
Fiduciary disclosure of medical mistakes: The duty to promptly notify patients of adverse health care events

TA Faunce* and SN Bolsin**

Fiduciary obligations are imposed by the common law to ensure that a person occupying a societal role with a high potential for the manipulation of vulnerable persons exercises utmost good faith. Australian law has recognised that the doctor-patient relationship, while not wholly fiduciary, has fiduciary aspects. Amongst such duties are those prohibiting sexual or financial abuse of patients or disclosure without express authority of confidential information. One important consequence of attaching such fiduciary duties to the doctor-patient relationship is that the onus of proof falls not upon the vulnerable party (the patient), but upon the doctor (to disprove the allegation). Another is that consent cannot be pleaded as an absolute defence. In this article the authors advocate that the law should now accept that the fiduciary obligations of the doctor-patient relationship extend to creating a legal duty that any adverse health care event be promptly reported to the patient involved. The reasons for creating such a presumption, as well as its elements and exceptions, are explained.

INTRODUCTION

Patients would never expect a doctor deliberately to lie to them about any aspect of their care. However, all health professionals may not view the ethical principle requiring disclosure of the full truth to patients as of equal ethical importance to those supporting a duty of beneficence and its more specific clinical aspects, such as competence. In many health care institutions, a counter-ethics ethos or “hidden curriculum” may positively inhibit such disclosure.¹

Fiduciary duty imposes an obligation of utmost good faith upon a party presumed by the law to be in a potentially manipulative position over another. The doctor-patient relationship has been characterised as having varying degrees of fiduciary responsibility in different jurisdictions. In North America, the relationship as a whole has been regarded as fiduciary in nature by many courts.² In Australia doctor-patient fiduciary duties have been restricted to duties designed to prevent financial and sexual abuse of patients, or disclosure of confidential information.³ One important consequence of attaching such fiduciary duties to the doctor-patient relationship is that the onus of proof falls not upon the vulnerable party (the patient) but upon the doctor (to disprove the allegation). Another is that consent cannot be pleaded as an absolute defence.

* BA, LLB (Hons), BMed, PhD; Senior Lecturer, Medical School, and Lecturer, Law Faculty, The Australian National University.

** MRACMA, FRCA, FANZCA, MHM; Director, Peri-Operative Care, Geelong Hospital, Victoria.

Correspondence to: Dr Thomas Faunce, Law Faculty, Fellows Road, The Australian National University, Acton, ACT 0200, Australia; email: Thomas.Faunce@anu.edu.au.

¹ Faunce TA and Bolsin SN, “Three Australian Whistle Blowing Sagas: Lessons for Internal and External Regulation” (2004) 181 (1) *Medical Journal of Australia* 44.

² *Cannell v Medical and Surgical Clinic* 315 NE 2d 278 (1974); *McInerney v MacDonald* (1992) 93 DLR (4th) 415 at 424 per La Forest J; *Norberg v Wynrib* (1979) 92 DLR (4th) 449; *Emmett v Eastern Dispensary and Casualty Hospital* 396 F 2d 931 (1967).

³ *Breen v Williams* (1996) 186 CLR 71.

In this article the authors advocate that the law should now accept that the fiduciary obligations of the doctor-patient relationship extend to a presumption that any adverse health care event will be promptly reported to the patient involved. The reasons for creating this presumption, its nature and exceptions are explained.

EXPANDING FIDUCIARY OBLIGATIONS IN DOCTOR-PATIENT RELATIONS

During the latter half of the 17th century judges in Chancery searched for alternative remedies,⁴ promoting the fundamental social virtues of fairness and justice, in matters of trust.⁵ Legal rules concerning trustee and beneficiary constituted the first “fiduciary relationship”.⁶ Subsequent judicial decisions incrementally extended those rules to other abstract legal subjects.⁷ As well as trustee for a cestui que trust (beneficiary), fiduciary legal rules attached to those categorised as a solicitor (for a client), partner (for co-partner), mortgagee (for mortgagor), agent (for principal), executor (for beneficiary), company director or liquidator or promoter (for their companies and receivers), as well as bailees, bankers, brokers and accountants.⁸

A legal subject deemed a “fiduciary” was legally obliged to “account for any benefit or gain which has been obtained or received in circumstances where a conflict, or significant possibility of conflict, existed between his fiduciary duty and his personal interest in the pursuit or possible receipt of such a benefit or gain”.⁹

Fiduciary relationships, on this interpretation, may be placed atop a three-tiered hierarchy of fundamental equitable principles (above unconscionability and good faith) designed to regulate conduct in voluntary or consensual non-familial relationships. These three concepts can be reconceptualised to express an ascending progression from permissible degrees of selfish, to selfless, behaviour.¹⁰

When doctors dealt improperly with their patient’s property (for example, by taking large gifts of land or money from the dying), judges in equity applied to them the legal rules of the fiduciary doctrine.¹¹

Yet Lord Scarman in *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871 stated the United Kingdom’s common law position in this manner (at 884):

There is no comparison to be made between the relationship of doctor and patient with [sic] that of solicitor and client, trustee and cestui qui trust or the other relationships treated in equity as of a fiduciary character. Nevertheless, the relationship of doctor and patient is a very special one, the patient putting his health and his life in the doctor’s hands.

In the late 20th century North American and Canadian decisions affirmed the legal principle that a doctor should act with “utmost good faith and loyalty”.¹² The legal rule derived from this principle required the doctor, as dominant party, to protect and advance the interests of the patient, to act as her or his representative or champion in preference to any other.

In *Norberg v Wynrib* (1979) 92 DLR (4th) 449 the majority in the Supreme Court of Canada held that the fiduciary principle provided an analytic legal model whereby such dishonourable doctors

⁴ Such as effective tracing of property through restitution and to obtain priority in the defendant’s insolvency: Millett PJ, “Equity’s Place in the Law of Commerce” (1998) 114 LQR 214.

⁵ The seminal case was *Keech v Sanford* (1726) 25 ER 223 (the *Rumford Market Case*).

⁶ Waters DM, “Banks, Fiduciary Obligations and Unconscionable Transactions” (1986) 35 Can Bar Rev 46.

⁷ Goff R and Jones G, *The Law of Restitution* (3rd ed, Sweet & Maxwell, London, 1986) p 632.

⁸ *Dent v Bennett* (1839) 41 ER 105; *Mitchell v Homfray* (1881) 8 QBD 587; *Billage v Southee* (1852) 9 Hare 534; *Gibson v Russell* (1843) 63 ER 46; *Redcliffe v Price* (1902) 18 TLR 466.

⁹ Jones G, “Unjust Enrichment and the Fiduciary’s Duty of Loyalty” (1968) 84 LQR 472.

¹⁰ Finn PD, “The Fiduciary Principle” in Youdan TG (ed), *Equity, Fiduciaries and Trusts* (1989) p 4.

¹¹ *Dent v Bennett* (1839) 41 ER 105; *Mitchell v Homfray* (1881) 8 QBD 587; *Billage v Southee* (1852) 9 Hare 534; *Gibson v Russell* (1843) 63 ER 46; *Redcliffe v Price* (1902) 18 TLR 466.

¹² See eg *McInerney v MacDonald* (1992) 93 DLR (4th) 415; *Cannell v Medical and Surgical Clinic* (1974) 315 NE 2d 278. Meagher JA in *Breen v Williams* (1994) 35 NSWLR 522 referred (at 570) to the tendency of Canadian decisions taking such a line “to widen the equitable concept of a fiduciary relationship to a point where it is devoid of all reasoning”.

could be legally held to the high standards which patient trust demanded.¹³ It held that a legal fiduciary duty should attach here because of the principle that a young woman's status as a patient rendered her vulnerable and at the mercy of the doctor. *Norberg v Wynrib* was applied soon after in *Taylor v McGillivray* (1993) 110 DLR (4th) 64, a case made remarkable by the persistence of the young victim in her search for justice and the consistent failure of regulatory authorities at every level toward her.

In *Breen v Williams* (1996) 186 CLR 71 at 83, however, the High Court of Australia interpreted the doctor-patient relationship as comprehensively covered by legal rules of fiduciary responsibility (at 108 per Gaudron and McHugh JJ). They emphasised that the primary legal duty of the doctor was to exercise reasonable care and skill in the provision of advice and treatment. It was not to act "on behalf of" a patient, or with "undivided" (at 93 per Dawson and Toohey JJ) or "uncompromising" (at 93) loyalty so as to avoid any conflict of interest whatsoever, or to warrant that treatment will be successful.¹⁴ There were only fiduciary "elements" in the relationship. These had evolved from the sensitive and intimate nature of patient reliance, the patient's need for bodily exposure, to divulge confidential information and her or his presumed inability to fully protect personal economic interests (at 135).

These restricted "fiduciary elements" were expressed as legal rules requiring that doctors keep patient information confidential, receive no more than proper remuneration and do not procure gifts, nor sexually intimidate or abuse the patient (at 92 per Dawson and Toohey JJ; at 107-109 per Gaudron and McHugh JJ; at 125 per Gummow J).¹⁵ The court was careful to leave open the capacity of the fiduciary concept to "monitor the abuse of loyalty reposed in the medical practitioner by a patient", particularly where the doctor has obtained a commercial or financial benefit or gain from the patient beyond the agreed fee (at 112 per Gaudron and McHugh JJ; at 94 per Dawson and Toohey JJ; at 136 per Gummow J).

Legal fiduciary rules may police important areas of clinical practice where patients are at high risk of exploitation due to an unwieldy criminal law. As well as threatening harsh sanctions for sexual impropriety, they may prevent, for example, managed care corporations contractually limiting tortious or contractual liability to patients in return for cheaper or more efficient or convenient services.¹⁶ They may also require doctors to disclose to patients, particularly in high-risk situations, any inducements by pharmaceutical companies that may have influenced a prescription decision.¹⁷ If injuries occur in such circumstances and a patient is able to make a credible case of conflict of interest, then the onus of proof will be on the doctor to establish, on the balance of probabilities, that the duty was not breached.¹⁸

A good example is given by *Moore v Regents of University of California* 793 P 2d 479 at 482 (1990). There the Supreme Court of California held that the legal fiduciary duties of the relevant doctors included a responsibility to disclose "all information material to the patient's decision" to undergo treatment (at 483). Progress in clinical medicine was recognised by the court to depend on research involving potentially conflicting loyalties.¹⁹ However, in *Breen v Williams* (1996) 136 CLR 71 at 136 Gummow J cited *Moore* in stating:

¹³ La Forest J, Gonthier and Cory JJ concurring, held that assault should have been allowed as consent was negated by the unequal power in the relationship. Sopinka J limited breach of fiduciary duty to improper disclosure of confidential information.

¹⁴ See *Greaves v Baynham Meikle* [1975] 1 WLR 1095 at 1100.

¹⁵ Informed consent does not appear to be based on the fiduciary principle in Australia: see *Rogers v Whitaker* (1992) 175 CLR 479.

¹⁶ Mehlman MJ, "Fiduciary Contracting: Limitations on Bargaining Between Patients and Health Care Providers" (1990) 51 U Pitt L Rev 365

¹⁷ Shimm DS, Spece RG Jr and DiGregorio MB, "Conflicts of Interest in Relationships Between Physicians and the Pharmaceutical Industry" in Spece RG, Shimm DS and Buchanan AE, *Conflicts of Interest in Clinical Practice and Research* (Oxford University Press, New York, 1996).

¹⁸ Cooter R and Freedman BJ, "The Fiduciary Relationship: Its Economic Character and Legal Consequences" (1991) 66 NYUL Rev 1045;

¹⁹ "Yet a physician who treats a patient in whom he [or she] has a research interest has potentially conflicting loyalties. This is because medical treatment decisions are made on the basis of proportionality – weighing the benefits to the patient against the risks to the patient ... the physician's extraneous motivation may affect his judgment and is, thus, material to the patient's

In such cases ... the fiduciary principle would *monitor the abuse of loyalty* reposed in the medical practitioner by the patient. The abuse of duty would involve derivation of a benefit of gain by use or by reason of the fiduciary position or of an opportunity or knowledge which resulted from it.²⁰

(emphasis added)

Exploring fiduciary aspects of the doctor-patient relationship would not necessarily restrict judicial and general regulatory attempts to integrate norms of bioethics and international human rights in this context.²¹ Rather, fiduciary legal rules should be seen as providing an alternative source of general legal principles to the criminal law in areas with a high potential for serious patient consequences from medical disloyalty to the relief of patient suffering.²²

A FIDUCIARY OBLIGATION TO PROMPTLY DISCLOSE ADVERSE EVENTS

It appears from the above discussion that courts began to work towards creating fiduciary duties in the doctor-patient relationship out of concern that the law needed to protect the inherent vulnerability of patients. In particular areas (sexual or financial abuse) the law considered that the dynamics of the relationship unquestionably required doctors to exercise utmost consideration for the protection of patients. In other areas (access to medical records, as distinct from medical information) the courts were more reluctant to attach fiduciary duties to the relationship.

Where patients have suffered an adverse event, surely their vulnerability has been heightened. The equitable case for attaching a fiduciary duty to relevant aspects of the doctor-patient relationship is also undoubtedly increased in such circumstances. Increasingly, hospital guidelines are requiring hospital staff to report as many adverse events as possible, including “near-miss” events. The reporting, however, is usually done to regulatory authorities as part of an anonymous sentinel event incident monitoring study. Often hospital guidelines mention an ethical obligation to inform the patient of the event. Occasionally, they may mention that this is actually important in heading off the possibility of subsequent litigation. Tort law reform legislation has permitted doctors to make an apology without this being construed as an admission of liability (see, for example, ss 11A-11C of the *Civil Law (Wrongs) Act 2002* (ACT)). Though this may facilitate early disclosure of an adverse event, it does not require it.

It may now be time for the courts to consider that the doctor-patient relationship involves a fiduciary element equally as troubling for a vulnerable patient as sexual or financial abuse. This concerns the obligation on a treating doctor to disclose with reasonable promptness adverse events that have occurred in relation to her or his patient. The obligation requires disclosure to the patient concerned or their guardian.

The common law doctrine of disclosure of material risk protects the rights of patients to obtain information prior to proceeding with medical treatment. It seems equally important for the law to ensure that patients have rapid access to information that may suggest that a medical procedure or treatment has involved a mistake or adverse event, even if no causally related damage can yet be substantiated. Without the assurance that such information will be disclosed as a part of a doctor’s (fiduciary) duty, patients may end up compromising their rights under new, restricted statutory periods of limitation. They may also be prevented from seeking additional necessary treatments, or change of treating doctor or institution, or properly evaluating the risks and benefits in relation thereto.

This right to prompt disclosure of information about an adverse event should not be one that can be taken away by signing a consent form, or by oral agreement. Few exceptions seem to be relevant.

consent”: *Moore v Regents of University of California* 793 P 2d 479 at 484 (1990). See also *Magan Medical Centre v Cal State Bd of Medical Examiners* 249 Cal App 2d 124; 132 57 Cal Rptr 256 (1967).

²⁰ See also Dawson and Toohey JJ at 94; *Hodgkinson v Simms* [1994] 3 SCR 377 at 406; (1994) 117 DLR (4th) 161 at 174 per La Forest J.

²¹ “The human body and its parts shall not, as such, give rise to financial gain”: *Convention on Human Rights and Bioethics*, Ch VII, Art 21. This provision is not connected to any fiduciary conception.

²² DeMott DA, “Fiduciary Obligations Under Intellectual Siege: Contemporary Challenges to the Duty to be Loyal” (1992) 30 (2) *Osgoode Hall LJ* 471; Rodwin MA, “Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System” (1995) 21 (2&3) *Am J Law and Med* 241.

One might be equivalent to therapeutic privilege under the disclosure of material risk doctrine: that the information would lead to an imminent risk of substantial harm to the patient (for example, because of recent psychiatric trauma or illness). Another could be necessity, though the relevant risk of harm would have to be substantial, imminent and well documented. In any event, such exceptions might often be covered by the requirement of reasonable promptness, some delay to take into account such factors being acceptable, but also requiring specific documentation.

One benefit of such a new fiduciary element to the doctor-patient relationship might be to ensure that fewer patients left hospital not knowing that an adverse event has occurred to them during their admission. The forced publicity of adverse events that the new standard could create might provide an important spur for quality and safety efforts in Australian health care to reduce the rates of such incidents.

CONCLUSION

The fiduciary duties owed in the doctor-patient relationship were not exhaustively stated by the High Court of Australia in *Breen v Williams*. It seems a logical extension of the principles underlying such a doctrine that it be extended to encompass an obligation upon the treating doctor so involved to disclose, reasonably promptly, an adverse event related to a patient's care. Such a transparency-facilitating duty has manifest advantages to patients, and possibly to the health care system as a whole.