

*DEAR HARVARD HEALTH LAW WORKSHOP: Thank you for engaging with this piece. It is a work in progress that is very much still at an exploratory stage. Among other things I am especially eager for examples (or counterexamples) with which to flesh out the core dynamics I discuss in Parts II.B and III. I look forward to our discussion! ---CZ*

## FIDUCIARY STATUS AND PROFESSIONAL IDENTITY: DOCTORS AND BEYOND?

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### INTRODUCTION

There's a well-recognized puzzle in health law: are doctors fiduciaries for their patients? Courts regularly call doctors fiduciaries, but the label has limited doctrinal force. In this Article, I suggest that the label may nevertheless be doing powerful, though subtle, work. Legal recognition of fiduciary status can bolster the professional identity that we want doctors to inhabit, and that doctors themselves find most satisfying. It clarifies that society expects doctors to authentically prioritize their patients' interests, and that this is a matter of duty, not an option. Fiduciary status, and the clarity it confers, can thus be an ethical resource that fiduciaries can draw on as they make decisions, with potentially powerful real-world impact on doctors' mindset and behavior. In short, fiduciary status is not just a source of burdens, but a wellspring of professional meaning and even empowerment. This observation has

Recent years have seen an explosion in the identification of fiduciary relationships by courts<sup>1</sup> and commentators.<sup>2</sup> Some have criticized this

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<sup>1</sup> See, e.g., Tamar Frankel, *The Rise of Fiduciary Law*, SCHOLARLY COMMONS AT B.U. SCH. L. 1 (2018).

<sup>2</sup> Prominent scholars have argued that, among others, politicians, juries, information technology companies, and even friends, should all be understood as fiduciaries. See Daniel B. Yeager, *Fiduciary-isms: A Study of Academic Influence on the Expansion of the Law*, CAL.W. SCH. L. SCHOLARLY COMMONS 1, 45 (2016) (stating that scholars have recognized "voting, judging, governance, politics, juries, and friendship" as fiduciary) (footnotes omitted); Jack M. Balkin, *Information Fiduciaries and the First Amendment*, 49 U.C. DAVIS L. REV. 1183, 1121 (2016) (arguing that in the digital age, online service providers, such as Facebook and Uber, assume fiduciary responsibilities "because we trust them with sensitive information"); James Grimmelman, *Speech Engines*, 98 MINN. L. REV. 868, 904 (2014) ("Search engines are not on the list of traditional fiduciaries, but the

expansion as gutting the meaning of the fiduciary role in its core contexts; others have argued that this “fiduciary creep” (especially in its more expansive recent entrants into public law domains) should be analyzed as a phenomenon that speaks to some broader feature of the current legal or social world.<sup>3</sup> Within the health law setting, scholars have recently argued that the fiduciary model should be expanded from doctor/patient relationships to new institutional and organizational settings.<sup>4</sup>

This article takes a step back and asks why the fiduciary label matters. In the context of medical care, at least part of the reason is that fiduciary status serves as an identity marker and ethical lodestar that structures decision-making. It can bolster the other-regarding core of the professional identity, add clarity to decision-making in tough cases or when there are multiple reasonable courses of action, and empower doctors faced with circumstances or policies that are not in their patients’ interests.

Whether this logic applies beyond doctors—to other caretakers, or to other professional settings entirely—is a question my analysis provokes but does not fully resolve. At minimum, however, it is worth considering whether the professional identity and ethical tools fiduciary status can provide would serve other caretakers well. I thus explore how fiduciary status might bolster and empower direct caretakers like nursing assistants and home health aides, who lack the professional status and gatekeeping power

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list is not closed. . . . [S]cholars argu[e] for treating legislators, judges, jurors, and even friends as fiduciaries.”) (footnotes omitted). *See also* Samuel L. Bray & Paul B. Miller, *Against Fiduciary Constitutionalism*, VA. L. REV. 1479, 1480 (2020) (highlighting that “a number of scholars have argued that the U.S. Constitution resembles a fiduciary document, and that it imposes fiduciary duties on various actors, including the President of the United States.”) (footnote omitted); Frankel, *The Rise of Fiduciary Law*, *supra* n.2, at 1–2 (arguing that fiduciary relationships are grounded in “legal areas, such as family law, surrogate decision-making, international law, agency law, employment law, pension law, remedies law, banking law, financial institutions’ regulation, corporate law, charities law[,] not for profit organizations law, and the law concerning medical services”, as well as other areas of knowledge, including economics, psychology, moral norms, and pluralism) (footnotes omitted); EVAN J. CRIDDLE & EVAN FOX-DECENT, *FIDUCIARIES OF HUMANITY: HOW INTERNATIONAL LAW CONSTITUTES AUTHORITY* 2 (2016) (characterizing states and international institutions as “fiduciaries of humanity”).

<sup>3</sup> *See, e.g.*, David Pozen, *Fiduciary Creep*, BALKINIZATION (March 2, 2020).

<sup>4</sup> Professor Barry Furrow, for instance, has argued for and provided a template for holding hospitals and health organizations liable as fiduciaries in a variety of settings. *See, e.g.*, Barry R. Furrow, *Patient Safety and the Fiduciary Hospital: Sharpening Judicial Remedies*, 1 DREXEL L. REV. 439 (2009); Furrow, *Don’t Let Go of the Rope*, tk. Dayna Bowen Mathew has argued, along similar lines, that fiduciary rules from derived from agency law should be extended to organizational actors implementing the mandates of the Affordable Care Act. Tk cite. Professor Isaac Buck, along similar lines, has argued that physicians’ fiduciary relationships should be expanded to include not only patients but also payors, and specifically to the payors of Medicare—that is, taxpayers generally. Isaac Buck, *Furthering the Fiduciary Metaphor: The Duty of Providers to the Payors of Medicare*, 104 CALIF. L. REV. 1043 (2016).

of doctors but, at their best, practically function with the mindset of a fiduciary as they care for some of our most vulnerable.

The Article proceeds as follows.

Part I traces the current difficulties surrounding the question of whether doctors are or should be categorized as “fiduciaries.” Courts regularly, but not uniformly, say that doctors are fiduciaries, or at least fiduciary-like. Yet they regularly decline to enforce fiduciary duties against physicians for a range of doctrinal reasons.<sup>5</sup> More generally, there is no coherent body of physician fiduciary law as we might expect to see in other fiduciary contexts. In assessing these trends, health law scholars tend either to focus on fiduciary duties’ impact on patient trust, or treat courts’ fiduciary language as simply a descriptive metaphor that may be more or less useful in describing doctors’ increasingly complex role in the modern world.<sup>6</sup> Scholars of fiduciary law, when they discuss doctors at all, tend to justify the status primarily with reference to doctors’ gate-keeping functions and the need to protect against the risks of self-dealing.<sup>7</sup>

Part II brings to the surface an important, and underappreciated, set of reasons that the fiduciary label can be powerful, related to the impact of formal fiduciary status on the fiduciary themselves. Fiduciary status can be meaning-generating, emboldening, and empowering, not just burdensome. Conferring fiduciary status on a group may affect their professional self-conception, as well as their understanding of what role society expects them to play. This may be especially important for those who would like to behave as fiduciaries, prioritizing their charges’ interests as much as possible, but who feel competing demands (e.g. from employers) to prioritize other concerns. Fiduciary status can bolster one’s ability (and will) to say to an employer or even the public: as a fiduciary for another party, I must resist the policy that you seek to impose. After making the point in general, I argue that legal recognition of the fiduciary status for doctors, in particular, may plan an important function in reinforcing doctors’ core sense of professional identity and clarifying their decision-making process in close cases.

Part III explores whether these dynamics counsel in favor of expanding fiduciary status more broadly in healthcare, especially to direct caretakers like nursing assistants and home health aides. If fiduciary status helpfully bolsters and empowers professionals like doctors, it may also promote a sense of agency and patient-oriented empowerment for lower-status caretakers, who frequently function as *de facto* fiduciaries for the very vulnerable, notwithstanding the low status afforded to their roles. At minimum, we should think seriously about whether or how those same

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<sup>5</sup> See *infra* n.tk.

<sup>6</sup> See *infra* n.tk.

<sup>7</sup> See *infra* n.tk.

benefits could be realized for those in these less professionalized and otherwise-disempowered roles.

### I. DOCTORS AS FIDUCIARIES: STATUS OR METAPHOR?

It is commonplace for courts to say that doctors are fiduciaries for their patients.<sup>8</sup> Often, the status offered in passing, without really fleshing out its implications.<sup>9</sup> Other times, doctors are held out as paradigmatic examples of fiduciaries,<sup>10</sup> complete with soaring rhetoric.<sup>11</sup> But as courts regularly acknowledge doctors' fiduciary status, the doctrinal consequences are murkier and sparser than one might expect.<sup>12</sup> Moreover, the appropriateness of fiduciary status—along with the concrete upshots that status does or should have for doctors—remains a veritable font of academic hand-wringing and ink-spilling.<sup>13</sup>

#### A. *Doctors, according to the Courts: Fiduciaries, but more in name than in practice*

United States courts have regularly characterized doctors as fiduciaries since the 1970s, and the provenance of the label traces back even farther.<sup>14</sup> And while commentators have at various points predicted that structural

<sup>8</sup> See Max Mehlman, *Why Physicians are Fiduciaries for their Patients*, 12 IND. HEALTH L. REV. 1, n.5 (2015) (providing an impressive collection of examples).

<sup>9</sup> See, e.g., *Cox v. Athens Reg'l Med. Ctr., Inc.*, 631 S.E.2d 792, 798 (Ga. Ct. App. 2006) fn. 14 (“We note that, ordinarily, physicians owe a fiduciary duty to their patients with respect to the care given.”); tk.

<sup>10</sup> Trustees, agents, and corporate directors are the more typical paradigmatic fiduciaries.

<sup>11</sup> See, e.g., *Lockett v. Goodill*, 430 P.2d 589, 591 (Wash. 1967) (“The relationship of patient and physician is a fiduciary one of the highest degree. It involves every element of trust, confidence and good faith.”). *Petrillo v. Syntex Lab'ys, Inc.*, 148 Ill. App. 3d 581, 594 (1986) (describing fiduciary duty of good faith as protecting the “sanctity” of the physician-patient relationship); tk more.

<sup>12</sup> See MARK A. HALL, FIDUCIARY PRINCIPLES IN HEALTH CARE, in THE OXFORD HANDBOOK ON FIDUCIARY LAW (Evan J. Criddle et al. eds., 2019) (providing overview of the range of settings in which courts and scholars continue to struggle with doctrinal consequences of fiduciary role for physicians); see also, e.g., *Birriel v. Odeh*, 431 B.R. 807, 813 (Bankr. N.D. Ill. 2010) (noting that “Illinois has long recognized a fiduciary relationship between a physician and patient,” but that “[t]here appears to be no reported Illinois decision in which a physician has been found subject to a claim for breach of fiduciary duty.”).

<sup>13</sup> The examples are manifold. tk.)

<sup>14</sup> See, e.g., *Wohlgemuth v. Meyer*, 293 P.2d 816, 820 (Cal. Ct. App. 1956) (“The doctor-patient relationship is a fiduciary one”); Thomas L. Hafemeister & Richard M. Gulbrandenson, *The Fiduciary Obligation of Patients to Just Say No if an ‘Informed’ Patient Demands Services that are Medically Unnecessary*, 39 SETON HALL L. REV. 335, n.tk. (2009) (tracing development of doctors' status as fiduciary in early 20<sup>th</sup> Century cases and collecting cases).

changes to the delivery of care (especially, for instance, the development of managed care in the '90s) would strain the utility of the fiduciary concept,<sup>15</sup> courts' penchant for asserting that physicians are fiduciaries shows no signs of abating.

But that is not to say that doctors' fiduciary status in the courts is unequivocal. The courts of three states have expressly stated that doctors are not fiduciaries.<sup>16</sup> Courts in another ten states (1) say that doctors are, or may be, fiduciaries, but (2) hold that one cannot bring a claim for breach of fiduciary duty against doctors, as a matter of law.<sup>17</sup> Even courts that use soaring language to characterize the doctor/patient relationship frequently use distancing language that stops a bit short of saying, flatly, that doctors *are* fiduciaries, for instance, by referring to doctors as "akin" to fiduciaries or characterizing certain aspects of the relationships as having "fiducial qualities."<sup>18</sup>

The Supreme Court has rarely, if ever, suggested that doctors are fiduciaries for their patients. Rather, its main contribution on the topic has been to confuse the issue considerably in the course of discussing the meaning of the term "fiduciary" for purposes of the tortured ERISA statute. In widely-cited dicta involving the interpretation of the concept of a "fiduciary" for purposes of ERISA, "every claim of fiduciary breach by an HMO physician making a decision would boil down to a malpractice claim, and the fiduciary standard would be nothing but the malpractice standard traditionally applied in actions against physicians."<sup>19</sup> While this discussion was in the service of the court's statutory interpretation, a number of courts have seized on this language to suggest that there is ordinarily no daylight between claiming that a doctor breached a fiduciary duty and a claim that the

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<sup>15</sup> Marc. A. Rodwin, *Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System*, 21 AM. J. LAW & MED. 242, 247-252 (1995).

<sup>16</sup> *McMahon v. New Castle Assocs.*, 532 A.2d 601, 604 (Del. Ch. 1987) ("One may place trust in a workman of any sort and does place trust in one's physician, but it would hardly be contended that such trust would warrant chancery's assuming jurisdiction over a claim that a workman or physician caused injury by want of due care—although a claim of that very type against a trustee will be entertained in a court of equity."); *Carlson v. SALA Architects, Inc.*, 732 N.W.2d 324, 331 (Minn. Ct. App. 2007) (citing *D.A.B. v. Brown*, 570 N.W.2d 168, 171 (Minn. Ct. App. 1997)) ("Minnesota has declined to classify even the physician-patient relationship as fiduciary."); *but see* Hall in OXFORD HANDBOOK, *supra* n. tk. at 11, 12 (arguing that the Delaware and Alabama cases may be better read as simply declining to authorize a cause of action in certain situations).

<sup>17</sup> See *Mehlman*, *supra* n.tk.

<sup>18</sup> See E. Haavi Morreim, *Blessed Be the Tie that Binds? Antitrust Perils of Physician Investment and Self-Referral*, 14 J.L. MED. 359, n.71 (1993) (collecting cases of courts using fiduciary language but stopping short of saying that doctors actually are fiduciaries).

<sup>19</sup> *Pegram v. Herdrich*, 530 U.S. 211, tk (2000).

doctor committed ordinary malpractice.<sup>20</sup> This, naturally, has exacerbated the trend of asserting that plaintiffs ordinarily cannot sue doctors for breach of fiduciary duty, at least when the claimed breach has something to do with the chosen course of treatment (rather than some farther afield interest, like litigation or external research purposes).

Even setting these concrete limitations aside, there is a striking absence of a body of case law that begins with the proposition that doctors are fiduciaries and articulates governing principles or legal liabilities derived from that proposition, or otherwise defining the bounds of doctors' fiduciary duties.<sup>21</sup> As Professor Rodwin has explained, "although doctors perform fiduciary-like roles and hold themselves out as fiduciaries in their ethical codes, the law holds doctors accountable as fiduciaries only in restricted situations."<sup>22</sup>

To be sure, in a few (important!) discrete areas, courts regularly identify legal duties that derive from the fiduciary nature of the doctor/patient relationship. Most importantly, many courts and commentators have grounded the obligations of informed consent in the "fiducial qualities" of the relationship.<sup>23</sup> Courts likewise hold that liability for breaches of confidential information stems from fiduciary (or fiduciary-like) qualities of the doctor/patient relationship. In a related line of cases that, though a bit afield from doctors' core role in provision of medical care, speaks to the heart of the risk of betrayal against which fiduciary obligations are intended to prevent, a few courts have held that doctors may not engage in *ex parte* communications with patients' legal adversaries.<sup>24</sup> And in the famous *Moore* case, the California Supreme Court held that patients could bring a claim for breach of fiduciary or lack of informed consent for doctor's failure to disclose his financial interest in the patient's organ tissue (from which the doctor

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<sup>20</sup> Tk examples.

<sup>21</sup> See Hall, Oxford Handbook. Michelle Oberman makes a similar point in Michelle Oberman, *Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U. L. REV. 451 (2000) (arguing that doctors addressing so-called maternal-fetal conflicts dramatically violate the fiduciary legal and ethical rules that ordinarily govern doctor/patient relationships).

<sup>22</sup> Rodwin, *Strains*, at tk; see also Hall, Oxford Handbook; but see Mehlman, *Fiduciaries*, at tk.

<sup>23</sup> See, e.g., *Canterbury v. Spence*, 464 F.2d. 772, 782 (D.C. Cir 1972); Hall, *Fiduciary Principles*, at 6-8.

<sup>24</sup> See, e.g., *Duquette v. Superior Ct. In & For Cty. of Maricopa*, 161 Ariz. 269, 275 (Ct. App. 1989) ("the *ex parte* conference involves conduct which could be violative of the duties of a fiduciary and would, therefore, be contrary to the public policy favoring the fiduciary nature of the physician-patient relationship."); *Sorensen v. Barbuto*, 177 P.3d 614, 618 (2008) ("[E]x parte communication between a physician and opposing counsel constitutes a breach of the physician's fiduciary duty of confidentiality"); *San Roman v. Children's Heart Ctr., Ltd.*, 954 N.E.2d 217, 223 (2010) ("even a treating physician's office partner was barred from *ex parte* communication with the defense attorney").

developed and patented a profitable cell line); that ruling has spawned a limited, though widely remarked-upon, body of law applying that principle.<sup>25</sup>

But even these doctrinal areas are not entirely clear-cut instances of the fiduciary relationship leading to doctrinal payoffs. With respect to patient confidentiality, for instance, the federal regulatory HIPAA scheme has displaced a significant amount of the prior common law. (The hundreds of pages of HIPAA regulation do not mention the word “fiduciary”).<sup>26</sup> Others have grounded patients’ medical privacy rights in the Constitution or state Constitutions, implicitly defining the relevant interest as an individually-held right to limit dissemination of medical information or to make personal medical decisions rather than as an obligation flowing from the relationship between patients and their doctors.<sup>27</sup> And even courts enforcing common-law or state statutory private rights of actions against physicians characterize those rights as arising from a variety of sources other than fiduciary duties, including, for instance, contract, malpractice or standard negligence standards, prohibitions on fraud or misrepresentation, or specific statutes.<sup>28</sup>

Similarly, in considering the scope of doctors’ obligation to provide informed consent, courts have required more narrow disclosure than fiduciary principles might suggest. As Professor Hall has pointed out, even though informed consent forms the doctrinal corner that courts most explicitly ground in a fiduciary relationship, courts are reluctant to require doctors to disclose risks beyond the medical risks arising from significant procedures. There is ordinarily no requirement that they disclose, for instance, medical errors, or the risks of declining to treat, or risks created by the doctors’ own experience (or lack thereof) with a particular course of treatment.<sup>29</sup>

In short, the fiduciary concept often seems more like an atmospheric legal gloss on the doctor/patient relationship, a background relationship status that must be acknowledged but need not generate meaningful legal consequences.

### *B. Doctors, According to Health Law Commentators: A Strained, But Useful Metaphor?*

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<sup>25</sup> Moore v. Regents of Univ. of Cal., 51 Cal. 3d 120, 129–32 (1990); tk further cites.

<sup>26</sup> TK confirm.

<sup>27</sup> See, e.g., Whalen v. Roe, 429 U.S. 589 (1977); Alfred v. Corrections Corp. of America, 437 Fed. Appx. 281 (5th Cir. 2010); Doe v. City of New York, 15 F.3d 264 (2d Cir. 1994)

<sup>28</sup> See, e.g., Biddle v. Warren Gen. Hosp., 715 N.E.2d 518 (Ohio 1999) (holding that Ohio recognizes an independent breach of patient confidentiality tort justified on the basis of public policy considerations, the fiduciary nature of the doctor/patient relationship, or customary expectations of doctors, and collecting cases variously recognizing a similar cause of action as a subset of other torts); tk.

<sup>29</sup> MARK A. HALL, FIDUCIARY PRINCIPLES IN HEALTH CARE, in THE OXFORD HANDBOOK ON FIDUCIARY LAW (Evan J. Criddle et al. eds., 2019).

In making sense of this muddle and assessing whether a fiduciary framework should govern doctor/patient relationships, health law scholars and bioethicists generally focus on whether the framework is helpful or harmful to promoting patients' trust and autonomy within the doctor/patient relationship.<sup>30</sup> Some take a legalistic view, arguing that doctors should be understood as fiduciaries and that physician practice and legal liabilities should be modified to reflect that normative position.<sup>31</sup> Others approach the concept of "fiduciary" as a limited metaphor, an occasionally useful concept that should be assessed based on its accuracy and utility rather than a source of independent obligation. Professor Marc Rodwin made this argument in an influential and widely-cited. (Rodwin's general approach, understanding the fiduciary label as a descriptive metaphor that can be more or less useful, is now widespread,<sup>32</sup> and has likely even influenced the courts that have declined to extend legal fiduciary duties to doctors).<sup>33</sup> And others argue that fiduciary duties simply don't work to protect patients, as compared to other regulatory mechanisms.<sup>34</sup>

### C. Fiduciary Theory Does Not Solve The Puzzle

So, courts and health law scholars are irresolute on work that doctors' asserted status as fiduciaries should do. What about scholars of fiduciary law?

In academic work about the defining nature of the fiduciary relationship, doctors (let alone other health professionals) tend to show up mostly as incidental examples, rather than as a core focus for theorizing.<sup>35</sup> Moreover,

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<sup>30</sup> See, e.g., Mark Hall, *Law, Medicine and Trust*, 55 STAN. L. REV. 463 (2002); Sage; Oberman; Scott; others. Mehlman does focus primarily on trust, but also briefly discusses the importance of fiduciary status as a justification for doctors' professional autonomy and social status. One level, the conceptual problems should not be hard: The foundational text of modern bioethics, for instance, plainly states: "The patient-physician relationship is a fiduciary relationship—that is, founded on trust or confidence; and the physician is therefore necessarily a trustee for the patient's medical welfare."

<sup>31</sup> See, e.g., Max Mehlman, *Why Physicians are Fiduciaries for their Patients*, 12 IND. HEALTH L. REV. 1 (2015) (tk); Anna Forkheim in new technology, Oberman; more

<sup>32</sup> Professor Isaac Buck, for instance, has recently argued that the fiduciary metaphor should be extended to include an obligation on doctors to minimize costs to taxpayers who fund Medicare. Along similar lines, Professor William Sage, for instance, has argued that health law's over-emphasis on 'relational' frameworks has come at the expense of law's ability to serve the public interest on health matters. —

<sup>33</sup> See Mehlman, *Fiduciaries*, at TK; others. m —

<sup>34</sup> Sam F. Halabi, *Against Fiduciary Utopianism, The Regulation of Physician Conflicts of Interest and Standards of Care*, 11 UC Irvine L. Rev. 433, 435 (2020)

<sup>35</sup> There are, of course, some exceptions to this rule. MARK A. HALL, FIDUCIARY PRINCIPLES IN HEALTH CARE, in THE OXFORD HANDBOOK ON FIDUCIARY LAW (Evan J. Criddle et al. eds., 2019). But even the various restatements are divided on whether doctors



as Professors Julian Velasco and Paul Miller put it, there tends to be a deep tension between descriptive accuracy (who do courts recognize as fiduciaries?) and intellectual coherence in theorizing about fiduciary law.<sup>36</sup> So while scholars by and large acknowledge that some degree of fiduciary status has been attained by the medical profession,<sup>37</sup> there is not necessarily agreement that this is a conceptually correct description.

Whereas health law scholars tend to focus on patient trust and quality of care, fiduciary scholars tend to focus on the risk of abuse. The classic way to understand fiduciary status is as law's solution to the problem of the risk of an abuse of delegated power.<sup>38</sup> The fiduciary relationship is an in-between sort of relationship, less totalizing than true status relationships (like lord and vassal, or perhaps parent and child), but less egalitarian and arms-length than an ordinary market relationship.<sup>39</sup> Fiduciaries undertake their obligations to their charges<sup>40</sup> voluntarily; but, having done so, the law places them in the position of an other-regarding, moral person, and requires them to behave as such.<sup>41</sup> Doctrinally, the primary means of doing this are the core fiduciary duties, the fiduciary duty of care and the duty of loyalty.

Fiduciary relationships can arise in a range of circumstances, and commentators have offered an array of theories for defining when, precisely, the status should attach.<sup>42</sup> The basic point, however, is that the law may find fiduciary relationships when, in order to achieve some important and socially

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are fiduciaries, and they provide little analysis of the question. *Contrast* Restatement (Second) of Contracts § 161(d), cmt. f (AM. L. INST. 1981) (“Even where a party is not, strictly speaking, a fiduciary, he may stand in such a relation of trust and confidence to the other as to give the other the right to expect disclosure. Such a relationship normally exists between members of the same family and may arise, in other situations as, for example, between physician and patient); Restatement (Third) of Trusts § 2 cmt. (b)(1) (AM. L. INST. 2003) (“Thus, a confidential relation may exist although there is no fiduciary relation and is particularly likely to arise between family members or close friends or on the basis of the confidence that arises between physician and patient or priest and penitent.”); *with* Reporter’s Notes to the Restatement (Third) of Agency § 8.2 (AM. L. INST. 2006).

<sup>36</sup> JULIAN VELASCO & PAUL MILLER, DELIMITING FIDUCIARY STATUS, OXFORD HANDBOOK ON FIDUCIARY LAW 76, 77 (D. Gordon Smith & Andrew Gold eds., 2018).

<sup>37</sup> Tk from memo

<sup>38</sup> Tamar Frankel, CALIF. L. REV.

<sup>39</sup> See Frankel, CALIF. L. REV.; Michelle Goodwin, \_\_\_\_\_

<sup>40</sup> There is not an agreed upon term for the person to whom a fiduciary owes duties; some commentators prefer “fiduciae,” others prefer “entrustor.” I use “charge” and “patient” throughout this piece simply because I am focused on caretaking relationships to which those terms seem more appropriate, though they of course may be stranger fits for certain other versions of fiduciary relationships (like director/shareholder).

<sup>41</sup> Tk Frankel, etc.

<sup>42</sup> Tk. While fiduciary relationships are often described in contrast to other forms of law (especially contract), in practice, the fiduciary construct frequently overlaps and works in tandem with contract, tort, and other areas of law. In other words, to say that a relationship is fiduciary is not to remove it altogether from these other important sources of law and modes of legal analysis, but rather to add an additional layer to the analysis.

desirable end, a person must make themselves vulnerable in particular ways to another party—the fiduciary—who in turn will gain power over the charge’s “significant practical interests.”<sup>43</sup> A key limiting principle is that fiduciaries need to be distinguished from mere service providers, like mechanics or plumbers, who may exercise discretion in important domains, but are sufficiently regulated by ordinary tort and contract principles and standard marketplace norms.<sup>44</sup>

Both the nature and purpose of fiduciary duties are subject to some dispute, though there is agreement in broad strokes about the exploitation-avoidance core. Some, for instance, view fiduciary duties as essentially contractual in nature; others argue that they are derived from deeper moral values or other sources of law.<sup>45</sup> Law-and-economics commentators explain that imposing fiduciary duties can help to resolve principle-agency problems in settings where it makes sense to allow agents significant discretion and monitoring or other agency costs are high. They solve for the impossibility of completely specified contracts governing certain transactions or relationships. On this view, the core function of the fiduciary duty, then, is deterrence—preventing bad actors from exploiting the vulnerability of their charges.<sup>46</sup> Other scholars understand fiduciary status as occupying a richer emotional terrain, serving purposes beyond mere deterrence.<sup>47</sup>

The rules governing fiduciaries are deeply context dependent.<sup>48</sup> Fiduciary duties are often formally demanding (notably, far more so than the obligations on generally imposed on doctors). At minimum, the law requires

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<sup>43</sup> The term “significant practical interests” is Professor Paul Miller’s. See Paul B. Miller, *Justifying Fiduciary Duties*, 58 MCGILL L.J. 1014 (2013). Other commentators use different terminology to describe a similar phenomenon. D. Gordon Smith, *The Critical Resource Theory of Fiduciary Law*, 55 VAND. L. REV. 1399, 1402 (2002) (“that fiduciary relationships form when one party (the ‘fiduciary’) acts on behalf of another party (the ‘beneficiary’) while exercising discretion with respect to a critical resource belonging to the beneficiary.”).

<sup>44</sup> As Frankel explained, “It makes no sense for every person to become a medical doctor, a lawyer, or the manager of a large enterprise. It is desirable for investors, patients, and clients to rely on people who command the expertise.” Tamar Frankel, *Fiduciary Law in the 21<sup>st</sup> Century*, 91 B.U. L. REV. 1289, 1293 (2011)

<sup>45</sup> See, e.g., Kelli A. Alces, *The Fiduciary Gap*, 40 J. CORP. L. 341 (2014) (collecting examples of each approach and describing the terms of the debate, before arguing that the approaches are compatible—and the “fiduciary gap,” discussed *infra* at tk--f we understand that contracting parties may have (aspirational) expectations that are higher than courts could reasonably enforce).

<sup>46</sup> Robert H. Sitkoff, *The Economic Structure of Fiduciary Law*, 91 B.U. L. REV. 1039, tk PAGE (2011).

<sup>47</sup> Tk Galoob & Lieb, others.

<sup>48</sup> This is not a coincidence: historically, it developed in the tradition of Equity, and has generally been extended to new relationships or contexts based on analogy to prior paradigm examples (especially that of the trustee), rather than by application of top-down principles. See, e.g., Deborah DeMott, *Beyond Metaphor: An Analysis of Fiduciary Obligation*, 37 DUKE L.J. 879 (1988).

fiduciaries to abide by norms that are stricter, more other-regarding, than the “morals of the marketplace.” A fiduciary is obligated to act with loyalty towards their charge, prioritizing their charge’s interests over their own and (especially) avoiding self-dealing or otherwise exploiting the beneficiary’s vulnerability. To make these requirements concrete, in many settings, courts impose more specific requirements, for instance to avoid or disclose conflicts of interest and meet minimum standards of care.<sup>49</sup>

While fiduciary status is thus formally quite powerful, in practice, legal enforcement of fiduciary duties is famously lax, and the consequences that attach to the label are accordingly somewhat attenuated. As with the other features of fiduciary law, commentators have offered an array of explanations for this gap, between the powerful conduct rules that court say fiduciaries must abide by, on the one hand, to the narrow circumstances in which liability actually applies, on the other. For instance, some assert that fiduciary duties are properly understood as largely aspirational.<sup>50</sup> Others have criticized this assessment as diminishing the force and importance of fiduciary duties: as Professor Velasco put it, “whatever aspirational means, it does *not* mean mandatory,” and fiduciary duties should be properly understood as mandatory—as true duties—even if there are good reasons that they are under-enforced.

For all its intricacies, fiduciary theory does lend support to the characterization of doctors as fiduciaries. Most importantly, doctors have ample opportunities for self-dealing, and their gate-keeping role with respect to medication and treatment means that they wield significant discretionary authority over an interest of great significance to patients. Patients are, in short, vulnerable to doctors, as in paradigmatic fiduciary relationships. Even the gap between status and enforcement is not wildly out of keeping with fiduciary norms in other contexts, though it seems to be on the far end of the spectrum. And yet, understanding of doctors’ fiduciary role largely as a mechanism for avoiding exploitation or disloyalty seems incomplete. When courts and commentators stress that doctors are fiduciaries, they don’t just prescribe disloyalty; they also are keying into, and thereby reinforcing, a much deeper and more affirmative vision of doctors’ role in society.

## II. A MISSING PIECE: THE PROFESSIONAL SELF-CONCEPTION MODEL

In this Part, I posit that what’s at stake in clearly labeling doctors as fiduciaries goes beyond patient trust (the focus of most health law views) or

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<sup>49</sup> See Alces, *supra* note 40, at 354 & n.17 (implicitly analogizing this reduction to narrower concrete rules to agency implementing regulations of legislation).

<sup>50</sup> Julian Valesco, *The Role of Aspiration in Fiduciary Duties*, 54 WM. & M. L. REV. 519 (2012) (collecting examples by scholars and judges writing in their extra-judicial capacities).

an avoidance of self-dealing (the focus of most fiduciary scholarship): the fiduciary label (or absence thereof) helps shape the professional self-conception of fiduciary professionals. In the existing scholarship, the effect of fiduciary status on how fiduciaries understand themselves appears only incidentally, shining through the cracks of arguments primarily cast in other terms. I seek to shine a direct spotlight on it here. In the case of doctors, in particular—a profession of healers, racked by burnout and pulled in myriad directions by private and public forces alike—the importance of reaffirming the fiduciary underpinnings of professional self-conception seems like an important part of the puzzle. On this theory, there is something important at stake in courts’ clear invocation of the fiduciary status, even when there are other policy reasons to decline to attach concrete doctrinal consequence.

### A. In Theory

In short, fiduciary status does not just impose burdens; it also can embolden and empower the fiduciary. Fiduciary status clarifies that the other-regarding core behind a professional identity has the backing of our legal and social order.

The power of fiduciary status stems in part from the nature of the obligations that the fiduciary status imposes, which are not just obligations to take certain specific actions (although it does that, too). Fiduciary status imposes cognitive requirements on the fiduciary: fiduciaries are required not only to act in a certain way, but to make decisions in a certain way, with loyalty and care.<sup>51</sup> Whether someone satisfies the requirements of their duties as fiduciaries depends, at least in part, on the content of their deliberations and the connection between those deliberations and their actions. They need to have acted *for the right reasons*. To undertake a fiduciary status is to undertake a commitment, and that commitment requires the fiduciary to act based on decisions made by placing “non-derivative significance” on the well-being of the charge.<sup>52</sup> This theory, among other things, provides one possible explanation for the fiduciary enforcement gap. If someone is motivated to act *solely* by reason of fear of legal liability, they may actually be acting for the wrong reason. Law protects against this possibility by guarding against over-enforcement and erring on the side of creating space for the right kinds of motivations to flourish.<sup>53</sup>

This means that when law identifies a professional role as a fiduciary one,

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<sup>51</sup> I am drawing here on the body of work developed by Professors Stephen Galoob and Ethan Lieb. See, e.g., Stephen R. Galoob & Ethan Lieb, *Fiduciary Loyalty, Inside and Out*, 92 S. CAL. L. REV. 69 (2018).

<sup>52</sup> *Id.* Galoob & Lieb, tk.

<sup>53</sup> *Id.* at 23. Or: Galoob & Lieb, *supra* note 26, at 23. *Fiduciary Loyalty, Inside and Out*, at 23

it affirms society's understanding that one who undertakes that profession undertakes an obligation to genuinely, cognitively, place priority on the patient's interests. It means that the provision of services is not, in the eyes of the legal system, meant to be merely transactional or arms-length. Genuine, authentic other-regarding behavior—putting the interests first—becomes obligatory, not supererogatory; in the realm of duty, rather than altruism.<sup>54</sup> Fiduciaries are not simply held to a standard of action; they are held to a standard with respect to the *way they go about* that action, an obligation to engage with loyalty and prudence.<sup>55</sup>

To be sure, the cognitivist aspects of a fiduciary role are difficult to police, and legal action with concrete remedies may not be available as a practical matter in the mine-run of cases where a fiduciary has failed to live up to these goals. But the practicalities of liability do not set the limits of the law's impact. Law and legal opinions speak to multiple audiences—to those who are concerned with the bottom line of what they need to do to avoid a lawsuit, and those who seek to comply with their legal obligations and social expectations regardless of bottom-line liability probabilities.<sup>56</sup> Most of the (limited) empirical literature assessing the impact of fiduciary status focuses on settings in which the status gives rise to straightforwardly distinct legal and economic incentives.<sup>57</sup> But incentives are not the sole driver of human behavior or self-conception. Emotions like guilt and empathy also drive behavior—and public rhetoric has the potential to shape, induce, or repress those emotions.<sup>58</sup> This suggests that fiduciary status—or even just rhetoric about fiduciary status—can meaningfully affect physician self-conception.

I don't mean to over-state the matter. The power of a fiduciary label is

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<sup>54</sup> Tk Lois Shepherd, others.

<sup>55</sup> See generally Lieb, Inside Out, at tk; JOHN C.P. GOLDBERG, THE FIDUCIARY DUTY OF CARE, in OXFORD HANDBOOK ON FIDUCIARY LAW 10–11 (Evan J. Criddle et al., eds. 2019) (tk).

<sup>56</sup> I draw here on the concept of acoustic separation, developed initially by Professor Meir Dan-Cohen, who explained that statements regarding “conduct rules” and “liability rules” are generally directed at different audiences, and elaborated on in the fiduciary context by Professors Valesco, Leib, and Galoob, among others. Tk more.

<sup>57</sup> The evidence, such as it is, suggests that fiduciary status meaningfully affects behavior in other fields, where this has been studied. For financial professionals, it appears to reduce exploitive behavior. For healthcare organizations, which occasionally are subject to rules providing that they owe fiduciary duties to the public at large, those duties seem to promote charitable behavior. See generally See JONATHAN KLINK AND MAX M. SCHANZENBACH, EMPIRICAL ANALYSIS OF FIDUCIARY LAW, in THE OXFORD HANDBOOK ON FIDUCIARY LAW (Evan J. Criddle et al. eds., 2019).

<sup>58</sup> Hila Keren, *Guilt-Free Markets? Unconscionability, Conscience, and Emotions*, 2016 BYU L. REV. 427 (2016) (arguing that even in situations where unconscionability doctrine may not provide relief to plaintiffs, it is important for courts to articulate moral social norms even in cases involving marketplace transactions by clarifying, rather than clouding, social moral norms and describing the harmed party with empathy rather than indifference))

limited by (among other things) human psychology, which tends to find ways to skew decision-making to one's own advantage. Doctors, for instance, "are more likely to think a procedure or prescription is warranted when they will benefit from the intervention as opposed to having no stake in the outcome."<sup>59</sup> Especially in a medical arena imbued with the logic of a competitive marketplace, this is reason for caution, or at least skepticism regarding the expressive value (alone) of law. Fiduciaries, like anyone else, are likely to subconsciously operate to their own advantage when circumstances permit. But a professional's conscious identity as a fiduciary seems, at minimum, likely to tilt the scales even in that subconscious weighing.

How, exactly, the legal fiduciary label affects professionals' self-understanding may vary with how consonant the label is with the rest of the professional's self-understanding. Law, of course, is not the only driver of professional identity, but it is one important medium through which ideas about identity and status permeate society.<sup>60</sup> If the fiduciary label does *not* match other aspects of one's conception of the relevant role morality, we might expect one of two outcomes: either a shift in professional role morality (perhaps subtle, perhaps over a long time) with the new input from the legal system, or resentment and pushback at the misalignment.

If, however, the legal label matches at least the ideal vision of one's professional role morality, then it seems reasonable to think that legal reinforcement of that status could have a number of salutary effects. When one is pulled in different directions by competing concerns, the clarity of the fiduciary label can be both clarifying and bolstering.<sup>61</sup> It may provide a sense that society recognizes and respects the nature of the task one has undertaken. And, in tough moments where one may be tempted to do what is easy or self-advantageous instead of what is best for the other person, knowing that putting the beneficiary's interest is not "going above and beyond," but rather fulfilling what one is duty-bound to do may give rise not only to better behavior, but also to less ambivalence about putting the other person's interests first.<sup>62</sup> Existing in our culture means that even the most scrupulous professionals are regularly flooded with messages that encourages a certain form of self-interested striving as the default expectation in workplace settings. The fiduciary label sends a clear message: the social expectation is *not* that you will push the limits of your own business-interest-maximization,

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<sup>59</sup> Donald V. Langevoort, *Psychological Perspectives on the Fiduciary Business*, 91 B.U. L. REV. 995, 1003 (2011).

<sup>60</sup> See, e.g., Eric J. Mitnick, *Law, Cognition, and Identity*, 67 LA. L. REV. 823, 863 (2007).

<sup>61</sup> Tk. [To elaborate on behavioral science regarding impact on self-conception of competing roles at work in various fields, moral injury, etc.].

<sup>62</sup> These are empirical supposition, on which I am canvassing the available research (and considering exploring in future projects).

but rather that you will authentically consider and prioritize the interests of your charge.

Perhaps most importantly, the fiduciary label as an ethical resource may be not only clarifying, but actively empowering. When, for instance, other actors—policymakers, employers, other professionals—propose policies that conflict with a fiduciary understanding of the interests she is charged with protecting, the fiduciary’s arguments against those policies will only be strengthened if they rest, not on altruism or policy mere preference, but on a formal fiduciary status. Pointing to formal fiduciary role can potentially clarifying expectations for oneself and bolstering ones’ position with respect to others. This may be powerful even in the absence of any practical likelihood of legal enforcement.<sup>63</sup>

A loose analogy may be helpful here. Professor Anna Offit has recently offered an illuminating account (based on extensive interviews) of how prosecutors use the concept of the imaginary jury as an ethical resource and rhetorical tool that they use to clarify their sense of justice understanding of their own professional role, even though there are vanishingly few jury trials. The jury serves this function and structures decision-making even when the likelihood of an actual jury trial approaches zero. It seems plausible that fiduciary professionals can use that status (or, perhaps) imagined adjudicators of their compliance with the fiduciary role, in somewhat analogous ways.

Imagine, for instance, a doctor deciding whether to perform a cesarean section on a patient in circumstances where either a cesarean or proceeding with a natural birth would be within the standard of care. (It turns out that in practice, whether doctors choose to proceed with a cesarean section in these circumstances appears to be meaningfully influenced by the compensation scheme: when cesarean sections are more profitable, doctors are more likely to perform them.<sup>64</sup> This sort of “induced demand” for more expensive (and sometimes risky) is widely considered a problem in healthcare.<sup>65</sup>) With a clear fiduciary identity—and an understanding that acting in the interests of the patient is a duty, not an extraneous act of generosity—a doctor might think to themselves, “[a]s a fiduciary, I am bound to make this decision in the way that I believe will best serve this particular patient.” They may even imagine a hypothetical court inquiring into their motives. With less clarity, and without resource of the fiduciary standard—if, for instance, they understood that their sole legal obligation is to provide care that meets a professional standard, along with a certain level of informed consent—it may

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<sup>63</sup> See generally Anna Offit, *Prosecuting in the Shadow of the Jury*, 113 NW. L. REV. 1071 (2019).

<sup>64</sup> See JONATHAN KLICK AND MAX M. SCHANZENBACH, EMPIRICAL ANALYSIS OF FIDUCIARY LAW, in *THE OXFORD HANDBOOK ON FIDUCIARY LAW* (Evan J. Criddle et al. eds., 2019 ) (reviewing literature).

<sup>65</sup> *Id.*

be harder to resist external or internal pressures to just go ahead with the ambiguous C-section. It may even be less clear to doctors themselves what the right thing to do is, all things considered.

Even where a fiduciary self-conception already exists, of course, the label may have downsides, of course. For instance, if the impression is that fiduciary obligations are just “one more legal burden” for beleaguered, over-regulated do-gooders, their imposition may weigh on the scale of dissatisfaction, disillusion, or burnout, rather than the reverse. (This might simply be a reason to err on the side of unnecessarily granular or onerous enforcement schemes, as we see in the doctrine). Along similar lines, rather than empowering fiduciaries, fiduciary status could in theory lead to greater exploitation of those workers, if more powerful actors rely on the fiduciary status to expect, for instance, that as fiduciaries, workers will continue to go above and beyond without needed support.<sup>66</sup> This may be reason to enact other protections, or to make sure that in at least some limit cases, fiduciary duties are enforceable in a way that will primarily impact employers or agencies (e.g. via doctrines like *respondeat superior*). In any event, it is important to recognize that to say that a worker is a fiduciary is not to say that they are to be a saint or a hero.

There are also possible downsides that may result from particularly exalted or self-important notions of what it means to be classified as a fiduciary—a misunderstanding of the role in its best form. In some cases, the entire point of the fiduciary relationship is that the fiduciary “knows best” with respect to an important set of interests. As Professor Frankel has explained, “it makes no sense for every person to become a medical doctor, a lawyer, or the manager of a large enterprise. It is desirable for investors, patients, and clients to rely on people who command the expertise.”<sup>67</sup> But that does not entail that fiduciaries are at liberty to disregard or ignore their charges’ particularized interests or goals. Indeed, part of a true fiduciary ideal may require the fiduciary to work to uncover the relevant preferences and interests, even when appreciating those interests requires a bit of sleuthing to uncover.<sup>68</sup> The relationship, properly conceptualized, sounds less in paternalism and more in notions of responsibility and fidelity. The below discussion of doctors’ professional identity fleshes out these dynamics in more depth.

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<sup>66</sup> TK; this dynamic seems especially high risk in Covid-times.

<sup>67</sup> Tamar Frankel, *Fiduciary Law in the 21<sup>st</sup> Century*, 91 B.U. L. REV. 1289, tk (2011)

<sup>68</sup> See generally Ethan J. Lieb and David Ponet, *Fiduciary Representation and Deliberative Engagement with Children*, 20 J. OF POL. PHIL. 178, 11-15 (2012) (identifying a “deliberative component” or “dialogic imperative” in various fiduciary duties). In many settings



*B. As Applied to Doctors*

In short, if we, as a society, want doctors to think of themselves as fiduciaries and identify as fiduciaries, it may be important for courts to articulate that role—even if no liability attaches. By labeling doctors as fiduciaries and treating them as such in meaningful, if incomplete, ways, courts reinforce and bolster the core, and imminently desirable, strand of medical professional norms that puts the patient first.

As an initial matter, physicians routinely describe themselves in fiduciary terms. When describing their mission in aspirational terms, physicians regularly self-describe as fiduciaries or use similar language. Physicians regularly hold themselves out to the public as fiduciaries, and prominent ethics guidance uses the fiduciary concept. The AMA’s ethics opinions on patient-physician relationships, for instance, regularly refer to physicians’ “traditional fiduciary role,” their “fundamental fiduciary obligations,” and similar concepts.<sup>69</sup> One of its ten “principles of medical ethics” provides: “A physician shall, while caring for a patient, regard responsibility to the patient as paramount.” While the AMA espouses other important priorities for doctors, including working to change laws that do not serve patients, supporting medical care for all, respecting the “rights” of patients and other healthcare providers, the principles thus leave no doubt about doctors’ acceptable priorities when a treatment relationship exists. (This is consistent with the preamble, which characterizes the principles as a continuation of the long-running “body of ethical statements developed primarily for the benefit of the patient.”).

The American College of Surgeons does not use the term “fiduciary,” but requires of its members the following pledge:

*“I pledge to pursue the practice of surgery with honesty and to place the welfare and the rights of my patient above all else. I promise to deal with each patient as I would wish to be dealt with if I were in the patient’s position, and I will respect the patient’s autonomy and individuality.”<sup>8</sup>*

Other medical societies include similar statements.<sup>9</sup>

To say that doctors are fiduciaries is not to say that they have no obligations beyond patient care. Just as lawyers have an obligation to zealously advocate for their client that is tempered by their obligations to the

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<sup>69</sup> <sup>69</sup> See, e.g., AMA Code of Medical Ethics Opinions on Patient-Physician Relationships (ama-assn.org) Op. 1.2.12 (noting that it would violate “fundamental fiduciary obligations” to fail to notify patients of conflicts of interest related to the use of telemedicine).

court system and the public more broadly, doctors' obligations to their patients are cabined by other interests that help define the realm of that obligation. For instance, doctors' behavior is necessarily cabined at least in extreme cases by concerns for public health. The AMA puts it this way: "[a]lthough physicians' primary ethical obligation is to individual patients, they also have a responsibility to protect and promote public health."<sup>70</sup> This formulation is vague and the devil is in the details, but the basic point is clear.

It is not surprising that doctors characterize themselves as fiduciaries. Among other things, the idea that doctors are obligated to prioritize patients' interests tracks patients' desires. (Notably, it does not, necessarily, track Americans' understandings of how doctors actually behave).<sup>71</sup> But there is no need to be cynical about doctors' marketing efforts here: the fiduciary label (or underlying ideology) is an important and storied part of the medical professionals' self-identity, even if there are other important limiting features or external components. So one way to frame the question is: do we want courts to reinforce or reduce the power of the fiduciary self-conception?<sup>72</sup>

Reinforcing doctors' professional self-conception may be especially important at this moment in time. Even prior to the COVID-19 crisis, doctors were suffering an epidemic of burnout and professional dissatisfaction. The causes for this are varied,<sup>73</sup> but one widely-cited contributor is a sense of moral injury, arising from circumstances where physicians end up participating in situations that offend their deeply-held values.<sup>74</sup> Other experts have recently posited that the "root causes" of burnout are "moral distress" and "professional ethical dissonance," resulting from an array of forces in healthcare technology, market dynamics, and changes in the sociological status of doctors that regularly place doctors in compromised ethical positions, leading to, as Professor Elizabeth Dzung puts it, "a culture

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<sup>70</sup> Code of Medical Ethics: Physicians & the health of the community, AMERICAN MEDICAL ASSOCIATION, <https://www.ama-assn.org/delivering-care/ethics/code-medical-ethics-physicians-health-community>.

<sup>71</sup> See, e.g., Robert R. Martin, *International variations in fiduciary and competence trust of physicians: A multilevel study*, 10 J. OF TR. RSCH. 23 (2020) (noting that the level of trust patients place in their physicians)

<sup>72</sup> Joseph H. King, *The Standard of Care for Residents and Other Medical School Graduates in Training*, 55 AM. U. L. REV. 683, 751 (2006) ("although physicians think of themselves as fiduciaries and courts sometimes label physicians as fiduciaries,... such legal fiduciary principles have been applied to physicians only in limited instances, such as obtaining patients' informed consent prior to treatment").

<sup>73</sup> The causes for this burnout are manifold, but the increase in administrative burdens and time spent with wonky electronic records system, as compared to time with actual patients, seems to be one important contributor. Rikinkumar S. Patel, Ramya Bachu, Archana Adikey, Meryem Malik, and Mansi Shah, *Factors Related to Physician Burnout and Its Consequences: A Review*, 8 BEHAVIORAL SCIENCES 98 (2018).

<sup>74</sup> Tk [To elaborate on research; cite to wendy dean, others],

of cynical care devoid of meaning.”<sup>75</sup>

In hard cases and tough moments, having the clear legal status as a fiduciary as a tool for thinking through decisions or taking tough stands seems important. The underenforcement<sup>76</sup> of that status may ultimately help doctors properly think through their responsibilities in this ethical mode, rather than for fear of liability (which might be especially important against the cultural backdrop of the litigation-fearing medical profession as it currently exists). Recall the hypothetical doctor above, considering a C-section for her patient. A clear legal and ethical construct that reminds her that her first and foremost concern must be what approach will be better for this patient may be clarifying and bolstering; it may make the doctor just that much less likely to say, “what the hell, go with the C-section,” without seriously considering the particular patient in more depth. And this seems more plausible if the primary driver is not one of litigation risk, but of fulfilling one’s foundational professional obligation.

There are at least a few potential practical takeaways for courts. First, as a practical matter, fiduciary status seems most likely to effect professional identity if it is framed, by courts and in the public mind, as a clear status (as is traditional in fiduciary law).<sup>77</sup> If, as I posit, encouraging a particular kind of professional identity (and serving as an ethical resource to bolster that identity) is an important practical function, it is probably best served when that label is clear, status-based, and straightforward. Legal assertions that doctors are “fiduciary-like” have responsibilities “akin to” fiduciaries, or that specific pieces of the relationship are “fiducial” or “confidential,” seem less likely to serve as an ethical resource in the way I imagine. More important, probably, is the bottom-line takeaway that doctors get from the legal system: are they, or are they not, fiduciaries for their patients?<sup>78</sup>

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<sup>75</sup> Elizabeth Dzung & Robert M. Wachter, *Ethics in Conflict: Moral Distress and Causes of Burnout*, 35 J. OF GEN. INTERNAL MED. 409 (2020).

<sup>76</sup> The relative under-enforcement of fiduciary obligations is not unique to the doctor/patient relationship. The doctrinal form it takes, however, is a bit distinct: whereas corporate duties tend to be under-enforced because of specific doctrines like the Business Judgment Rule, which is expressly intended to enable the exercise of a wide range of judgments, there is something vaguer, more piecemeal, and more ambivalent, about the approach in the doctor/patient setting, the courts do *not* say, “doctors have fiduciary duties, but in deference to the wide array of good-faith judgments that one might make, we will only actually enforce violations in litigation for relatively extreme cases.” More often, the reasoning is something more akin to, “doctors are fiduciaries! But do not owe fiduciary duties that can be independently enforced in court. *TK* (Hall & Olenski)

<sup>77</sup> *The Idea of Status*, in FIDUCIARY LAW, CONTRACT, STATUS, AND FIDUCIARY LAW (Paul B. Miller & Andrew S. Gold, eds., Oxford Univ. Press 2016) (noting, among other things, that “[w]here a designation of fiduciary status is (a) relatively well settled as a matter of authority; and (b) this fact is relatively widely known, the simplifying assumptions that status invites juridically are likely to have corollaries for the social behavior those who may participate in.”).

<sup>78</sup> See generally LAWRENCE FRIEDMAN, *IMPACT* (HARV. U. PRESS 2016) (discussing

Second, and relatedly, if, as medicine evolves, we reached a conclusion that we actually do *not* want doctors to identify and make decisions as fiduciaries—if, instead, the better self-conception is that of steward of public resources, say, or arms-length service provider—then courts may be doing a disservice to both doctors and the public by continuing to use the fiduciary language. Constant legal assertions about a mode of decision-making that one is not actually expected to meet seems likely only to contribute moral distress, role confusion, or resentment.

The bottom line, though, is that if we want doctors to place non-derivative significance on the patient's interests in every patient-care decision, the courts may be on to something. Doctors' status as fiduciaries matters, even when its doctrinal upshots are limited.

### III. EXPANDING THE FIDUCIARY IDENTITY IN HEALTH CARE: OTHER CARETAKERS

In short, for doctors, at least, fiduciary status may be important less for the liability rules it establishes than for the professional identity it helps form and reify. The clarity of the fiduciary identity is not just a burden, it is also a potential source of empowerment.

This raises an important question: taking these impacts of the fiduciary status seriously, are there others to whom courts should consider granting categorical, or presumptive, fiduciary status? Over the past decade or so, there has emerged a small academic cottage industry devoted to expanding the notion of fiduciary obligations outside their traditional realm, ordinarily for reasons that focus on concerns about power and self-dealing.<sup>79</sup> Focusing on the empowerment/professional identity dynamics discussed above, we might also ask: where are there recurring circumstances in which vulnerable people are in the charge of ground-level actors who might be better-positioned to protect the vulnerable than those with greater formal authority? With that guiding question, this Part suggests that we should think seriously about the possibility that other people in non-professional paid, intimate caretaking roles—roles like home health aides or certified nursing assistants—should be considered fiduciaries. This is not necessarily because of a need for greater liability for those whom play this crucial role in our economic, medical, and intimate order. Rather, it is because these workers *actually perform and identify* as de facto fiduciaries. There may be upsides to having law recognize this reality. Doing so would both respect the

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bluntness with which even relatively sophisticated regulated professionals tend to understand legal rules surrounding their profession, including, *e.g.*, reception of the *Tarasoff* case).

<sup>79</sup> See *supra* n.tk.

social needs and expectations for these intimate caretakers and also respect the lived reality of these workers, and may come along with many of the potential positive impacts addressed above.

As things currently stand, there is remarkably little law on the duties owed by other paid caretakers.<sup>80</sup> A few cases have discussed the somewhat separate question of whether CNAs and those in similar roles' duty of care in the tort context is one of negligence or of professional malpractice, generally concluding that the ordinary negligence standard applies.<sup>81</sup> The reasoning in those cases tends to be notably dismissive of the skill or difficulties those roles entail.<sup>82</sup> And courts have recognized that patients may be incredibly vulnerable to CNAs or home health aides, although frequently this arises in cases that are not directly about the question of fiduciary status.<sup>83</sup> Courts have also held that care facilities like nursing homes are not fiduciaries to their patients in part on the basis of an *a fortiori*-type argument that so holding would require that fiduciary duties apply to lower-level employees and high-level employees alike.<sup>84</sup>

And yet, direct caretakers have much in common with traditional fiduciaries. They are routinely given high levels of discretion in managing

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<sup>80</sup> This is partially the result of the fact that historically, nursing home and other long-term care agreements were nearly uniform in their requirement that binding arbitration agreements be signed as a condition of entry. These agreements have recently been defanged by regulatory changes. See Final Rule, Medicare and Medicaid Programs; Revision of Requirements for Long-term Care Facilities: Arbitration Agreements, 84 Fed. Reg. 138 (July 18, 2019) <https://www.federalregister.gov/documents/2019/07/18/2019-14945/medicare-and-medicaid-programs-revision-of-requirements-for-long-term-care-facilities-arbitration>.

<sup>81</sup> See, e.g., *Estate of French v. Stratford House*, 333 S.W.3d. 546 (Tenn. 2011) (CNAs qualifications and training insufficiently extensive and specialized to subject to malpractice standards).

<sup>82</sup> *Myers v. Heritage Enters. Inc.*, 820 N.E.2d 604 (Ill. App. 2004) (noting that nursing assistants were not “professionals” because of their training standards—120 hours of theoretical and clinical work and a certification degree, but “no requirement to obtain a high school diploma”—and their duties (“bathing, feeding, weighing, dressing, transferring, and communicating with patients, as well as assisting with toileting functions”)); *but see Evans v. Heritage Manor Stratmore Nursing & Rehab. Center, LC*, 244 So.3d 737 (Ct. App. La. 2017) (holding that diaper change was medical care and that nursing assistant who struck patient when he became adversarial during change had committed malpractice).

<sup>83</sup> *Baldes v. State*, 276 P.3d 386, 389 (Wyo. 2012) (holding that CNA employed by home healthcare agency who sexually abused victim was person of “authority” for purposes of criminal statute, explaining that “in a situation involving a provider of medical services, a client may be rendered exceptionally vulnerable by the nature of the illness or disability for which he seeks service”).

<sup>84</sup> *Manor Care, Inc. v. Douglas*, 234 W. Va. 57, 76 (2014) (“If the Court were to find a fiduciary relationship between Plaintiff and [the nursing home licensee and administrators], then a reasonable inference could be made that each and every employee of [the nursing home], from the janitorial staff who cleaned Plaintiff’s room to the chief executive officer who established policies and procedures for [the nursing home], owed a fiduciary duty to the Plaintiff.”)

the day-to-day lives of their charges; their role requires deep trust, as home health aides are often given near-complete access to a home; they work with a significantly vulnerable population; and they are generally difficult to monitor.

Intimate caretaking roles exist at the intersection of two classic fiduciary roles: doctors and family members<sup>85</sup>. Elder care and long-term care, especially for the aging, occupy an ambiguous place in our cultural and caretaking institutions, in the gap between medicine and (usually unpaid, female) family-based labor.<sup>86</sup> The medical system relegates even relatively sophisticated, medical-seeming tasks (ranging from catheter care to wound cleaning and even providing chemotherapy) to home caretakers.<sup>87</sup> In other words, the work of home health aides and other “subsidiary” healthcare adjacent workers can be understood as delegated family or medical care—and both caretaking family members and medical providers generally have fiduciary, or fiduciary-like, duties to each other.<sup>88</sup> (Notably, home health aides engage in communicative strategies that imagine themselves in roles like “friend,” “parent,” or “personal trainer,” (at least the first two of which have fiduciary undertones) to more effectively engage with their charges).<sup>89</sup>

More fundamentally for present purposes, caretakers already behave and identify as fiduciaries in many settings—while also experiencing deep conflicts about the nature of their roles.<sup>90</sup> Many perform more than they are asked or required out of a sense of loyalty to the clients or patients in their charge (rather than, say, loyalty to their organization).<sup>91</sup> That loyalty is a

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<sup>85</sup> See generally Elizabeth S. Scott & Ben Chen, *Fiduciary Principles in Family Law*, OXFORD HANDBOOK OF FIDUCIARY LAW, (Evan Criddle et al., eds., 2019)

<sup>86</sup> Elizabeth Chiarello, *Medical and Familial Claims to Long-Term Care: Institution Gaps and Shifting Jurisdictions*, 43 L. & SOC. INQUIRY, 238, (page) (2017).

<sup>87</sup> This phenomenon may be caused by, or at least exacerbated by, the shift from fee-for-service to prospective payment financing systems. “[L]ay caregivers serve as a repository for the care medical providers do not do and are charged with performing professional work in the absence of professional training or titles. Though a portion of the “dirty work” is relegated to various, subordinated health professionals like nurses, health aides, and hospice workers, what sets long-term care apart is that many of these tasks traverse the medical/familial boundary as family caregivers adopt significant medical responsibilities.”

<sup>88</sup> Restatement (Second) of Torts § 551. In most states, a marriage creates a relationship of trust and confidence between the spouses, requiring the utmost good faith in their dealing with each other.

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<sup>90</sup> One study of assistant nurses in nursing homes suggested that the nurses’ self-understanding as “torn carers” was part of the storyline explaining why nurses provided elder care that was inconsistent with their personal values. Anette Lundin, et al., *Assistant Nurses’ Positioned Accounts for Prioritizations in Residential Care for Older People*, 61 Gerontologist 573 (2020).

<sup>91</sup> Marie Hjalmarsson, “We’re not supposed to work with ICT—we’re supposed to work with the Clients”: Home Health Aides in Sweden using Loyalty as Resistance”, 15 J.

source of professional satisfaction and meaning.<sup>92</sup> Low-status workers in health care also reportedly receive instruction in, and embrace, an attitude of “professionalism,” notwithstanding their low status.<sup>93</sup> But they also “struggle to justify their social identity” in light of the low status accorded to their roles,<sup>94</sup> and experience their relative disempowerment as a barrier to good care.<sup>95</sup>

Extending the fiduciary status to direct caregivers could, potentially, bolster and reinforce the positive caregiving identity. Moreover, the fiduciary identity may empower workers for conditions that are protective of both the workers and patients. Even within a formally disempowered role, the evidence suggests that this sense of loyalty is a launching pad for subtle forms of resistance against organizational policies that, in their view, harm patients.<sup>96</sup> For the small subset of American home health aides who have obtained the protections of unionization, for instance, the workers have fought expressly for protection from punitive employment actions that stem from workers’ standing up for their patients’ rights, and stories of strikes uniformly include assertions.<sup>97</sup> Without unionization, these forms of resistance are inevitably subtle, but fiduciary status might elevate and energize these subtle dynamics. It might also empower more active resistance and whistleblowing, especially in more egregious cases.

There are reasons for pause. For instance, although paid caretakers

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WORKPLACE RTS., 19. (arguing that in the classic Hirschmann framework, in which dissatisfied members of an organization or community must choose between “voice,” “exit,” or “neglect,” they frequently have few options for meaningful “voice” or “exit.” And yet, by and large, the evidence suggests they choose a fourth option: loyalty to their patients (and, perhaps, neglect of their corporate employers).

<sup>92</sup> Clare L. Stacey, *Finding Dignity in Dirty Work: the Constraints and Rewards of Low-Wage Home Care Labour*, 27 *SOCIO. HEALTH & ILLNESS* 831 (2005) (“Qualitative interviews suggest that home care workers have a conflicted, often contradictory, relationship to their labour. Workers identify constraints that compromise their ability to do a good job or to experience their work as meaningful, but they also report several rewards that come from caring for dependent adults”); Susan G. Pfefferle & Dana Beth Weinberg, *CNAs Making Meaning of Direct Care*, 18 *Qual. Health Res.* 952 (2008) (describing how CNAs make meaning of their work despite devaluations such as lack of respect from management and residents, and the physical and emotional demands of such low status work.”).

<sup>93</sup> Laura L. Ellingson, *The Poetics of Professionalism Among Dialysis Technicians*, 26 *HEALTH COMM’NS* 1 (2011).

<sup>94</sup> The low social status afforded to those in these roles is not inevitable: it appears to be partially a function of the low educational requirements often required, and partially a function of more general social dynamics that de-value nurturing caregiving roles. See Peggy S. Kendall, Muriel Scott & Krista Jolivet (2019), *“Well, You Can’t Force Them”:* *Altercasting in the Home Health Care Context*, 70 *COMMUNICATION STUDIES* 99-113 (2019).

<sup>95</sup> Nancy Foner, *The Hidden Injuries of Bureaucracy: Work in an American Nursing Home*, 54 *HUM. ORG.* 229 (1995).

<sup>96</sup> Tk Finnish study, Hjalmarsson

<sup>97</sup> TK (Michael Fischl sources, news collection re: union efforts).

exhibit fiduciary qualities, especially deep loyalty, they are relatively disempowered in the world, in contrast to most traditional fiduciaries, and there may be equitable reasons to avoid adding even a spectral level of fear about fiduciary-style liabilities in these settings. There is likewise a risk that the fiduciary label could be used to further *exploit* an already exploited group.

Moreover, as a matter of theory, some of the classic indicia of fiduciaries, of course, are missing, or at least relatively limited, in at least a significant chunk of these relationships. Caretakers besides doctors also may not formally exercise the same formal sort of control over a “critical resource” as doctors do in their gatekeeping role for medication or treatments, for instance (though in practice, of course, many caretakers do exert such control).

Part of my point here, though, is that limiting the discussion to these formalistic legal terms misses something crucial. What world do we want? A world where caretakers are plainly told: courts have held that you are fiduciaries; that means that your primary responsibility is to look out for the interests of your clients. Or the world where the message is, instead: this is an arms-length employment relationship?

On this line of reasoning, one might well ask, where is the stopping point—should we require every service provider who transacts with a vulnerable patient to adopt a fiduciary mindset? As my old torts professor used to tell us, the flip side of every “slippery slope” argument is a “wacky wall.” It may be that expanding fiduciary obligations more broadly would serve society well, even when it comes at the expense of conceptual purity of the fiduciary concept. But even if we aren’t willing to take things that far, we should think seriously about the tools at our disposal to affect the incentives, recognition, and professional identity for those who take the charge of caring for some of our most vulnerable and bear many of the hallmarks, but not the status markers, of other fiduciaries.

#### CONCLUSION

In a million small ways, law structures professional categories and shapes our understanding of the appropriate expectations for those in various roles. Fiduciary status can be an ennobling affirmation of the nature of one’s work, as well as a powerful ethical tool and a source of empowerment. Notwithstanding the judicial and scholarly wishy-washiness on the subject, our understanding of what a doctor *is* is shaped in part by a collective (if complicated) understanding that physicians function as fiduciaries. We should think seriously about the expectations that our legal system sets not only for physicians and other already high-status professionals, but also for those with less formal status or power who nevertheless care for our vulnerable, often in the highest tradition of fiduciary values.