

PATIENT SAFETY AND THE FIDUCIARY HOSPITAL: SHARPENING JUDICIAL REMEDIES*

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I. INTRODUCTION

Banks evaporate, markets shed value, and jobs float ghost-like into economic history. We no longer trust our bankers and brokers, our realtors, our mutual fund administrators, and our regulators. Can our hospitals be far behind? They offer us treatment, but also all too often deliver unexpected infections, injury as the result of errors, aggressive debt collection practices, rude behavior, and concealment of secrets about their mistakes – not a pretty picture.

What does a hospital owe its patients? Should they promise us a trouble-free procedure or stay? Honest and candid disclosure of their mistakes? The best care currently available? And if they fail, what can we expect? A refund? Restitution for services that ended up valueless, damaging, or lethal? Damages for dishonesty as well as personal injury and suffering? An apology, plus all of the above? Shame?¹

My goal is to set out a preliminary agenda for expanding health care institutional responsibility for patient safety using fiduciary law, and its shadowy tracings in tort and regulatory law, to develop a richer model of responsibility. Part II will lay out a brief framework for fiduciary responsibility; Part III will look at judicial and regulatory developments that are creating the DNA for a fiduciary duty; Part IV will examine what such a role might mean for an institution; Part V will discuss regulatory and private sector attempts to incentivize institutional guarantees of safe health care; and Part VI concludes.²

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1. See generally David Ong, *Fishy Gifts: Bribing With Shame and Guilt* (Nov. 8, 2009) (unpublished working paper), available at <http://ssrn.com/abstract=1303051>.

2. This is the third article in my ongoing look at patient safety and its development in American health policy and law. Earlier articles include Barry R. Furrow, *Regulating Patient Safety: Toward a Federal Model of Medical Error Reduction*, 12 WIDENER L. REV. 1 (2005), and Barry R. Furrow, *Data Mining and Substandard Medical Practice: The Difference Between Privacy, Se-*

II. THE NATURE OF FIDUCIARY RESPONSIBILITY

Fiduciary law is a prime example of judge-made law intended to govern relationships laden with conflicts of interest. The law historically developed around commercial parties—agents, brokers, bankers, corporations, partnerships—and also parent-child relationships and trusts. A fiduciary in American law is someone who has a special obligation to look after the interests of another with loyalty and with the understanding that self-interest is to be subordinated to the interest of the other, vulnerable, person. Justice Cardozo described it this way:

Many forms of conduct permissible in a workaday world for those acting at arm's length, are forbidden to those bound by fiduciary ties. A trustee is held to something stricter than the morals of the market place. Not honesty alone, but the punctilio of an honor the most sensitive, is then the standard of behavior.³

Fiduciary analysis covers a multiplicity of behaviors, from corporate conduct to parent-child relations, but as a body of judge-made law, it lacks clear definition and clear duties—rather it fluctuates according to the context.⁴ As the Supreme Court wrote in *SEC v. Chenery* over sixty-five years ago: “[T]o say that a [person] is a fiduciary only begins analysis; it gives direction to further inquiry. To whom is he a fiduciary? What obligations does he owe as a fiduciary? . . . And what are the consequences of his deviation from duty?”⁵

Fiduciary law offers expressive norms to guide actors in roles we deem valuable, and we need to pay attention to those to whom the norms apply and the remedies that a breach of a fiduciary duty imposes. Fiduciary law does several useful things to promote the protection of beneficiaries and constrain fiduciary breaches.

First, it establishes a norm of special obligations, surrounding a role with higher expectations than we normally allocate

crets and Hidden Defects, 51 VILL. L. REV. 803 (2006) [hereinafter *Data Mining and Substandard Medical Practice*].

3. *Meinhard v. Salmon*, 164 N.E. 545, 546 (N.Y. 1928).

4. See D. Gordon Smith, *The Critical Resource Theory of Fiduciary Duty*, 55 VAND. L. REV. 1399, 1410 (2002).

5. 318 U.S. 80, 85-86 (1943).

to others in contract relationships. These norms may be internalized as part of the imposition of the fiduciary role. Relying on self-enforcement through internalization is, however, often a weak solution, since the counter-pressures are many. Fiduciary duty therefore provides additional incentives—it loads the fiduciary relationship with duties that raise the baseline for conduct and any measurement of failure and breach of duty.

Second, it gives special legal rights to those who are protected. It creates distinct procedural advantages compared with common law plaintiffs, at times creating a duty where none existed previously. The law may stop statutes of limitations from tolling, may relax proof requirements, or otherwise ease a plaintiff's burden of proof.

Third, it expands remedies to include not only normal tort damage claims but also punitive damages and the use of equitable tools.⁶ It opens up the arsenal of remedies to include classic equitable tools such as restitution⁷ and punitive damages.⁸

Fiduciary duty analysis typically assumes three dimensions.⁹ First, fiduciaries—as experts in their domains of knowledge—have, and need, substantial discretion in their ability to act. A fiduciary often deals with specialized knowledge requiring education and substantial experience with the sub-

6. See RESTATEMENT (SECOND) TORTS § 874 (1979) and its treatment of breach of fiduciary duty. Under section 874, “[o]ne standing in a fiduciary relation with another is subject to liability to the other for harm resulting from a breach of duty imposed by the relation.” Comment b suggests that the drafters saw breach of fiduciary duty as a tort, allowing recovery of money damages. Ordinarily, according to Comment b, “The remedy of a beneficiary against a defaulting or negligent trustee is . . . in equity; the remedy of a principal against an agent is . . . at law. However, irrespective of this, the beneficiary is entitled to tort damages for harm caused by the breach of duty arising from the relation . . .” *Id.* cmt. b. A plaintiff may be entitled to “restitutionary recovery,” to capture “profits that result to the fiduciary from his breach of duty and to be the beneficiary of a constructive trust in the profits.” *Id.* The plaintiff may also in some cases recover “what the fiduciary should have made in the prosecution of his duties.” *Id.*

7. Douglas Laycock, *The Scope and Significance of Restitution*, 67 TEX. L. REV. 1277, 1284, 1286 (1989).

8. Ernest J. Weinrib, *The Fiduciary Obligation*, 25 U. TORONTO L.J. 1, 15, 20 (1975). The fiduciary obligation, in its roots, “is a device for controlling and purifying the exercise of a discretion to advise or negotiate. More broadly it is part of a pervasive policy of the law to protect the integrity of commercial organizations.” *Id.* at 15.

9. For an excellent treatment of hospital fiduciary responsibilities in the Canadian context, see generally Moe Litman, *Fiduciary Law in the Hospital Context: The Prescriptive Duty of Protective Intervention*, 15 HEALTH L.J. 295 (2007), available at http://findarticles.com/p/articles/mi_hb1361/is_15/ai_n28566478.

ject.¹⁰ The fiduciary is a kind of “super” agent of the beneficiary for the same reasons that agents are necessary in complex relationships performing complex tasks. This is the more important component of fiduciary duty for my analysis of hospital duties to promote patient safety and protect patients.

Second, fiduciaries are powerful as a result of their special knowledge, skill, and experience—they can alter the interests of their beneficiaries through the unilateral exercise of their special power. The term “power” here means an ability to make changes that affect the entrustor.¹¹

Third, fiduciaries are expected to be loyal to their beneficiaries, given the beneficiaries’ dependence on the fiduciary and his power.¹² The relationship is grounded in disparities in power and access to information and experience. As a result the notion of the vulnerable beneficiary is often used, particularly to describe patients in the health care setting.

The core question therefore in fiduciary analysis is when the heightened norms of the role are justifiably imposed. The typical analysis is based on worries about conflicts of interest, aiming to set a high standard of behavior on the fiduciary in

10. See, for example, *Clay v. Thomas*, 198 S.W. 762, 767 (Ky. 1917), where the court talks about the “business acumen” of the trustee, suggesting that a trust exists to take advantage of the specialization of the professional manager. This trust relationship “presupposes superior business capacity, better judgment, and broader experience in commercial transactions possessed by the trustee, and there would be no occasion for the relationship, were these facts not true.” *Id.* See generally Alison Grey Anderson, *Conflicts of Interest: Efficiency, Fairness, and Corporate Structure*, 25 UCLA L. REV. 738, 740 (1978).

11. See Arthur J. Jacobson, *The Private Use of Public Authority: Sovereignty and Associations in the Common Law*, 29 BUFF. L. REV. 600, 603 (1980) (“The fiduciary relation is at once the minimum, or kernel, of association, and a distribution of a portion of sovereignty to one of the participants in the relation. All other associations—agency, partnership, joint stock company, trust, and corporation—are built upon this primitive element as a series of modifications of fiduciary relations.”).

12. A particularly useful analysis of loyalty can be found in Deborah A. DeMott, *Breach of Fiduciary Duty: On Justifiable Expectations of Loyalty and Their Consequences*, 48 ARIZ. L. REV. 925, 936 (2006):

My suggestion is that the definition of fiduciary relationship be cast in terms general enough to encompass the range of well-established circumstances in which fiduciary duties are conventionally applied, while also providing some analytic guidance to help a court determine whether the circumstances of a particular relationship also justify the imposition of fiduciary duties. *The defining or determining criterion should be whether the plaintiff (or claimed beneficiary of a fiduciary duty) would be justified in expecting loyal conduct on the part of an actor and whether the actor’s conduct contravened that expectation. This test turns on what’s distinctive about fiduciary duties—duties framed to safeguard loyalty to the interests of the beneficiary*

(emphasis added).

order to minimize his own self-serving opportunistic desires at the expense of the beneficiary's interests.¹³ The parent-child relationship and those of dependent adults develop this notion. The law thus defines as fiduciary those agency relationships in which the principal is unable fully to protect and assert his own interests, thus providing the agent a peculiar opportunity and incentive either to shirk or cheat.¹⁴ Detection and monitoring of dishonesty and shirking may simply be too difficult, and the doctrine recognizes that the agent's performance is complex and multifactorial, requiring substantial discretion.

These three attributes—specialized knowledge, power, and loyalty—describe a large sphere we cede to the fiduciary over important beneficiary interests. I want to expand this analysis of fiduciary duty into a tripartite perspective on fiduciary duty in the health care setting. Power remains one of the core attributes, properly focused on the centrality of special knowledge and access to special tools, resources, and experience; loyalty is a second, focused on the importance of reducing disloyalty through minimizing conflicts of interest in the health care relationship; and the third is stewardship,¹⁵ by which I mean the commitment of a provider to good management of complex assets and services. Stewardship captures the world

13. See Smith, *supra* note 4, at 1410. See generally Carol M. Rose, *Trust in the Mirror of Betrayal*, 75 B.U. L. REV. 531 (1995).

14. Elizabeth S. Scott, *Parents as Fiduciaries*, 81 VA. L. REV. 2401, 2419-20 (1995).

15. Health system stewardship is best defined in WORLD HEALTH ORG., THE WORLD HEALTH REPORT 2000: HEALTH SYSTEMS: IMPROVING PERFORMANCE 45 (2000), available at http://www.who.int/whr/2000/en/whr00_en.pdf:

The fourth function is called *stewardship*, because the concept is well described by the dictionary definition: *the careful and responsible management of something entrusted to one's care*. People entrust both their bodies and their money to the health system, which has a responsibility to protect the former and use the latter wisely and well. The government is particularly called on to play the role of a steward, because it spends revenues that people are required to pay through taxes and social insurance, and because it makes many of the rules that are followed in private and voluntary transactions. It also owns facilities on trust from the citizens. Private insurers and practitioners, however, perform this function in only a slightly restricted degree, and part of the state's task as the overall steward or trustee of the system is to see to it that private organizations and actors also act carefully and responsibly. A large part of stewardship consists of regulation, whether undertaken by the government or by private bodies which regulate their members, often under general rules determined by government. But the concept embraces more than just regulation, and when properly conducted has a pervasive influence on all the workings of the system.

(footnote omitted).

of institutional practices and complex systems and moves fiduciary law into modern health care delivery.

This stewardship prong of a health care fiduciary duty recognizes the situational risks of the health care setting, which poses a different problem from conflict of interest reduction. The fiduciary has to protect the beneficiary patient against external risks to her health, privacy interests, and safety. These risks might include hospital-based infections, medical errors during procedures, leakage of confidential patient information, physical harm from assaultive employees, and other third-party sources of injury. Patients as beneficiaries are especially vulnerable to these external risks of harm.¹⁶ To what extent then can patients rely on the hospital to act as a fiduciary to protect them from these external risks?¹⁷ This kind of "situational" vulnerability, in the words of one commentator, occurs when the risks are self-incurred as in commercial relationships.¹⁸ Trusts are classic situational vulnerabilities, in which the beneficiary is vulnerable to the trustee's power and prudence. The hospital setting seems to fall in the situational setting, in which the patient became dependent because of illness and has chosen a particular facility (or it was chosen for her by her physician).

In professional service-based fiduciary relationships, including physician-patient relationships, service providers who are fiduciary actors, at least ordinarily, have substantial influence over their patients and clients. This is so, even though these relationships operate within consent-based regimes which require free and informed choices to be made by patients and clients. In advisory and professional service relationships, important health, emotional, psychological, and economic interests of patients and clients are almost always subject to the powerful influence of expert fiduciary actors.¹⁹ This vulner-

16. See Weinrib, *supra* note 8, at 7; see also Tamar Frankel, *Fiduciary Law*, 71 CAL. L. REV. 795, 801, 809-10 (1983).

17. There is no doubt that patients are vulnerable in most health care settings, particularly in the hospital. Mark A. Hall, *The Legal and Historical Foundations of Patients as Medical Consumers*, 96 GEO. L.J. 583, 584-86 (2008).

18. Litman, *supra* note 9, at 301 ("It has been suggested that fiduciary law is concerned with 'personal' rather than 'situational' vulnerability. Personal vulnerability has been defined as 'the existence of a disadvantage compelling the individual who possesses it to deal with the world on less than equal terms.' Situational vulnerability, on the other hand, occurs when parties are placed or place themselves in circumstances where they are susceptible to harm.").

19. See generally Maxwell J. Mehlman, *Dishonest Medical Mistakes*, 59 VAND. L. REV. 1137

ability can be overstated, since vulnerability connotes a level of weakness that fails to capture many fiduciary relationships; it is not weakness so much as a disparity in power that puts the patient/beneficiary at risk. A person may be vulnerable before the relationship is established (guardian-dependent, provider-patient), but that vulnerability must implicate the power of the fiduciary before the law is concerned. As Moe Litman writes: "it is not vulnerability at large that fiduciary law is concerned with but vulnerability to the acts and omissions of a fiduciary actor."²⁰ This vulnerability and attendant trust fails to capture the essence of the role that health care presents and that fiduciary duty stands to correct.

III. THE DOCTOR-PATIENT RELATIONSHIP: POWER AND LOYALTY

Consider the case of Bonnie Rauch, an elderly woman who broke her elbow—an injury repairable through surgery.²¹ The risks of such surgery were very high for Bonnie—she was elderly and was taking a wide variety of medication for heart disease and other medical problems that would complicate any surgery. And the elbow repair could have waited, or other nonsurgical solutions could have been sought.²² Both ethical norms of beneficence and standards of good medical practice would dictate that the doctor not operate.

Beneficence assumes that the doctor does what is best for the patient. Respect for patient autonomy further requires that the patient be informed of the benefits, risks, and alternatives to a medical procedure. Decision making is shared, so that even if the standard of care is to perform the operation, the patient can say no. Bonnie Rauch's example represents the operation of both nonmaleficence and autonomy—ethical principles at the core of American contract law, absorbed into the tort doctrine of informed consent, and built into more complex decision making processes in hospitals and other institutions.

In Rauch's case, the surgeon operated and she died. His technique was flawless but his motivation and judgment were

(2006), for a useful discussion of the struggles of commentators over the very meaning of "fiduciary."

20. Litman, *supra* note 9, at 303.

21. Rauch v. Mike-Mayer, 783 A.2d 815, 818 (Pa. Super. Ct. 2001).

22. *Id.* at 818-19, 825-26.

suspect: he disregarded the patient's interests; he was disloyal in the sense that he ignored her personal condition; and he exerted his power against her best interests. The court allowed the case to proceed to trial, reversing summary judgment for the defendant in light of plaintiff's experts.²³ Much of the court's discussion focused on the duty of a hospital to protect patients like Bonnie from unnecessarily risky operations by implementing a surgical approval policy.²⁴ In other words, the court assumed, as part of their analysis of the expert testimony, the hospital's duty, fiduciary in nature, to protect their patients against a risk posed by one of their own staff physicians. We will revisit this new fiduciary duty in Section IV.

The notion of the physician as a fiduciary with obligations to protect vulnerable patients is the starting point for any ethical and legal discussion of health care providers' obligations.²⁵ The physician is motivated by classic ethical virtues of beneficence and nonmaleficence, in part in response to the vulnerability of patients and to the physician's superior knowledge and skill imparted by medical training. The courts have nipped and tugged at the edges of the provider-patient relationship, developing legal doctrines in malpractice cases, with informed consent doctrine as an important development. Judicially developed general legal and ethical principles govern the dyadic relationship of a sole practitioner and patient. What are the doctor's obligations to patients? Under what circumstances is a doctor responsible to patients?

A fiduciary obligation in medicine means that the physician focuses exclusively on the patient's health, the patient assumes the doctor's single-minded devotion to him, and the doctor-patient relationship is expected to be free of conflict. One ethicist defines a health care fiduciary as someone who commits to becoming and remaining scientifically and clinically competent, acts primarily to protect and promote the interests of the patient, keeps self-interest systematically secondary, and maintains and passes on medicine as a public trust for current

23. *Id.* at 828.

24. *Id.* at 826-28.

25. See generally THOMAS PERCIVAL, *MEDICAL ETHICS; OR, A CODE OF INSTITUTES AND PRECEPTS, ADAPTED TO THE PROFESSIONAL CONDUCT OF PHYSICIANS AND SURGEONS* (Classics of Medicine Library 1985) (2003).

and future physicians and patients.²⁶ Medical ethicists frequently speak of the doctor's special duties in relation to the patient, often characterizing the doctor as a special friend to the patient, connected by bonds of loyalty normally subsumed within the meaning of friendship. It is a strong agency relationship in which we trust the physician as our agent to look out for our best interests because we are unable to do so effectively.²⁷

A fiduciary or confidential relationship can exist without an express or implied contract. The relationship arises when one person reposes special trust and confidence in another person²⁸ and that other person—the fiduciary—undertakes to assume responsibility for the affairs of the other party. The person upon whom the trust and confidence is imposed is under a duty to act for and to give advice for the benefit of the other person on matters within the scope of the relationship.²⁹ Fiduciary duties, when they are applied in a health care relationship, are often described as the highest standard of duty imposed by law.³⁰

The fiduciary dimension of the physician-patient relationship imposes on the physician the duty of good faith and fair dealing,³¹ a duty not to be confused with the obligations of

26. LAURENCE B. MCCULLOUGH, A PRIMER ON BIOETHICS 3 (2d ed. 2006), available at <http://net.acpe.org/InterAct/Ethics/BioethicsPrimer.pdf>.

27. Hans Jonas describes this duty owed by the physician to a patient as a "sacred trust," an intense obligation to ignore social and other concerns which interfere with the care of the specific patient:

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 interests of medical science, nor of the patient's family, nor of his co-sufferers, or future sufferers from the same disease. The patient alone counts when he is under the physician's care [T]he physician is bound not to let any other interest interfere with that of the patient in being cured. But, manifestly, more sublime norms than contractual ones are involved. We may speak of a sacred trust; strictly by its terms, the doctor is, as it were, alone with his patient and God.

Hans Jonas, *Philosophical Reflections on Experimenting with Human Subjects*, in PHILOSOPHICAL ESSAYS: FROM CURRENT CRED TO TECHNOLOGICAL MAN 105, 124 (1980).

28. *Hope v. Klabal*, 457 F.3d 784, 791 (8th Cir. 2006); *Lank v. Steiner*, 213 A.2d 848, 852 (Del. Ch. 1965), *aff'd*, 224 A.2d 242 (Del. 1966).

29. *McRedmond v. Estate of Marianelli*, 46 S.W.3d 730, 738 (Tenn. Ct. App. 2000); RESTATEMENT (SECOND) OF TORTS § 874 cmt. a (1979).

30. *Overstreet v. TRW Commercial Steering Div.*, 256 S.W.3d 626, 642 (Tenn. 2008).

31. *Watts v. Cumberland County Hosp. Sys.*, 343 S.E.2d 879, 884 (N.C. 1986); *Black v. Littlejohn*, 325 S.E.2d 469, 482 (N.C. 1985); *Jacobs v. Physician Weight Loss Ctr.*, 620 S.E.2d 232, 236 (N.C. Ct. App. 2005).

physicians and medical care providers to exercise reasonable care. A breach of fiduciary duty may be considered constructive fraud, putting the burden on the physician to prove that he did not act for his own benefit. Fiduciary duty also has a duty of skill and competence, which is also the domain of torts, but here is refocused on the failure of loyalty rather than either care or skill. These two failures can overlap, since it is often hard to draw a line between the categories, and a tort violation can also create a claim for equitable jurisdiction and relief.³²

The law has layered obligations on the physician-patient relationship, in light of inherent conflicts. The patient, lacking equality in the relationship, is, in Judge Spottswood Robinson's words, "well nigh abject" due to his ignorance of medicine and uncertainty about treatment.³³ The law, acknowledging this inequality, and not completely trusting physician ethics and objectivity, has created legal frameworks to equalize the relationship and empower the patient.³⁴ The doctrine of informed consent is one such example, but disclosure obligations stretch beyond informed consent, to include disclosure of possible economic conflicts of interest, and even personal shortcomings of the physician independent of treatment risks, such as inexperience.³⁵ Other examples of special treatment include the confidentiality of medical information, the refusal to enforce waivers of liability, and the prohibition of lawyers' ex parte contacts with opposing parties' physicians.

Is trust the core value of health care fiduciary law? Preserving, justifying, and enhancing trust is the fundamental goal of much of medical ethics and a major objective in health care

32. See generally Litman, *supra* note 9 (discussing Canadian law).

33. *Canterbury v. Spence*, 464 F.2d 772, 782 (D.C. Cir. 1972).

34. See the writings of Eric J. Cassell for descriptions of the medical role and patient vulnerability. ERIC J. CASSELL, *THE NATURE OF SUFFERING AND THE GOALS OF MEDICINE* (1991); ERIC J. CASSELL, *THE HEALER'S ART* (1976). The law has accepted this notion of the power of physicians and their special knowledge. See 61 AM. JUR. 2D *Physicians, Surgeons, Etc.* § 142 (2002):

The relationship of physician and patient has its foundation on the theory that a physician is learned, skilled, and experienced in those subjects about which the patient ordinarily knows little or nothing, but which are of the most vital importance and interest to him, and therefore the patient must necessarily place great reliance, faith, and confidence in the professional word, advice, and acts of the physician or other practitioner.

35. See, e.g., *Johnson v. Kokemoor*, 545 N.W.2d 495, 507 (Wis. 1996) (discussing obligation of surgeon to disclose inexperience with a dangerous aneurysm surgical procedure).

law and public policy.³⁶ Mark Hall has argued that in the health care setting, trust must be a central goal.³⁷ He constructs a patient driven instrumental view of trust as underpinning the stability of the health care system. We do not completely trust our doctors because of situational pressures that may at times corrupt or at least tempt them. Doctors work for economic and other gains, as we all do; they are weak at times, prey to needs and pressures not aligned with those of their patients; they are under tremendous pressures from patients, insurers, their own needs, other doctors, and drug companies; and they work in complex systems. Conflicts of interest run through the physician-patient relationship, and as a result physicians may not always be loyal solely to patients and patient interests.

Is trust the key, however? Is the law's goal to create trust, or to promote fair dealing and excellence in practice? Trust by the beneficiary is an important aspect of fiduciary duty, but it focuses on the state of mind of the beneficiary, while my interest is on the nature of the role and loyalty owed by the fiduciary. The key to fiduciary duty in my analysis is the use of legal norms and legal remedies to promote the higher level of conduct to which we hold fiduciaries. To paraphrase Cromwell, "Put your trust in physicians, but keep your powder dry."³⁸

Once the physician-patient relationship is established, the law imposes a higher level of duty on physicians than normal contract law would require for arms-length transactions. The terms of the contract are largely fixed in advance of any bar-

36. Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 470-71 (2002) ("Trust is the core, defining characteristic of the doctor-patient relationship—the 'glue' that holds the relationship together and makes it possible. Preserving, justifying, and enhancing trust is a prominent objective in health care law and public policy and is the fundamental goal of much of medical ethics.").

37. *Id.* at 472.

38. In *Irish Minstrelsy Being a Selection of Irish Songs, Lyrics, and Ballads*, Halliday Sparling wrote:

There is a well-authenticated anecdote of Cromwell. On a certain occasion, when his troops were about crossing a river to attack the enemy, he concluded an address, couched in the usual fanatic terms in use among them, with these words—"Put your trust in God; but mind to keep your powder dry."

Halliday Sparling, *Preface* to Colonel Valentine Blacker, *Oliver's Advice*, in *IRISH MINSTRELSY BEING A SELECTION OF IRISH SONGS, LYRICS, AND BALLADS* 326 (Halliday Sparling ed., Adamant Media Corp. 2005) (1887).

gaining, by standard or customary practices that the physician must follow at the risk of liability for malpractice. We impute to both the physician and the patient standard intentions and reasonable expectations.³⁹ Second, principles of professional ethics impose fiduciary obligations on physicians in a variety of ways. Courts draw on these fiduciary obligations, looking outside the parameters of contract law analysis in judging the obligations of a physician to treat a patient. The courts stress that the physician's obligation to his patient, while having its origins in contract, is governed also by fiduciary obligations and other public considerations "inseparable from the nature and exercise of his calling."⁴⁰ Third, professionals are constrained in their ability to withdraw from their contracts by case law defining patient abandonment. A doctor who withdraws from the physician-patient relationship before a cure is achieved or the patient is transferred to the care of another may be liable for abandonment.⁴¹

Fiduciary rules aim to manage or reduce these conflicts of interest in health care. Numerous cases characterize the relationship as a fiduciary one and describe a range of physician failures that are defined as breaches of her fiduciary duty to her patient.⁴² The case law typically looks at the failures of an individual physician in her treatment of a patient.

A. Breaches of Patient Confidentiality

One of the fiduciary duties that a physician assumes when he undertakes to treat a patient is the duty to refrain from disclosing a patient's confidential health information unless the patient expressly or impliedly consents or unless the law requires or permits disclosure.⁴³ The scope of this fiduciary duty depends upon the particular agreement, if any, between the

39. See ROBERT GOODIN, PROTECTING THE VULNERABLE: A RE-ANALYSIS OF OUR SOCIAL RESPONSIBILITIES 63, 64-65 (1985).

40. Norton v. Hamilton, 89 S.E.2d 809, 812 (Ga. Ct. App. 1955).

41. See Cole v. Marshall Med. Ctr., Nos. C053066, C053344, 2007 WL 1576391, at *5 (Cal. Ct. App. June 1, 2007); Payton v. Weaver, 182 Cal. Rptr 225, 229 (Cal. Ct. App. 1982).

42. See, e.g., Stafford v. Shultz, 270 P.2d 1, 7-8 (Cal. 1954); Fure v. Sherman Hosp., 380 N.E.2d 1376, 1380 (Ill. 1978); Zeigler v. Ill. Trust & Savings Bank, 91 N.E. 1041, 1047 (Ill. 1910); Adams v. Ison, 249 S.W.2d 791, 792-93 (Ky. 1952); 61 AM. JUR. 2D *Physicians, Surgeons, Etc.* § 142 (2002).

43. Sorensen v. Barbuto, 177 P.3d 614, 617-18 (Utah 2008).

patient and the physician and upon the applicable state and federal statutes and regulations.

The physician's duty of confidentiality has been described as "far from revolutionary."⁴⁴ Most courts explain the role of a fiduciary duty in maintaining confidentiality as a pragmatic one:

Patients bear [sic] their bodies to their physicians with the expectation that what the physician hears and sees will remain unknown to others. If it were otherwise, patients would be reluctant to freely disclose their symptoms and conditions to their physicians in order to receive proper treatment. Accordingly, we have long recognized that physicians have a fiduciary relationship with their patients.⁴⁵

This duty of confidentiality is one of the most robust of the fiduciary duties, demonstrating judicial concerns about patient willingness to discuss intimate personal health details with their physicians if they cannot count on confidentiality of that information.

B. Concealment of Underlying Provider Negligence

Courts have also shown little patience for physician lies—concealment of their role in causing patient injury through malpractice. Courts have viewed such concealment as a form of lying that strips away some powerful legal defenses that would otherwise be available. Patients may suffer injuries that are concealed by their physicians until the statute of limitations runs on the patients' right to sue. Tort doctrine has developed a notice of equitable estoppel, or fraudulent concealment in some states, to bar the provider from raising an af-

44. *Sorensen v. Barbuto*, 143 P.3d 295, 300 (Utah Ct. App. 2006) ("[E]x parte communication between a physician and opposing counsel constitutes a breach of the physician's fiduciary duty of confidentiality."), *aff'd in part, rev'd in part*, 177 P.3d 614 (Utah 2008). Other courts have also observed that fiduciary duty is tied to patient confidentiality. *See, e.g., Doe v. Cmty. Health Plan-Kaiser Corp.*, 709 N.Y.S.2d 215, 217 (N.Y. App. Div. 2000) (recognizing gravamen of the complaint to be "fundamentally the breach of the fiduciary duty of confidentiality"); *Alexander v. Knight*, 177 A.2d 142, 146 (Pa. Super. Ct. 1962) ("[M]embers of a profession, especially the medical profession, stand in a confidential or fiduciary capacity as to their patients."); *Morris v. Consolidation Coal Co.*, 446 S.E.2d 648, 654 (W. Va. 1994) ("[A] fiduciary relationship exists between a treating physician and a claimant . . .").

45. *Overstreet v. TRW Commercial Steering Div.*, 256 S.W.3d 626, 642 (Tenn. 2008) (Koch, J., concurring) (citations omitted).

firmative defense of the running of the statute of limitations. If the doctor-patient relationship is a continuing one, the patient's need for diligence in discovering negligent causes of his condition is reduced. As one court wrote, "During the continuance of the professional, fiduciary relationship between the physician and the patient, 'the degree of diligence required of a patient in ferreting out and learning of the negligent causes of his condition is diminished . . .'"⁴⁶ As the Illinois Supreme Court wrote in *Witherell v. Weimer*,⁴⁷ "In the circumstances alleged to be present here, we believe that considerations of fundamental fairness require that the defendant doctors be held estopped by their conduct from now urging that plaintiff should have sooner complained against them for a condition they repeatedly assured her she did not have."⁴⁸ In other words, patients can count on their doctors to be straight with them when something goes wrong.

The equitable tool of estoppel blocks the defendant from raising an affirmative defense of the statute of limitations in such cases, leading in some states to a separate action for fraudulent concealment. This fiduciary principle is grounded on concealment, a lie perpetrated by a provider to protect his interests at the expense of the patient's right to sue.

This principle is readily applicable not only to physicians but also the hospitals and other institutional providers who have every incentive to conceal information about patient harms.

C. *Concealment of Economic Conflicts and Split Loyalties*

Courts have been less willing to impose an obligation on physicians to disclose putative economic conflicts of interest. This theory was frequently raised in the era of managed care litigation, and usually was rebuffed by the courts.⁴⁹ The major precedent to the contrary is *Moore v. Regents of the University of*

46. *Peik v. Kawesch*, No. D048562, 2007 WL 1821381, at *5 (Cal. Ct. App. June 26, 2007) (quoting *Sanchez v. S. Hoover Hosp.*, 553 P.2d 1129, 1135 (Cal. 1976)).

47. 421 N.E.2d 869 (Ill. 1981).

48. *Id.* at 876.

49. *See, e.g., Pegram v. Herdrich*, 530 U.S. 211, 237 (2000) (holding that "mixed eligibility decisions by HMO physicians are not fiduciary decisions under ERISA"); *Neade v. Portes*, 739 N.E.2d 496, 505-06 (Ill. 2000) (declining to "recognize a new cause of action for breach of fiduciary duty against a physician for the physician's failure to disclose HMO incentives").

California.⁵⁰ Moore alleged that his personal physician, Dr. Golde, failed to disclose the extent of his research and economic interests in Moore's cells before obtaining consent to the medical procedures by which the cells were extracted. The court held: "[A] physician who is seeking a patient's consent for a medical procedure must, in order to satisfy his fiduciary duty and to obtain the patient's informed consent, disclose personal interests unrelated to the patient's health, whether research or economic, that may affect his medical judgment."⁵¹

The fiduciary breach arguably offers a remedy and a norm that is broader than informed consent doctrine. Judge Broussard, concurring and dissenting, observed that the breach of fiduciary duty encompasses the postoperative conduct of defendants as well as the presurgical failure to disclose, so that the plaintiff can recover by "establishing that he would not have consented to some or all of the extensive postoperative medical procedures if he had been fully aware of defendants' research and economic interests and motivations."⁵² The fiduciary duty, unlike an informed consent cause of action, requires "only that the doctor's wrongful failure to disclose information proximately caused the plaintiff some type of compensable damage."⁵³ Both punitive and compensatory damages are available in such cases.

D. Disclosure of Inexperience and Provider Risks

Some informed consent controversies involve the question of whether the physician should have discussed and disclosed his experience with a procedure, and the merits of a referral of the patient to a more experienced surgeon.⁵⁴ In *Johnson v. Kokemoor*,⁵⁵ a case involving a difficult basilar bifurcation aneurysm surgery, the defendant surgeon, in response to patient

50. 793 P.2d 479 (Cal. 1990).

51. *Id.* at 485.

52. *Id.* at 500 (Broussard, J., concurring in part and dissenting in part).

53. *Id.*

54. See Aaron D. Twerski & Neil B. Cohen, *Comparing Medical Providers: A First Look at the New Era of Medical Statistics*, 58 BROOK. L. REV. 5, 27-33 (1992) (noting the development of sophisticated data regarding risks of various procedures and statistical models comparing the success rates of medical providers signal changes in informed consent law); see also Douglas Sharrott, Note, *Provider-Specific Quality-of-Care Data: A Proposal for Limited Mandatory Disclosure*, 58 BROOK L. REV. 85, 118-37 (1992).

55. 545 N.W.2d 495 (Wis. 1996).

questions, failed to disclose his lack of experience and the difficulty of the proposed procedure.⁵⁶ The court observed that “[a] reasonable person in the plaintiff’s position would have considered such information material in making an intelligent and informed decision about the surgery.”⁵⁷ Given a potentially lethal surgery and highly varied success rates among surgeons, the court allowed the admission of this statistical evidence. *Johnson* stands for a proposition that a surgeon’s experience or lack thereof may be material to a patient’s decision about whether to proceed with that particular doctor, not with the medical procedure itself. Where the procedure is intricate and challenging, so that experience matters a great deal, and comparative data is available, other courts have been sympathetic to allowing the jury to consider experience as part of the risks and benefits facing a patient.⁵⁸

In general, however, the *Johnson* principle of disclosure has not been enthusiastically expanded, since other courts have properly viewed the case as involving a unique collection of data regarding aneurysm surgery.⁵⁹ It has been seen as a special case.

As the federal government funds thousands of studies of effectiveness over the next few years, data as to outcomes and experience will be much more available, and if it is available, it should be disclosed and discussed with patients. This duty is

56. *Id.* at 499. See also *Goldberg v. Boone*, 912 A.2d 698 (Md. 2006), where the court allowed a “material risk” instruction in a case involving a complex mastoidectomy to remove a cholesteatoma. Plaintiff alleged that the surgeon should have informed him that, due to the hole in his dura, the revisionary procedure would be more complex than a standard revisionary mastoidectomy and that “there were more experienced surgeons to perform the procedure in the region than Dr. Goldberg, who only had performed one revisionary mastoidectomy in the past three years.” *Id.* at 702, 716-17.

57. *Johnson*, 545 N.W.2d at 50.

58. See *Goldberg*, 912 A.2d at 702-03; see also *Hales v. Pittman*, 576 P.2d 493, 496-98 (Ariz. 1978) (discussing the battery count of the plaintiff’s complaint, and proposing that the doctor should disclose both the general statistical success rate for a given procedure and his particular experience with that procedure); *Hidding v. Williams*, 578 So. 2d 1192, 1196-97 (La. Ct. App. 1991) (holding the physician’s failure to inform violated Louisiana informed consent requirements where plaintiff sued alleging, in part, that the physician had failed to disclose that he was a chronic alcoholic).

59. Most courts have resisted requirements that specific percentages of risks be disclosed, arguing that medicine is an inexact science. See *Kennedy v. St. Charles Gen. Hosp. Auxiliary*, 630 So. 2d 888, 892 (La. Ct. App. 1993); *Whiteside v. Lukson*, 947 P.2d 1263, 1265 (Wash. Ct. App. 1997); see also *Ornelas v. Fry*, 727 P.2d 819, 823-24 (Ariz. Ct. App. 1986) (refusing to allow evidence as to alcoholism of anesthesiologist as a separate claim of negligence, absent a showing that the physician was impaired at the time of the procedure).

only likely to expand in such a case. If experience matters in terms of patient risk, then hospital disclosure of its own and its physicians' outcomes experience is a logical extension of these early judicial statements of a duty to disclose experience or lack thereof.⁶⁰

E. Failures of Medical Professionalism

Claims of emotional distress in the health care setting are sometimes allowed to proceed to the jury, even without evidence of a breach of a standard of care or the support of expert medical testimony. Such cases illustrate the operation of a fiduciary duty owed by providers to patients under the right facts, easing the plaintiff's ability to sue and recover against a provider in an action for the negligent infliction of emotional distress. In *Campbell v. Delbridge*, the plaintiff, a Jehovah's Witness, was reinfused with blood even though he had given explicit instructions, which were in his medical record, that he refused such reinfusions.⁶¹ The court held that the heart of the plaintiff's claim was:

[T]hat the care provided by defendants . . . fell below the standard of medical professionalism understood by laypersons and expected by them. . . . The evidence concerning the lack of communication between the doctor and the PACU nurses, the possible mix-up in patient charts, and the doctor's admission of error are capable of being resolved by a fact finder without the testimony of experts.⁶²

Breaches of professionalism by health care providers have led to relaxation of the burden of proof by the courts.⁶³ Here

60. Experience does matter, in terms of volume of cases handled. See, e.g., Ioannis Rouvelas & Coa Jia et al., *Surgeon Volume and Postoperative Mortality After Oesophagectomy for Cancer*, 33 EURO. J. SURGICAL ONCOLOGY 162 (2007); Selywn. O. Rogers & Robert. E. Wolf et al., *Relation of Surgeon and Hospital Volume to Processes and Outcomes of Colorectal Cancer Surgery*, 244 ANNALS SURGERY 1003 (2006) (greater surgeon and hospital volumes associated with improved outcomes for patients undergoing surgery for colorectal cancer). See generally Richard J. Veerapen, *Informed Consent: Physician Inexperience is a Material Risk for Patients*, 35 J. L. MED. & ETHICS 478, 481-82 (2007).

61. 670 N.W.2d 108, 109 (Iowa 2003).

62. *Id.* at 112, 113 (quoting *Oswald v. LeGrande*, 453 N.W.2d 634, 638 (Iowa 1990)) (quotations omitted).

63. In *Oswald v. LeGrande*, the plaintiff gave birth to an apparent stillborn child, which turned out in fact to be alive, and lived briefly. 453 N.W.2d 634, 636-37 (Iowa 1990). The staff

it is the vulnerability of the plaintiffs to insensitive provider behavior that triggers a fiduciary analysis and invocation of the fiduciary benefits of a lowered standard of proof and relaxation of evidentiary rules.

IV. HOSPITALS AS SYSTEM FIDUCIARIES: THE MODEL OF STEWARDSHIP

A. *The Problem of Hospital-Caused Harm*

Provider-caused injury is a predictable feature of hospital care. American medicine harms too many patients, in spite of its technological prowess. It is only since 1999 with the Institute of Medicine report *To Err is Human*⁶⁴ that policymakers have started to pay serious attention to the extent of patient injury at the hands of the American health care system. Books with such titles as *Internal Bleeding: The Truth Behind America's Terrifying Epidemic of Medical Mistakes*⁶⁵ and *Wall of Silence: The Untold Story of the Medical Mistakes that Kill and Injure Millions of Americans*⁶⁶ lambast American medicine from a medical insider's perspective, or a patient's perspective, while medical journalists attack in books like *Demanding Medical Excellence*.⁶⁷

Patients suffer unnecessary injuries and death at the hands of health care providers, both because they receive substandard care and because they fail to get necessary and effective treatments. The Institute of Medicine's now familiar 1999 projection of up to 98,000 deaths per year, and hundreds of thou-

and physician acted badly in several ways toward the plaintiff and her husband, and the Iowa Supreme Court concluded:

No expert testimony is needed to elaborate on whether the statements by the nurses and Dr. Clark were rude and uncaring; a lay fact finder could easily evaluate the statements in light of the surrounding circumstances to determine whether the language used or message conveyed breached the standard of care expected of medical professionals, and determine the harm, if any, resulting to the plaintiffs.

64. COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* (Linda T. Kohn, Janet M. Corrigan, & Molla S. Donaldson eds., 2000) [hereafter cited as IOM REPORT], available at <http://www.nap.edu/books/0309068371/html>.

65. ROBERT M. WACHTER & KAVEH G. SHOJANIA, *INTERNAL BLEEDING: THE TRUTH BEHIND AMERICA'S TERRIFYING EPIDEMIC OF MEDICAL MISTAKES* (2004).

66. ROSEMARY GIBSON & JANARDAN PRASAD SINGH, *WALL OF SILENCE: THE UNTOLD STORY OF THE MEDICAL MISTAKES THAT KILL AND INJURE MILLIONS OF AMERICANS* (2003).

67. MICHAEL L. MILLENSON, *DEMANDING MEDICAL EXCELLENCE: DOCTORS AND ACCOUNTABILITY IN THE INFORMATION AGE* (1997).

sands of avoidable injuries and extra days of hospitalization,⁶⁸ has been enlarged by more recent analyses. A HealthGrades analysis of Medicare data projected a casualty rate almost twice the Institute of Medicine figures, or 195,000 deaths per year attributable to adverse medical events.⁶⁹ The Centers for Disease Control and Prevention (CDC) has estimated that medical errors, if ranked as a disease, would be the sixth leading cause of death in the United States, outranking deaths due to diabetes, influenza and pneumonia, Alzheimer's disease, and renal disease.⁷⁰ Others rank health care, more generally defined, as the third leading cause of death in this country.⁷¹

New market and regulatory initiatives have been developed to try to reduce these problems. The general strategies include legislative initiatives to force disclosure of hospital adverse events and "near misses" to state regulators; disclosure of adverse events to patients, accompanied by an apology; publication of performance data about relative risks; "Pay For Performance" initiatives from corporate groups that have spread to Medicare payment; and legal tools ranging from warranties of performance by some providers to patients to improvements in tort liability rules of disclosure of physician performance.⁷²

It is tempting to conclude that these initiatives mean real progress, but a hard look at the current regulatory picture suggests that these admirable efforts are glacial in nature in

68. IOM REPORT, *supra* note 64, at 26-27. But see Susan Dentzer, *Media Mistakes in Coverage of the Institute of Medicine's Error Report*, 6 EFFECTIVE CLINICAL PRAC. 305, 305 (2000) (noting that the statistic of 98,000 deaths per year, an extrapolation from a New York study, received all the media attention, while the much less newsworthy estimate of 44,000 deaths per year, an extrapolation from a Utah-Colorado study, received much less media attention), available at http://www.acponline.org/clinical_information/journals_publications/ecp/novdec00/dentzer.pdf.

69. HEALTHGRADES, INC., HEALTHGRADES QUALITY STUDY: PATIENT SAFETY IN AMERICAN HOSPITALS (2004), available at http://www.healthgrades.com/media/DMS/pdf/HG_Patient_Safety_Study_Final.pdf.

70. HEALTHGRADES, INC., HEALTHGRADES QUALITY STUDY: SECOND ANNUAL PATIENT SAFETY IN AMERICAN HOSPITALS REPORT (2005), available at <http://www.healthgrades.com/media/DMS/pdf/PatientSafetyInAmericanHospitalsReportFINAL42905Post.pdf>; see also CTNS. FOR DISEASE CONTROL & PREVENTION, DEPT. OF HEALTH & HUMAN SERVS., NATIONAL VITAL STATISTICS. REPORTS, DEATHS: PRELIMINARY DATA FOR 2002 4 (2004), available at http://www.cdc.gov/nchs/data/nvsr/nvsr52/nvsr52_13.pdf.

71. Bruce Spitz & John Abramson, *When Health Policy Is the Problem: A Report from the Field*, 30 J. HEALTH POL. POL'Y & L. 326, 329 (2005).

72. See generally Chapters 1, 4, 5, and 6 of BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS (6th ed. 2008), for a discussion of the various regulatory initiatives.

terms of real culture change in hospitals. As Brennan and Berwick observed more than a decade ago, "Variation in practice runs rampant—beyond the bounds of common sense. Hospitals and doctors continue to perpetrate harms in their work, albeit unintended ones. And it is no easier now to cause an alcoholic surgeon to stop operating than it was forty years ago."⁷³ Little has changed since they stated their critique.

The law needs to provide incentives toward the goal of "flawless execution," the health care equivalent of zero defects in industrial production generally.⁷⁴ Any analysis of hospital obligations to patients therefore begins with four basic propositions. First, a high magnitude of patient injury occurs through unsafe and ineffective practices. Second, we know in many of these cases of injury how to provide better care. Third, we also have the tools to ferret out evidence of bad, ineffective, and dangerous care and its causes, even though it is "concealed—buried under a mass of data in complex and often chaotic health care institutions."⁷⁵ Some risks are deliberately concealed, others are potentially discoverable but no effort is exerted to discover the problems. Fourth, we allow hospitals (and their physicians) to continue to practice bad medicine in spite of all we know.⁷⁶ Spitz and Abramson write:

What other industry would tolerate such disregard for professional standards? Who would buy their products? What would happen if we learned that defense contractors failed to follow production protocol 45 percent of the time and that ninety-eight thousand soldiers died annually because of the low quality of their equipment?⁷⁷

73. TROYEN A. BRENNAN & DONALD M. BERWICK, *NEW RULES: REGULATION, MARKETS, AND THE QUALITY OF AMERICAN HEALTH CARE* 339 (1996).

74. The phrase "flawless execution" is used by Robert M. Wachter, *The End of the Beginning: Patient Safety Five Years After 'To Err Is Human,'* HEALTH AFF., Nov. 30, 2004, at W4-534, W4-535, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.534v1>. He notes that as medicine has grown more complicated and sophisticated, the need for coordination has grown. "It should come as no surprise, then, that without a culture, procedures, and technology focused on flawless execution, errors would become commonplace. One study found that the average ICU patient experiences 1.7 errors per day, nearly one-third of which are potentially life-threatening. Most involve communication problems." *Id.* at W4-535.

75. *Data Mining and Substandard Medical Practice*, *supra* note 2, at 812.

76. See Mark R. Chassin, Robert W. Galvin, & Nat'l Roundtable on Health Care Quality, *The Urgent Need to Improve Health Care Quality*, 280 J. AM. MED. ASS'N 1000, 1002-03 (1998).

77. Spitz & Abramson, *supra* note 71, at 329.

Their point is that we tolerate a level of patient injury that would be unacceptable in other commercial or industrial settings. Why should this be allowed? And what can we require of hospitals to force them to improve their practices?

B. Legal Recognition of the Nature of the Hospital as a Fiduciary Enterprise

Consider the nature of the modern hospital. Hospitals are big businesses, spending millions marketing themselves through “expensive advertising campaigns.”⁷⁸ They provide a range of health services, and the public expects emergency care, radiological and other testing services, and other functions, as a result of hospitals’ self-promotion. And yet the legal relationships in the hospital are byzantine, creating two strongly autonomous management structures side by side: a hospital administrative structure in parallel with the hospital medical staff, which operates as a staff of independent contractors. The very existence of this odd structure shields hospitals from liability under agency law rules for the errors of their physicians, even when it is hospital systems that have allowed the physicians to fail.

Hospitals do not effectively inform the public about the legal consequences of this structure – which insulates them through the independent contractor defense to a vicarious liability claim – except in somewhat cryptic and confusing documents upon admission to hospitals. The courts have noted this confusing and troubling aspect of the hospital-physician-patient relationship, and have increasingly been willing to stretch agency exceptions.⁷⁹ Physicians may have independent judgment and discretion to treat, but health care is too complex to

78. *Kashishian v. Port*, 481 N.W.2d 277, 282 (Wis. 1992) (noting the substantial sums of money spent by U.S. hospitals on advertising in 1989, and the fact that many people recall such advertising).

79. *Baragan v. Providence Mem’l Hosp.*, No. 08-99-00028-CV, 2000 WL 1731286, at *2 (Tex. App. Nov. 22, 2000). The court ran through the arguments for aborting the independent contractor defense:

Hospitals are run much like any large corporation and must operate in a financially responsible manner. The community sees the hospital as the provider of medical services. Accordingly patients come to the hospital to be cured, and the doctors who practice there are perceived to be the hospital’s instrumentalities, regardless of the nature of the private arrangements between the hospital and a physician.

Id. (citations omitted).

relieve the hospital of its responsibilities for patient care.⁸⁰

A hospital arguably is a co-fiduciary with its physicians and staff, taking on a high duty to protect patient safety and health. McCullough has argued such a duty as a strong ethical obligation. He writes:

Healthcare organizations that deliver or influence the delivery of healthcare are co-fiduciaries with healthcare professionals of the population patients for whom the organization is responsible, so that each receives an evidence-based standard of care.⁸¹

The language of fiduciary duty has been creeping from ethical discussions about the doctor-patient relationship into legal discourse about errors in the hospital setting. Courts have noted that patients rely on hospitals, just as they rely on physicians, to treat their condition with loyalty and skill. Courts have also observed that patients in most cases rely on the reputation of the hospital, not any particular doctor, and for that reason select a particular hospital.⁸²

Courts have held that hospitals must follow their own rules for patient care because patients trust them to do so. In *Williams v. St. Claire Medical Center*, the court held that a hospital owes a duty to all patients, including the private patients of staff physicians, to enforce its published rules and regulations pertaining to patient care.⁸³ The nurse anesthetist was required under hospital rules to work under the direct supervi-

80. See *Scott v. SSM Healthcare St. Louis*, 70 S.W.3d 560, 568 (Mo. Ct. App. 2002) (“Physicians must be free to exercise independent medical judgment; the mere fact that a physician retains such independent judgment will not preclude a court, in an otherwise proper case, from finding the existence of an employer–employee or principal–agent relationship between a hospital and physician. Courts in other states, as well, have strongly rejected the notion that such a relationship cannot be found merely because the hospital does not have the right to stand over the doctor’s shoulder and dictate to him or her how to diagnose and treat patients.”) (citations omitted).

81. MCCULLOUGH, *supra* note 26, at 4.

82. See, e.g., *White v. Methodist Hosp. S.*, 844 S.W.2d 642, 647 (Tenn. Ct. App.1992). If the negligence results from emergency room care, most courts have held that a patient may justifiably rely on the physician as an agent unless the hospital explicitly disclaims an agency relationship. See *Ballard v. Advocate Health & Hosp. Corp.*, No. 97 C 6104, 1999 WL 498702, at *3 (N.D. Ill. July 7, 1999). A promotional campaign or advertising can create such reliance. See *Gragg v. Calandra*, 696 N.E.2d 1282, 1287-88 (Ill. App. Ct. 1998) (unless patient is put on notice of the independent status of the professionals in a hospital, he or she will reasonably assume they are employees); *Clark v. Southview Hosp. & Fam. Health Ctr.*, 628 N.E.2d 46, 52-53 (Ohio 1994) (promotional and marketing campaign stressed the emergency departments).

83. 657 S.W.2d 590, 594 (Ky. Ct. App.1983).

sion of a certified registered nurse anesthetist, and he was alone when he administered the anesthesia to the plaintiff.⁸⁴ Because of problems with the administration, the plaintiff went into a coma. The court stated:

[W]hile the patient must accept all the rules and regulations of the hospital, he should be able to expect that the hospital will follow its rules established for his care. Whether a patient enters a hospital through the emergency room or is admitted as a private patient by a staff physician, the patient is entering the hospital for only one reason . . . "Indeed, the sick leave their homes and enter hospitals because of the superior treatment there promised them."⁸⁵

Some American courts have begun to assume a fiduciary obligation in the hospital setting. The concealment or withholding of information has often led to acknowledgment of the special status not only of the physician but the hospital with regard to patient interests. As the court wrote in *Wohlgemuth v. Meyer*:

The doctor-patient relationship is a fiduciary one and it is incumbent on the doctor to reveal all pertinent information to his patient. The same is true of the hospital-patient relationship. In the event of the death of the patient while under the care of the doctor and the hospital, the spouse has a right to know the cause of death. Withholding information would in a sense amount to misrepresentation.⁸⁶

Academic writing has also argued that such a fiduciary duty can be placed on hospitals.⁸⁷

84. *Id.* at 594-95.

85. *Id.* at 594 (quoting *Univ. of Louisville v. Hammock*, 106 S.W. 219, 220 (Ky. 1907)).

86. 293 P.2d 816, 820 (Cal. Dist. Ct. App. 1956).

87. Academic commentators have also argued, or perhaps just assumed, that hospitals are fiduciaries, in special circumstances. See, e.g., Robert Gatter, *The Mysterious Survival of the Policy Against Informed Consent Liability for Hospitals*, 81 NOTRE DAME L. REV. 1203, 1268-70 (2006) ("As hospitals have taken on responsibilities to organize the delivery of health care to their patients, they enter into fiduciary relationships with each of their patients as well."); Maxwell Mehlman, *Fiduciary Contracting: Limitations on Bargaining Between Patients and Health Care Providers*, 51 U. PITT. L. REV. 365, 366 (1990) ("Hospitals, as health care providers, must also fulfill the obligations imposed by their fiduciary relationship with their patients."). Some commentators also characterize health insurers as fiduciaries for certain purposes. See, e.g., Clifford A. Cantor, *Fiduciary Liability in Emerging Health Care*, 9 DEPAUL BUS. L.J. 189, 212 (1997); Peter D.

Other courts have phrased the fiduciary duty more broadly to encompass not only staff privilege decisions but also patient safety. The court in *Grodjesk v. Jersey City Medical Center* wrote:

Judicial support should be given generally to hospital management decisions. Ordinarily, judicial judgments should not override the policies of an institution. However, courts should not be loathe to intervene when there has been a clear violation of the hospital's fiduciary duty to provide proper and adequate facilities for patient care or when there has been a deprivation of the constitutional right of its attending staff members to fully practice their profession.⁸⁸

We have seen health care get more expensive, insurance coverage shrink, and hospitals pursue aggressive bill collection techniques. Should our institutional providers be treated just like other providers, like car dealers or retailers? Or is there room for fiduciary obligations even where resources are scarce?

In *Muse v. Charter Hospital of Winston-Salem, Inc.*, a physician treating a depressed and suicidal teenager was faced with a limit on insurance coverage for the boy's treatment in the hospital.⁸⁹ Convincing evidence was presented (and believed by the jury) that Charter Hospital of Winston-Salem, Inc. had a policy or practice that required physicians to discharge patients when their insurance expired, and in the court's words, "this policy interfered with the exercise of the medical judgment of Joe's treating physician."⁹⁰

Joe Muse, a teenager, while in the hospital, had auditory hallucinations, suicidal and homicidal thoughts, and major depression. As his insurance coverage limits approached his doctor decided he needed a blood test to determine the proper dosage for an antidepressant drug. The blood test was scheduled the day after Joe's insurance was to expire. Joe's doctor asked for a two day extension. The parents signed a note to pay for the extra two days, but the test results did not come back three days later. Joe was discharged the day before and

Jacobson & Michael T. Cahill, *Applying Fiduciary Responsibilities in the Managed Care Context*, 26 AM. J.L. & MED. 155, 157 (2000).

88. 343 A.2d 489, 500 (N.J. Super. Ct. Ch. Div. 1975).

89. 452 S.E.2d 589, 593 (N.C. Ct. App. 1995), *aff'd*, 464 S.E.2d 44 (N.C. 1995).

90. *Id.* at 594.

referred to an outpatient therapist. After a short trip with his parents, Joe killed himself.⁹¹ The court, in reviewing the jury verdict for the plaintiffs on appeal, found strongly for the doctor:

[I]t seems axiomatic that the hospital has the duty not to institute policies or practices which interfere with the doctor's medical judgment. We hold that pursuant to the reasonable person standard, Charter Hospital had a duty not to institute a policy or practice which required that patients be discharged when their insurance expired and which interfered with the medical judgment of Dr. Barnhill.⁹²

How are we to interpret what the court is mandating? Surely doctors cannot dictate the level of unfunded care that a hospital must maintain; that is too complex a calculation for a clinician to make on the fly. Something both more limited and more potent is happening here. We see a strong judicial assertion of the primacy of the physician's clinical judgment trumping institutional resource limits, in an exceptional case where a patient's life is arguably at risk and a duty to treat has been assumed. We see the hospital therefore positioned by the court as a co-fiduciary, in McCullough's sense, obligated to protect one of its patients by respecting its own staff physician's assessment of risk for a high-risk patient. This species of fiduciary duty imposes an affirmative duty to continue the treating relationship in an extreme case, requiring absorption of costs in such a rare life-threatening context.⁹³ If harm results, then the hospital is liable in tort for money damages and possible punitive damages as well. The hospital may be a co-fiduciary with the physician in this case, but the sole defendant.

C. Hospital Board Responsibilities

Federal law requires that hospital bylaws reflect the hospital governing board's responsibility to ensure that "the medical

91. *Id.* at 593.

92. *Id.* at 594.

93. The problem with judicial pronouncements is that they are not always so limiting in their language and interpretation. The early *Wickline v. California* decision held, in a more nuanced decision, that a physician has to at least understand reimbursement constraints and be willing to push until their limits are reached. 239 Cal. Rptr. 810, 819 (Cal. Ct. App. 1986).

staff is accountable to the governing body for the quality of care provided to patients."⁹⁴ States typically also mandate that the governing board is responsible for the competence of the medical staff.⁹⁵

Most American hospitals are incorporated as non-profits under Section 501(c)(3) of the Internal Revenue Code. As such, the duties of nonprofit boards of directors have been limited by comparison to for-profit corporations. Compliance programs in the nonprofit healthcare context are usually for the purpose of detecting and preventing fraud in accordance with federal and state anti-fraud laws. Corporate negligence might apply to boards of trustees of hospitals, however, under the right set of circumstances.⁹⁶ The court in *Zambino* noted that Pennsylvania courts "have extended the doctrine of corporate liability to other entities in limited circumstances, such as when the patient is constrained in his or her choice of medical care options by the entity sued, and the entity controls the patient's total health care."⁹⁷

The corporate negligence argument is based on the duty of a board of directors of a nonprofit hospital not only to detect and prevent fraud, but to detect and prevent patient injury. It does not seem like such a stretch in an era of revelations about failures of patient safety. The traditional board fiduciary duties of care and obedience can arguably include responsibility of nonprofit hospital directors to ensure that the hospital promotes health. This new interpretation blends the oversight obligations stemming from the duty of care with the duty of obedience requiring obedience with the laws.⁹⁸

94. 42 C.F.R. § 482.12(a)(5) (2008).

95. See, e.g., *Lo v. Provena Covenant Med. Ctr.*, 796 N.E.2d 607, 614 (Ill. App. Ct. 2003) (holding that the hospital has an "inherent right to summarily suspend the clinical privileges of a physician whose continued practice poses an immediate danger to patients").

96. See, e.g., *Zambino v. Hosp. of the Univ. of Pa.*, No. 06-3561, 2006 WL 2788217, at *1 (E.D. Pa. Sept. 26, 2006).

97. *Id.* at *1-*2 ("The plaintiffs are entitled to develop a factual record to support the applicability of this theory of liability to the various hospital entities or affiliates they named as defendants. They may be able to show that the trustees, health system or urologic practice group are hospital entities, in which case, the defendants concede, plaintiffs may bring a corporate negligence claim against them."); see also *Fox v. Horn*, No. 98-5279, 2000 WL 49374, at *8 (E.D. Pa. Jan. 21, 2000) (applying doctrine to a company that contracted to provide physicians and medical services at a prison where the plaintiff was incarcerated); *Shannon v. McNulty*, 718 A.2d 828, 835-36 (Pa. Super. Ct. 1998) (extending doctrine to an HMO that provided health care services similar to a hospital).

98. See Sarah Kaput, *Expanding the Scope of Fiduciary Duties to Fill a Gap in the Law: The Role*

The reform of hospital corporate governance focuses on overcoming the lack of accountability that is frequently identified with the non-profit sector. Nonprofit directors are subject to fewer lawsuits than for-profit directors largely because nonprofit corporations have no shareholders.⁹⁹ Furthermore, hospital directors are well insulated from personal liability because of state shield laws.¹⁰⁰ These protections have historically minimized the possibility of increased penalties as a means to change behavior in the nonprofit sector. This appears to be changing, however, as nonprofits begin to act more like commercial hospitals. Studdert et al. see increased activity by regulators at all levels, and by private plaintiffs to counterbalance this push toward more market driven, less fiduciary actions. They note: "As nonprofit hospitals strike out in these directions, federal regulators, state officials, and plaintiffs will police the resultant frictions between the hospitals' business practices and their charitable obligations."¹⁰¹ Even some Sarbanes-Oxley principles are being applied to non-profits as well as for-profit boards, as the current climate increases demands for transparency and responsible action by all corporations.¹⁰²

It is time to test the principle that boards of directors of a hospital can be held to a fiduciary duty to protect patient safety or face the risk of litigation for their breach.

D. Corporate Negligence Law as a Fiduciary Doctrine

The law of corporate negligence is a malpractice doctrine that spells out the duties owed by a hospital to its patients to

of Nonprofit Hospital Directors to Ensure Patient Safety, 38 J. HEALTH L. 95 (2005); Russell Massaro, *Investing in Patient Safety: An Ethical and Business Imperative*, 56 TRUSTEE 20, 23 (2003); Peggy Sasso, *Searching for Trust in the Not-for-profit Boardroom: Looking Beyond the Duty of Obedience to Ensure Accountability*, 50 UCLA L. REV. 1485, 1529 (2003).

99. See, e.g., 15 PA. CONS. STAT. ANN. § 5752(a) (West 1995) (permitting nonprofit corporations to be set up on a stock or nonstick basis).

100. See, e.g., 15 PA. CONS. STAT. ANN. § 5741 (West 1995).

101. David M. Studdert, Michelle M. Mello, Christopher M. Jedrey & Troyen A. Brennan, *Regulatory and Judicial Oversight of Nonprofit Hospitals*, 356 NEW ENG. J. MED. 625, 631 (2007).

102. See Reni Gertner, *Non-profit Hospitals Facing Scrutiny Due to Sarbanes-Oxley Fallout*, DAILY REC. & KAN. CITY DAILY NEWS-PRESS, Mar. 3, 2006 ("Two provisions of Sarbanes-Oxley apply directly to non-profit entities: (1) the whistleblower provision, which says that an organization can't fire an employee for reporting illegal activities involving a federal issue; and (2) the document retention provision, which requires organizations to keep and maintain documents after they become aware of an investigation."), available at http://findarticles.com/p/articles/mi_qn4181/is_20060303/ai_n16193588/?tag=content;col1.

keep them safe, or face tort liability. The now-classic statement of this doctrine is found in *Thompson v. Nason Hospital*.¹⁰³ *Thompson* combines duties that can be found in isolation in the case law of other jurisdictions. Corporate negligence thus includes four hospital duties: (1) a duty to use reasonable care in the maintenance of safe and adequate facilities and equipment; (2) a duty to select and retain only competent physicians; (3) a duty to oversee all persons who practice medicine within its walls as to patient care; and (4) a duty to formulate, adopt and enforce adequate rules and policies to ensure quality care for the patients.¹⁰⁴

The rationale for an expanded view of hospital responsibility is well articulated in *Pedroza v. Bryant*.¹⁰⁵ The Washington Supreme Court noted the emergence of the modern hospital as a "multifaceted health care facility responsible for the quality of medical care and treatment rendered."¹⁰⁶ The *Pedroza* court went on to say:

To implement this duty of providing competent medical care to the patients, it is the responsibility of the institution to create a workable system whereby the medical staff of the hospital continually reviews and evaluates the quality of care being rendered within the institution. . . . The hospital's role is no longer limited to the furnishing of physical facilities and equipment where a physician treats his private patients and practices his profession in his own individualized manner.¹⁰⁷

The core duty of a hospital, duty one, is Selection and Retention of Competent Doctors, and in many jurisdictions, it is what is meant by corporate negligence. Probably the most important function of a hospital is to select high quality physicians for its medical staff.

Duty two, Maintenance of Safe Facilities and Equipment, is really an extension of common law obligations of all institutions that invite the public onto their property. It encompasses

103. 591 A.2d 703 (Pa. 1991).

104. *Id.* at 707.

105. 677 P.2d 166, 169-70 (Wash. 1984).

106. *Id.* at 169.

107. *Id.* (quoting *Moore v. Board of Trustees*, 495 P.2d 605, 608 (Nev. 2001)).

slip-and-fall cases, and all forms of injury that patients and visitors might suffer while in the hospital.

Duty three, Supervision of All Who Practice Medicine in the Hospital, captures the emerging fiduciary standard for hospitals. It encompasses staff physicians and all other health professionals, acknowledging that modern medicine is a “team” operation. Courts increasingly recognize the team nature of medical practice in hospitals, and liability follows from this recognition.

A prime example of an evolving judicial perception of the hospital’s obligations can be found in *Hoffman v. East Jefferson General Hospital*.¹⁰⁸ The plaintiff underwent two surgical procedures: a hysteroscopy with endometrial ablation and, while under the anesthesia, a laparoscopic cholecystostomy.¹⁰⁹ The first procedure was vaginal and the second was abdominal. Plaintiff suffered severe burns on her buttocks during the operation as the result of the use of a speculum that had been sterilized and was too hot.¹¹⁰ The hospital would sterilize the instruments and provide the means for cool down. It was the responsibility of hospital employees to communicate the status of the equipment—whether it was sufficiently cooled down—to the doctor, but the final decision as to when to use the equipment was the doctor’s.¹¹¹ The court found it was the responsibility of all members of the surgical team, whether hospital employees or independent doctors, to make sure the instruments were cool.¹¹² The use of “team responsibility” means that the hospital is a central actor in patient safety, as the manager of hospital teams. The hospital as co-fiduciary starts to take shape.

Thompson’s duty four, “to formulate, adopt and enforce adequate rules and policies to ensure quality care for the patients,” moves well beyond monitoring staff, drawing out scrutiny to how the institution operates as a system, and allowing plaintiffs to search for negligence in the very design of the operating framework of the hospital. In *Hook v. Auriemma*, the plaintiff argued that after colon surgery, she manifested

108. 778 So. 2d 33 (La. Ct. App. 2000).

109. *Id.* at 34.

110. *Id.*

111. *Id.* at 35.

112. *Id.* at 41, 43.

signs and symptoms consistent with an abdominal infection from a bowel perforation, but was not transferred to the intensive care unit.¹¹³ The court allowed the suit to proceed on *Thompson's* fourth duty.

Coordination of multiple providers, as well as effective team design, is part of the expanding role of the modern hospital. The problem with health care delivery is not just that patient care is complicated, but that institutional politics and the inertia that seizes hospitals as they struggle for revenue in tough health care markets makes change difficult. The malpractice cases are often striking for their description of the level of errors that providers have tolerated in chaotically managed institutions. Hospitals need strong policies to ensure coordination among providers as a patient undergoes complex procedures.¹¹⁴ In *Jennison v. Providence St. Vincent Medical Center*,¹¹⁵ the plaintiff sued the hospital and physicians after she suffered severe brain injury while recovering from surgery. The court of appeals held that there was sufficient evidence that the hospital was negligent in failing to have policies and procedures controlling verification of placement and use of central venous lines in the hospital's post anesthesia care unit.¹¹⁶ The court noted the shortcomings of the hospital's policies:

[The] hospital had no policy or procedure regarding the followup on central lines placed in the OR when a patient is transferred to the PACU. The call from radiology could potentially go to one of five different people, depending on whom the radiologist decides to call. Furthermore, no written documentation was required once one of those people received the call from radiology, thus precluding other people from knowing whether the call was ever actually made. Hospital's policy and procedure required verification, but it did

113. 74 Pa. D. & C.4th 186, 188 (Pa. Com. Pl. 2005).

114. Expert testimony is required to establish a corporate negligence claim, unless it involves simple issues such as structural defects within the common knowledge and experience of the jury. *See generally* *Neff v. Johnson Mem'l Hosp.*, 889 A.2d 921 (Conn. App. Ct. 2006) (noting the complexity of the staff credentialing process and holding that plaintiff needed an expert to determine what the standard of care was for a hospital in allowing a physician with three malpractice cases in his history to be recredentialed).

115. 25 P.3d 358 (Or. Ct. App. 2001).

116. *Id.* at 361-63.

not control what happened thereafter.¹¹⁷

We can begin to outline the nature of a hospital's fiduciary duty to patients, starting with clear obligations to coordinate care to minimize patient safety risks. The law of corporate negligence continues to expand, and it carries within this expansion the kernel of an expanding fiduciary duty on hospitals.¹¹⁸ The expansion is marked by the ready application of expanded duties of responsibility to patients, in which the hospital is viewed as a corporate management structure with responsibilities to its patients, measured by its own internal practices as well as those of other similar hospitals. It represents a real expansion of liability beyond the old view of the hospital as little more than a laboratory for the medical staff.

The adoption of a fiduciary role for hospitals would sharpen the definition of the hospital's coordination and management role, blurring the line between administration and the medical staff of so-called "independent contractors." It would expose administrators and even board members to potential liability and also justify punitive damages at times.

E. Corporate Transparency

1. Informing Patient Choices

The traditional view of the courts is that the responsibility for obtaining the patient's consent is the physician's, not the hospital's. And many courts continue to hold that the hospital only assists in administering the process, typically through its nursing staff, but has no duty except under very narrow circumstances. Older case law has often deferred to the expertise of the treating physician.¹¹⁹ The expansion of hospital responsibilities, however, includes a duty to obtain a proper informed consent from a patient under the right circumstances.¹²⁰ Institutional responsibility to ensure that a patient's

117. *Id.* at 363.

118. *See, e.g.,* *Larson v. Wasemiller*, 738 N.W.2d 300, 304-09 (Minn. 2007) (recognizing a negligent credentialing cause of action in Minnesota because hospital has a duty to protect patient from third parties).

119. *See, e.g.,* *Gotlin v. Lederman*, 367 F. Supp. 2d 349, 362 (E.D.N.Y. 2005); *Foster v. Traul*, 120 P.3d 278, 282 (Idaho 2005); *Cirella v. Cent. Gen. Hosp.*, 630 N.Y.S.2d 93, 93-94 (N.Y. App. Div. 1995).

120. *See* *Rogers v. Samson*, 276 F.3d 228, 234 (6th Cir. 2002) (holding that the hospital had a

informed consent is obtained generally exists only in two limited areas: (1) documentation of patient consent for the record, and (2) experimental therapies. If a nurse fails to obtain a properly executed consent form and make it part of the patient record, the hospital may be liable for this failure as a violation of its own internal procedures.¹²¹

Hospitals in fact assert substantial control over the consent process, through standardized forms and even new processes for automated consent. The U.S. Department of Veterans Affairs, for example, has been implementing an automated informed consent application known as iMedConsent™ in its medical centers,¹²² and many hospitals across the country are considering or implementing similar informed consent aids.¹²³ Hospitals control the consent process through their standard hospital forms.¹²⁴ And the Medicare program requires of hos-

duty to obtain a patient's informed consent to the removal of his entire penis in order to prevent the progression of necrotizing fasciitis throughout his groin area); *Magana v. Elie*, 439 N.E.2d 1319, 1322 (Ill. App. Ct. 1982) (holding that the hospital has duty to obtain patient's informed consent).

121. See, e.g., *Butler v. S. Fulton Med. Ctr., Inc.*, 452 S.E.2d 768, 772 (Ga. Ct. App. 1994). If a hospital participates in a study of an experimental procedure, it must ensure that the patient is properly informed of the risks of the procedure. See *Kus v. Sherman Hosp.*, 644 N.E.2d 1214, 1221 (Ill. App. Ct. 1995) (holding that "a hospital, as well as a physician, may be held liable for a patient's defective consent in a case involving experimental intraocular lenses" where hospital was part of a research study on intraocular lens implantation).

122. Consider the automated consent process described at DIALOGMEDICAL, THE CASE FOR INFORMED CONSENT (2005), <http://www.dialogmedical.com/collateral/Informed%20Consent.pdf>. The implementation of iMedConsent™ by the Veterans Health Administration is described in an information letter of February 22, 2007. This Veterans Health Administration (VHA) Information Letter clarifies expectations for use of the iMedConsent™ software program and establishes guidelines for local customization of the consent forms in the iMedConsent™ library. Informed consent for treatments and procedures is essential to high quality patient care. Implementation of national standards for the informed consent process will help ensure that veterans across the country receive the information that they need before giving their consent to treatment. Letter from VETERANS HEALTH ADMIN., DEPT. OF VETERANS AFFAIRS, DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT'S INFORMATION LETTER: VETERANS IMEDCONSENT™ GUIDANCE, IL 10N-2007-001 (2007), available at http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=1541.

123. For good general discussions of contemporary informed consent issues, see Steven Clarke and Justin Oakley, *Informed Consent and Surgeons' Performance*, 29 J. MED. & PHIL. 11 (2004); Heyward Bouknight, *Between the Scalpel and the Lie: Comparing Theories of Physician Accountability for Misrepresentations of Experience and Competence*, 50 WASH. & LEE L. REV. 1515 (2003); Robert Gatter, *Informed Consent and the Forgotten Duty of Physician Inquiry*, 1 LOY. U. CHI. L.J. 557 (2000); Frances H. Miller, *Health Care Information Technology and Informed Consent: Computers and the Doctor-Patient Relationship*, 31 IND. L. REV. 1019 (1998); Arnold J. Rosoff, *Informed Consent in the Electronic Age*, 25 AM. J.L. & MED. 367 (1999).

124. Consider the following language, taken from a standard hospital form:

Inpatient/Non-Surgical: *Consent to Medical and Surgical Procedures*. The under-

pitals that proper informed consent be obtained.¹²⁵

The language of hospital forms and the law imposing duties on hospitals to administer the process mandates a co-fiduciary duty on hospitals and treating physicians. What we observe here is that the hospital's duties to obtain a proper consent, along with other institutional providers, is expanding through federal law, which is indirectly building an extra layer of responsibility on the hospital as co-fiduciary. We see an erosion of the separation between the administration of a hospital and its medical staff as the law increases the obligations of hospitals to insure proper consent.

2. *Protecting Patient Information*

Hospitals not only collect informed consent information, they generate and store confidential patient information relevant to their treatment. Courts have recognized a common law tort of breach of confidential relationship that attaches to hospitals.¹²⁶ The Health Insurance Portability and Accountability Act (HIPAA) has now also become a source of standard-setting norms for providers.¹²⁷ The courts have allowed a

signed consents to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or procedures, or hospital services rendered to the patient under the general and special instructions of the patient's physician(s).

Surgical Patient: Consent to Medical and Surgical Procedures. The undersigned consents to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services, and which may include but are not limited to laboratory procedures, x-ray examination, anesthesia, medical or surgical treatment or procedures, or hospital services rendered to the patient under the general and special instructions of the patient's physician(s).

(on file with Author). These are labeled "condition of admission" and to be signed by all patients entering a hospital.

125. CTRS. FOR MEDICARE & MEDICAID SERVS., DEPT. OF HEALTH & HUMAN SERVS., REVISIONS TO HOSPITAL INTERPRETIVE GUIDELINES FOR INFORMED CONSENT, S&C-07-17 9 (2007), available at <http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter07-17.pdf>:

The medical record must contain a document recording the patient's informed consent for those procedures and treatments that have been specified as requiring informed consent. Medical staff by-laws should address which procedures and treatments require written informed consent. There may also be applicable Federal or State law requiring informed consent. The informed consent form contained in the medical record should provide evidence that it was properly executed.

126. See, e.g., *Doe v. Medlantic Health Care Group, Inc.*, 814 A.2d 939, 951 (D.C. 2003).

127. For a detailed analysis, see JANLORI GOLDMAN ET AL., AMERICAN ASSOCIATION OF RETIRED PERSONS, THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT PRIVACY

range of private actions that use HIPAA standards as a foundation for proof of informational privacy breaches. See, for example, *Herman v. Kratche* where the plaintiff's confidential medical records from non-work-related medical examinations were sent to her employer, Nestle USA, Inc.¹²⁸ These records were protected and should never have been sent. The court held that the clinic that sent the records was liable to the plaintiff because it made an unauthorized disclosure of her personal health information to her employer: "[A] physician's breach of a patient's confidence in the form of an unauthorized disclosure of that patient's medical information is an independent tort separate and distinct from the tort of invading one's privacy."¹²⁹

A fiduciary duty existed, according to the court, which found that the "Clinic, as plaintiff's medical provider, held a fiduciary position with plaintiff as its patient and had a duty to keep plaintiff's medical information confidential. There is also no doubt that the Clinic breached that duty."¹³⁰ And there was no HIPAA exception allowing such a disclosure. Courts have also been willing to use HIPAA standards for measuring a disclosure violation, so long as the suit is not based directly on HIPAA.¹³¹

3. *Error Tracking and Transparency*¹³²

Reports from the Institute of Medicine, beginning with *To Err Is Human*, focused attention on medical systems and the level of errors they produced. Hospitals and other providers were asked to respond by developing error tracking systems and strategies for improvement including disclosure of both errors and so-called "near misses," events that could have resulted in patient injury but were detected in time. It can be argued that hospitals—as fiduciaries obligated to protect pa-

RULE AND PATIENT ACCESS TO MEDICAL RECORDS, HEALTH PRIVACY PROJECT (2006), available at http://assets.aarp.org/rgcenter/health/2006_03_hipaa.pdf.

128. No. 86697, 2006 WL 3240680, at *1-3 (Ohio Ct. App. Nov. 9, 2006).

129. *Id.* at *2.

130. *Id.* at *3.

131. See, e.g., *Acosta v. Byrum*, 638 S.E.2d 246, 253 (N.C. Ct. App. 2006)

132. For a rich discussion of the merits of information disclosure, see generally William M. Sage, *Regulating Through Information: Disclosure Laws and American Healthcare*, 99 COLUM. L. REV. 1701 (1999).

tients—should have implemented such ideas decades before. As early as 1858, Florence Nightingale developed the use of statistical methodology to show the effects of unsanitary conditions in military field hospitals. Her approach laid the groundwork for standard statistical approaches for hospitals.¹³³

The idea of systematically tracking errors in hospitals was also promoted almost one hundred years ago by Dr. Ernest Codman, a Boston doctor who wanted hospitals and doctors to track their practices and evaluate outcomes of their patients, an ideal he developed around 1920. To Codman, patient harm due to infections or unnecessary or inappropriate operations was a hospital “waste product.” Such performance measurement was a clear threat to physicians, and when the American College of Surgeons (ACS) developed its program of hospital standardization after World War I, the analysis of patient outcomes and reporting of preventable errors—Codman’s most central ideas for error reduction—were omitted.¹³⁴

Reporting errors or adverse events is essential to system approaches. States that have mandatory reporting requirements for errors have found that underreporting is too often the norm. But the fact that underreporting occurs does not mean that performance cannot be improved.¹³⁵ A movement toward mandatory reporting models is observable. The Joint Commission Sentinel Events Policy and Procedures,¹³⁶ the new Centers for Medicare and Medicaid Services (CMS) rules on hospital error,¹³⁷ and the Pennsylvania statute creating the Pa-

133. FLORENCE NIGHTINGALE, NOTES ON MATTERS AFFECTING THE HEALTH, EFFICIENCY AND HOSPITAL ADMINISTRATION OF THE BRITISH ARMY (1858). See generally Bernard Cohen, Florence Nightingale, 250 *SCI. AM.* 128 (1984), available at <http://smccd.net/accounts/case/biol675/docs/nightingale.pdf>.

134. See VIRGINIA A. SHARPE & ALAN I. FADEN, MEDICAL HARM: HISTORICAL, CONCEPTUAL, AND ETHICAL DIMENSIONS OF IATROGENIC ILLNESS 31-32 (1998).

135. The reasons for such poor performance are several. Mandatory systems lack support from physicians, who are worried about liability, damage to reputation, and the hassle factor of any reporting system. See generally Brian Liang, *Promoting Patient Safety Through Reducing Medical Error: A Paradigm of Cooperation Between Patient, Physician, and Attorney*, 24 *S. ILL. U. L.J.* 541 (2000); J. ROSENTHAL ET AL., CURRENT STATE PROGRAMS ADDRESSING MEDICAL ERRORS: AN ANALYSIS OF MANDATORY REPORTING AND OTHER INITIATIVES (2001).

136. THE JOINT COMM’N, SENTINEL EVENT POLICY AND PROCEDURES 1, 3 (2007), available at http://www.jointcommission.org/NR/rdonlyres/F84F9DC6-A5DA-490F-A91F-A9FCE26347C4/0/SE_chapter_july07.pdf.

137. See Press Release, Centers for Medicare and Medicaid Servs., Eliminating Serious, Preventable, and Costly Medical Errors—Never Events (May 18, 2006) [hereinafter CMS Press

tient Safety Authority all require disclosure of errors.¹³⁸

Poor compliance with such disclosure requirements is inexcusable, particularly as to near misses—the analogy here might be to a trustee of a trust for minors who fails to implement the latest software to track stock and mutual fund prices of investments on behalf of the trust.¹³⁹

a. Sentinel Events and the Joint Commission

The Joint Commission is a private accreditor, granted authority by federal and state governments to accredit hospitals. The Joint Commission Sentinel Event Policy has adopted the view of medical errors of the Institute of Medicine report *To Err is Human*. It requires reporting on two levels: first to the Joint Commission, and second to patients. Sentinel events must be reported. A sentinel event is defined as “an unexpected occurrence involving death or severe physical or psychological injury, or the risk thereof,” including unanticipated death or major loss of functioning unrelated to the patient’s condition; patient suicide; wrong-side surgery; infant abduction/discharge to the wrong family; rape; and hemolytic transfusion reactions.¹⁴⁰ If hospitals fail to report serious events to the Joint Commission, and the Joint Commission learns of the events from a third party, the hospital must conduct an analysis of the root cause or risk loss of accreditation.¹⁴¹ Loss of ac-

Release], available at <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1863>.

138. 40 PA. STAT. ANN. § 1303.307 (West Supp. 2009).

139. See, e.g., John R. Clark, *Leadership Series: Is Your Institution Leaving Patient Safety Information at the Bedside?*, 4 PATIENT SAFETY ADVISORY 109 (2008), available at [http://www.patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2008/Dec5\(4\)/Pages/109.aspx](http://www.patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2008/Dec5(4)/Pages/109.aspx). Clark laments:

We noticed that some hospitals reported fewer than 10% of the average for their group. This means the average hospitals in their group gets 10 times the information about weaknesses in their systems as these low-reporting hospitals. . . . Hospitals that are not capturing near-miss, or Incident, events are hurting their ability to identify and correct problems before they harm patients. Hospitals with 10, 20, and 100 times more information are going to learn ways to improve their systems much faster.

Id.

140. THE JOINT COMM’N ON ACCREDITATION OF HEALTHCARE ORGS., HOSPITAL ACCREDITATION STANDARDS 53 (2001); THE JOINT COMM’N, *supra* note 136, at 1, 3.

141. THE JOINT COMM’N ON ACCREDITATION OF HEALTHCARE ORGS., SENTINEL EVENT ALERT (2002), available at <http://www.jointcommission.org/SentinelEvents/SentinelEventAlert>.

creditation is rarely exercised, however.¹⁴² The sentinel events policy is an error reducing and transparency promoting policy, exactly what we would expect from a hospital acting as a fiduciary on our behalf, ferreting out errors and informing us of them.

*b. "Never Events"*¹⁴³

The concept of "never events" was first developed by the National Quality Forum (NQF)¹⁴⁴ to describe gross medical errors, errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility. Examples of never events include: surgery on the wrong body part; foreign body left in a patient after surgery; mismatched blood transfusion; major medication error; severe "pressure ulcer" acquired in the hospital; and preventable post-operative deaths.

The never events development in twenty odd states is a major step, forcing providers to disclose adverse outcomes on the list to the state department responsible, with the goal of improving their operations. It is more than just information disclosure. It allows for systematic recording and tracking of errors, for purpose of analysis of patterns of adverse events, feedback to hospitals, and in some states, information for consumers as to the relative performance of hospitals and other providers. Many states have enacted legislation requiring reporting of incidents on the NQF list.¹⁴⁵ Minnesota in 2003 was one of the first to pass a statute requiring mandatory reporting of never events:

The Minnesota law requires hospitals to report the NQF's 27 "never events" (now 28) to the Minnesota Hospital Association's web-based Patient Safety Registry. The law requires hospitals to investigate each event, report its underlying cause, and take corrective

142. Lisa Girion & Rong-gong Lin, *Healthcare – Drastic Setback for OC Hospital*, L.A. TIMES, Dec. 6, 2008, at 1 (noting that Joint Commission revocation of accreditation is a rare occurrence).

143. CMS Press Release, *supra* note 137.

144. See National Quality Forum, <http://www.qualityforum.org/projects/completed/sre/> (last visited March 5, 2009).

145. See CMS Press Release, *supra* note 137.

action to prevent similar events. In addition, the Minnesota Department of Health publishes an annual report and provides a forum for hospitals to share reported information across the state and to learn from one another.¹⁴⁶

Other states, including New Jersey, Connecticut and Illinois, have adopted reporting requirements for never events.¹⁴⁷

4. *Disclosing Outcome Data to Promote Patient Choice*

Reporting of comparative outcomes of hospitals can be valuable to patients as they try to choose the best locus for their operations.¹⁴⁸ Infection control report cards are one such example.¹⁴⁹ Comparative data needs to be carefully extracted and presented, and such reports can help patients evaluate hospital performance.¹⁵⁰ It may not be easy to evaluate and compare institutions, but like so many quality measures, the technologies of data comparison can only improve as regulators increase the pressure for disclosure of such data, and norms of hospital performance change to incorporate such values.¹⁵¹

As general outcomes data accumulate and the methodolo-

146. CMS Press Release, *supra* note 137; see also MINN. STAT. ANN. § 144.7065 (West 2009).

147. CMS Press Release, *supra* note 137.

148. Martin N. Marshall et al., *The Public Release of Performance Data: What Do We Expect to Gain? A Review of the Evidence*, 283 J. AM. MED. ASS'N 1866 (2000); Eric C. Schneider & Arnold M. Epstein, *Use of Public Performance Reports: A Survey of Patients Undergoing Cardiac Surgery*, 279 J. AM. MED. ASS'N 1638 (1998).

149. See Robert A. Weinstein, Jane D. Siegel & P.J. Brennan, *Infection-Control Report Cards – Securing Patient Safety*, 353 NEW ENG. J. MED. 225 (2005).

150. *Id.* at 225 (“We have also learned that we must select denominators carefully in order to avoid artificial inflation or deflation of rates; that sophisticated information technology is required; and that it can be difficult to define useful benchmarks, especially for small hospitals, so that reporting a trend for a particular hospital may provide more useful information than does comparing hospitals.”).

151. Ashish K. Jha, Zhonghe Li, John Orav & Arnold Epstein, *Care in U.S. Hospitals – The Hospital Quality Alliance Program*, 353 NEW ENG. J. MED. 265, 272 (2005):

Our findings indicate that quality measures had only moderate predictive ability across the three conditions. Although a high quality of care for acute myocardial infarction predicted a high quality of care for congestive heart failure, the former was only marginally better than chance at identifying a high quality of care for pneumonia. These data do not provide support for the notion that ‘good’ hospitals are easy to identify or consistent in their performance across conditions. Our data suggest that evaluations of hospitals’ performance will most likely need to be based on a large number of conditions.

gies of collection improve, the argument for outcome disclosure becomes compelling. It has recently been proposed that “physicians have an ethical obligation to inform patients of hospital outcome disparities for select cancers.”¹⁵² One criticism of this approach was presented by Robert J. Weil, who objected to the locus of disclosure on the physician. He argued: “[I]t is unclear who exactly should disclose the hospital outcomes data to the patient. Does the burden of disclosure fall upon the surgeon or the hospital?”¹⁵³ Based on the shifting burden of obtaining informed consent, I would argue that disclosure should fall on the hospital. One can argue for a hospital duty to inform patients of hospital outcomes data, where such reliable data is available, as a logical extension of informed consent doctrine.¹⁵⁴

5. *Disclosing Adverse Events to Patients*

Adverse event reporting is often coupled with disclosure of classes of bad outcomes to patients and their families. This disclosure idea developed as the result of a program begun by a Veterans Administration (VA) hospital, and has been adopted by the VA system. It served as the model for Pennsylvania’s legislation creating the Patient Safety Authority. The VA, as of 2005, requires disclosure of adverse events to patients and their representatives, including adverse events that have or are expected to have a clinical effect on the patient or necessitate a change in the patient’s care.¹⁵⁵

152. See Nadine Housri, Robert J. Weil, David I. Shalowitz & Leonidas G. Koniaris, *Should Informed Consent for Cancer Treatment Include a Discussion About Hospital Outcome Disparities?* 5 PUB. LIBR. SCI. MED. 1413 (2008) [hereinafter *Informed Consent for Cancer Treatment*], available at <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.0050214>.

153. *Id.*

154. One can note, as Weil does in *Informed Consent for Cancer Treatment*, *supra* note 152, that there are problems with gathering such data and being sure that it is reliable, and still say that once reliability is achieved, a hospital’s duty is to share it with patients. The principle of transparency should govern in such a case.

155. See DEP’T OF VETERANS AFFAIRS, VETERANS HEALTH ADMIN., DIRECTIVE NO. 2005-049, DISCLOSURE OF ADVERSE EVENTS TO PATIENTS (2005), available at http://www.sorryworks.net/pdf/VA_Link.pdf:

(1) Adverse events that have had or are expected to have a clinical effect on the patient that is perceptible to either the patient or the health care team. For example, if a patient is mistakenly given a dose of furosemide (a diuretic that dramatically increases urine output), disclosure is required because a perceptible effect is expected to occur.

The Joint Commission disclosure standard also requires that “[p]atients, and when appropriate, their families, are informed about the outcomes of care, including unanticipated outcomes.”¹⁵⁶ The intent statement provides: “The responsible licensed independent practitioner or his or her designee clearly explains the outcomes of any treatments or procedures to the patient and, when appropriate, the family, whenever those outcomes differ significantly from the anticipated outcomes.”¹⁵⁷ This practitioner is someone with clinical privileges, typically the patient’s attending physician

Pennsylvania created a Patient Safety Authority that mandates reports to the Authority by hospitals of all “serious events.”¹⁵⁸ Fines may be levied for failures to report, and that statute provides for whistleblower protections, among other things.¹⁵⁹ Pennsylvania also adopted a patient notification requirement.¹⁶⁰ The patient notification requirements of the Joint Commission and the Veterans Administration raise the risk that patients will become aware of errors for the first time. The patient disclosure requirements of Joint Commission and the Pennsylvania statute have the potential to not only reduce medical errors but also the frequency of malpractice litigation, if done well.¹⁶¹

(2) Adverse events that necessitate a change in the patient’s care. For example, a medication error that necessitates close observation, extra blood tests, extra hospital days, or follow-up visits that would otherwise not be required, or a surgical procedure that necessitates further (corrective) surgery.

(3) Adverse events with a known risk of serious future health consequences, even if the likelihood of that risk is extremely small. For example, accidental exposure of a patient to a toxin associated with a rare, but recognized serious long-term effect (e.g., HIV infection or increased incidence of cancer).

(4) Adverse events that require providing a treatment or procedure without the patient’s consent. For example, if an adverse event occurs while a patient is under anesthesia, necessitating a deviation from the procedure the patient expected, the adverse event needs to be disclosed. Patients have a fundamental right to be informed about what is done to them and why.

156. THE JOINT COMM’N ON ACCREDITATION OF HEALTHCARE ORGS., REVISIONS TO JOINT COMMISSION STANDARDS IN SUPPORT OF PATIENT SAFETY AND MEDICAL/HEALTH CARE ERROR REDUCTION RI.1.2.2 (2001), available at <http://www.dcha.org/JCAHOREvision.htm>.

157. *Id.*

158. 40 PA. STAT. ANN. § 1303.308(a) (West 2002).

159. § 1303.308(c).

160. § 1303.308(b).

161. See Thomas H. Gallagher et al., *Patients’ and Physicians’ Attitudes Regarding the Disclosure of Medical Errors*, 289 J. AM. MED. ASS’N 1001 (2003) (finding that patients are troubled by the unwillingness of physicians to discuss the cause and future prevention of medical errors).

We see again a developing regulatory duty, both state and federal, to force hospitals to gather data and share it with the public. This form of transparency about adverse events and errors represents another form of evolution of the hospital to a different kind of fiduciary for its patient population.

V. REMEDIES AND FIDUCIARY DUTIES: WARRANTS OF PERFORMANCE

The high level of patient injury in American hospitals violates a patient's reasonable expectations of care within a health care system. It is not high quality care when the level of errors, some extremely destructive, is so high. One suggestion has been a regulatory approach that rewards institutional guarantees of safe health care, in order to motivate hospitals to provide high quality care. Brennan and Berwick propose a regulatory policy that requires providers to guarantee a safe level of care, with the accompanying promise of "prompt, easily claimed redress when that promise is broken."¹⁶² The guarantees might encompass "timely access, information exchange, modernity of therapy, and outcomes that are well within the reach of all providers of care."¹⁶³ Codman's idea of the end result report should be developed as a part of this, generating data on patterns of defects which can be analyzed in order to design improvements.

Tort reform circled around some of these questions, at least in the 1970s,¹⁶⁴ and then moved on to protecting physicians

The Sorry Works! Coalition has been heavily involved in promoting the benefits of an apology approach. See Sorry Works! Coalition, About Us, <http://www.sorryworks.net/about.phtml> (last visited Apr. 26, 2009). A partial list of academic articles includes: Jonathan R. Cohen, *Advising Clients to Apologize*, 72 S. CAL. L. REV. 1004 (1999); Douglas N. Frenkel & Carol B. Lieberman, *Words That Heal*, 140 ANNALS INTERNAL MED. 482 (2004); G.B. Hickson et al., *Factors That Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*, 267 J. AM. MED. ASS'N 1359 (1992); K.M. Mazor et al., *Communicating with Patients about Medical Errors: A Review of the Literature*, 164 ARCHIVES INTERNAL MED. 1690 (2003); K. M. Mazor et al., *Health Plan Members' Views About Disclosure of Medical Errors*, 140 ANNALS INTERNAL MED. 409 (2004); Lee Taft, *Apology and Medical Mistake: Opportunity or Foil?*, 14 ANNALS HEALTH L. 55 (2005).

162. BRENNAN & BERWICK, *supra* note 73, at 355. "Responsive regulation need not always specify the content of guarantees, but it can encourage a culture of ambition by ensuring that some guarantees exist and can be invoked easily when violated." *Id.*

163. *Id.* at 354.

164. Some of the reform proposals of the seventies, like Medical Adversity Insurance, offered payments for scheduled injuries, a more sophisticated precursor to the "Never Events" legislation of today. Medical adversity insurance, first proposed by Clark Havighurst and

from suits to the greatest extent possible.

A. Federal Reimbursement Policy

The CMS has adopted a nonpayment strategy that is based on the never event approach, recognizing the added costs to the Medicare program in treating the consequences of such events. This CMS position on never events and payment is a significant step toward "Pay for Performance." Tying Medicare payments to quality is a significant incentive for providers to reduce the levels of adverse events.¹⁶⁵ CMS writes:

Clearly, paying for "never events" is not consistent with the goals of these Medicare payment reforms. Reducing or eliminating payments for "never events" means more resources can be directed toward preventing these events rather than paying more when they occur. The Deficit Reduction Act represents a first step in this direction, allowing CMS, beginning in FY 2008, to begin to adjust payments for hospital-acquired infections. CMS is interested in working with our partners and Congress to build on this initial step to more

Lawrence Tancredi, was a system whereby a patient experiencing a medical outcome that is on a list of avoidable outcomes would be automatically compensated for certain expenses and losses, and foreclosed from any other recovery for those outcomes. Litigation or arbitration could be pursued for outcomes not covered by the policy. The lists of adverse outcomes would be developed by panels of doctors, lawyers, and consumers and this system could be imposed by statute or by contracts between providers and patients. See Clark Havighurst & Laurence Tancredi, "Medical Adversity Insurance" – A No-Fault Approach to Medical Malpractice and Quality Assurance, 51 MILBANK MEMORIAL FUND Q. 125 (1973); Clark Havighurst, *Medical Adversity Insurance – Has Its Time Come?*, 1975 DUKE L.J. 1233 (1975); Laurence Tancredi, *Designing a No-Fault Alternative*, 49 L. & CONTEMP. PROBS. 277 (1986). A variation on the Tancredi proposals was provided by Professor O'Connell, who proposed a variety of elective no-fault options using a list of covered injuries and contract agreements between providers and patients. See Jeffrey O'Connell, *Neo-No-Fault Remedies for Medical Injuries: Coordinated Statutory and Contractual Alternatives*, 49 L. & CONTEMP. PROBS. 125 (1986).

165. CMS will deny payment where hospital never events occur. The rule implements a provision of the Deficit Reduction Act of 2005 (DRA), Pub. L. No. 109-171, § 5001(c), 120 Stat. 4, 30 (2006), that takes the first steps toward preventing Medicare from giving hospitals higher payment for the additional costs of treating a patient who acquires a condition (including an infection) during a hospital stay. Already the feature of many state health care programs, the DRA requires hospitals to begin reporting secondary diagnoses that are present on the admission of patients, beginning with discharges on or after October 1, 2007. Beginning in FY 2009, cases with these conditions will not be paid at a higher rate unless they are present on admission. The rule identifies eight conditions, including three serious preventable events (sometimes called "never events") that meet the statutory criteria.

broadly address the persistence of “never events.”¹⁶⁶

CMS launched a national Quality Initiative in 2002.¹⁶⁷ The hospitals will be separated into deciles by performance. The top hospitals, in the top ten and twenty percent, will receive a two percent bonus payment. If hospital performance falls below the payment adjustment threshold by year three, the hospital will receive reduced Medicare reimbursement. The Medicare payment could be reduced by one or two percent.¹⁶⁸

How does this relate to a judicially constructed fiduciary obligation? It provides a federal standard for an expanded concept of the hospital as a warrantor of certain levels of performance, or they do not get paid. Since the government is the payer, in effect we have a performance contract.

B. *Private Warranties of Performance.*

One of the most interesting developments is the concept of a warranty of proper performance. The Geisinger Clinic, an integrated healthcare delivery system in northeastern Pennsylvania, has begun such a “warranty” program.¹⁶⁹ Their program warranties that forty key processes will be completed for every patient who undergoes elective coronary artery bypass graft (CABG).¹⁷⁰ Geisinger does not guarantee good clinical results, but it agrees to charge a standard flat rate to cover any necessary care for related complications during the ninety days after surgery.¹⁷¹ Geisinger is actively working to extend this approach to other surgical procedures, and diseases treated on an outpatient basis, such as diabetes and hypertension, could be next.¹⁷²

Treatment costs induced by errors and adverse events are usually either covered by insurance or absorbed by patients, families, insurers, employers and state and private disability

166. CMS Press Release, *supra* note 137.

167. See generally CTSS. FOR MEDICARE & MEDICAID SERVS., REWARDING SUPERIOR QUALITY CARE: THE PREMIER HOSPITAL QUALITY INCENTIVE DEMONSTRATION FACT SHEET (2004), available at <http://www.allhealth.org/BriefingMaterials/HospitalPremierFS200602-175.pdf>.

168. *Id.*

169. See Thomas H. Lee, *Pay for Performance, Version 2.0?*, 357 NEW ENG. J. MED. 531, 531 (2007).

170. *Id.*

171. *Id.*

172. *Id.*

and income support programs. This means that the adverse outcomes are externalized to other payors and not internalized by providers best able to reduce these hazards or prevent them. The added costs of a failed intervention caused either by error or by a failure to use an effective approach include added acute care costs, lost income, lost household production, and extra pain. As Leape and Berwick note:

[P]ayers often subsidize unsafe care quite well, although unknowingly. In most industries, defects cost money and generate warranty claims. In health care, perversely, under most forms of payment, health care professionals receive a premium for a defective product; physicians and hospitals can bill for the additional services that are needed when patients are injured by their mistakes.¹⁷³

Only tort suits have traditionally imposed these excess costs on the hospital or provider that was responsible for the patient's injury. There is a growing attempt to gather data, so that corporate purchasers can select providers based on the best treatments and survival rates. The Leapfrog Group is the most visible current example of this manifestation. Leapfrog members are encouraged to refer patients to hospitals with the best survival odds that staff intensive care units with doctors having credentials in critical care, and use error prevention software to prescribe medications.¹⁷⁴

VI. CONCLUSION: FIDUCIARY DUTY AS "PROTECTIVE INTERVENTION"

Tort litigation has evolved in the hospital setting, as the courts have stretched agency law and pushed the boundaries of other doctrines, albeit timidly. Tort suits may avoid traditional defenses like statutes of limitations, and punitive damages may expand the size of the award. Dissolution of the independent contractor defense opens the hospital to vicarious liability for medical staff errors. And new duties lie at the interface of fiduciary law and tort law.

173. Lucian L. Leape & Donald M. Berwick, *Five Years After To Err Is Human: What Have We Learned?*, 293 J. AM. MED. ASS'N 2384, 2388 (2005).

174. LEAPFROG GROUP, LEAPFROG GROUP FACT SHEET, http://www.leapfroggroup.org/media/file/FactSheet_LeapfrogGroup.pdf (last visited Apr. 6, 2009).

Fiduciary duties are expanding in tandem with expanded tort obligations. Warranty claims can force institutions to compete over best procedures. And the possibility of restitution of money spent on health care expands the incentive pressures on institutions to pay attention to patients as a central focus.

The recognition of institutional responsibility to better handle informed consent, disclosure of data, and revelation of errors turns the hospital finally into a recognizable legal fiduciary with an obligation to protect its patients from harm from third parties.¹⁷⁵

This duty of “protective intervention” captures the more intense obligations whose shadows we can see cast by regulatory initiatives and institution-assumed obligations. Hospitals now have to collect data on adverse events and report them to the state regulators and to patients in many states. They have to manage and coordinate their care to protect their patients. It is no longer a world in which the hospital is little more than a brick shell for physicians, with a loose contract relationship with patients.

A fiduciary duty provides the building blocks for remedies that strengthen the patient’s recovery opportunities. As Litman writes:

Affirmative obligation can import a broad duty to protect beneficiaries, not only from potential misconduct of fiduciaries themselves, but from potentially harmful behaviour of third parties and even other sources of potential harm. In the health care context, such an affirmative duty has the potential to enhance the security and safety of hospitalized patients.¹⁷⁶

Such an expansion pushes back against two decades of so-called tort reform that has weakened the ability of injured

175. Transparency raises the costs of noncompliance, which may include shame among other results for board members and hospital administrators who are perceived as having failed to act as a fiduciary for their patients. See David A. Skeel, Jr., *Shaming in Corporate Law*, 149 U. PA. L. REV. 1811, 1817 (2001). My colleague Alex Geisinger cautions however that the use of shaming is a complex process. See generally Alex Geisinger, *A Group Identity Theory of Social Norms and Its Implications*, 78 TUL. L. REV. 605, 608 (2004). I prefer legal tools that are backed with judicial muscle rather than the imprecise and often ineffective use of internalization reflected in shame analysis. That is not to say that norms do not change with their evocation by the courts.

176. See Litman, *supra* note 9.

plaintiffs to recover against hospitals. It strengthens the hands of internal hospital risk managers and compliance officers, as they advise administrators of the increasing necessity of implementing modern data mining, electronic medical records, reporting of adverse events, and better coordination and management of the institution.¹⁷⁷ And it properly imposes on hospital managers a higher duty to protect their patients, their beneficiaries, from harm to the greatest extent possible. They have become “fiduciaries,” stewards of their patients’ safety.

177. See generally Margo Schlanger, *Operationalizing Deterrence: Claims Management (in Hospitals, a Large Retailer, and Jails and Prisons)*, 2 J. TORT L. 1 (2008). Schlanger found that in hospitals, “damage actions regulate risky enterprise by inducing organizations to develop claims management capabilities—that is, the capacity to process any resulting disputes.” *Id.* at 2. She notes that these claims management practices and staff can “improve safety, reduce risk, and increase compliance with external legal requirements.” *Id.*