



<b>Title</b>	<b>Doctors as fiduciaries: A legal construct of the patient-physician relationship</b>
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# Doctors as fiduciaries: a legal construct of the patient-physician relationship

Fidelity is the most fundamental ethical principle regulating the medical profession, and it requires medical professionals (MPs) to put their patients' interests ahead of all others, including their own. The MPs who contracted and/or died of severe acute respiratory syndrome in the 2003 epidemic clearly illustrated both the glory and cost of living with this principle.<sup>1</sup> Yet, if we look at the four classic models of the patient-physician relationship (PPR): 'contractual', 'paternalistic', 'collegial', and 'mentoring',<sup>2</sup> none appears to mandate this level of fidelity from the MP, legally or ethically, because these models of the PPR have been narrowly construed to provide a normative evaluation of patient autonomy rather than professionalism and professional obligations. This may be why medical fidelity has not been given its proper place in modern bioethics. We need a PPR model that is more commensurate with this core value of the medical profession; the legal fiduciary model may be best suited the task.

The fiduciary concept is not new to the medical community; the PPR has been recognised as a fiduciary relationship (FR) in the West by the American College of Legal Medicine.<sup>3</sup> Beauchamp and Childress<sup>4</sup> unequivocally state that "The patient-physician relationship is a fiduciary relationship—that is, founded on trust or confidence; and the physician is therefore necessarily a trustee for the patient's medical welfare." Without explicitly mentioning the term 'fiduciary', the Council on Ethical and Judicial Affairs of the American Medical Association has stated: "The relationship between patient and physician is based on trust and gives rise to physicians' ethical obligations to place patients' welfare above their own self-interest..."<sup>5</sup>

## The characteristic attributes of a fiduciary relationship

### *Explicitly for the exclusive benefit of one party*

Most relationships exist for the mutual benefit of all parties, but an FR is explicitly established for the benefit of one party. In the paradigmatic FR of trustee-beneficiary, "the purpose of the relationship and the role and reason of one party in it [is] to promote the interest of the other".<sup>6</sup> As fiduciaries, trustees have a legal duty to act altruistically by relinquishing their

own self-interests and administering the trust solely on behalf of and in the interests of the beneficiaries. Likewise, a PPR exists for the benefit of the patient, and the functions performed by MPs are solely for the benefit of the patient, despite MPs being monetarily compensated for their services.

### *Delegated discretionary power*

In an FR, the beneficiary delegates discretionary powers to the fiduciary, eg principal-agent, who is then held to strict fiduciary standards of conduct. In the PPR, MPs are delegated discretionary power in matters of health care (eg prescribing medicine) by the community and for the benefit of the community, as well as directly from individual patients they attend to. In the course of treating patients, MPs often expose patients' bodies and solicit very personal information that would otherwise be strictly private. Patients forego privacy in deference to the MP's medical knowledge in order to facilitate their health care. Pellegrino<sup>7</sup> aptly remarks that "the knowledge the physician offers is not proprietary; ... [it] is not individually owned and ought not be used primarily for personal gain, prestige, or power. Rather, the profession holds this knowledge in trust for the good of the sick."

### *Inequality and susceptibility to abuse*

The acquisition of powers by one party implies an inequality of influence, knowledge, and bargaining ability in an FR, and this provides the fiduciary "a special opportunity to exercise the power or discretion to the detriment of that other person..." (Mason J in *Hospital Products Ltd v United States Surgical Corporation*, 1984). Inherent in the FR is the fact that the fiduciary is susceptible to misusing or abusing the entrusted power and position to promote his own interests or to undermine the beneficiary's interests or both. Similarly, in a PPR, MPs possess privileged information and technical superiority that endow them with significant power over patients, and render the MP susceptible to abusing that power and harming patients. Fiduciary safeguards are necessary to prevent such abuses.

### *Trust, vulnerability, and expectation*

In an FR, one party's position of power implies that the other party must repose trust and confidence: the

Latin root of 'fiduciary' means 'to trust'. In a PPR, because of the predicament of illness and the MP's monopoly of knowledge, patients must necessarily repose trust and confidence in MPs. The Canadian Supreme Court holds that trust and loyalty are the real basis for treating the PPR as an FR (McInerney v MacDonald, 1992), and imposes fiduciary obligations on MPs to act in their patients' best interests.

One party's ascendancy also entails the other party's dependence on and vulnerability to the former's exploitation and manipulation. Some legal experts consider dependence and vulnerability more important attributes than trust and loyalty in an FR. Patients in a PPR have transferred the necessary power to the MPs, leaving them vulnerable and at the MPs' mercy. Furthermore, a PPR is usually established at a time when patients are most helpless and least capable of protecting themselves, and are therefore entirely dependent on MPs. Some judges have compared the patient's vulnerability in a PPR to that between 'a parent and his child' or a 'guardian and his ward' and justified the law's use of fiduciary standards to regulate MPs for patients' protection.

### **Fiduciary obligation of fidelity as morality and law**

Once an FR is established, fiduciary obligations are due, and fidelity or loyalty is universally considered the most fundamental obligation: "the beneficiary is entitled to the uncompromised loyalty of and honest services provided by its fiduciaries, and... any act compromising that loyalty is, in and of itself, a harm to the principal."<sup>8</sup> In a PPR, MPs are bound by a professional duty of fidelity to put patients' interests above all others, even their own. Divided roles, interests, or activities that compromise loyalty or judgement and create a conflict of interest between patients and MPs are specifically disallowed.<sup>9</sup> For a social function as important as the PPR, this "fiduciary expectation" is justifiable and consistent with the Hippocratic tradition: "The actions of medical practitioners are supposed to promote the interests of patients above all others, including the physician."<sup>10</sup> Philosopher Hans Jonas summarises this duty: "In the course of treatment, the physician is obligated to the patient and to no one else. He is not the agent of society, nor of the interest of medical science, the patient's family, the patient's co-sufferers, or future sufferers from the same disease. The patient alone counts when he is under the physician's care...[H]e is bound not to let any other interest interfere with that of the patient in being cured....

We may speak of a sacred trust; strictly by its terms, the doctor is, as it were, alone with his patient and God."<sup>11</sup>

Fidelity is also a legal duty: "The law expects fiduciaries to be loyal to [beneficiaries], to be scrupulously honest with them, and to act solely for their benefit." (Johnson v Buttress, 1936). One court sums up the duty by saying: "The law of fiduciary duty rests...on the acceptance of the implications of the biblical injunction that '[n]o man can serve two masters.' (Matt. 6:24). Duty and self-interest, like God and Mammon, make inconsistent calls on the faithful. Equity solves the problem in a practical way by insisting that fiduciaries give undivided loyalty to the persons whom they serve." (Gaudron and McHugh JJ in Breen v Williams, 1995-1996). In this view, it is both unethical and illegal for the fiduciary to be in a position where interest and duty may conflict.

In many common law countries, fiduciary laws have been passed to deal with the abuse of loyalty by MPs. These laws impose a higher standard than traditional tort or contract principles<sup>12</sup> and may appear either as prescriptions or proscriptions or both. Proscriptive fiduciary laws exact loyalty from MPs by either (1) preventing MPs from exerting 'undue influence' over their patients, eg coercion, or (2) preventing the patient's trust from abuse, eg breaching confidence or abandoning patients. Prescriptive laws impose affirmative obligations on MPs to act in their patients' best interests and with good faith and loyalty. For example, the Canadian Supreme Court has held that professional conduct must take a form such that patients may perceive that "the duty of the doctor to act with utmost good faith and loyalty has been fulfilled," (La Forest J, McInerney v MacDonald, 1992) which may include affirmative duties such as allowing patients full access to their medical records, attending to sick people before their formal acceptance as patients in an emergency, or treating contagious high-risk patients in an epidemic even at the risk of harming themselves or their families.

### **Conclusion**

The monopoly, power, and ascendancy of the MP, and the dependence, trust, and vulnerability of patients justify our claim that the relational model that best describes the PPR is the FR, which takes fidelity as the fundamental norm for its regulation. This fiduciary expectation of fidelity creates a legal and moral affirmative duty for MPs to serve the patients' best

interests, even at the expense of their own, in both emergency and non-emergency situations.

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## Answers to CME Programme *Hong Kong Medical Journal* October 2005 issue

*Hong Kong Med J* 2005;11:331-5

### I. Kawasaki disease in Hong Kong, 1994 to 2000

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|---|----------|----------|----------|----------|----------|
| A | 1. True  | 2. False | 3. False | 4. False | 5. False |
| B | 1. False | 2. True  | 3. False | 4. False | 5. False |

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### II. Polycystic ovarian syndrome in Hong Kong Chinese women: patient characteristics and diagnostic criteria

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|---|---------|----------|----------|---------|----------|
| A | 1. True | 2. True  | 3. False | 4. True | 5. False |
| B | 1. True | 2. False | 3. False | 4. True | 5. False |