes a duty of confidentiality in communications,¹⁸⁹ and owes the principal the duty to act with the care, competence, and diligence usually exercised by agents in comparable situations.¹⁹⁰ The

180. *Id.* at 64.

181. *Id.*

182. RESTATEMENT (THIRD) OF AGENCY § 8.01 (2006).

183. *Id.* §§ 8.01-8.05 (defining duty of loyalty).

184. *Id.* §§ 8.02, 8.04.

185. *Id.* § 8.05(1).

186. *Id.* § 8.12(1).

187. *Id.* § 8.12(2).

188. *Id.* § 8.12 (“An agent has a duty, *subject to any agreement with the principal.*”) (emphasis added).

189. *Id.* § 8.05(2).

190. *Id.* § 8.08.

agent's duty of care, competence, and diligence may emanate from the common law, statutes, regulations or contractual agreements, but agency law, unlike the law of negligence, does not depend on reference to a reasonableness standard to define this duty.¹⁹¹ Also, an agent's duty may be modified by contract and a principal may consent to permit conduct that would otherwise breach the agent's duty of care.¹⁹² An agent owes the principal a duty to act reasonably and avoid engaging in conduct that will likely damage the principal's enterprise or reputation.¹⁹³ It is said that the agent owes a "duty of good conduct."¹⁹⁴ Courts speak in terms of what is reasonable¹⁹⁵ and material¹⁹⁶ to disclose when they are describing the agent's duty to provide information. However, the agent's fiduciary duty of disclosure differs from the negligence duty because of the impact that agreements between the principal and agent can have on shaping that duty.¹⁹⁷ Principals may agree to limit the scope of an agent's duty to disclose, or to expand it.¹⁹⁸ In fact, the Restatement says that it is really the extent and nature of the principal-agent relationship that defines the scope of the agent's duty to disclose.¹⁹⁹

191. *See id.* § 8.08 & cmt. b.

192. *See id.* § 8.12 cmts. b,c.

193. *Id.* § 8.10.

194. *Id.*

195. *See, e.g.,* Rookard v. Mexicoach, 680 F.2d 1257, 1263 (9th Cir. 1982) (explaining that the scope of a travel agent's duty of disclosure is limited to what is reasonable under the circumstances).

196. *See, e.g.,* United States v. Schwab, 88 F. Supp. 2d 1275, 1286-87 (D. Wyo. 2000) (holding that an insurance agent's duty was to disclose material information to insurance company deciding whether to issue life insurance policies).

197. *See generally* RESTATEMENT (THIRD) OF AGENCY § 8.06 (2006).

198. *See* Jones v. Jackson Nat'l Life Ins. Co., 819 F. Supp. 1372, 1381 (W.D. Mich. 1993), *aff'd*, 27 F.3d 566 (6th Cir. 1994) (holding that where a principal-agent relationship was created by contract, that contract precluded the application of "general principles of agency law"). *But cf.* RESTATEMENT (SECOND) OF AGENCY § 381 cmt. a (1958) (citing First Nat'l Bank of Mandan v. Larsson, 271 N.W. 289, 291 (N.D. 1937)) (holding that even if an agreement was for an agent to collect debt only, the agent should disclose information obtained in collecting debt that makes it important for the principal to take immediate legal action).

199. RESTATEMENT (THIRD) OF AGENCY § 8.11 cmt. c (2006).

The law of agency also defines the reciprocal duties that a principal owes to the agent.²⁰⁰ Some mirror the duties just described as obligations of the agent but they are not fiduciary duties generally. For example, a manufacturer of home health products that employs a salesman as its agent owes its employee a fiduciary duty to deal fairly during employment contract negotiations because the clinic is the employee's agent.²⁰¹ A reciprocal duty requires the employee principal to reveal important information to the agent, such as known financial risks,²⁰² and also requires the principal to refrain from conduct that will injure the manufacturer's reputation and business.²⁰³

Certainly, this summary of the structure and obligations that attend the agency relationship is not intended to be comprehensive. Instead, this overview serves the purpose of distinguishing the agency form of fiduciary relationship that is relevant to physicians and patients, and then, based on that distinction, identifying the specific legal rules that define the agent's fiduciary duties owed in the medical treatment interaction. The next step in this analysis acknowledges that all providers in American health care are not individual physicians. Indeed, the fiduciary model ably accommodates the variety of institutional providers, some of which deliver health care in the managed care setting. Managed care organizations, health plans, and even the new ACOs created by the ACA can deliver health care through a single entity that delivers and finances medical care. Especially in light of the new organizational landscape created by the ACA, the fiduciary

200. *See id.* §§ 8.13-8.15.

201. *See id.* § 8.13 cmt. b.

202. *See Metro. Enter. Corp. v. United Techs. Int'l Corp.*, 2005 WL 2300382, at *9 (D. Conn. 2005) ("The relationship between principal and agent is confidential and fiduciary, and under this relationship, an agent owes his principal a full duty of disclosure. A principal, on the other hand, has the obligation to exercise good faith in the relationship and to disclose facts which, if known, would likely cause the agent to suffer pecuniary loss.") (quoting *McLendon v. Ga. Kaolin Co.*, 782 F. Supp. 1548, 1563 (M.D. Ga. 1992)).

203. RESTATEMENT (THIRD) OF AGENCY § 8.15 cmt. d (2006); *see also Taylor v. Cordis Corp.*, 634 F. Supp. 1242, 1247 (S.D. Miss. 1986) (explaining that the corporation principal, as part of a duty of good faith, would have to inform sales agents of problems with products when there was a "concomitant threat to the professional reputation of the sales agent").

care model must address the legal rules that govern providers well beyond the paradigmatic physician. The model must address provider organizations and networks that both deliver and finance health care services because these providers are fiduciaries, but they are not mere agents. The next section explains this important distinction to further refine the fiduciary medicine model.

3. *Health Plans as Trustees.* Remarkably, the simple step of defining agency as the form of fiduciary relationship that applies to the provider-patient relationship has a powerful and far-reaching corrective impact. But while this step distinguishes fiduciary relationships within the health care context, it does not erase the diversity of those fiduciary relationships. Identifying that the fiduciary relationship between a physician and patient is an agency relationship and not a trusteeship provides much of what health law scholars have found lacking in the fiduciary doctrine over the past twenty-five years. Recall, for example, that Mark Hall found the explanatory and enforcement powers of fiduciary law “highly indeterminate, despite its syllogistic mode, because fiduciary law does not consist of an integrated body of concrete rules or precise doctrine that applies uniformly to all forms of fiduciary relationships.”²⁰⁴ Hall was right. No monotheism called “fiduciary law” could possibly fit all forms of medical relationships uniformly. In fact, some health care relationships are properly characterized as, and analogized to, trustee arrangements.

The law of trusts correctly describes those fiduciary relationships in health care that involve the disposition of property.²⁰⁵ The clearest case in point is the position occupied by health plan administrators charged with paying medical claims from a corpus of invested premiums that are effectively held in trust to pay medical claim benefits. Plan administrators collect, invest, and hold premiums as property in order to pay medical claims from those invested funds. Thus, a health plan administrator acts as a fiduciary trustee for the benefit of enrollees or subscribers to the health plan.

204. Hall, *supra* note 102, at 490.

205. See RESTATEMENT (THIRD) OF TRUSTS §§ 1-2 (2003).

In *Firestone Tire & Rubber Co. v. Bruch*, the United States Supreme Court addressed “the appropriate standard of judicial review of benefit determinations by fiduciaries or plan administrators under ERISA.”²⁰⁶ Applying *Firestone* to resolve the conflict of interest that arises when an employer-sponsored disability insurance plan administrator is responsible both for determining a beneficiary’s eligibility and paying benefits on claims, the Supreme Court in *Metropolitan Life Insurance Company v. Glenn* concluded that:

In “determining the appropriate standard of review,” a court should be “guided by the principles of trust law”; in doing so, it should analogize a plan administrator to the trustee of a common-law trust; and it should consider a benefit determination to be a fiduciary act (*i.e.*, an act in which the administrator owes a special duty of loyalty to the plan beneficiaries).²⁰⁷

The *Metropolitan Life* Court affirmed the decision to set aside the insurer’s denial of long-term disability benefits based in part on an analogy to trust law.²⁰⁸

Metropolitan Life confirms that health plan administrators occupy a fiduciary role in making coverage decisions and their role is analogous to the role of a trustee.²⁰⁹ The four factors identified earlier to distinguish agency from trust arrangements apply here to distinguish providers who act as agents in a medical treatment relationship, from providers who act as trustees in administering health plan coverage decisions.²¹⁰ First, health plan administrators are obligated to exercise their discretionary authority to make coverage determinations in accordance with the terms of the health plan contract, but they do not fall under the direct control of plan beneficiaries or even employer-sponsors in making those decisions.²¹¹ Second, the plan administrator holds title to the premiums that enrollees pay.²¹² The plan administrator uses the funds

206. 489 U.S. 101, 105 (1989).

207. 554 U.S. 105, 110, 111 (2008) (quoting *Firestone*, 489 U.S. at 111-13).

208. *Id.* at 112-13, 119.

209. *Id.* at 111.

210. See SCOTT ET AL., *supra* note 142, § 2.3.4 at 62-67; *supra* pp. 755-56.

211. See *supra* pp. 755-56.

212. See *id.*

to invest and pay benefits to satisfy claims. These invested premium funds constitute the property a health plan patient transfers to her provider. Third, the plan administrator, unlike an agent, cannot bind employers or employees in contract or tort while operating within the scope of its fiduciary obligations.²¹³ In *Metropolitan Life*, the plan administrator was entitled to Social Security benefits as a collateral source of compensation for the benefits it paid.²¹⁴ But the facts of this case reveal that only the beneficiary could claim the funds from the Social Security Administration, though the funds were ultimately paid to the trustee administrator.²¹⁵ On the other hand, the trustee administrator, not the beneficiaries in *Metropolitan Life*, would bear the legal liability of any losses or encumbrances that might burden the invested funds.²¹⁶ Finally, although an agency relationship is terminable at will by either party and generally ends on the death of the principal or the agent, the trust relationship established by the health plan contract would survive the death of a beneficiary, as would the duty to cover a claim arising from medical care delivered before the beneficiary's death.²¹⁷

In summary, the *Metropolitan Life* decision illustrates the relevance of the law of trusts to regulate certain relationships between patients and health plan providers.²¹⁸ Moreover, the case provides the second principle upon which to build an accurate fiduciary medicine model—the fiduciary medicine model applies agency law to govern provider relationships that involve only the delivery of health care services, while the model applies the law of trusts to those health care relationships that accomplish the disposition of property. Whether acting as agents or trustees, most major stakeholders in America's new health care delivery and financing system will operate in a fiduciary capacity. However, the majority of fiduciary relationships operating in American health care, and the majority of those likely to emerge from implementation of

213. *See id.*

214. *Metropolitan Life*, 554 U.S. at 109.

215. *See id.*

216. *See supra* pp. 755-56.

217. *See id.*

218. *See Metropolitan Life*, 554 U.S. at 112-13.

the ACA, are best described as agency, *not* trust fiduciary relationships. The next section explains why.

B. *Beyond Physicians and Patients*

The explanatory strength of the fiduciary medicine model increases exponentially when agency law is applied beyond cases involving individual physician-patient or insured-insurer relationships, to other health care interactions. A series of complex and overlapping agency relationships comprise the American health care system and, as discussed earlier, are likely to proliferate under the ACA.²¹⁹ Moreover, the ACA considerably expands the government's financial role in regulating and sustaining health care markets.²²⁰ Beginning in 2013, the federal government will subsidize access to private health insurance markets through premium assistance tax credits.²²¹ The federal government will pay for expansion of the public insurance market as well; from 2014 to 2020, the government will cover between 90% and 100% of the cost of extending Medicaid to childless adults with incomes up to 133% of the federal poverty level.²²²

When the ACA is fully implemented, the state and federal governments will be the most influential fiduciary

219. *See supra* Section I, text accompanying notes 19-24. The two most prominent expansions will be through statewide entities that will market insurance and new, integrated provider organizations; both will introduce numerous new market players. Under Sections 1301-1321 of the ACA, each state must create or join insurance exchanges that will market and regulate insurance. Patient Protection and Affordable Care Act, 42 U.S.C.A. §§ 18021-18024, 18031-18033, 18041 (West Supp. 2010). Section 3022 introduces Accountable Care Organizations ("ACOs"), new provider organizations that will receive incentives to encourage them to take advantage of shared savings. *Id.* § 1395jjj.

220. *See supra* Section I, text accompanying notes 26-40.

221. 26 U.S.C.A. § 36B (West Supp. 2010).

222. *See* BARRY FURROW ET AL., HEALTH CARE REFORM SUPPLEMENT TO HEALTH LAW CASES, MATERIALS AND PROBLEMS 146-47 (6th ed. 2010). The Congressional Budget Office has estimated that sixteen million new recipients will be eligible to receive Medicaid coverage, at an estimated cost to the federal government of \$434 billion between 2010 and 2019, and \$20 billion to the states during the same period. *Id.*; *see also* *Medicaid and Children's Health Insurance Program Provisions in the New Health Reform Law*, KAISER FAMILY FOUNDATION 1-2 (Apr. 6, 2010), <http://www.kff.org/healthreform/upload/7952-03.pdf>.

actors in the complex network of agency relationships that will deliver, finance, and regulate health care in America. In this role, government entities will be responsible to represent two principals: the American patient population and the American public generally.²²³ I assert that the rules and procedures that govern fiduciary relationships provide the best legal regime to order the new organizational structures introduced under the ACA and monitor the expanded role that state and federal governments will occupy. The following hypothetical scenario is illustrative.

1. *Mercy Medical Hospital—A Managed Care Scenario.* In the new health care landscape, a single institution can be simultaneously involved in a complex network of relationships; in some of these relationships, an institution serves as principal, while in others, it serves as agent. To sketch out a few of these relationships—imagine a single fictional hospital. Call it Mercy Medical Hospital (“Mercy Medical”). Mercy Medical stands in an agency relationship as principal to many who provide health care on its premises. Mercy Medical acts as a principal on behalf of its directly-hired employees, such as nurses and lab technicians, and operates as a principal with respect to the independent contractor physicians who provide in-house services, such as radiologists, hospitalists, and emergency department physicians. In the agency relationship between Mercy Medical and other physicians—the surgeons and internists with admitting privileges at the hospital—Mercy Medical typically has less control. Nevertheless, the law may hold Mercy Medical responsible as a principal for the negligent acts of any of these physicians if the hospital exercises sufficient control over them in these agency relationships.²²⁴ By enforcing quality assurance standards, conducting peer review hearings, or imposing privileging restrictions, Mercy Medical may not only act as the principal to these physicians, but also as an agent for patients who expect high quality medical services from the hospital.

223. See THOMAS E. GETZEN, HEALTH ECONOMICS: FUNDAMENTALS AND FLOW OF FUNDS 349 (1997).

224. See, e.g., *Sampson v. Contillo*, 865 N.Y.S.2d 634, 637-38 (App. Div. 2008) (holding that a genuine issue of fact existed as to whether the hospital had an agency relationship with a radiologist, and that the issue of fact precluded granting summary judgment to the hospital).

In its relationships with members of the health care network outside the hospital, Mercy Medical may have further agency responsibilities. Mercy Medical may be in a contractual relationship with a health plan or insurer. In this case, Mercy may implement quality assurance and utilization reviews to discharge its responsibility as an agent of the payers who set cost containment objectives to control reimbursements to the hospital for patient care. As a result of the ACA, Mercy Medical is likely to participate in an ACO, for example, in which it contractually links itself with other providers to serve Medicare and privately-insured patients using integrated evidence-informed medical systems, comprehensive patient care bundling, and salary-based payment systems.

If Mercy Medical is a private, for-profit institution, the hospital then owes a fiduciary obligation to its shareholder principals.²²⁵ However, if Mercy Medical is a non-profit hospital, it owes a fiduciary duty to the foundation or charity that has organized the hospital under its charter or founding documents, and quite possibly even to the

225. Professors Mark Loewenstein and William Wang question the wisdom of holding out a corporate entity as an agent of its shareholders. See Mark J. Loewenstein & William K.S. Wang, *The Corporation as Insider Trader*, 30 DEL. J. CORP. L. 45, 47-53 (2005). They point out that courts have reached mixed results on the question of whether a corporation owes a fiduciary duty to individual shareholders who have competing interests and no direct control over corporate directors. *Id.* at 48. Because of the overwhelming consensus in literature and common law, the lesson I take from the insightful analysis by Professors Loewenstein and Wang is that agency relationships are not uniform. Principals have varying degrees of control over the agents who act on their behalf. Multiple principals may have competing interests among themselves and even interests that conflict with their agents to some degree. In closely-held corporations, corporate directors (who are often majority shareholders) may owe a higher fiduciary responsibility to shareholders than is owed to those in a larger entity. See, e.g., *Crosby v. Beam*, 548 N.E.2d 217, 221 (Ohio 1989); *Hagshenas v. Gaylord*, 557 N.E.2d 316, 324 (Ill. App. Ct. 1990). A hospital with significant control over staff radiologists may be held vicariously liable for those doctors' negligence, while the same hospital may have considerably less control over a multi-specialty group of doctors who work at the hospital as independent contractors. See *Sampson*, 865 N.Y.S.2d at 637. The latter group may be comprised of physicians with conflicting interests and the hospital may not have an employment contract with any of them, but an agency relationship can still exist between the hospital and these doctors if the elements of the law of agency are satisfied. See *id.* In sum, neither the number of principals, the diversity of their interests, nor the fact that their control over their representative is indirect dispositively precludes a finding that agency exists.

government which has forgone tax revenue in order to support its non-profit status.²²⁶ If Mercy Medical is a publicly-owned hospital, then it is reasonable to conclude that its agency obligations run to the municipality or government that chartered the hospital, and ultimately to the people who pay taxes to support its services. In all these relationships, Mercy Medical simultaneously acts as an agent of the patients who use its facilities; it is, at bottom, a provider of medical care. Moreover, agency theory allows us to conceive of the host roles that Mercy Medical and other actors in health care occupy as both agents and principals. Home health agencies, skilled nursing facilities, nursing homes, and pharmaceutical companies all owe some level of fiduciary duties as agents, sub-agents, and dual-agents to one another and to the patients they ultimately serve.

This network of relationships would benefit from clear and predictable rules of agency law to organize the discharge of these fiduciary duties in health care interactions. This is the work of the fiduciary medicine model. Health economists have been unraveling the structure of these organizational relationships for over forty-five years, and a brief look at their literature sheds considerable light on the network of health care relationships that agency law can order.²²⁷ The ubiquity of agency relationships in our health care system is not news to health economists who have used economic tools to describe this phenomenon for years. While it is beyond the scope of this Article to comprehensively explore that literature in light of the understandings about medical agencies developed here, a brief look at basic economic agency theory is a worthwhile exercise for our purposes.

One cautionary note is in order before turning to the economic literature. I employ the analytical tools offered by health economists as descriptive assets, not normative ones. My purpose for looking at the basic principles of agency theory as applied to health care agencies is to organize the relevant legal relationships and provide a systematic way of

226. See *Lukes v. Dep't of Pub. Welfare*, 976 A.2d 609, 622-24 (Pa. Commw. Ct. 2009) (finding that agreements between a nonprofit health plan and the state were products of an agency relationship).

227. The seminal work in this field was written in 1963. See Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963).

identifying some of the operational questions that these agency relationships raise. For example, while most health economists would probably agree about the centrality of the agency relationship,²²⁸ there is disagreement about: “(a) who the decision maker is and (b) whether there is more than health in the patient’s utility function.”²²⁹ Indeed agency in health economics seems very much a descriptive technique rather than an analytical tool.

The essential point to be taken here is that the economists’ agency theory is not used to suggest, much less choose, between a market or government, public or private, contractarian or egalitarian solution to the questions of how to organize a health system. In fact, I affirmatively disavow the ability of these analytical tools to make such a choice. The single most important conclusion to draw from this analysis is that patients remain the driving principals at the core of all health agency relationships. Therefore, the important work of deciding what solutions should apply to the conflicts that arise in agency relationships must focus on the best interests of the principal, who the law must support as the controlling decision maker in order to operate consistently with the fiduciary rules of agency. With this important caveat understood, a few basic observations provided by the economic literature are in order.

Economists have long accepted the concept of an agency relationship between a physician and a patient.²³⁰ More importantly, economists have identified and described the chief shortcoming of this and all other agency relationships—the problem of non-alignment.²³¹ Whereas “[t]he perfect agent physician is one who chooses as the

228. See Mandy Ryan, *Agency in Health Care: Lessons for Economists from Sociologists*, 53 AM. J. ECON. & SOC. 207, 207 (1994) (arguing that the concept of agency is widely accepted). *But cf.* Gavin Mooney & Mandy Ryan, *Agency Principles in Health Care: Getting Beyond First Principles*, 12 J. HEALTH ECON. 125, 125 (1993) (arguing that agency theory raises more questions than supplies answers when applied to physician-patient relations).

229. Gavin Mooney, *Communitarianism and Health Economics*, in THE SOCIAL ECONOMICS OF HEALTH CARE 40, 43-44 (John B. Davis ed., Routledge 2001).

230. See, e.g., SHERMAN FOLLAND ET AL., THE ECONOMICS OF HEALTH AND HEALTH CARE 206 (5th ed. 2007).

231. See generally Michael C. Jensen & William H. Meckling, *Theory of the Firm*, 3 J. FINANCIAL ECON. 305, 305-60 (arguing that separation of ownership and control leads to conflict of interest).

patients themselves would choose if only the patients possessed the information that the physician does,”²³² in reality it has been shown through empirical studies that physician and nurse preferences diverge from patient wishes, and that the agency itself is not perfect.²³³ When conflicts of interest arise, physicians do not always act in a patient’s best interest; ensuring that physicians do so through contractual means is not always possible.²³⁴ Moreover, the problem of physicians acting as agents is exacerbated by their role as agent for a second principal—the payer.²³⁵

Dranove and White catalogued the now-classic list of problems that arise when agents’ interests diverge from those of their principals in health care.²³⁶ The uncertainty of delivering health care is generally exacerbated where these problems prevail. Principals cannot adequately control the conduct of their agents because monitoring is either

232. FOLLAND ET AL., *supra* note 230, at 207.

233. See Einat Neuman & Shoshana Neuman, *Agency in Health-care: Are Medical Care-givers Perfect Agents?*, CTR. FOR ECON. POLICY RESEARCH (Discussion Paper Series No. 6612) (2007), www.cepr.org/pubs/dps/DP6612.asp. Using Discrete Choice Experiments, the authors evaluated the preferences of 323 women who had recently given birth with respect to privacy of rooms, attitude of staff, professionalism of medical staff, information availability, and travel time to the hospital, and then compared their preferences to thirty staff members of a large Israeli public hospital. *Id.* at 4-5. From the observed differences in these two groups’ preferences, the authors conclude that “[t]he clear empirical finding is that the agent has a biased perception of the principal’s preferences and therefore perfect agency does not exist. . . . [Therefore] [i]nforming the unaware medical care-givers about the patients’ preferences, will improve treatment and patients’ satisfaction.” *Id.* at 8.

234. See *id.*; Eduardo Bruera et al., *Patient Preferences Versus Physician Perceptions of Treatment Decisions in Cancer Care*, 91 J. CLINICAL ONCOLOGY 2883 (2001); Mark Ebell et al., *The Do-Not-Resuscitate Order: A Comparison of Physician and patient Preferences and Decision-Making*, 91 AM. J. OF MED. 255 (1991) (noting similarities and differences between physicians and patients in making DNR decisions).

235. “In the area of provider reimbursement, the provider, acting as an agent, faces two principals: the patients and, when there is health insurance, the insurers.” PHILIP JACOBS & JOHN RAPOPORT, *THE ECONOMICS OF HEALTH AND MEDICAL CARE* 148 (5th ed. 2004).

236. See generally David Dranove & William D. White, *Agency and the Organization of Health Care Delivery*, in II HEALTH ECONOMICS: CRITICAL PERSPECTIVES IN THE WORLD ECONOMY 233, 235-45 (Anthony J. Culyer ed., 2006).

impossible or prohibitively expensive. For example, the information asymmetry between the agent and the principal increases the transaction costs of monitoring and the likelihood that the agent will be an imperfect representative of the agent's interests.²³⁷ The agent may then squander the principal's resources and profits by allowing bias to influence purchasing decisions, investing lavishly in their own self-interest, acting too conservatively in avoiding risks the principal would rather take, or acting slothfully so as not to fully pursue the principal's priorities and interests.²³⁸ Additionally, patients incur a series of transaction costs associated with each of the providers who furnish medical care: search costs to determine the services needed, contracting costs to reach agreement as to the types and terms of these services and the agreed upon prices, and enforcement costs to ensure that they have met agreed performance objectives.²³⁹ Individual patients lack the information needed to make these transaction-related determinations, increasing the agency and transaction costs further. However, in the modern American health care delivery network, the agency relationships are attenuated by the fact that not only have networks of providers become complex and extended, but patients also have aggregated to form purchasing groups or classes of enrollees, beneficiaries, and subscribers. The fiduciary medicine model helps to organize the diversity of patient interests that characterize modern health care markets deeply penetrated by managed care organizations and the new provider groups that the ACA introduces. The next section explains how the fiduciary medicine model serves to align the diverse interests of large patient populations with their provider fiduciaries.

2. Patients as Enrollees, Subscribers and Beneficiaries.

The array of providers and payers that interact with patients in today's health care market do not encounter individual patients *qua* patients, but rather encounter and contract with patients as their agents in aggregate groups. In 2010, national managed care enrollment reached 135.4 million people; this meant that 43.8% of Americans are enrolled in managed care programs that operate as agents through Medicare and Medicaid payers, or private

237. *See id.* at 236.

238. *See id.* at 241-43.

239. JACOBS & RAPOPORT, *supra* note 235, at 87.

employers.²⁴⁰ These patients do not establish individual agency relationships with Managed Care Organizations (“MCOs”), but contract as groups with their agent organizations. Significantly, patients and their physician agents are increasingly less likely to be engaged in the one-on-one agency relationship that has provided the prototypical agency model.²⁴¹ Today, the patient in the fiduciary medicine model must be seen as a member of a group of principals that distantly controls many different providers through various agency and sub-agency arrangements that includes payers, managed care organizations, hospitals, insurers, health plans, long-term care facilities, home health agencies, pharmaceutical firms and physicians. MCOs create networks to serve aggregated groups of patients who seek services through employers or other aggregating institutions. Employers go into the market to obtain insurance products on behalf of groups of employees.²⁴²

The question of who can represent the patient understates the reality that the patient is an aggregated population. This population is comprised of the employed and the unemployed; citizens and aliens; adults and children; the wealthy, the poor, and those in between; the

240. *Managed Care Fact Sheets—National Statistics*, MCOL, <http://www.mcarcol.com/factshts/factnati.htm> (last visited Apr. 16, 2010); Paul Mackun & Steven Wilson, *Population Distribution and Change: 2000 to 2010*, U.S. CENSUS BUREAU (Mar. 2011), <http://www.census.gov/prod/cen2010/briefs/c2010br-01.pdf>.

241. Physician practice patterns have changed to meet the needs of the new provider environment. The number of solo practice physicians is declining, and physicians are aggregating into larger groups and providing care in multiple specialties. In 2004-2005, the proportion of physicians in solo or two-physician practices had decreased to 32.5%, down from 40.7% in 1996-1997. COUNCIL ON LONG RANGE PLANNING & DEV., AM. MED. ASSOC., *HEALTH CARE TRENDS 2008*, at 57 (2008). In 1996 physician practices with eleven or more physicians represented 15.6% of all office-based doctors. *Id.* By 1999, that percentage had increased to 18.5% of all office-based practices. *Id.* This trend of physicians concentrating within a single practice group increases the likelihood that physicians will share patients rather than remain in a single physician-patient relationship. Clearly, the physician-patient relationship that stands at the core of the agency model that we have been discussing up to this point has changed to a larger, more complex interaction.

242. Dayna Bowen Matthew, *Controlling the Reverse Agency Costs of Employment-Based Health Insurance*, 31 WAKE FOREST L. REV. 1037, 1038 (1996).

young and the elderly; the very healthy and the very ill; and those of different racial, cultural, and religious backgrounds. In other words, the patients who consume health care are a collective principal population with divergent and sometimes competing interests.²⁴³

These trends are precisely the phenomena Rodwin pointed to as the three sources of “strain” on the fiduciary metaphor.²⁴⁴ However, unlike Rodwin, I do not conclude that the future of the fiduciary model is dim.²⁴⁵ Instead, I propose to adopt a more comprehensive model of fiduciary obligations—one that fits the health care delivery relationships paradigmatically, viewing a full range of health care actors as agents of patient groups—to replace the garden-variety fiduciary that has ceased to fit today’s health care industry. To accomplish this transition, I offer economic agency theory as an apt descriptor to organize the complexity of the agency relationships that occur between networks of providers and financiers who supply medical goods and services, and the aggregated collections of consumers who directly and indirectly purchase health care services.

Dranove and White show how familiar agency costs are multiplied throughout the health care delivery system.²⁴⁶ In addition to the physician-patient agency relationship explored earlier, other health care providers, including hospitals, long-term care and skilled nursing facilities, home health agencies, managed care organizations, governments, and employers are also agents in our system.²⁴⁷ All of these providers operate as fiduciaries in their capacity as agents of the groups of patients that enroll, subscribe to, or are contractually named as beneficiaries to their services. To these patient populations, they owe the same duties of loyalty, disclosure, confidentiality, care, competence, and diligence as physicians do in their relationships with individual patients. Yet, whatever competing priorities physician agents face when providing

243. *Id.* at 1039.

244. Rodwin, *supra* note 70, at 253.

245. *Id.* at 255 (pointing to a growing scholarship advocating that we dispense with fiduciary obligations in favor of determining obligations by contract).

246. Dranove & White, *supra* note 236, at 239.

247. See JACOBS & RAPOPORT, *supra* note 235, at 148.

care to their individual patients are multiplied significantly when institutional providers seek to fulfill their fiduciary responsibilities to a large, diverse patient population. A closer look first at patient relationships with hospital providers, and then with payers such as managed care organizations, will provide two illustrations of the complexity of conflicting agency relationships that exist in serving patient groups.

Most hospitals proclaim that their primary concern is the patient.²⁴⁸ However, “this sort of general assertion does not address how prices are set, the trade-off between one group of patients and another (e.g., surgery or immunization, abortion or family planning clinics), or the trade-offs between employees and doctors.”²⁴⁹ The hospitals’ incentives are complicated further by the fact that each possible ownership structure will create another layer of agency relationships.²⁵⁰ Administrators of non-profit hospitals, now over 68% of hospital providers in the United States,²⁵¹ stand in an agency relationship representing their board of trustees, religious order, or governing foundation. By analogy, even those hospitals in America which are publicly owned may be considered agents of the governing locality that incorporated the hospital. The agency analysis extends to describe the non-profit hospital as a sub-agent of the government that has delegated the duty to provide health care to the indigent. For example, by enacting a favorable tax code, the government (acting as a principal) has delegated charitable care duties to non-profit hospitals to behave as agents in exchange for foregone tax revenues.²⁵² Whatever their ownership structures, hospitals, like every other provider-agent, are subject to the control of multiple

248. GETZEN, *supra* note 223, at 175.

249. *Id.*

250. *See id.* at 174-75.

251. *See Health, United States, 2010*, U.S. DEP’T OF HEALTH AND HUMAN SERVS., 372 tbl.113 (2010), <http://www.cdc.gov/nchs/data/hus/hus10.pdf> (last visited Apr. 10, 2011) [hereinafter *Health, United States, 2010*].

252. Fred Joseph Hellinger, *Tax-Exempt Hospitals and Community Benefits: A Review of State Reporting Requirements*, 34 J. HEALTH POL’Y & L. 37 (2009); *see also* James E. Tyrell, III, *Non-Profits Under Fire: The Effects of Minimal Charity Requirements Legislation on Not-for-Profit Hospitals*, 26 J. CONTEMP. HEALTH L. & POL’Y 373 (2010); L. Seaton et al., *Tax Exempt Hospitals and Community Benefit*, 21 HEALTH LAW 37 (2009).

principals. All these fiduciary relationships operate in tension with the hospital's professed commitment to "the patient above all." Yet, hospitals must declare allegiance to this priority in order to attract patients.

The agency framework highlights the way that third-party payers act as principals on behalf of patient groups using different payment systems to control hospitals in this setting.²⁵³ The payer's choice to contract for either retrospective or prospective reimbursement *per diem*, per case, or per admission reimbursement, or even the structure of fee schedules, is a reflection of the ways in which payers attempt to control hospitals and cause their interests to realign with the cost-minimizing priorities of the patient and the payer.²⁵⁴ Thus, when third-party payers are organized as MCOs, they may also be seen to function in dual roles as both a principal and an agent in each of these provider relationships. As principals, they seek to monitor and minimize the cost of delivering health care using gatekeepers, utilization reviews, pre-certification requirements, withholds, and other financial incentives.²⁵⁵ At the same time, because nearly 90% of MCO funds flow from employee benefit plans,²⁵⁶ MCO managers serve as agents acting on behalf of the employees who are, at bottom, the patients who drive the health care network. Yet these employees' interests may not always align with their employers who contract for their medical care.²⁵⁷ MCOs act as patients' agents when they create networks that employers (acting as patient sub-agents) can offer in lieu of wages to their employees.²⁵⁸ In these relationships, the patient-principals are faced with controlling the conduct of at least three layers of agents: their employers, the health plans with which they contract, and the providers engaged by managed care health plans. In order to minimize the

253. JACOBS & RAPOPORT, *supra* note 235, at 154-156.

254. *See id.*

255. Jennifer Arlen & W. Bentley MacLeod, *Malpractice Liability for Physicians and Managed Care Organizations*, 78 N.Y.U. L. REV. 1929, 1976 (2003); Dionne Koller Fine, *Physician Liability and Managed Care: A Philosophical Perspective*, 19 GA. ST. U. L. REV. 641, 647 (2003).

256. GETZEN, *supra* note 223, at 216.

257. Matthew, *supra* note 242, at 1037.

258. *See id.* at 1038.

deleterious impact of the divergence between patients' interests and the interests of each layer of agency, patients would ideally only pay plans to reimburse providers who delivered the desired health outcomes—for example, a cure for every malady. But of course this is impossible. Therefore, agency law can serve to realign the patients' interests as principals with the interests of their employers, providers, and third-party payers. This is the third principle of the fiduciary medicine model—the model provides substantive and procedural rules that re-align the diverse interests of patient groups who contract through their employers or other agents to obtain health care from integrated provider organizations.

The primary fiduciary responsible to deliver health care to American patients under the ACA is no longer the individual physician or even independently operating institutional firms, but instead providers acting as part of a network of agents, sub-agents, principals, and co-principals. This new fiduciary will no longer serve just an individual patient, but must act to coordinate services on behalf of a collective principal—the American patient population. The agency rules of law that make up the fiduciary medicine model can contribute a legal order to providers, patients, and payers that will clarify obligations, protect the responsible exercise of professional judgment, and incentivize the re-alignment of patient, payer, and provider interests. However, these rules are incomplete without considering the role of the manager responsible for creating, financing, and stabilizing the health care markets in which all other agents, trustees, and principles operate. This section has provided the third element of the fiduciary medicine model: fiduciary rules and procedure are suited to align the diverse array of interests and actors in the health care markets. The next section completes the fiduciary medicine model by explaining the quintessentially fiduciary role that government occupies in the health care market.

C. *The State as Fiduciary in Health Care*

The agency relationship is at the core of our democratic form of government.²⁵⁹ Organized originally to reflect the

259. David S. Law, *A Theory of Judicial Power and Judicial Review*, 97 GEO. L.J. 723, 723 (2009).

terms of corporate charters, each of the colonies evolved into sovereigns that ultimately ceded authority to the federal government to act on their behalf as an agent. I therefore extend the economic agency theory of the state, based on these historic facts, to explain that in passing the ACA, Congress acted within its fiduciary capacity as an agent to accomplish what the people of the United States could not accomplish independently, or could not accomplish well apart from their government. I argue that this legal authority is constrained by the ethical duties that accompany all fiduciary medical relationships. This section shows that the state operates as a fiduciary agent as a descriptive matter of history and positive law. Next, this section explores the normative force of this premise in the delivery of health care, particularly by showing that governments ought to be held to a fiduciary standard. This argument is supported first by analogical reasoning to show that the structure of other recognized fiduciary relationships—particularly those between physicians, other providers, and patients—are instructive. Then, I will demonstrate the strong empirical and pragmatic grounds for adding the relationship between the state, acting through governments, and its people to the category of agency relationships that provide health care to patients. I conclude this section by arguing that the fiduciary medicine model provides ample justification for the view that Congressional enactment of the ACA provided near-universal access to health care to discharge a fiduciary obligation of the state.²⁶⁰

1. *The Descriptive Case for the State as Fiduciary Agent.* The principal-agent relationship “lies at the heart of democratic government.”²⁶¹ In this form of government, the people stand in the office of principals, and delegate their power to government officials who are their agents. The people employ mechanisms such as their right to vote, participate in juries, and judicial review of government decisions to minimize agency costs that arise from self-dealing or when the interest of the government as agent

260. I am indebted to Drs. Paul Miller and Charles Weijer for the outline of my argument in this section; I found their argument persuasive in *Fiduciary Obligation in Clinical Research*, 34 J.L. MED. & ETHICS 424 (2006).

261. Law, *supra* note 259, at 723.

diverges from the interests of the people.²⁶² These roots of the democratic agency in American government predate the United States Constitution.

In the United States, constitutions arose first from the corporate charters that formed the governing documents for the trading companies that later became colonies. In each colony, the people constituted a governing body as an agency and granted, limited, and controlled the government's exercise of power through charters.²⁶³ "The colonists generally came to understand these corporate charters as 'constitutions' in the modern American sense—foundational political instruments constituting and limiting governmental power."²⁶⁴ From this nation's inception, "[l]ike corporate officers, government officials were merely agents of principals who had prescribed limits on the agents' power in the founding charter."²⁶⁵ From the perspective of its delegated power to provide for the common good, our state and federal governing bodies operate as corporate agencies, in which the people-principals have delegated the power to accomplish the goals of the sovereign.

Chief Justice John Marshall affirmed this agency relationship as one of "common sense" by declaring, "the whole political system is founded on the idea that the departments of government are the agents of the nation."²⁶⁶ Modern theorists have carried this foundational principle forward and described it as the doctrine of "popular sovereignty." In the words of Professor Carlos González, "[t]he central idea of popular sovereignty is that the people are the one and only sovereign in a civil society; as sovereign the people may cede governing authority to a constituted government, which is charged with the duty to pursue public-regarding policies."²⁶⁷ The corporate analogy to the governmental agency relationship has also remained

262. See Akhil Reed Amar, *The Bill of Rights as a Constitution*, 100 YALE L.J. 1131, 1132 (1991).

263. Akhil Reed Amar, *Of Sovereignty and Federalism*, 96 YALE L.J. 1425, 1432-33 (1987).

264. *Id.* at 1433.

265. *Id.* at 1434.

266. See Marshall, *supra* note 16, at 211.

267. Carlos E. González, *Reinterpreting Statutory Interpretation*, 74 N.C. L. REV. 585, 636 (1996).

apt over the centuries as Justice Iredell wrote in 1793, “[a]ny body politic (sole or aggregate) whether its power be restricted or transcendent, is in this sense ‘a corporation.’ . . . In this extensive sense, not only each State singly, but even the United States may without impropriety be termed ‘corporations.’”²⁶⁸ Professor Akil Amar notes that “[t]he analogy between corporate charters and political constitutions had profound implications.”²⁶⁹ Certainly, not all of the implications that result from the analogy were apparent to early colonial leaders, but the important point for this analysis is to appreciate the ubiquity of the corporate analogy that Professor Amar describes as having “seeped deep into the thought patterns of the men who would eventually label themselves Federalists in 1787.”²⁷⁰ The analogy remains pervasive today, according to Professor González:

Much as the law of agency or the law of trusts sets forth rules that guide and constrain corporate agents and trustees, under popular sovereignty theory constitutions, [statutes, and regulations] set forth rules guiding and constraining an agent/government. Ideally, a constitution [statute, or regulation] affords the agent/government enough power so that it may act for the good and betterment of the principal/people, but at the same time constrains the agent/government from engaging in self-dealing policies or policies at odds with the public interest.²⁷¹

To say that a state, acting through its constituted government, acts as the agent of its citizens is not to make a normative judgment about the manner or extent to which a government should intervene in the delivery of health care in order to accomplish the priorities of its people. Instead, the fact that government functions as an agent is a description of the most fundamental agency relationship relevant to the fiduciary medicine model. The observation that government functions as the agent of its citizens²⁷² may conjure up fears of governmental inefficiency, waste, or a

268. Amar, *supra* note 263, at 1433 (quoting *Chisholm v. Georgia*, 2 U.S. (2 Dall.) 419, 447 (1793) (opinion of Iredell, J.)).

269. *Id.* at 1433-34.

270. *Id.*

271. González, *supra* note 267, at 637 (statutory and regulatory references added).

272. *See* GETZEN, *supra* note 223, at 349.

political agenda as extreme as “socialized medicine.” Indeed, the American government could have acted as the people’s agent in reforming the health care system by completely taking over the production of health care goods and services, financing its endeavors by a tax disbursed through a single payer system, and regulating the cost of health care through a global budget. But clearly the American government did not take this socialized medicine approach under the ACA. Instead, the United States Congress acted in its capacity as agent to ensure that health care markets operate competitively and with as little interference as possible by enforcing all private agreements, facilitating the free flow of information among competitors and purchasers, and minimizing regulatory oversight.

The most important point here is not to advocate or advance a particular approach to the agency function that government performs. Instead, the goal is to correctly describe the government’s agency function so that the same legal tools available to manage all other agency relationships might also be considered to ensure that government will act in the furtherance of its principal’s objectives. Professor Getzen quotes Abraham Lincoln to describe “[t]he Role of Government” in the chapter of his health economics text by the same name: “To do for the people what needs to be done, but which they cannot, by individual effort, do at all, or do so well, for themselves.”²⁷³ My argument is that the fiduciary rules of agency provide legal support, justification, and even incentive for a decision by the American government to do for the American people what they as principals have determined needs to be done for patient populations, but which no individual patient or patient population can do well for themselves.²⁷⁴

2. *The Normative Case for the State as Fiduciary Agent.*

In order to determine whether, as a matter of principle, the relationship between the government and patients

273. *Id.* at 334.

274. It is beyond the scope of this article to explore the causes of action that may be brought against the state for breach of fiduciary duty owed to citizens. However, these actions are bound to arise if the fiduciary medicine model is adopted. Courts may be guided by the rich body of case law that describes lawsuits brought by Native Americans against the government to recover for breach of fiduciary obligations that the government owes in managing land. *See, e.g., Mitchell v. United States*, 664 F.2d 265 (Ct. Cl. 1981).

should be recognized as a fiduciary relationship, we can turn to statements about what a fiduciary relationship ought to accomplish. Professor Deborah DeMott's instrumentalist description of a fiduciary is a useful point of departure.²⁷⁵ In her landmark article, Professor DeMott set out to develop a general theory of the fiduciary obligation that would serve both a retrospective and a prospective purpose.²⁷⁶ First, DeMott sought to correct what she saw as an erroneous reliance on contract law to support previous theories of the fiduciary obligation,²⁷⁷ thus rejecting theories that described the fiduciary obligation as one characterized by voluntariness, entrustment, unjust enrichment, and dependency.²⁷⁸ Prospectively, DeMott articulated a general theory that provides the analytical grounds to justify identifying fiduciary relationships beyond the conventional categories.²⁷⁹ DeMott concluded that "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."²⁸⁰ A fiduciary relationship, then, is one in which discretion ought to be controlled by law. DeMott, it turns out, has indeed identified a normative characteristic of fiduciary relationships.

All fiduciary relationships are characterized by an inherent risk that the fiduciary might abuse the power entrusted to her/it, and that the mechanisms for defending against this abuse outside the law are inadequate.²⁸¹ Corporate directors may compromise the value of investors' shares; trustees may squander the corpus of a trust; business partners may encumber one another's assets. In each of these cases, the victim of abuse entrusted the abusing party with the discretion and power that was ultimately used to harm. Moreover, in each case, the

275. Deborah A. DeMott, *Beyond Metaphor: An Analysis of Fiduciary Obligation*, 1988 DUKE L.J. 879 (1988).

276. *Id.*

277. *See id.* at 885-88.

278. *See id.* at 879-80.

279. *Id.* at 880.

280. *Id.* at 915.

281. *See* Frankel, *supra* note 138, at 808.

entrusting party had no ability to monitor the fiduciary's behavior or punish the harm. The reasons to recognize these relationships as fiduciary are to facilitate entrustment and provide control for the imbalance in power.

Professor Melvin Eisenberg has convincingly argued that in addition to the fiduciary duties of care and loyalty that corporate managers owe to shareholders, the law also imposes a duty of good faith that encompasses an obligation to act with honesty, decency, consistency with prevailing corporate norms, and fidelity to the office entrusted to them.²⁸² Eisenberg argued that these expanded obligations are needed to establish a legal standard of conduct and provide more specific obligations than the general duties of loyalty and care.²⁸³ Moreover, Eisenberg observed that a broader duty of good faith will address conduct that falls outside the baseline duties of loyalty and care—conduct protected by the business judgment rule or that may not cause financial harm, but that nonetheless represents a “high degree of wrongfulness.”²⁸⁴ The duty of good faith requires corporate managers to respond to social norms and changes in social interests and priorities.²⁸⁵ This duty of good faith imposes obligations of candor.²⁸⁶ The duty of candor augments the duty to inform and the obligation to act through acceptable norms and processes that extend beyond the liability rules.²⁸⁷ Indeed, the duty of candor looks at the ends achieved by corporate agents to examine the appropriateness of the procedures chosen to achieve those ends.²⁸⁸

This fiduciary duty of candor that controls agency in the corporate context is needed in the health care context to control the government's exercise of discretion where the power imbalance between agent and principals is great. Fiduciary rules may require honesty, sincerity, and fidelity

282. See Melvin A. Eisenberg, *The Duty of Good Faith in Corporate Law*, 31 DEL. J. CORP. L. 1 (2006).

283. *Id.* at 26.

284. *Id.* at 29.

285. *Id.* at 30-31.

286. *Id.* at 38.

287. *Id.* at 50-51.

288. *Id.* at 38.

far beyond the levels of ordinary actors, and may require the government's responsiveness to social norms. These normative justifications for the application of fiduciary law to corporate directors and officers apply with multiplied force to the governments that finance, administer, and deliver health care to Americans.

The primary payer in the United States health care system is the United States Government. In 2008, for example, America's national health expenditures totaled \$2.3 trillion.²⁸⁹ Personal health care expenditures accounted for \$1.95 trillion of that amount.²⁹⁰ Nearly half—46.5%—of those expenditures were paid by federal, state, or local governments.²⁹¹ That is to say that in 2008, the government was the source of funding for 56.9% of all hospital care; 34.7% of all physician and clinical care; 62.2% of all nursing home care; 79.1% of all home health care; and 37.2% of all prescription drug expenditures.²⁹² In its role as “payer-in-chief,” the government is the system's largest principal controlling each of these providers in the dual agency relationship that operates as the providers deliver care to patients they treat. Yet in each of these relationships, by expending public funds, the government is also acting as the agent of the citizenry that provides the money to purchase these services through tax revenues and Medicare premiums.²⁹³

Even beyond its role as primary payer, the state, through government, plays a pervasive role in discharging its fiduciary responsibilities as agent of the American citizens throughout the health care delivery system. In 2008, for example, the government paid \$69.4 billion (3% of total national health expenditures) in public health services.²⁹⁴ This included expenditures such as the direct delivery of public health care through government public

289. *Health, United States, 2010*, *supra* note 251, at 387-88 tbl.125.

290. *Id.* at 369-70 tbl.125.

291. *Id.* at 32 & fig.23, 371-72 tbl.126.

292. *Id.* at 371-72 tbl.126.

293. *See, e.g.*, GETZEN, *supra* note 223, at 335 (describing the primary sources of government funds in 1997).

294. *See Health, United States, 2010*, *supra* note 251, at 369-70 tbl.125 & n.2 (referring to public health services as “[g]overnment public health activities” in table 125).

health agencies.²⁹⁵ A recent GAO report on graduate medical education explained further that “[t]he federal government invests significantly in medical education through various programs to help ensure that the anticipated supply of new physicians meets the nation’s health care needs.”²⁹⁶ These payments totaled \$8.76 billion in 2008 and included direct and indirect financing for graduate medical payments at teaching institutions, as well as loan programs and scholarships guaranteed or administered through the federal government.²⁹⁷ The federal government operates as an agent of its citizens by financing medical education, which creates physician capacity for health care delivery. Moreover, as ACA implementation proceeds, the government will significantly increase its role, acting as agent in the delivery of health care by financing research and development of new health technologies, the problems of health care disparities, and biomedical approaches to diseases and illness.²⁹⁸ For example, the Agency for Healthcare Research and Quality, a division of the federal Department of Health and Human Services, expended nearly two-thirds of its 2000 annual budget (\$203.8 million) to finance grants and contracts for medical researchers throughout the nation.²⁹⁹

In all these capacities, the government uses its constitutionally-delegated authority to regulate interstate commerce, and relies on its taxing and spending powers to effectuate health care policy and reform. As such, the agency relationship between the government and its people may exhibit the same divergences of interests, monitoring, and transaction costs that characterize any other agency relationship. Theoretically, a government may fail to

295. *Id.*

296. Letter from Kathleen M. King & George A. Scott, GAO Graduate Med. Educ. (GAO-09-438R), to The Hon. George Miller et al., House of Representatives 1-6 (May 4, 2009) (*available at* <http://www.gao.gov/new.items/d09438r.pdf>).

297. *Id.* at 1-2.

298. *See* 42 U.S.C.A. § 1320e (West Supp. 2010) (establishing the Patient-Centered Outcome Research Institute); *see also* 26 U.S.C.A. § 9511 (West Supp. 2010) (establishing a Patient-Centered Outcome Research Trust Fund).

299. JOHN M. EISENBERG, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, QUALITY RESEARCH FOR QUALITY HEALTH CARE, *available at* <http://www.ahrq.gov/about/qr4qhc/qr4qhc-1.htm#director>.

maximize public welfare or become captured by special interest bureaucrats or political groups, thus corrupting the execution of its fiduciary responsibilities. In practice, whether distributing reimbursement funds, establishing vaccination programs, processing medical school loan applications, or overseeing biomedical research grants, government officials may fail to act loyally in accordance with public preferences and mandates and may fail to exercise duties of care, competence, and diligence as required by their fiduciary roles. Agency law may provide recourse for these public conflicts of interest, and governments may enforce agency law in order to re-align the interests of its own agents or agencies with the interests of public citizens. An example of how this law may be applied to require a government to serve the public's interest may be found in a recent Fourth Circuit case involving the government of Rwanda.³⁰⁰

In *Republic of Rwanda v. Uwimana*, the Rwandan government commenced an adversary proceeding in bankruptcy court to recover public funds that a former ambassador spent to procure asylum for himself and his family soon after the outbreak of civil war in his home country.³⁰¹ Holding that the ambassador had improperly used his country's public funds, the Fourth Circuit Court of Appeals agreed with the district court's finding that "ambassadors are, by definition, fiduciaries for the country they represent [which had] . . . entrusted him with state secrets and financial assets, and undoubtedly expected his undivided loyalty and faithful service."³⁰² Further, the court of appeals found that the discretion afforded to the ambassador "arose within the context of a principal-agent relationship" which required him to act to further the

300. See *Republic of Rwanda v. Uwimana (In re Uwimana)*, 274 F.3d 806 (4th Cir. 2001), which held that:

An agent must avoid conflicts of interests with his or her principal and "[i]f the agent is to receive any benefit from a transaction in which he is serving his principal, the agent must fully disclose any interest he has in the transaction and receive the consent of his principal to proceed, even if the principal ultimately was to benefit from the transaction."

Id. at 812 (quoting *Gussin v. Shockey*, 725 F. Supp. 271, 275 (D. Md. 1989)).

301. *Id.* at 808-09.

302. *Id.* at 811.

interest of the state.³⁰³ Finally, applying agency law, the court concluded that “under basic principles of agency law, Aloys Uwimana plainly breached his duty to Rwanda.”³⁰⁴

The *Uwimana* case teaches three lessons. First, the fiduciary principles of agency law can be used to redirect public spending away from self-interested objectives and toward state objectives. Second, in the same way that a Rwandan official was held responsible to his nation, officials of the United States government may be made subject to the rules of agency law as fiduciaries in the delivering and financing of medical care, medical education, medical research, and public health care generally in order to discharge the fiduciary obligations of the state. Government officials, as agents of the American population, owe a fiduciary duty of loyalty to the public generally, and to the patient population specifically.

However, it is the third lesson from the *Uwimana* case that may be the most profound. To apply the agency model to a state, acting through its government officials without full consideration of the ethical dimensions of the relationship between that government and its people, is to completely misuse and misapply agency law. It risks destruction of both the descriptive and prescriptive usefulness of the fiduciary medicine model. The government of Rwanda, plaintiff in the *Uwimana* case, won its claim in court without reference to any political, humanitarian, social, and moral considerations related to the work of that government in 1994 that made it prudent, and even urgent, for the defendant ambassador to seek asylum in the United States.³⁰⁵ The *Uwimana* court’s application of agency law in this case appears to have been blind to the possibility that the ambassador’s cause was just, and to the likelihood that the Rwandan government was not only furthering injustice but was also conducting a brutal genocide of nearly

303. *Id.* at 812.

304. *Id.*

305. For one hundred days beginning in early April 1994, and continuing through July 1994, the Hutu government of Rwanda conducted a brutal and systematic mass killing of the country’s Tutsi population and their Hutu sympathizers, assassinating between 500,000 and 1,000,000 people in a genocide that wiped out nearly three-quarters of the Tutsi population in Rwanda. See ALISON DESFORGES, *LEAVE NONE TO TELL THE STORY: GENOCIDE IN RWANDA* 6, 17-18 (1999).

1,000,000 people at the time. Such a phlegmatic application of agency law cannot be optimal.

Professor J. Gregory Dees has argued that principal-agency models are descriptively and prescriptively deficient because they “blind . . . [analysts and policymakers] to important ethical dimensions of contractual arrangements.”³⁰⁶ Professor Dees identified four major biases that result from an unqualified reliance on the heuristic device of employing the principal-agency model to solve legal and policy problems, such as the organization of health care relationships in the United States. The problems are that the resulting laws and policy may: “1) [i]gnore the principal’s obligations to the agent, 2) [d]evelop excessive distrust and disrespect for agents [in the relevant relationships and proposed solutions], 3) [o]verlook ethical constraints, such as fairness, [that should control the principals and agents] and 4) [m]iss solution possibilities that include ethical norms.”³⁰⁷ The *Uwimana* case is an example of an accurate application of agency law, without consideration of the ethical context or norms that might have given rise to a solution that was faithful to the legal principles of agency law, but also sufficiently cognizant of the ethical imperatives that underlie it. A more nuanced

306. J. Gregory Dees, *Principals, Agents, and Ethics*, in *ETHICS AND AGENCY THEORY* 25, 31 (Norman E. Bowie & R. Edward Freeman eds., 1992).

307. *Id.* at 35. I focus here on the second and third biases that Professor Dees identifies. However, the implications of Professor Dees’ first and second biases also have significant importance to the fiduciary medicine model. They deserve further attention than can be provided here. In fact, the principal-agency relationship in health care should not be understood as a series of one-way obligations flowing only from providers and financiers to the patient population. The responsibilities of the principal owed to the agents in this model are significant. The agency model can accommodate these as well. The Restatement (Third) of Agency § 8.15 (2006) describes the principal’s duty to deal fairly and in good faith with the agent and to provide information to the agent about risks of harm or financial loss. These duties obligate patients to exercise personal responsibility for their own health care, to conserve financial resources in consuming health care, and provide the legal limitations on agents’ liability for harms unknown to them. The Restatement explains that the “agency-law duties of principals to their agents are less numerous than the duties of agents to principals . . . because an agent’s position always enables the agent to take action with consequences for the principal’s legal relations . . .” *RESTATEMENT (THIRD) OF AGENCY* § 8.13 intro. note (2006). However, Dees’ caution that the law must not excessively distrust and burden agents alone is indeed applicable to the fiduciary medicine model as well.

application of the law may have avoided a decision that lent the imprimatur of American judicial support to a regime engaged in a horrific genocide. So as not to repeat the error of the *Uwimana* court's use of the agency model, the final section of this paper is dedicated to addressing the ethical issues inherent in applying the fiduciary medicine model to organize and understand the agency relationships that make up the American health care delivery system. This section has presented the fourth and final principle of the fiduciary medicine model: the state owes a fiduciary duty of good faith, loyalty, and care as an agent in public and private health care markets.

D. *Limits and Objections*

In summary, the fiduciary medicine model is based on these four fundamental principles: first, agency is the primary fiduciary relationship that characterizes the treatment relationship between medical providers and their patients, thus agency law is the body of rules that should govern these relationships. Second, while the law of agency governs most medical treatment relationships, the law of trusts governs those health care relationships that dispose of property, such as the role of health plan administrators who collect premiums and pay claims. Third, fiduciary law provides the substantive and procedural legal rules needed to align the diverse interests of patients who enroll, subscribe, or are beneficiaries under contracts with integrated health care organizations. Fourth, when the state and federal governments manage health care markets as payers, regulators, educators, and researchers, the state owes fiduciary duties of loyalty, good faith, and due care to its citizens. Regulation based upon these seemingly straightforward four principles will hold providers and payers accountable to the underlying intent and objectives they have already articulated for themselves.³⁰⁸ Nevertheless, the fiduciary medicine model represents a sea change in the way and extent to which American health law fits with the structure and substance of American health care delivery. As with any sea change, there may be turbulence.

308. See *infra* Section I.A.1.

“Fiduciary duties are the highest standard of conduct imposed by law.”³⁰⁹ While it is appropriate to impose the highest standard on the high calling of healing and saving lives, the decision to elevate the legal responsibilities of health care providers to explicitly require the highest legal obligations will not be welcome at first. Providers may fear expanded legal scrutiny of their affairs, and view the fiduciary standard as an intrusion on their medical autonomy. Jurists may also object to the burden this model imposes on them. While fiduciary rules are clear, they are not simple. Applying fiduciary standards is a complex and fact-specific endeavor that may meet resistance that is not uncommon to a call to replace a familiar, albeit ill fitting and ineffective, legal paradigm.³¹⁰ And notwithstanding its strengths, the fiduciary model also presents doctrinal challenges in its own right. For example, damages in tort or contract available under current law more completely compensate victims than fiduciary damages may in the private medical context. Also, the efficacy of awarding fiduciary damages without proof of injury will require a paradigm shift that may appear threatening at first. However, the flexibility of applying equitable remedies in place of damages may prove an attractive alternative in the long run. Despite these objections and limitations, the fiduciary medicine model offers a final advantage over current alternatives that must be discarded: the fiduciary medicine model is not only a legally and politically optimal approach, it is also optimal from a social perspective.

This is because the fiduciary medicine model presented here addresses what Professor Dees calls the “Level 3 questions.” These “Level 3” questions ask what fiduciary arrangements “would be best . . . from a social perspective. Desirable . . . [fiduciary agreements] should respect rights, promote social welfare, and support (or, at least, not undermine) our shared values about the kind of society we

309. Nicolas P. Terry, *Physicians and Patients Who “Friend” and “Tweet”*: Constructing a Legal Framework for Social Networking in a Highly Regulated Domain, 43 IND. L. REV. 285, 304 (2010).

310. See, e.g., Gary A. Varnavides, *The Flawed State of Broker-Dealer Regulation and the Case for an Authentic Federal Fiduciary Standard*, 16 J. CORP. AND FIN. L. 203, 211 (2011).

want to maintain.”³¹¹ To be useful at all, the fiduciary medicine model must operate to lead to socially preferred arrangements. The next section of the Article turns to the final step of showing how the theoretical fiduciary medicine model constructed thus far can work to improve the social and practical organization of health care delivery in the United States.

III. IMPLEMENTING THE FIDUCIARY MEDICINE MODEL

Having defined the substantive content of the fiduciary medicine model, as well as demonstrated the need for and efficacy of this analytical paradigm, I now turn to showing how the model can work. This section sets out two approaches that legislatures and courts can use to implement the fiduciary medicine model. Most directly, state legislatures can enact an enabling statute to guide stakeholders in discharging and courts in construing the fiduciary responsibilities actors will have under the ACA. This section suggests a model for such legislation. Alternatively, this section also introduces a way in which courts may use the fiduciary medicine model on a case-by-case basis as challenges to the statute arise.

A. *A Proposed Standard for Judicial Review*

Courts will be called upon to answer new questions about the reformed health care landscape, and they will be asked to resolve familiar disputes in light of the new legislative enactments. This section shows how the fiduciary medicine model provides a paradigm to guide courts in reaching consistent and predictable rules for regulating health care relationships. The first example demonstrates how the model applies to greatly improve and clarify the conflicts of interest that pervade health care interactions,

311. Dees, *supra* note 305, at 33. In Dees’ analysis, Level 1 questions ask what agreements would best serve the individual interests of the principal and agent parties to a fiduciary relationship. *Id.* at 31. Level 2 questions ask what joint solutions the parties to a fiduciary relationship would bargain to reach between or among them. *Id.* Level 3 questions go to the moral gap that usually occurs, according to Dees, as a result of applying the principal-agent model as a heuristic, as I have done here, without refining the model to correct for the ethical biases inherent in it. *Id.* This discussion addresses the moral gap that Dees has identified.

which increasingly will be characterized by organizational structures that depend upon financial integration of several stakeholders in the health care market. The second example applies the fiduciary medicine model to show how the courts can construe existing and post-reform law of informed consent to improve both the theory and practice of shared medical decision making.

1. *Financial Conflicts of Interest.* In the past, courts have declined to enforce fiduciary principles to regulate the impact of financial incentives on physicians “even though courts recognize the obvious force that fiduciary principles have in doctor-patient relationships and that these principles are generally hostile to financial conflicts of interest.”³¹² This hostility runs counter to the ACA. Many of the structures created by the reform statute rely directly upon legislatively-sanctioned methods of offering financial incentives to providers. These entities can only succeed if existing law changes to protect their intended functions. For example, under Title III, Part III of the ACA which Congress titled “Encouraging Development of New Patient Care Models,” Section 3022 charges the Secretary of the Department of Health and Human Services to establish a “Shared Savings Program” to reward groups of providers and suppliers who coordinate care through a new entity called an “Accountable Care Organization.”³¹³ Each ACO will be made up of group practices, networks of individual practices, partnerships or joint ventures between hospitals and professionals, or hospitals and professionals who are “willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.”³¹⁴ ACOs will be financially rewarded for their efficiency gains because they will receive additional payments beyond the existing fees when they lower costs.³¹⁵ The Secretary will choose the payment model to apply to ACOs, and much will depend on the form that these new entities take.³¹⁶ However, whether through a partial

312. Hall, *supra* note 102, at 504.

313. See 42 U.S.C.A. § 1395jjj(a) (West Supp. 2010); see also *supra* note 113 and accompanying text.

314. *Id.* § 1395jjj(b)(1)-(2).

315. *Id.* § 1395jjj(d)(1)(B).

316. *Id.* § 1395jjj(d)(1)(B)(ii).

capitation model,³¹⁷ a fee-for-service model returning savings based on benchmark expenditure levels set by the Center for Medicare and Medicaid Services,³¹⁸ or other payment models,³¹⁹ ACOs will receive annual incentive bonuses in exchange for achieving savings per Medicare beneficiary. The congressional objective for the Shared Savings Program is to extend ACOs beyond the Medicare patient population. The ideal is to penetrate private insurance markets with the ACO model that incorporates evidence-based medical practice with sharing financial risk throughout the market.³²⁰

Financial risk-sharing will also be central to another organizational form that the ACA calls “patient-centered medical home[s].”³²¹ These medical homes represent an integrated model for the delivery of coordinated medical care that the ACA incentivizes to improve the quality and control the cost of health care delivery. The ACA approves a National Pilot Program to implement payment bundling. Bundling will allow services from different physicians to be grouped together for billing purposes, in order to increase integration and “improve the coordination, quality, and

317. *Id.* § 1395jjj(i)(2).

318. *Id.* § 1395jjj(d)(1)(B).

319. *Id.* § 1395jjj(i)(3).

320. See MEDPAC, REPORT TO THE CONGRESS: IMPROVING INCENTIVES IN THE MEDICARE PROGRAM 39-42 (June 2009), available at http://www.medpac.gov/documents/jun09_entirereport.pdf; KELLY DEVERS & ROBERT BERENSON, URBAN INST., CAN ACCOUNTABLE CARE ORGANIZATIONS IMPROVE THE VALUE OF HEALTH CARE BY SOLVING THE COST AND QUALITY QUANDARIES? 7 (2009), available at http://www.urban.org/UploadedPDF/411975_accountable_care_orgs.pdf; Steven M. Shortell & Lawrence P. Casalino, *Health Care Reform Requires Accountable Care Systems*, 300 J. AM. MED. ASS'N 95, 97 (2008).

321. 42 U.S.C.A. § 256a-1(c)(2) (West Supp. 2010). Title III, Section 3502 of the ACA defines patient-centered medical homes as:

a mode of care that includes—(A) personal physicians or other primary care providers; (B) whole person orientation; (C) coordinated and integrated care; (D) safe and high-quality care through evidence-informed medicine, appropriate use of health information technology, and continuous quality improvements; (E) expanded access to care; and (F) payment that recognizes added value from additional components of patient-centered care.

Id.

efficiency of health care services.”³²² Another example is in Section 3027, which extends and finances gain-sharing demonstration projects that began in New York and West Virginia.³²³ Under gain-sharing arrangements, physicians and hospitals share financial risk in the hope of sharing in the financial benefits of integrated medical practice.³²⁴ All of these newly-enacted programs create opportunities for providers to combine and share the financial risk of delivering health care goods and services. Financial risk sharing is not new; however, to the extent that courts have in the past found the law hostile to such “conflicts of interest,” the law must be corrected.³²⁵

In fact, agency law under the fiduciary medicine model is not uniformly hostile to financial conflicts of interest. Admittedly, there is no agency statute or case directly on point that magically solves the potential for self-dealing and conflicts of interest that arise when financial rewards incentivize high-quality patient care. However, the principles of the fiduciary medicine model would direct courts to apply Section 8.06(2) of the Restatement (Third) of the Law of Agency, and the cases construing those provisions, to find specific guidance “from an integrated body of concrete rules” that evince a reasoned approach to governing ACOs, medical homes, and other new forms of integrated delivery organizations.³²⁶

The Restatement (Third) of Agency Law provides that a principal may consent to allow an agent to act for more than one principal in a transaction among the three parties.³²⁷ This provision expressly accommodates agents who may act on behalf of multiple principals in transactions, such as one where a physician acts as the agent for both the patient-principal that she treats and for the payer-principal who pays her bill. The Restatement offers considerable guidance concerning the fiduciary obligations that a physician bears in such a case of dual-agency—a case that presents itself ubiquitously throughout the health care delivery system in

322. *Id.* § 1395cc-4(a)(1).

323. *See id.* § 1395ww.

324. *See id.*

325. *See* Hall, *supra* note 102, at 504.

326. *Id.* at 490; *see also* RESTATEMENT (THIRD) OF AGENCY § 8.06(2) (2006).

327. *See* RESTATEMENT (THIRD) OF AGENCY § 8.06(2) cmt. d (2006).

America.³²⁸ First, the physician-agent must disclose to each principal not only the fact that she acts for the other principal, but also “all other facts that the agent knows, has reason to know, or should know would reasonably affect the principal’s judgment.”³²⁹ Beyond disclosure, agency rules admonish the physician-agent to deal fairly and in good faith with each principal.³³⁰ These, of course, are broad exhortations that have to be fleshed out in actual cases involving litigated disputes in order to have meaning or provide any guidance. Indeed, courts have been able to find such guidance in some analogous contexts that are instructive.

In *National Plan Administrators, Inc. v. National Health Insurance Co.*,³³¹ a health insurance underwriter sued a third-party administrator and its parent company, alleging that the defendants’ transfer of the plaintiff’s cancer health insurance policies to a competing insurer breached their fiduciary duty as agents for the plaintiff.³³² The parties had entered a contractual agreement that provided that the plaintiff would underwrite insurance products developed and marketed by the defendants, but that the defendants’ services were not exclusive to the plaintiff.³³³ In other words, the original defendant, National Plan Administrators (“NPA”), was an agent of the original plaintiff and principal, National Health Insurance (“National Health”), but NPA also served as the agent for

328. *Id.* § 8.06.

329. *Id.* § 8.06(2)(b)(i)-(ii).

330. *Id.* § 8.06(2)(a).

331. 235 S.W.3d 695 (Tex. 2007).

332. *Id.* at 697. The lower appellate court agreed with the plaintiff’s claims, holding that the defendant administrator owed a fiduciary duty to the plaintiff insurer, and that the defendant’s burden to show its fiduciary obligation to show fairness in the transaction with the subsequent purchaser—a second principal—had not been discharged. See *Nat’l Plan Adm’rs, Inc. v. Nat’l Health Ins. Co.*, 150 S.W.3d 718, 730-32 (Tex. Ct. App. 2004), *rev’d*, 235 S.W.3d 695 (Tex. 2007). Although the Texas Supreme Court overruled that decision, finding that the Texas Insurance Code did not place a fiduciary burden on the defendant third-party administrator, the lower court’s description of the duties that an agent owes in representing multiple principals, as well as the cases cited are helpful for future cases in which a fiduciary obligation does exist. *Nat’l Plan Adm’rs*, 235 S.W.3d at 700-04.

333. *Nat’l Plan Adm’rs*, 150 S.W.3d at 724.

other insurers, including one of its direct competitors. Thus NPA served several other principals in addition to National Health.

During the course of the relationship, the principal, National Health, gave notice to its agent that it had ninety days to find a buyer for its book of business because National Health would no longer underwrite cancer policies.³³⁴ The agent approached another of its principals to purchase National Health's policies, and in so doing allegedly disclosed confidential information to a competitor.³³⁵ The principal, National Health, ultimately lost a considerable amount of business to the competitor who purchased only the most profitable policies, and left behind the highest risk policies which were not marketable.³³⁶ National Health sued its agents, NPA and the parent company, as well as the competing principal, alleging fraud, breach of contract, and breach of general fiduciary obligations.³³⁷ Although the jury and the intermediate court of appeals both found that the defendant agents did breach their fiduciary duty to National Health, awarding compensatory and punitive damages to the principal,³³⁸ the Texas Supreme Court reversed this decision, holding that the defendant third-party administrator and its parent company did not breach any general fiduciary duty owed to National Health.³³⁹ In its analysis, the Texas Supreme Court reviewed the agency rules that apply to enforce fiduciary obligations that arise by virtue of legislation, the common law, and contractual agreement between parties.³⁴⁰ This analysis offers several insights that could guide courts and lawmakers facing questions involving the impact of financial incentives on

334. *Id.* at 727.

335. *Id.* at 727-28.

336. *Id.* at 728.

337. *Id.* at 729.

338. *Id.*

339. Nat'l Plan Adm'rs, 235 S.W.3d at 701, 704. In the main, this holding was based on the court's finding that the Texas Insurance Code did not place a fiduciary duty on third-party administrators. However, in its analysis of other fiduciary duties the defendant owed to its principal insurer, the court provided helpful insight concerning the law pertaining to dual agencies. *See id.*

340. *See id.*

medical judgment when physicians occupy the role of agent to multiple principals, including a payer.³⁴¹

First, the Texas Supreme Court demonstrated that an agency relationship imposes a very specific and “certain” set of fiduciary duties on the parties.³⁴² Approving the Restatement of Agency,³⁴³ the court next confirmed that these specific duties may be altered by the parties’ contractual agreement.³⁴⁴ Thus, the *National Health* court concluded that fiduciary duties between agent and principal owed under statute or law may be altered by the parties’ agreement.³⁴⁵ The role that contractual agreements have in shaping fiduciary responsibilities between parties is one of the most important doctrinal distinctions between trust and agency law where medical relationships are concerned.

The Texas high court considered the scope of NPA’s fiduciary duties imposed under the state’s Insurance Code.³⁴⁶ While that statute indeed provided that anyone who solicited insurance on behalf of an insurance company shall be held to be the agent of the company, the court read other provisions in the statute that addressed third-party administrators’ fiduciary obligations specifically to supersede the general agency provision.³⁴⁷ “Even if we assume the Code provisions pertaining to agents generally also apply to third-party administrators, the Legislature

341. Note that not all relationships between a physician and a payer are agency relationships. For example, a physician may have no contractual connection to a patient’s insurer whatsoever, and thus may not be held to represent that payer in an agency relationship. On the other hand, payers who selectively contract with physicians and through a master or operating agreement impose financial and other incentives to contain costs are acting as principals exercising some degree over physicians as their agents.

342. *Nat’l Plan Adm’rs*, 235 S.W.3d at 700.

343. *Id.*

344. *Id.* at 702 (“This section makes the basic point that an agent’s duties of performance to the principal are subject to the terms of any contract between them.”) (quoting RESTATEMENT (THIRD) OF AGENCY § 8.07 cmt. a (2006)). “Accordingly, factors which must be taken into consideration when determining the scope of an agent’s fiduciary duty to his or her principal include not only the nature and purpose of the relationship, but also agreements between the agent and principal.” *Id.* at 700.

345. *Id.* at 700-02.

346. *See id.* at 700-01.

347. *Id.*

clearly and specifically addressed certain fiduciary duties in the Code, yet it did not impose a general fiduciary duty on agents in general or on third-party administrators.”³⁴⁸ This holding teaches that legislatures may, and indeed *must*, carefully define the fiduciary duties that will apply to govern an agency relationship in order to avoid confusion and give effect to their intent. Where lawmakers have been unclear about defining these obligations, judicial decisions may not line up with legislative intent.

Lastly, the *National Health* court declared, “fiduciary duties are equitable in nature and generally not subject to hard and fast rules.”³⁴⁹ These lessons should embolden private parties as well as policymakers who have been timid about addressing the impact that financial incentives in managed care contracts may have on physicians’ medical obligations to patients. The rules of agency offer guidance and flexibility for the law to develop practical and enforceable rules that can accommodate the need to ensure physician loyalty to patients in their treatment relationships, and also allow them to honor their contractual and perhaps legislative commitments to contain costs while providing high quality care.

This case provides an example of how the fiduciary medicine model can provide a guiding body of common law cases to aid courts. The post-reform health care markets will contain an increasingly important collection of financially integrated entities that will rely upon financial incentives to improve health care quality and efficiency. The *National Health* approach is useful to balance fiduciary rules that seek to protect physicians’ independent medical judgments from the taint of financial incentives.³⁵⁰

The fiduciary medicine model can address a wide range of thorny fiduciary issues in other aspects of the dual-agency issue that are pervasive in the health care context.³⁵¹

348. *Id.* at 701.

349. *Id.* at 702.

350. See Hall, *supra* note 102, at 504.

351. See, e.g., *Arthur D. Little Int’l, Inc. v. Dooyang Corp.*, 928 F. Supp. 1189, 1208 (D. Mass. 1996) (discussing how disclosure to the principal of a conflict of interest in accordance with duty did not absolve the firm of “all other fiduciary duties as an agency”); *Kirkruff v. Wisegarver*, 697 N.E.2d 406, 411 (Ill. App. Ct. 1998) (discussing the burden to show full disclosure of all relevant information to the principal before entering a transaction and the duty to still render

It can also address other fiduciary matters, such as the prohibition against physicians gaining material benefit from transactions on behalf of their principals,³⁵² fraud and abuse prohibitions against kickbacks and self-referrals, and incidents of the medical relationship itself. The fiduciary medicine model may offer guidance to courts and legislators in non-financial matters involving physicians and patients as well. Moreover, the model can do more than rigid legal rules can to incentivize advanced interactions between related parties. The next section applies the fiduciary medicine model to a fiduciary relationship that traditional legal rules have been ineffective in monitoring. The objective of informed consent law is to promote shared medical decision making between patient and physician.³⁵³ Negligence principles have been summarily ineffective in this regard.³⁵⁴ The fiduciary medicine model introduces flexibility and protections that are much more likely to not only regulate but also cultivate the care environment and relationships policymakers seek.

2. *Informed Consent.* The example of informed consent is instructive because it represents a discrete issue between patients and physicians—the most basic fiduciary unit—that had not been resolved before health reform, despite the clear understanding that this relationship is fiduciary in character. Therefore, applying the corrective refinements in the fiduciary model would improve informed consent law even without the improvements enacted under the ACA. However, the fact that the ACA goes further to adopt a new “patient decision aid” approach to informed consent also serves to demonstrate the fiduciary objectives that Congress sought to serve by enacting this part of the reform.³⁵⁵

“competent and independent advice to the principal”); *Lane v. Oustalet*, 873 So. 2d 92, 99 (Miss. 2004) (holding that a dual agent has “separate burdens” to each principal); see also RESTATEMENT (THIRD) OF AGENCY §§ 3.14, 3.15 (2006) (regarding the hierarchy of duties to multiple agents and sub-agents).

352. See RESTATEMENT (THIRD) OF AGENCY § 8.02 (2006).

353. Jaime Staples King & Benjamin W. Moulton, *Rethinking Informed Consent: The Case for Shared Medical Decision-Making*, 32 AM. J.L. & MED. 429 (2006).

354. See Alan Meisel, *From Tragedy to Catastrophe: Lawyers and the Bureaucratization of Informed Consent*, 6 YALE J. HEALTH POL’Y & ETHICS 479, 480-82 (2006).

355. See 42 U.S.C.A. §§ 299b-33 to -34 (West Supp. 2010).

a. Clarifying Existing Law. Elsewhere I have argued that if courts applied fiduciary rather than negligence rules to informed consent cases, this change would help to revive the legal doctrine's usefulness to all patients while also improving its application to religious, racial, and ethnic minority patients.³⁵⁶ My article was a contribution to a sizeable literature addressing the gap between the legal duties imposed under the informed consent law that courts and theorists articulate, and what doctors actually do³⁵⁷ when they talk with their patients to obtain their consent to treat.³⁵⁸ Still, in informed consent cases, courts regularly assert that the physician-patient relationship is one of "trust and confidence," giving rise to the physician's fiduciary obligation to provide information to the patient.³⁵⁹ Yet, case law does not flesh out the content of the physician's fiduciary duty or provide guidance to courts that want to apply fiduciary law to resolve informed consent disputes. The fiduciary medicine model would give content to the informed consent doctrine, both procedurally and doctrinally.

The fiduciary medicine model would impose an agent's duty on physicians to share decision-making authority with

356. See Matthew, *supra* note 125.

357. See *id.*; see also Carl E. Schneider, *After Autonomy*, 41 WAKE FOREST L. REV. 411, 417-25 (2006) (reviewing empirical literature that shows that physicians do not effectively inform and patients do not adequately understand what is going on in the informed consent conversation).

358. Peter Schuck first noted the "informed consent gap" in 1994. See Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899, 903-04 (1994). Many have suggested expansion of the scope of the physician's duty to fill this gap. See, e.g., Mark A. Hall, *A Theory of Economic Informed Consent*, 31 GA. L. REV. 511 (1997); Frances H. Miller, *Health Care Information Technology and Informed Consent: Computers and the Doctor-Patient Relationship*, 31 IND. L. REV. 1019 (1998). Some urged that a greater focus on patient autonomy would fix the problem. See, e.g., Mary Anne Bobinski, *Autonomy and Privacy: Protecting Patients from Their Physicians*, 55 U. PITT. L. REV. 291 (1994). But when jurists did train a focused eye on patient autonomy, others called "the suffocating hegemony of the autonomy principle" a failing policy. See Schneider, *supra* note 357, at 413.

359. See, e.g., *Moore v. Webb*, 345 S.W.2d 239, 243 (Mo. Ct. App. 1961); *Tracy v. Merrell Dow Pharm., Inc.*, 569 N.E.2d 875, 879 (Ohio 1991); *Hunter v. Brown*, 484 P.2d 1162, 1166 (Wash. Ct. App. 1971).

their patients, rather than merely satisfy the disclosure requirements negligence law requires. The duty to act in the best interest of a patient would counsel that providers consider the individual patient's needs and preferences with respect to the extent of information, communication style, who shares in medical decision making, and the level of deference the patient wishes to give to the provider. Agency law would also require providers to offer patients information that is responsive to the varying degrees of autonomy or collaboration a patient prefers, the circumstances of the illness, as well as the cultural and religious values that the patient and family hold. The physician's duty of loyalty under agency law would influence the communication style chosen for each patient. Courts reviewing informed consent challenges would examine the procedure and context of information that the patient received in order to make an informed medical choice, to determine whether the provider honored the duty to act in good faith.³⁶⁰

The fiduciary model expands the scope of a provider's obligation to inform a patient of her medical options and obtain her consent to treat. This model asks a physician to communicate information in a way that takes account of the patient holistically and seeks to provide information that will be useful to a patient's decision. The physician's obligation under the fiduciary model of informed consent is not overly burdensome. In the same way that courts now apply agency law to hold realtors or travel agents responsible for investigating the circumstances of market or

360. State legislatures could also revise existing informed consent statutes to reflect agency rather than negligence law principles. As an illustration, take for example the Florida statute entitled the "Florida Medical Consent Law." FLA. STAT. § 766.103 (2005 & Supp. 2011) (codifying the common law informed consent doctrine). Should the Florida legislature wish to replace the negligence principles underlying this law, lawmakers could revise the language in paragraphs (a)(1) and (a)(2) to prohibit action for failure to obtain informed consent against the providers protected under the statute who had acted in the best interest of their patients, fulfilled their duties to act loyally for the patient's benefit, and subordinated their own interests and the interests of third parties to the interest of the patient. Further, the statute might obligate providers to honor their duty of confidentiality in all communication, and to act with care, competence, and diligence. The difference would be that these provisions would not refer to the reasonableness standard of care defined by the medical community, but would instead depend upon standards of agency law that have construed these terms in other agency contexts.

political conditions that are particularly relevant to their clients,³⁶¹ agency law principles provide a basis for expanding and contextualizing the informed consent conversation between providers and patients. In these cases, patients would have the procedural benefits of an agency action where the burden of proof is on the fiduciary to show that no breach occurred once the obligation to protect patient interests is shown. The injury in these cases would be the provider's failure to engage patients in shared decision making, rather than the mechanical and now meaningless negligence obligation to deliver cursory information about risks, benefits, and alternatives to proposed care. Agency law would also provide a more structured protection for providers who exercise due care to discharge their duties of loyalty and good faith to patients, similar to the way in which the business judgment rule protects corporate directors and managers who employ reasonable and prudent decision making to avoiding loss or harm.³⁶² Agency principles impose reciprocal obligations upon principals that would require patients to provide information that providers need in order to make the informed consent conversation a meaningful one.³⁶³

b. Reforming Consent Law. The ACA reforms the law of informed consent by carving out a category of patients who are facing the option to elect "preference sensitive care," and introducing a "program to facilitate shared decision-making" to regulate informed consent in those cases.³⁶⁴ The ACA's regulatory approach to consent calls for an independent entity to develop standards for educational tools called "patient decision aids."³⁶⁵ The ACA requires that these tools be evidence-based, disclosing

361. See, e.g., *Rookard v. Mexicoach*, 680 F.2d 1257, 1261–63 (9th Cir. 1982) (holding that a travel agent who is not "a mere ticket-agent" has a duty to a customer to "warn of those dangers of which he is aware, or should be aware" because of the dependent relationship).

362. RESTATEMENT (THIRD) OF TRUSTS § 90 (2007).

363. See RESTATEMENT (THIRD) OF AGENCY § 8.15 (2006) ("A principal [must] provide the agent with information about risks of physical harm or pecuniary loss that the principal knows, has reason to know, or should know are present in the agent's work but unknown to the agent.").

364. 42 U.S.C.A. § 299b-36 (West Supp. 2010).

365. *Id.* § 299b-36(b)(1).

traditional information—risks, benefits, and options—but doing so in a way that is appropriate to the age, culture, educational background, and health literacy of the patient.³⁶⁶ The ACA instructs the Health and Human Services Secretary to award grants to establish resource centers that would provide technical assistance in developing and disseminating information about best practices to implement the shared decision making program.³⁶⁷

The ACA's stated purpose in this section is to "facilitate collaborative processes between patients, caregivers or authorized representatives, and clinicians that engages the patient, caregiver or authorized representative in decision-making, provides patients, caregivers or authorized representatives with information about trade-offs among treatment options, and facilitates the incorporation of patient preferences and values into the medical plan."³⁶⁸ This purpose is clearly grounded in the expectation that providers will be guided by patients in the way that a principal guides an agent. Also, the ACA broadens the scope of considerations a physician must include to determine what additional decision makers must be included, what preferences and values must be a part of the doctor's consent conversations, and the particular patient's decision making style³⁶⁹ in much the same way that a fiduciary agent serving a patient's best interest would. But despite the fiduciary characteristics of this rule, the ACA's regulatory approach to shared decision making is only a partial improvement upon the negligence rules that currently prevail.

The regulatory rules apply only to "preference sensitive care," and although this term is defined in the ACA,³⁷⁰ courts will be left to choose what cases fall within the ACA's regulations and which cases fall without. The ACA appears to preserve the existing negligence standard for those cases that are not preference sensitive, resulting in a mix of rules

366. *Id.* §§ 299b-36(c)-(d).

367. *Id.* § 299b-36(e).

368. *Id.* § 299b-36(a).

369. *Id.* §§ 299b-36(c)-(d).

370. *See id.* § 299b-36(b)(2).

and outcomes that will be difficult for patients and providers to use as a guide to ordering their future conduct. The terms of the new standards for patient aids will have the advantage of being developed and tested by medical experts, but they will not be easily linked with legal standards that could inform enforcement uniformly and predictably. As with any standard that must await case-by-case challenges to give substance and boundaries to its terms, the future effectiveness of the shared decision making provision of the ACA is uncertain. Should courts construe the statute to reflect a fiduciary standard, and should courts adopt the fiduciary model's agency standard to inform their review of the case, then the law will offer clear guidance upon which many can rely to improve doctor-patient communication. But if courts make inconsistent judgments about the statute's language, the law will have sub-optimal impact on the way physicians and their patients relate. The problem is that no standard of construction or review is expressly included in the ACA. The repair for this defect is simple; the plain language of the statute could state the drafters' intent to impose a fiduciary standard of behavior on the actors subject to the terms of the law. The next section offers model language that could be used by states to codify the fiduciary medicine model.

B. *A Proposed Legislative Enactment*

The Uniform Prudent Investor Act ("UPIA") is found in Restatement (Third) of Trusts³⁷¹ and was drafted by the National Conference of Commissioners on Uniform State Laws ("Commission").³⁷² The rule was approved at the Commission's 1994 Annual Conference³⁷³ and offers states a model statute to define the standard of care owed by trustees who manage trust assets.³⁷⁴ Immediately this uniform statute is distinguishable from the health care agency relationships under consideration here in that it defines trustee obligations, and not obligations owed by an

371. See RESTATEMENT (THIRD) OF TRUSTS § 90 (2007).

372. John H. Langbein, *The Uniform Prudent Investor Act and the Future of Trust Investing*, 81 IOWA L. REV. 641, 641 & n.3 (1996).

373. See *id.* at 641.

374. See RESTATEMENT (THIRD) OF TRUSTS § 90 (2007).

agent to a principal.³⁷⁵ However, because of the many similarities in the legal duties owed by both trustees and agents, the UPIA provides an instructive example of how the law may operationalize the fiduciary medicine model.

Recall that in the hypothetical example of Mercy Medical Hospital,³⁷⁶ the hospital stands in an agency relationship as the principal with varying degrees of control over its agents. The hospital may have substantial control over some directly-hired employees such as nurses, laboratory technicians, and orderlies. But it will have less control over other agents such as independently-contracted radiologists and hospitalists who are hired by the institution, and far less control over physician groups with admitting privileges such as physicians who operate in its surgical suites. On the other hand, Mercy Medical is an agent representing the often-competing interests of patients, payers, health plans, and its organizing entities, which could be a board of trustees, a charity, a foundation, or even a group of shareholders. The range of relationships regulated by the UPIA may also be applied to bring legal order to the agency relationships involving Mercy Medical. Hypothetically, a “Prudent Provider Rule” might read as follows:

§1. Prudent Provider Rule

(a) Except as otherwise provided in subsection (b), a health care provider who delivers medical goods or services owes a duty to patients to comply with the prudent provider rule set forth in this Act.

(b) The prudent provider rule, a default rule, may be expanded, restricted, eliminated, or otherwise altered by the provisions of a provider-patient relationship. A provider is not liable to a patient to the extent that the provider acted in reasonable reliance on the mutually agreed-upon provisions of the relationship.

§ 2. Standard of Care

(a) A provider shall deliver those medical goods and services that are in the best interest of the patient who has

³⁷⁵. *See id.*

³⁷⁶. *See supra* Part II.B.1.

entrusted himself or herself to the provider, as a prudent provider would, by considering the medical condition, patient history, physical, social, and cultural background, and other information reasonably relied upon by other prudent providers, the purposes, terms, requirements of the patient's entrustment, and other circumstances of the relationship. In satisfying this standard, the provider shall exercise reasonable care, skill, and caution.

(b) In addition, the provider must

- (1) conform to fundamental fiduciary duties of loyalty and impartiality;
- (2) act with prudence in deciding whether and how to delegate authority and in selecting and supervising agents; and
- (3) incur only costs that are reasonable in amount and appropriate to the responsibilities of the overall duties of patient care.

(c) A provider's treatment and management decisions respecting individual patients must be evaluated not in isolation, but in the context of the patient's medical condition as a whole and as a part of an overall treatment strategy, having risk and benefit objectives reasonably suited to the circumstances of the individual patient.

(d) Among circumstances that a provider shall consider in treating and managing a patient are such of the following as are relevant to the patient:

- (1) general scientific, medical, and economic conditions given the setting in which medical goods and services are being provided;
- (2) the possible effect of future uncertainty in either the patient's condition or in other factors that may impact it;
- (3) the expected health consequences of treatment decisions or strategies;
- (4) the role that each treatment decision or course of action plays within the overall health of the patient, which may include family history or past medical history;
- (5) the expected prognosis for timing and extent of recovery;
- (6) other resources, interests, or concerns of the patient including social, familial, cultural,

religious, and philosophical concerns expressed by the patient;

- (7) needs for mobility, regularity of activity, and preservation or appreciation of physical capacity; and
- (8) without any regard to the special relationship or special value, if any, to the purposes of the relationship to one or more of the beneficiaries.

(e) A provider shall make a reasonable effort to verify facts relevant to the care, treatment, and management of patient entrusted to him/her.

(f) A provider may provide any kind of medical care goods and services of a type of medical care consistent with the standards of this Act.

(g) A provider who has special skills or expertise, or is named provider in reliance upon the provider's representation that the provider has special skills or expertise, has a duty to use those special skills or expertise.

These statutory terms would provide guidance for the primary relationships between Mercy Medical and its patients, and all caregivers working directly within its auspices and control as they interact with patients as well. To the extent that Mercy Medical extends admitting privileges or offers its physical plant for use by other health care professionals, a Prudent Provider Act might further provide as follows:

§ 3. Delegation of Provider Functions

A provider may delegate patient care and treatment functions that a reasonable provider of comparable skills could properly delegate under the circumstances, using reasonable care, skill, and caution in:

- (a) selecting an agent;
- (b) establishing the scope and terms of the delegation, consistent with the terms of the patient care relationship; and
- (c) periodically reviewing the agent's actions in order to monitor the agent's performance and compliance with the terms of the delegation.

In performing a delegated function, an agent owes a duty to the provider and to patients to exercise reasonable care to comply with the terms of the delegation.

The scope of these obligations can be expanded far beyond simple negligence rules to include the duties of loyalty, prohibitions against self-interested behavior, and the duty of good faith. Finally, the Prudent Provider Act would distinctively control the administrative relationships in which Mercy Medical operates as an agent for payers such as a managed care organization, health plans, employers, or its organizing authority. In those cases, the act may specify fiduciary obligations as follows:

§4. Administrative Provisions of the Provider Relationship

In the delivery of medical goods and services, the provider

(a) has a duty to conform to any applicable statutory and contractual provisions governing the financing of patient care;

(b) has a duty to conform to any applicable statutory provisions governing the organization of the provider and its related entities; and

(c) has the powers expressly or impliedly granted by the terms of its organizing entity or entities and the organizations providing for the financial reimbursement of medical goods and services it provides.

Of course, all the shortcomings of a uniform act must be acknowledged in this hypothetical exercise, as well as the advantages the statute could bring. The standards of conduct defined in a Prudent Provider statute will not immediately resolve all agency conflicts that arise in health care relationships; the law will have to evolve over time as courts interpret the rules and lawmakers amend the statute.³⁷⁷ The Prudent Provider provisions will have to be adapted to extend to insurers, plan administrators, and

377. See GEORGE GLEASON BOGERT ET AL., *THE LAW OF TRUSTS AND TRUSTEES* § 612 (2009).

other actors in the health care industry. All common law constructions will not be uniform, and some unintended consequences may result and require revision of the statute.³⁷⁸

Yet, the hypothetical Prudent Provider statute's helpfulness cannot be denied for three important reasons. First, it demonstrates that a state legislature, wishing to adopt a set of default fiduciary rules from agency law to govern and guide providers, patients, and third-party payers, could easily draft an enabling statute much along the lines of the UPIA. Second, as the UPIA places emphasis on an overall investment portfolio strategy for trustees, a similar statute might synthesize and bring the orderly legal regime of agency law to oversee the complex networks of obligations owed by health care providers to patients and those with whom they interact to access health care goods and services. Third, the broad acceptance of the UPIA—adopted in forty-three jurisdictions as of 2006³⁷⁹—offers a paradigm for creating the type of overhaul in the standard of care applicable to health care relationships. This shift would involve a transition from a predominately negligence-based regime, to a regime adopting the fiduciary medicine model advanced here. Most importantly, promulgating a statute to enact the fiduciary medicine model would establish legal guidelines that are flexible yet predictable in a way that will better serve the interests of patients who depend upon providers, and providers who desire to responsibly manage the loyalties they owe to their patients, payers, and the health care delivery system overall.

CONCLUSION

Prior to passage of the ACA, the disorder and misunderstanding that characterized fiduciary law in American health care jurisprudence left few casualties. The resulting body of conflicting health law cases was little help

378. See, e.g., Langbein, *supra* note 372, at 669 (describing the overall impact of the new uniform act in positive terms and declaring it a “giant first step”). Langbein described some of the act’s likely consequences as “unsettling”. *Id.* at 643.

379. BOGERT ET AL., *supra* note 373, §§ 616-666; see also MARILYN E. PHELAN, NONPROFIT ENTERPRISES: CORPORATIONS, TRUSTS, AND ASSOCIATIONS § 4.15 n.1 (2000 & Supp. 2009).

to the industry in ordering its affairs, and policymakers lost use of a legal paradigm that could have brought clarity to the health care industry. However, now that health reform promises to reconfigure the entire organizational landscape in which health care is delivered, financed, researched, studied, measured, and evaluated, the disorder and confusion are no longer tenable. American health reformers may have shunned the public option, a single-payer, and any true form of socialized medicine. But even the market-based reform that has emerged re-casts our federal and state governments into the central role as manager of competitive private insurance markets, subsidizer of public Medicaid and Medicare markets, and overseer of a national strategy to improve health care quality. Moreover, the ACA introduces a rash of new organizations and entities that have never before existed and have no precedent to guide their operation or interaction. Thus, the need for an orderly, well-developed body of law to implement and sustain the new entities and roles created by health reform could not be more urgently needed. Indeed, the viability of health reform may depend upon it.

This Article has constructed a fiduciary medicine model, capable of turning a well-intentioned but unguided series of fiduciary rules into a long-standing, judicially enforceable, predictable set of obligations to guide a network of health care providers, payers, and even governments in their work to provide universal health care. By bringing clarity to the legal rules that apply to health care delivery, the fiduciary medicine model makes three essential contributions. First, it gives depth and substance to the legal rules shaping the relationships that already exist in the health care delivery network. The fiduciary medicine model is both faithful and responsive to the fundamental physician-patient relationship that has been recognized from antiquity, but for which the laws of negligence and contract alone provide an insufficient regulatory base. Second, it enlarges the existing understanding of responsibilities and obligations that apply not only within the physician-patient relationship, but throughout the network of agency relationships among all providers, consumers, financiers, administrators, and organizers of health care delivery. Finally, the model provides a legal framework to organize and enforce the new relationships that will arise as the Patient Protection and Affordable Care Act is implemented.

The fiduciary law and other laws that regulated our prior health care landscape were as varied as the actors and organizations that comprised the industry itself. However, the reform that Congress has enacted seeks to construct and manage a system of markets that deliver coordinated and cost effective care. The fiduciary medicine model is a well-suited complement, able to deliver the coordinated, thorough, and efficient legal paradigm needed to regulate and preserve the new American health care system.