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POSITION PAPER

The Fiduciary Duty of Psychiatrists

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On entry into the medical profession, a physician is expected to assume the codes of conduct and ethics of that profession. The codes are reiterated, refined, and embodied by local, national, and international professional organizations. Explicit and implicit in the codes of the profession is the centrality of the physician–patient relationship.[1]

Nonetheless, the social, political, and economic context in which medicine is practiced continues to give rise to concerns about the current process of both de-professionalization and the degradation of the physician–patient relationship.[2]

The nature of the physician-–patient relationship has been under increasing legal scrutiny, especially with easier access to case law and precedent. In addition, there is the increasing weight of legislative and economic factors effecting physicians, arguably more so psychiatrists. These competing obligations have presented psychiatrists with ethical dilemmas and have already altered the traditional view of the physician–patient relationship.

Psychiatrists find themselves increasingly in situations where they are acting as dual agents, that is, as physicians with additional responsibilities to organizations, industry and the state. As a consequence there is a need to reexamine the inherent nature of the relationship between physician and patient. The Canadian Psychiatric Association has prepared this position paper outlining how these dual loyalties have effected the psychiatrist–patient relationship and makes recommendations to guide the psychiatrist about these duties concerning their patients.

The Profession of Medicine and the Physician–Patient Relationship

Although the rich history of medicine provides the backdrop to any definition of the profession of medicine and the physician–patient relationship, it is usually the courts that have provided the more current interpretation. As can be expected, many of the codes of conduct were adopted years ago and were expected to stand the test of time. However, professional organizations' conduct guidelines for physicians are

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more frequently updated than before to reflect the changing political and legal environment. Professional organizations have also attempted to provide definitions and (or) standards for their members.

Much of the physicians' obligation to their patients derives from the 5th-centuryBC Hippocratic oath that embodies the ethical principles of beneficence and non-maleficence. As a profession, psychiatry is part of a group that makes public declarations that members will act in a certain way—with society and the group available to discipline them if they do not. The hallmarks of professions are competence in a body of knowledge and skills, acknowledgement of specific duties and responsibilities to the people it serves and to society, and the right to train, admit discipline, and dismiss members.

Several codes or declarations have been prepared to outline obligations or expectations of physicians. The Canadian Medical Association has adopted a code of ethics for physicians and, as physicians, psychiatrists adhere to this code.[3] The Declaration of Geneva, amended by the World Medical Assembly in Italy in October 1983 states,

> I solemnly pledge myself to consecrate my life to the service of humanity …. the health of my patient will be my first consideration . . . I will respect the secrets which are confided in me, even if the patient has died . . . I will not permit consideration of ethnic origins, nationality, race, political affiliation or social standards to intervene between my duty and my patient . . . I make these promises solemnly, freely and upon my honour.

The Declaration of Hawaii, approved by the General Assembly of the World Psychiatric Association in July 1983, includes the following statements:

> The psychiatrist should inform the patient of the nature of the condition, therapeutic procedures, including possible alternatives, and of the possible outcome . . . whatever the psychiatrist has been told by the patient, or has noted during examination or treatment, must be kept confidential unless the patient relieves the psychiatrist from this obligation, or to prevent serious harm to self or others makes disclosure necessary. The psychiatrist should stop all therapeutic, teaching or research programs that may involve contrary to the principles of this declaration.[4]

The International Code of Medical Ethics adopted by the 3rd General Assembly of the World Medical Association, London, England, October 1949 and amended by the 22nd World Medical Assembly Sydney, Australia, August 1968 and the 35th World Medical Assembly Venice, Italy, October 1983 and the WMA General Assembly, Pilanesberg, South Africa, October 2006, defines the duties of physicians in general and states:

> A physician shall not permit concerns of profit to influence the free and independent exercise of professional judgment on behalf of patients . . . the physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception . . . a physician shall act only in the patient's interest when providing medical care which might have the effect of weakening the physical and mental condition of the patient.

The International Code of Medical Ethics defines the duties of the physician to people during sickness, stating,

> A physician shall owe his patients complete loyalty and all the resources of his science, whenever an examination or treatment is beyond the physician's capacity, he should summon another physician who has the necessary ability . . . the physician shall preserve absolute confidentiality in all he knows about his patient even after the patient has died . . .

The principles of Medical Ethics of the American Medical Association, with Annotations applicable to psychiatry, indicate,

> A physician shall, in provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environments in which to provide medical services.[5]

The American Board of Internal Medicine's "Project Professionalism 1995" suggests striving for excellence in the following areas: altruism, accountability, excellence, duty, honour, integrity and respect for others.[6] All of these statements, ethical principles, and codes of conduct help define our professional duties including our duties to our patients.

Fiduciary Duty

The psychiatrist–patient relationship also falls within a class of legal relationships called fiduciary relationships. In Black's *Law Dictionary* "fiduciary duty" is defined as "a duty to act for someone else's benefit, subordinating one's personal interests to that of the other person. It is the highest standard of duty implied by the law."[7] Patients usually depend on and trust the knowledge, professionalism, and skills of physicians for their health care needs, and, in so doing, create a physician's fiduciary of responsibility. As a result of this fiduciary duty, patients are entitled to certain rights. In support of these rights, the American Medical Association's Policy E-10.01, entitled,

"Fundamental Elements of the Physician/Patient Relationship," states:

> From ancient times, physicians have recognized that health and well-being of patients depend on a collaborative effort between physicians and patients. Patients share with physicians the responsibility for their own health. The patient–physician relationship is of greatest benefit to the patient when they bring medical problems to their physician in a timely fashion, provide information about their medical condition to the best of their ability, and work with a physician in a mutually respectful alliance.[8]

It further states that physicians can best contribute to this alliance by serving as their patient's advocate by fostering these rights: … the right to receive from a physician and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their physician as to the optimal course of action. Patients are also entitled to obtain copies or summaries of their medical records, to have their questions answered, to be advised of potential conflicts of interest that their physician may have, and to receive independent professional opinions. The documents also address the issue of a patient's right to accept or refuse treatment. There is an implication of courtesy, respect, dignity, responsiveness, and timeliness. Confidentiality is also addressed. The continuation of health care provision is identified, as is the basic right to have adequate health care.

One of the most fundamental features of medical professionalism is a fiduciary responsibility to patients, implying a duty or obligation to act in the patient's best medical interests. The term that best captures this sense of obligation is beneficence, which contrasts with altruism, because the latter act is supererogatory and is beyond what constitutes obligation.

As with any duty, there is liability. An important consequence is that the psychiatrist can therefore not use his or her relationship with the patient for personal benefit, except with the full knowledge and consent of that patient. In situations such as this, where one partner holds power, the consent given may be exposed to additional scrutiny.

The psychiatrist clearly needs to act in the best interests of their patients, in whom they place their trust. Patients should expect "loyalty, confidentiality and that their best interests" are taken care of. Patients can also expect that there is no dual agency on the part of the psychiatrist.

Factors Affecting the Psychiatrist–Patient Relationship

During the past several years, many factors have affected the psychiatrist–patient relationship. There is a view that the practice of medicine has changed quite significantly, more so in the United States than in Canada.

> Healthcare has become commercialized as never before, professionalism has given way to entrepreneurialism. The health care system is now widely regarded as an industry, and medical practice is a competitive business.[9]

Certain components of Canadian health care have become profit making enterprises, requiring health care to be viewed with another outcome, namely, profitability.

One of the major attributes of professionalism in medicine is the independent judgment of the practitioner about what constitutes best clinical practice. Independent thinking along with professional autonomy is a highly valued attribute of professionals. One of the biggest threats to the fiduciary relationships psychiatrists have with their patients is the ubiquitous dual agency phenomenon in medicine.

Currently, there are many situations where dual roles exist for the psychiatrist. This change, be it insidious in its arrival or welcomed by practitioners, has transformed psychiatry. Legislation has given psychiatrists the power and thus the obligation to act as agents for social control. Where suicidal risk once dominated certification or detention under various Mental Health Acts, dangerousness to third parties has become the major factor for certification. In fact, dangerousness is more likely to influence certification and admission decision-making than the need for respite or to prevent suicide.

The power and the obligation inherent in various legislative acts, including Mental Health Acts, place competing obligations on the psychiatrist. Third party interests may be considered to outweigh that of the patient. The legislation that gives psychiatrists the option to detain, creates an obligation where failure to follow through and exercise this power can result in legal action against the psychiatrist. This can significantly influence the practice of psychiatrists.

Dual Agency

Dual agency may very well be one of the biggest threats to the traditional physician–patient relationship. An examination of the changes affecting psychiatric practice reveals a remarkable shift in responsibility from the patient to other agencies. Dual obligations, especially where there may be a variance in desirable

outcomes, can create conflict of interest. The mere declaration of the conflict, arguably now obligatory, in and of itself, highlights the weakness in the current state of the physician–patient relationship.

One area that recently grew in scope is the legislated, mandated, breaches of confidentiality. For example, there is a responsibility to the state to inform child protective agencies of patients who are considered to potentially pose a risk to children. Patients cannot rely on the confidentiality of their information if they might pose a risk on the roads (Ministry of Transportation in various provinces), on railways (The Railway Act), in the air (Federal Aeronautics Act), or if they carry certain infectious diseases. There may be an expectation—and in certain provinces an obligation—that if you suspect a registered health professional has acted improperly towards a patient, you will inform the respective college. Psychiatrists who make use of provincial Mental Health Acts and associated legislation, breach confidentiality and may act at odds with the wishes of their patients. Insurance company requirements may shift the psychiatrist's position from one of responsibility to their patient to one of judgment. Complications can occur such as when a third party assessment reveals that the patient poses a threat to themselves or others.

Psychiatrists doing forensic work have a responsibility not only to their patients but often also to another party or parties. Where the Review Boards created under part XX.I of the Criminal Code is concerned, the primary responsibility is arguably to the safety of the public. Forensic patients may very well believe that the host of professionals attending to them, while either in- or outpatients, will keep their information confidential. However, that is not the case—a fact occasionally obscured by the aura of the hospital, despite being warned of the lack of confidentiality.

Once the post-Tarasoff era was fully under way, the duty to warn, inform, or protect was incorporated into the practice of psychiatry. The duty to our patients had become the duty through our patients.[10] No longer did we see patients sitting before us, but we saw the potential for harm that they could cause to the greater community. Threats and violent ideation appeared to give psychiatrists permission to breach confidentiality. Despite our sometimes poor understanding of the law's application to psychiatry, these duties were widely discussed and played out in clinical arenas. Only after Smith *v.* Jones did the Supreme Court of Canada articulate a Canadian position in this regard.[11]

Psychiatrists receive payment from various sources such as organizations, hospitals, agencies, and government. Many psychiatrists conduct their practices within these same organizations and many receive salaries or salary equivalents. Research departments, billing departments, hospital records departments, and hospital foundations may have access to patient information at different times. It may be surprising to some how much teaching hospitals break open the physician–patient relationship into a team–patient relationship.[12] In fact, in hospital or clinics, strict psychiatrist–patient confidentiality is often unacceptable.

As part of organizations, psychiatrists have been expected to consider various other factors when making the clinical decisions.[13] Bed pressures, cost containment, pharmacy costs, staffing costs when ordering one-on-one observations, and length of stay data, are only some of these factors. Physician use data and practice profiles can create pressure on physicians to discharge patients (possibly prematurely) to stay close to the median. The circulation of this information amongst peers may promote behaviour driven more by statistics than good patient care. Payment schedules that incent physicians to discharge patients quickly, and health service organizations that have disincentives to refer out to specialists, create financial conflicts of interest.[14, 15]

As medicine becomes more egalitarian, one of the consequences has been its de-professionalization. Although still considered trustworthy, surveys have found that today, more than ever before, patients have less trust in their physicians.

It has become more acceptable for organized medicine and the pharmaceutical industry to collaborate. Professional organizations receive an increasing percentage of their budget revenue from the pharmaceutical industry and many reputable scientific journals rely on them for advertising. Many key physician decision leaders and influential academics receive funding, directly and indirectly, from pharmaceutical companies. The potential for loss of this revenue creates pressure to maintain the flow of funds and not upset the source. Given that this trend is unlikely to reverse, and given that funds flow with an expectation of influence, how much of that influence is made known to patients?

Psychiatric research receives much of its funding from industry, creating a whole new set of ethical dilemmas.[16] The Canadian Medical Association policy dealing with relationships with industry states that the research must be

> ethically defensible, socially responsible and scientifically valid . . . sponsors assure that results are made public in a reasonable time period . . . remuneration for enrollment/participating . . . is not enticement . . . inform participants of the fee . . . [17]

Psychiatrists who are involved in both clinical practice and research are in a particular ethical dilemma. They owe their patients primary fiduciary duty, but, at the same time, they have to recruit patients as subjects and deliver to funding agencies and industry. The needs of both parties may be quite different and competing. Full disclosure of these facts to the patient will help significantly in avoiding some of the pitfalls.

One issue that has been of particular importance is the area of informed consent. Many patients will consider their physician's invitation to participate in a research study as tacit approval of the trial drug. In fact, where there is a proven and acceptable treatment, as in many areas of psychiatry, patients need to know that such a treatment exists and is available to them. Informed consent may be better thought of as informed choice, where patients are made fully aware of their options. In addition, patients need to know what the psychiatrists involved stand to gain by their enrolment in the research study. The disclosure needs to be "full, frank and timely."[18] The consent obtained should allow the patients to realistically assess the risk posed to them by the divided loyalties of their fiduciaries.

American case law, although not generally precedential for Canadians, holds some interesting lessons. Wickline *v* State[19] is a case where a physician's inability to stand up to a managed care organization's request to discharge a patient, led to the development of gangrene and a subsequent amputation. Here it was held that "the physician, who complies without protest with the limitations imposed by third party payers, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for patient care." In Neade *v* Portes and Primary Care Family Centres,[20] a patient died after a referral for specialized investigation was not made, in the context of incentives not to refer. Pegram v Herdich involves a case where a critical ultrasound was delayed and inconveniently located to save the physician owners of a health maintenance organization money.[21,22] In Andrews-Clarke *v* Travelers Insurance,[23] a patient successfully committed suicide after being refused the rehabilitation he seemingly required.

In a Supreme Court of Canada case Reibl *v* Hughes,[24] the court held that a

> physician has a duty to disclose, unasked, what the objective, reasonable person in the patient's position would want to know before agreeing (or refusing) a medical intervention.

It is in this context that informed consent and (or) choice should be seen. Patients have an expectation that their psychiatrist is acting in their best interests. Any potential conflict of interest or dual obligation should be disclosed to the patient, unasked, as part of that consent.

In another Canadian case, Norberg *v* Wynrib (SCR 226), Chief Justice McLachlin, in her dissent on the issue of quantum, said,

> the relationship of physician-patient can be conceptualized in a variety of ways. It can be viewed as a creature of contract, with the physician's failure to fill his or her obligations giving rise to an action for breach of contract. That undoubtedly gives rise to a duty of care, the breach of which constitutes the tort of negligence.[25]

Summary

As professionals, psychiatrists have a fiduciary relationship to their patients. Professional ethics dictate that the interests of their patients are primary and that psychiatrists act only in the interests of the patients that they look after. However, psychiatrists are often put in situations where they are under the sway of two or more authorities, and two or more conflicting moral principles. In certain areas of conflict, such as forensic psychiatry or where there are clearly defined employers, the conflict may be more easily distinguished. There are other areas where the conflicts are not as visible. There are many situations where the psychiatrist is put in a position where he or she has to weigh the patient's interests against the interests of society. Judge Bazelon has called "the hidden agendas behind psychiatric decision making" as points where one's duties to the patient conflict with one's duties to society, to one's profession, or even to one's personal needs or principles. As psychiatrists, we are encouraged by society to enforce certain social goals and, in so doing, act as agents for social control. There are numerous legislative and legal obligations that effect the fiduciary relationship between psychiatrist and patient. In those situations, the dual agency is clear.

The therapeutic alliance and the psychiatrist–patient relationship are under significant threat. It is important that psychiatry begins to get a clearer sense of how one of its most powerful tools, the psychiatrist–patient relationship, has been affected by these forces. We know that psychiatrists have a clear fiduciary relationship to their patients. This duty resonates within the core of the professional identity of psychiatry and has long formed part of that identity. If the profession cannot hold true to its own value system, it may be that the courts may hold to it. It is by increasing the awareness of the role of psychiatrists in society and their competing obligations that change can be effected. Patients have an expectation that psychiatrists will act in their best interests.

Recommendations

1. Psychiatrists and trainees need to be aware of their fiduciary duty to their patients and its implications.
2. Training curricula should include a description of the Codes of Conduct applicable to psychiatry, the nature of the psychiatrist–patient relationship, and the fiduciary duty of psychiatrists. The intent would be to enhance the current state of the psychiatrist–patient relationship.
3. Limitations of confidentiality should be made apparent both to the patient and to the psychiatrist.
4. Any competing loyalties need to be disclosed to patients so that they can make informed decisions about the care they receive.
5. Potential influences effecting the fiduciary relationship between a physician and a patient need to be made clear to patients so that they are informed about the type of (therapeutic) relationship into which they are entering.
6. Personal advantages of any significance accruing to the psychiatrist as a result of a particular treatment offered to a patient should be disclosed to the patient as part of the informed consent process.
7. Informed consent (informed choice) means patients are made fully aware of their options.
8. When enrolled in a research study, patients need to know what the psychiatrists involved stand to gain. The disclosure should be "full, frank and timely."[20]
9. Consent should allow patients to realistically assess the risk posed to them by the divided loyalties of their fiduciaries.

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