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Lean on Me: A Physician's Fiduciary Duty to Disclose an Emergent Medical Risk to the Patient

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LEAN ON ME: A PHYSICIAN'S FIDUCIARY DUTY TO DISCLOSE AN EMERGENT MEDICAL RISK TO THE PATIENT

THOMAS L. HAFEMEISTER*
SELINA SPINOS**

ABSTRACT

This analysis has two purposes. The first is to establish that physicians owe their patients a fiduciary duty. Courts and commentators have widely acknowledged that this duty exists because of the nature of the special relationship between a physician and a patient. Application of this duty has been sparse, however, in part because its jurisprudential foundation has received virtually no attention. This Article explores that foundation and establishes the strong basis for recognizing and applying this doctrine.

The second purpose is to apply this doctrine to an issue that has generated considerable attention, both within and outside the medical profession: the concern that some physicians are failing to disclose medical errors and other emergent medical risks (collectively referred to as EMRs) to patients who are unaware of these developments. There is widespread recognition that patients want and need to trust their doctors and the hospitals to which they turn for help in times of sickness and injury. This Article asserts that physicians' fiduciary duty to patients encompasses a duty to disclose EMRs to patients who are unaware of them. Although most physicians and professional organizations agree that such disclosures should be readily provided, these disclosures are not always forthcoming. Recognizing a fiduciary-based duty to disclose will encourage physicians to share crucial information with patients, which in turn will enable patients to avoid or mitigate potential harm. By routinely disclosing this information, physicians will deepen the trust of their patients in them and thereby facilitate the partnership between patients and physicians that should be the hallmark of health care.

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INTRODUCTION

During medical treatment, a physician may discover or cause a medical condition that could result in material harm to the patient. In other words, an emergent medical risk (EMR) may arise—something that neither the physician nor the patient knew about when treatment began, but that now poses a risk of harm to the patient.

Picture two scenarios involving a cholecystectomy, a surgical procedure intended to remove the gallbladder. In the first scenario, a physician accidentally nicks the patient’s bile duct with a surgical instrument. The physician immediately stitches up the bile duct, and the damage seems fully repaired. Later, when preparing the patient for discharge, the doctor explains that she had to repair the nicked bile duct during surgery. After reassuring the patient that he should be fine, the physician tells the patient that the repair puts him at greater risk of a stricture—or narrowing—of the bile duct. The doctor tells the patient, “Be alert for any pain in the right upper quadrant of your abdomen and for symptoms of jaundice such as yellowing, which you would probably first see in the whites of your eyes. If you feel pain in this area or notice any

signs of jaundice, please call me immediately. I don't expect this to happen, but you should know about this risk and contact me if symptoms develop."

In the second scenario, a physician flawlessly performs a gallbladder surgery. But while operating, he notices a benign (noncancerous) tumor of the liver, known as a hemangioma. The doctor knows that this type of tumor usually does not cause patients any problems and thus does not require immediate removal, but recognizes that this condition could lead to bleeding during pregnancy or after external trauma. When the patient is stabilized after surgery, the doctor informs her of the hemangioma. After reassuring the patient that this benign tumor will probably never cause her any trouble, the physician warns her, "There's a small chance that if you are pregnant or suffer external trauma, as might occur in a car accident, this benign tumor may result in internal bleeding. If you become pregnant or are injured in an accident, please mention this condition to your treating physician."

Both of these scenarios involve medical risks that either did not exist or were unknown prior to treatment. Rather, these risks emerged as the result of the physician's conduct or the physician's discovery of a previously unknown medical condition. In the first scenario, the physician caused the risk through a medical error—a risk that remained even after the physician repaired the damage of the nicked bile duct. In the second scenario, the physician performing an unrelated procedure just happened to notice a medical condition likely to pose a future risk to the patient. Both of these medical conditions were unknown before surgery and became evident only during the course of treatment. Both should result in a disclosure of the condition to the patient to prevent or minimize future harm.

In each scenario described above, the physician took appropriate steps to disclose the emergent risk. By sharing needed information about the risk and the possibility of future harm, the doctor enabled the patient to guard against a known risk. Unfortunately, a different approach may be used by some physicians. When mishaps or discoveries occur, a doctor may fail to inform the patient of the EMR. As this Article will assert, the failure to disclose EMRs not only strays from sound medical practice, but also violates a physician's fiduciary duty to the patient. In both of the scenarios described above, unless the physician discloses the EMR, the patient will likely not learn of these risks until they manifest themselves as a dangerous medical complication. As a result, the patient may suffer serious harm that could have been readily prevented by the physician with a brief discussion. In the scenarios presented, disclosure is not just the right thing to do—it is a legal duty. Whenever physicians become aware of

EMRs that materially endanger the medical condition of their patients, these doctors have a fiduciary duty to give their patients information that will enable them to protect themselves from harm.¹

The first Part of this Article describes how ethical codes governing medical behavior already direct physicians to disclose EMRs, and that many regulatory bodies and states similarly require physicians to provide these disclosures. The next Part notes that despite widespread consensus on the need for disclosure, such disclosures are not always forthcoming.

This Article then argues for broader recognition that physicians have a legal duty to disclose EMRs to their patients—a duty that flows from fiduciary law. As will be discussed, physicians owe various fiduciary obligations to their patients, including a duty to disclose to their patients any needed medical information related to treatment. EMRs are adverse medical conditions that the physician has discovered or caused in the course of treatment of which the patient is likely unaware and that could result in material harm to the patient if not disclosed. Disclosing these risks falls within the scope of a physician's fiduciary responsibilities.

After examining lawsuits that have identified a breach of the physician's fiduciary obligation to a patient, the Article addresses some steps that physicians must take to satisfy this duty. The Article details the elements, defenses, and damages associated with a claim for breach of fiduciary duty. It also explains why this cause of action is more appropriate than a medical-malpractice or informed-consent claim. After addressing what a physician should do when another doctor fails to disclose, the Article highlights some benefits of enforcing a fiduciary duty to disclose EMRs.

I. CURRENT RESPONSES TO EMERGENT MEDICAL RISKS (EMRS)

Medical errors vividly illustrate one facet of EMRs. In the landmark report *To Err Is Human*, the Institute of Medicine found that between 44,000 and 98,000 people die each year from medical errors in American hospitals and that these errors cost the nation between \$17 and \$29 billion every year.² These startling statistics provoked cries for health-care reform

1. See *infra* Part V. Although the following discussion focuses on physicians, the analysis provided applies to all health-care providers when the equivalent of a physician-patient relationship has been established.

2. COMMITTEE ON QUALITY OF HEALTH CARE IN AMERICA, INSTITUTE OF MEDICINE, *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 1* (Linda T. Kohn et al. eds., 2000). Medical error encompasses not only inadequate care, but typically also adverse medical events that involved unintended acts of omission or commission, or acts that fall short of the intended outcome. JOINT

to reduce the occurrence and impact of medical error. But even if better systems are implemented to reduce medical error, doctors acknowledge that errors are as unavoidable as death and taxes.³ As fallible human beings performing complex, demanding, and sometimes unpredictable procedures, physicians will occasionally fail to meet their aspirations of flawless diagnoses and treatment.⁴

Indeed, recent studies reveal that, despite extensive efforts to reduce medical errors,⁵ these errors continue and are unlikely to vanish from the medical landscape. In 2007, the widely respected health-care rating organization, HealthGrades, Inc., reported on patient safety in American hospitals.⁶ Analyzing data gathered between 2003 and 2005, the study found that 1.16 million incidents threatening patient safety occurred in over 40 million Medicare-funded hospitalizations.⁷ Further, the rates associated with more than half of the various specific patient-safety indicators studied had worsened over these years.⁸ Because of various disincentives to reporting mistakes, errors may be even more frequent.⁹

Until the twenty-first century, most medical errors were shrouded by silence.¹⁰ Today, medical scholars and practitioners recognize the value of

COMMISSION, 2002 HOSPITAL ACCREDITATION STANDARDS 339 (2002); *see also* Lucien L. Leape, *Error in Medicine*, 272 JAMA 1851, 1851 (1994).

3. ROBERT M. WACHTER & KAVEH G. SHOJANIA, INTERNAL BLEEDING: THE TRUTH BEHIND AMERICA'S TERRIFYING EPIDEMIC OF MEDICAL MISTAKES 369 (2005).

4. *See, e.g.*, JEROME GROOPMAN, HOW DOCTORS THINK 24 (2007) (noting that up to fifteen percent of medical diagnoses are inaccurate).

5. For example, the Institute of Medicine (IOM) has engaged in efforts since 1996 to assess and improve the nation's quality of health care. Institute of Medicine of the National Academies, *Crossing the Quality Chasm: The IOM Health Care Initiative*, <http://www.iom.edu/CMS/8089.aspx> (last visited Mar. 31, 2009) (including a list of more than a dozen released reports). *See also* Centers for Medicare and Medicaid Services, *Quality Initiatives, General Information*, <http://www.cms.hhs.gov/quality/initiativesgeninfo/> (last visited Mar. 31, 2009) (describing the CMS Quality Initiative, launched in 2001, which includes the Nursing Home Quality Initiative, the Home Health Quality Initiative, the Hospital Quality Initiative, the Physician Focused Quality Initiative, the End Stage Renal Disease Quality Initiative, and the Physician Voluntary Reporting Program); The Leapfrog Group, *Informing Choices, Rewarding Excellence, Getting Health Care Right* (2007), <http://www.leapfroggroup.org/home> ("On behalf of the millions of Americans for whom many of the nation's largest corporations and public agencies buy health benefits, The Leapfrog Group aims to: [r]educe preventable medical mistakes . . .").

6. HEALTH GRADES, INC., HEALTHGRADES QUALITY STUDY: FOURTH ANNUAL PATIENT SAFETY IN AMERICAN HOSPITALS STUDY (Apr. 2007), *available at* <http://www.healthgrades.com/media/DMS/pdf/PatientSafetyInAmericanHospitalsStudy2007.pdf>.

7. *Id.* at 2. Moreover, as Medicare-funded hospitalizations constitute only a portion of all hospitalizations, the total number of patients experiencing these incidents is even higher than reported.

8. *Id.*

9. *See* Maxine M. Harrington, *Revisiting Medical Error: Five Years After the IOM Report, Have Reporting Systems Made a Measurable Difference?*, 15 HEALTH MATRIX 329, 332 (2005).

10. Kurt Darr, *Uncircling the Wagons: Informing Patients About Unanticipated Outcomes*, HOSP. TOPICS, Summer 2001, at 33, 33; *see also* WACHTER & SHOJANIA, *supra* note 3, at

disclosing medical mistakes. They have expressed widespread agreement that patients have a need—and a right—to know when medical errors involving them have occurred.¹¹ Hospitals in turn have heeded this message, and most promote some form of disclosure.¹² A recent survey of institutional risk managers revealed that sixty-nine percent have established disclosure practices.¹³ In March 2006, a consensus statement of Harvard-affiliated hospitals declared the value of disclosing errors to patients, taking responsibility for these errors, and making efforts to prevent future errors.¹⁴

The duty to disclose errors and other emergent risks has been widely embraced as a principle of medical ethics by various professional organizations. This includes the American Medical Association (AMA), whose ethical code has been accepted as the professional code for physicians by virtually all state medical societies, which in turn license and regulate the behavior of physicians.¹⁵ The AMA's Code of Medical Ethics states:

It is a fundamental ethical requirement that a physician should at all times deal honestly and openly with patients. Patients have a right

24 (“This lack of understanding [of why medical errors happen] is attributable [in part] . . . to the difficulty that outsiders have in breaking through [health care professionals’ and administrators’] culture, language, and, yes, our code of silence.”).

11. See, e.g., WACHTER & SHOJANIA, *supra* note 3, at 291; Steven Berman, *Reporting Outcomes and Other Issues in Patient Safety: An Interview with Albert Wu*, 28 JOINT COMMISSION J. ON QUALITY IMPROVEMENT 197, 198 (2002); Darr, *supra* note 10, at 35; Thomas H. Gallagher et al., *Patients’ and Physicians’ Attitudes Regarding the Disclosure of Medical Errors*, 289 JAMA 1001, 1001 (2003) (noting that error disclosure “respects patient autonomy and truth-telling, is desired by patients, and has been endorsed by multiple ethicists and professional organizations”); Ros Sorensen et al., *Health Care Professionals’ Views of Implementing a Policy of Open Disclosure of Errors*, 13 J. HEALTH SERVICES RES. & POL’Y 227, 227 (2008) (finding that health professionals have positive views about open disclosure of medical errors); Andrew E. Thurman, *Institutional Responses to Medical Mistakes: Ethical and Legal Perspectives*, 11 KENNEDY INST. ETHICS J. 147, 155 (2001) (asserting that health-care “[p]roviders . . . have a legal and ethical duty to disclose . . . clinical consequences” of medical mistakes).

12. WACHTER & SHOJANIA, *supra* note 3, at 260–61.

13. Thomas H. Gallagher et al., *National Survey: Risk Managers’ Attitudes and Experiences Regarding Patient Safety and Error Disclosure*, 26 J. HEALTHCARE RISK MGMT. 11, 11 (2006).

14. MASSACHUSETTS COALITION FOR THE PREVENTION OF MEDICAL ERRORS, WHEN THINGS GO WRONG: RESPONDING TO ADVERSE EVENTS: A CONSENSUS STATEMENT OF THE HARVARD HOSPITALS (2006), <http://www.ihl.org/IHI/Topics/PatientSafety/SafetyGeneral/Literature/WhenThingsGoWrongRespondingtoAdverseEvents.htm>.

15. “The AMA’s Code of Ethics is widely disseminated and has provided the most commonly cited standard for courts, legislatures, administrative agencies, medical boards and other peer review entities. Most medical societies, and virtually all state medical societies, accept the code as the profession’s code.” ETHICS AND QUALITY OF CARE: REPORT OF THE AMERICAN MEDICAL ASSOCIATION AND THE FEDERATION OF STATE MEDICAL BOARDS 3 (1995), http://www.fsmb.org/pdf/1995_grpol_Ethics_and_Quality_of_Care.pdf.

to know their past and present medical status and to be free of any mistaken beliefs concerning their conditions. Situations occasionally occur in which a patient suffers significant medical complications that may have resulted from the physician's mistake or judgment. In these situations, the physician is ethically required to inform the patient of all the facts necessary to ensure understanding of what has occurred. Only through full disclosure is a patient able to make informed decisions regarding future medical care. . . . This obligation holds even though the patient's medical treatment or therapeutic options may not be altered by the new information. Concern regarding legal liability which might result following truthful disclosure should not affect the physician's honesty with a patient.¹⁶

This directive shows that the medical profession generally embraces the responsibility of fully disclosing to patients the substance of any EMR. Moreover, the Chair of the AMA Board of Trustees, speaking to all AMA members, has urged doctors to respect the trust of their patients in them by speaking with patients "clearly" and "completely" about the issues that arise in the course of the physician-patient relationship.¹⁷ It is unacceptable¹⁸ for physicians to hide medical errors or other EMRs from patients under the AMA and other medical codes of ethics.¹⁹

16. AMERICAN MEDICAL ASSOCIATION COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS: CURRENT OPINIONS WITH ANNOTATIONS § 8.12 (2008) [hereinafter CODE OF MEDICAL ETHICS].

17. Cecil B. Wilson, *Trust: A Reciprocal Relationship Between Us and Patients*, *AMA Leader Commentary*, AM. MED. NEWS, May 7, 2007, <http://www.ama-assn.org/amednews/2007/05/07/edca0507.htm> (statement of the chair of the AMA Board of Trustees).

18. Violations of professional ethics may result in the state medical licensure board taking action against the noncompliant physician. Professional consequences range from mere reprimand to permanent loss of license. See Timothy Stoltzfus Jost, *Oversight of the Quality of Medical Care: Regulation, Management, or the Market?*, 37 ARIZ. L. REV. 825, 863 (1995).

19. Echoing the AMA's position, the American College of Physicians has declared that "physicians should disclose to patients information about procedural and judgment errors made in the course of care, if such information significantly affects the care of the patient." American College of Physicians, *American College of Physicians Ethics Manual* (3rd ed.), 117 ANNALS INTERNAL MED. 947, 950 (1992). The principle established by the American College of Physicians is somewhat more narrow than that adopted by the American Medical Association in that disclosure is only required "if such information significantly affects the care of the patient." *Id.* Similarly, the Ethics Manual of the Annals of Internal Medicine urges disclosing information "whenever it is considered material to the patient's understanding of his or her situation, possible treatments, and probable outcomes," including "information about procedural or judgment errors made in the course of care if such information is material to the patient's well-being." American College of Physicians, *Ethics Manual: Fourth Edition*, 128 ANNALS INTERNAL MED. 576, 579 (1998), available at <http://www.annals.org/cgi/content/full/128/7/576>. See also Lee Taft, *Disclosing Unanticipated Outcomes: A Challenge to Providers and Their Lawyers*, HEALTH LAW. NEWS, May 2008, at 11, 12 ("Disclosure has long been ethically

Hospitals, accreditation organizations, regulators, and legislators are also developing models of behavior to encourage physicians to discuss harmful errors with patients.²⁰ For example, the Joint Commission,²¹ which accredits various qualifying health-care entities, requires physicians to tell patients about unanticipated medical outcomes, including acts that are unintended or that fail to achieve their intended outcome.²² Further, health-care purchasers, various groups dedicated to improving health-care quality, and government agencies that fund health care have collaborated with the National Quality Forum (NQF), the leading government-advisory board on health-care quality, to develop a single set of thirty “safe practices” for hospitals, including the prompt disclosure of unanticipated medical outcomes to patients and their families.²³ While compliance with these practices is voluntary,²⁴ these safe practices are supported by entities that value health-care quality, including the Joint Commission, the Institute for Healthcare Improvement, the Agency for Healthcare Research and Quality, and the Centers for Medicare and Medicaid Services.²⁵

Paralleling this consensus, legislation has been enacted that imposes a statutory obligation to disclose on health-care providers. States that mandate reporting of adverse medical events include California, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Kansas, Maine, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, New York, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, and Washington.²⁶ Most of these state laws mandating

mandated by professional associations such as the American Medical Association (AMA), the American College of Physicians, and the American Nurses Association.”).

20. Thomas H. Gallagher et al., *Disclosing Harmful Medical Errors to Patients*, 356 NEW ENG. J. MED. 2713, 2713 (2007). See Taft, *supra* note 19, at 12 (“Disclosure is required by regulation, emerging standards, ethics, and, in some states, disclosure statutes.”).

21. Formerly known as the Joint Commission on Accreditation of Health Care Organizations. BARRY R. FURROW ET AL., *LIABILITY AND QUALITY ISSUES IN HEALTH CARE* 148 (6th ed. 2008).

22. REVISIONS TO JOINT COMMISSION STANDARDS IN SUPPORT OF PATIENT SAFETY AND MEDICAL HEALTH CARE ERROR REDUCTION (2001), available at <http://www.dcha.org/JCAHOREvision.htm>. Further, the Joint Commission also calls for hospitals to self-report any sentinel event, which is “an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof.” The Joint Commission, *Sentinel Event Policy and Procedures* (2007), http://www.jointcommission.org/SentinelEvents/PolicyandProcedures/se_pp.htm.

23. Laura Landro, *Health-Care Industry Agrees on Set of Rules for Patient Safety*, WALL ST. J., Nov. 1, 2006, at D1, available at http://online.wsj.com/article/SB116234626074809703.html?mod=djem_jiewr_hc; see also National Quality Forum, *Safe Practices for Better Healthcare* (2007), http://www.qualityforum.org/projects/completed/safe_practices/.

24. Gallagher et al., *supra* note 20, at 2715. While compliance is voluntary, the NQF system is linked to pay-for-performance standards. *Id.*

25. *Id.* at 2714.

26. National Academy for State Health Policy, *Quality and Patient Safety: State Adverse Event Reporting Rules and Statutes*, http://www.nashp.org/_docdisp_page.cfm?LID=2A789909-5310-11D6-

disclosure direct these reports to independent administrative bodies. This external reporting requirement may lead to internal structural changes that improve health-care systems, but they provide little relief, assistance, or protection to affected patients. Just eight of these states—California, Florida, Maryland, Nevada, New Jersey, Pennsylvania, Vermont, and Washington—currently require disclosure of serious unanticipated medical outcomes to the patients.²⁷ Further, only Pennsylvania provides specific sanctions for nondisclosure.²⁸ Without mandating disclosures to patients and without imposing sanctions on health-care providers for a failure to disclose, such legislation is unlikely to ensure or even enhance the disclosure of emergent adverse medical risks to patients.²⁹

BCF000A0CC558925 (last visited Mar. 31, 2009) (Ohio and Oregon are also listed by the National Academy, but the National Academy notes that Ohio does not have specific reporting requirements for hospitals and reporting in Oregon is voluntary). Vermont is not included in the National Academy's list, but its mandatory reporting requirement can be found at VT. STAT. ANN. tit. 18, § 1915 (2008). See also Cindy Skrzycki, *Medicare Says 'No' to Bed Sores and Other Hospital Complications*, WASH. POST, Oct. 21, 2008, at D02, available at <http://www.washingtonpost.com/wp-dyn/content/article/2008/10/20/AR2008102002772.html> ("About 20 states already require reporting of medical errors."). For reflections on current reporting systems and suggestions for future reporting systems, see WACHTER & SHOJANIA, *supra* note 3, at 376–77; see also Berman, *supra* note 11, at 203–04.

27. CAL. HEALTH & SAFETY CODE § 1279.1(c) (West 2008) ("The facility shall inform the patient or the party responsible for the patient of the adverse event."); FLA. STAT. ANN. § 395.0197 (West 2006) ("(1) Every licensed facility shall . . . establish an internal risk management program that includes all of the following components: . . . (d) A system for informing a patient or [the patient's proxy] that the patient was the subject of an adverse incident."); MD. CODE REGS. 10.07.06.01 (2007) ("The purpose of this chapter is to provide a safe environment for patients by requiring hospitals to: . . . H. Provide a process to notify a patient or, if appropriate, a patient's family, whenever an outcome of care differs significantly from an anticipated outcome."); NEV. REV. STAT. ANN. § 439.855(2) (West 2008) ("A representative . . . shall, not later than 7 days after discovering or becoming aware of a sentinel event that occurred at the medical facility, provide notice of that fact to each patient who was involved in that sentinel event."); N.J. STAT. ANN. § 26:2H-12.25(d) (West 2007) ("A health care facility shall assure that the patient affected by a serious preventable adverse event . . . or, in the case of a minor or a patient who is incapacitated, the patient's parent or guardian or other family member, as appropriate, is informed of the serious preventable adverse event."); 40 PA. STAT. ANN. § 1303.308(b) (West 2008) ("A medical facility . . . shall provide written notification to a patient affected by a serious event."); VT. STAT. ANN. tit. 18, § 1915 (2008) ("The rules adopted pursuant to this chapter shall require hospitals to: (1) develop, maintain, and implement internal policies and procedures that meet the standards of the department to: . . . (D) disclose to patients, or, in the case of a patient death, an adult member of the immediate family, at a minimum, adverse events that cause death or serious bodily injury."); WASH. REV. CODE ANN. § 70.41.380 (West 2008) ("Hospitals shall have in place policies to assure that, when appropriate, information about unanticipated outcomes is provided to patients or their families or any surrogate decision makers."). See Gallagher et al., *supra* note 20, at 2715; National Academy for State Health Policy, *supra* note 26; Taft, *supra* note 19, at 12 & 16 nn.9–10.

28. Gallagher et al., *supra* note 20, at 2715.

29. For a discussion of proposed legislation that would have this effect and a call to enact this legislation, see Caroline Ann Forell & Anna Sortun, *The Tort of Betrayal of Trust*, 42 U. MICH. J.L. REFORM (forthcoming 2009).

Finally, patients strongly support efforts to enhance the disclosure of errors and other medical risks. In a study employing focus groups, all fifty-two participating patients voiced their desire for information on medical mistakes that affected them. These patients “unanimously wanted information regarding an error’s cause, consequences, and future prevention.”³⁰ After reviewing the literature on communication with patients about medical errors, scholars have found that patients and families strongly support disclosure.³¹ Indeed, Florida voters enacted a state constitutional amendment that permits access to medical errors noted in their records.³² But doctors and hospitals may not have recorded these errors in patient files or may hesitate to disclose them,³³ and the Florida amendment does not require physicians to disclose errors or other EMRs when they occur.

Despite the strong desire of patients to know about medical errors and other EMRs that affect them, evidence shows that patients do not always receive this critical information.³⁴ As the next Part discusses, the many ethical, regulatory, and legislative efforts seeking to increase disclosure have not solved the problem of undisclosed errors and other EMRs.

30. Gallagher et al., *supra* note 11, at 1006. See generally C. Wilkinson et al., *Preferences of Acutely Ill Patients for Participation in Medical Decision-Making*, 17 QUALITY & SAFETY HEALTH CARE 97, 98 (2008) (66% of 152 patients recently admitted to an acute care hospital “sought ‘very extensive’ or ‘a lot’ of information about their condition”).

31. Kathleen M. Mazor et al., *Communicating with Patients About Medical Errors: A Review of the Literature*, 164 ARCHIVES INTERNAL MED. 1690, 1692 (2004).

32. Under a Florida constitutional amendment, patients have a right to check records of past mistakes made by their doctors and hospitals. FLA. CONST. art. X, § 25(a). The Florida Supreme Court held that the “Patients’ Right to Know Amendment,” or Amendment 7, applied retroactively to give patients access to *all* past mistakes, not just those after the amendment passed in 2004. *Florida Hosp. Waterman, Inc. v. Buster*, 984 So. 2d 478 (Fla. 2008). However, a challenge to this amendment remains pending in the United States District Court for the Northern District of Florida. *Florida Hosp. Ass’n v. Viamonte*, No. 4:08cv312-RH/WCS, 2008 WL 5101755, at *1 (N.D. Fla. Nov. 26, 2008) (denying a motion to dismiss based on a series of procedural grounds). The challenge to the amendment was filed by the Florida Hospital Association and the Florida Medical Association, as well as individual hospitals and patients, who “assert that Amendment 7 violates the federal Constitution and is preempted by federal statutory provisions requiring the confidentiality of certain records.” *Id.*

33. For a discussion of reports from California regarding an inability to access patient records following an adverse medical event, despite a federal law (the Health Information Portability and Accountability Act) that establishes that every patient or the designated representative of the patient has the right to see and copy the patient’s medical record, see Robert Davis, *Patients Often Struggle for Access to Medical Records*, USA TODAY, Apr. 29, 2008, http://www.usatoday.com/news/health/2008-04-29-medical-records_N.htm.

34. Gallagher et al., *supra* note 20, at 2713 (noting “a divide between [patient] expectations and actual clinical practice is increasingly evident”); Taft, *supra* note 19, at 13 (“[R]ecent data suggest that disclosure occurs only infrequently.”).

II. FAILURE TO DISCLOSE

Despite a broad consensus that physicians have an obligation to tell patients about material risks that emerge during treatment, some physicians fail to do so. A survey of more than 1,600 physicians across a broad range of specialties found much agreement—but less action—on this ethical and increasingly legal obligation.³⁵ This study determined that 85% of the physicians believed that they needed to disclose all significant medical errors to patients or their guardians (93% agreed that physicians should report all significant medical errors to a hospital, clinic, or other authority).³⁶ Despite the widespread professional agreement about the need for this disclosure, 46% of the physicians had failed to report at least one serious known medical error during their careers.³⁷ These studies reveal the gap between agreed-upon norms regarding disclosure of an EMR and what sometimes happens in practice.³⁸

Likewise, one recent study found that nearly all of the physicians surveyed claimed that they would disclose medical errors to patients—further showing a consensus has developed among physicians that disclosure should occur. Yet 19% of the responding physicians acknowledged that they had not disclosed a minor error (an error resulting in prolonged treatment or discomfort to a patient) and 4% admitted not disclosing a major error (an error resulting in disability or death).³⁹

Thomas Gallagher, a physician who has extensively surveyed patient and physician attitudes toward error disclosure, has also found that doctors support disclosing medical mistakes, but has likewise noted that practice does not always coincide with this widely held belief.⁴⁰ In Gallagher's study, which used focus groups, the forty-six participating doctors agreed on the principle that patients should be informed of all harmful errors, often characterizing disclosure as an ethical imperative.⁴¹ Yet some of these physicians admitted that they may hide an error that is not apparent

35. Eric G. Campbell et al., *Professionalism in Medicine: Results of a National Survey of Physicians*, 147 ANNALS INTERNAL MED. 795, 796–98 (2007).

36. *Id.* at 797.

37. *Id.* at 798.

38. *Id.* at 796–98.

39. Lauris C. Kaldjian et al., *Disclosing Medical Errors to Patients: Attitudes and Practices of Physicians and Trainees*, 22 J. GEN. INTERNAL MED. 988, 988 (2007) (reporting results of a survey of physicians and trainees across the country; of the 538 who responded—77% of those who received the survey—97% said they would disclose a hypothetical error resulting in minor harm to a patient and 93% said they would disclose major harm to a patient).

40. Gallagher et al., *supra* note 11, at 1003–04.

41. *Id.* at 1003.

to patients, even when the error is serious,⁴² citing various rationales for avoiding disclosure, such as believing the patient would not want to know of the error.⁴³

Many concerns can place a doctor's interests into conflict with those of the patient and potentially compromise the physician's ultimate duty to promote the best interests of the patient.⁴⁴ One reason that some physicians may ignore the prevailing wisdom calling for disclosure is that the disclosure can take a heavy emotional toll.⁴⁵ Disclosing error—and admitting failure—is psychologically difficult for doctors who strive for perfection.⁴⁶

Time constraints may also limit communication between physicians and patients. In a society where the delivery of health care is dominated by managed care, physicians are encouraged to quickly process patients and not linger over issues that could increase costs by requiring additional time or resources.⁴⁷ Although doctors are still expected to provide appropriate medical care within the assigned time constraints, they may find it easier to meet these constraints by avoiding difficult conversations.⁴⁸ Further, doctors may not be reimbursed for costs tied to redressing some medical errors.⁴⁹

42. Thomas H. Gallagher et al., *Choosing Your Words Carefully: How Physicians Would Disclose Harmful Medical Errors to Patients*, 166 ARCHIVES INTERNAL MED. 1585, 1591 (2006).

43. *Id.* But see Wilkinson et al., *supra* note 30, at 98.

44. See CODE OF MEDICAL ETHICS, *supra* note 16, at xxix, lxi (“III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient. . . . VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.”). Beyond the context addressed here, physicians in general have been recognized as having a duty to disclose all material conflicts of interest to their patients when obtaining informed consent for treatment. BARRY R. FURROW ET AL., HEALTH LAW 327–31 (2d ed. 2000); see, e.g., Moore v. Regents of the Univ. of Cal., 793 P.2d 479 (Cal. 1990), *cert. denied*, 499 U.S. 936 (1991) (requiring disclosure of financial conflicts of interest); see also Lori Andrews, *Studying Medical Error In Situ: Implications for Malpractice Law and Policy*, 54 DEPAUL L. REV. 357, 376 (2005) (contending that if nondisclosure allows health-care providers to avoid lawsuits where they might be required to pay damages to a patient, then medical errors create a conflict of interest and the errors must be disclosed).

45. JOHN D. BANJA, MEDICAL ERRORS AND MEDICAL NARCISSISM ix (2005).

46. Cherri Hobgood et al., *Profiles in Patient Safety: When an Error Occurs*, 11 ACAD. EMERGENCY MED. 766, 768 (2004) (discussing the “ideal of error-free practice that permeates physician culture”).

47. See FURROW ET AL., *supra* note 44, at 340 (explaining that because “physicians feel increased pressure to see more patients, particularly in the managed care setting, full disclosure and open discussion is less likely to occur.”).

48. Thomas L. Hafemeister & Richard M. Gulbrandsen, Jr., *The Fiduciary Obligation of Physicians to “Just Say No” if an “Informed” Patient Demands Services that Are Not Medically Indicated*, 39 SETON HALL L. REV. 335, 358–60 (2009).

49. See, e.g., *Maine Law Bans Hospitals from Charging for Treatment to Correct Medical Errors*, 17 BNA'S HEALTH L. REP. 688, 688 (May 15, 2008) (“Under what is believed to be a first-in-

Physicians may also feel that a full exploration and discussion of adverse medical events is better left to physician committees, hospital administrators, or external evaluators focused on improving health care in general.⁵⁰ But while these groups may help provide information for valuable systemic changes, they do not give patients necessary information about their own medical condition.

Most of all, physicians dread outraged patients and malpractice suits, cited by some doctors as “the single most powerful force” keeping errors in the shadows.⁵¹ Physicians fear possible lawsuits because they can result in high emotional and legal costs,⁵² an entry in the National Practitioner’s Data Bank,⁵³ and suspension or revocation of a medical license.⁵⁴ A lawsuit may lead to increased medical-malpractice premiums, if the physician is fortunate enough not to lose coverage entirely.⁵⁵ In a field that

the-nation law, hospitals in Maine beginning in July [of 2008] will be prohibited from charging for treatment to correct medical errors.”); Tom Murphy, *WellPoint to Stop Select Reimbursements*, INT’L BUS. TIMES, Apr. 2, 2008, available at <http://www.ibtimes.com/articles/20080402/wellpoint-to-stop-select-reimbursements.htm> (reporting that Medicare and health insurers like WellPoint, Inc. and Aetna are limiting payments for costs associated with some medical errors or other preventable injuries); Skrzycki, *supra* note 26 (“Regulators at the Centers for Medicare and Medicaid Services told about 3,500 U.S. hospitals that as of Oct. 1, they won’t be reimbursed for . . . so-called ‘never events’ that patients should never acquire during a hospital stay. The dozen treatment areas on the list are considered ‘reasonably preventable’ and aren’t present when a patient checks in. . . . States and private insurers also have begun to ask for more reporting of errors.”).

50. See Campbell et al., *supra* note 35, at 797 (determining that although 85% of physicians believed they needed to disclose all significant medical errors to patients or their guardians, 93% believed they needed to report all significant medical errors to a hospital, clinic, or other authority).

51. WACHTER & SHOJANIA, *supra* note 3, at 296.

52. Although their legal costs and any judgment will typically be covered by their malpractice insurance, the anxiety and embarrassment associated with a public airing of their asserted deficient actions, the impingement on what may be their very busy schedule, and the distraction caused by an ongoing lawsuit are all significant deterrents for physicians.

53. Any entity (including an insurance company) that “makes payment under a policy of insurance, self-insurance, or otherwise in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical-malpractice action or claim,” must report “information respecting the payment and circumstances thereof” to the National Practitioner Data Bank (NPDB). 42 U.S.C. § 11131 (2000). The NPDB was established by Congress to provide an available repository of information pertaining to the professional competence or conduct of licensed professionals, with licensure boards and hospitals, but not the general public, having access to this information when checking on licensees and reviewing applications for staff privileges, respectively. FURROW ET AL., *supra* note 44, at 80–81.

54. See, e.g., U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, STATE DISCIPLINE OF PHYSICIANS: ASSESSING STATE MEDICAL BOARDS THROUGH CASE STUDIES 28 (2006), <http://aspe.hhs.gov/daltcp/reports/2006/stdiscp.pdf> (charting sanctions used by state medical boards and documenting that all states permit their medical boards to suspend or revoke physician licenses).

55. Thomas H. Gallagher & Wendy Levinson, *Disclosing Harmful Medical Errors to Patients: A Time for Professional Action*, 165 ARCHIVES INTERNAL MED. 1819, 1819 (2005) (noting that physicians face skyrocketing medical-malpractice premiums and the possible loss of insurability after just one claim). *But see* FURROW ET AL., *supra* note 44, at 347 (“[Malpractice insurance rates for physicians] are typically determined based on the claims experience of the rating class rather than on the experience of the individual physician.”).

aspires to perfection, doctors legitimately worry that distributing information about their medical errors and medical-malpractice suits will jeopardize their reputations and careers.⁵⁶ At the same time, one national study found that actual involvement in malpractice litigation did not diminish a physician's later willingness to disclose,⁵⁷ nor should it.

Recently, medical scholars have promoted disclosure as good policy⁵⁸ that may actually reduce the risks of litigation.⁵⁹ Research shows that poor communication between a physician and a patient often triggers lawsuits.⁶⁰ In contrast, candid disclosures and discussions can strengthen the bond between physicians and patients, defuse patient anger about perceived medical errors, and reduce the number of lawsuits.⁶¹ Patients agree that robust disclosure will "enhance their trust in their physicians' honesty and . . . reassure them that they [a]re receiving complete information about

56. Kaldjian et al., *supra* note 39, at 994; *see also* Barron H. Lerner, *In a Hospital Hierarchy, Speaking Up Is Hard to Do*, N.Y. TIMES, Apr. 17, 2007, at F5, available at www.nytimes.com/2007/04/17/health/17essa.html (reporting that medical students and residents often fear upsetting the hierarchy by reporting concerns, and that "[e]ven when students do speak up, they may be ignored").

57. Kaldjian et al., *supra* note 39, at 994 (observing that physicians exposed to malpractice litigation were not less inclined to disclose errors).

58. Thurman, *supra* note 11, at 147.

59. *See, e.g.*, Berman, *supra* note 11, at 200 (explaining that when patients are perceived as and encouraged to be active participants in medical decision making, a relationship of mutual respect and appreciation is more likely to ensue, which in turn helps disclosure seem more natural and decreases the chances of litigation); Kevin Sack, *Doctors Start to Say "I'm Sorry" Before "See You in Court,"* N.Y. TIMES, May 18, 2008, at A1, available at <http://www.nytimes.com/2008/05/18/us/18apology.html> ("By promptly disclosing medical errors and offering earnest apologies and fair compensation, [prominent academic medical centers] hope to restore integrity to dealings with patients, make it easier to learn from mistakes and dilute anger that often fuels lawsuits."). Legal commentators have made similar arguments. *See* Robin E. Ebert, *Attorneys, Tell Your Clients to Say They're Sorry: Apologies in the Health Care Industry*, 5 IND. HEALTH L. REV. 337, 339 (2008) ("[C]ommunication between physicians and patients can help ease the tension of looming litigation."); Jennifer K. Robbenolt, *Apologies and Legal Settlement: An Empirical Examination*, 102 MICH. L. REV. 460 (2003); Taft, *supra* note 19, at 15 ("In the wake of preventable error, lawyers [for health care providers] should consider . . . data that point to the short- and long-term economic benefits of disclosure. Lawyers should be aware of studies illustrating how disclosure identifies and invites correction of system errors Weighing the potential for disclosure to save lives and promote healing, and not just to generate monetary consequences, should be part of the process of advising healthcare clients on this issue.").

60. *See, e.g.*, Wendy Levinson et al., *Physician-Patient Communication: The Relationship with Malpractice Claims Among Primary Care Physicians and Surgeons*, 277 JAMA 553 (1997); Charles Vincent et al., *Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action*, 343 LANCET 1609 (1994).

61. Darr, *supra* note 10, at 33 (asserting that patients who are treated fairly through full disclosure are less likely to sue, while hiding information from patients may incite their ire—and lawsuits); *see also* E. J. Mundell, *Doctor-Patient Bond Frays After Medical Mistake*, WASH. POST, Oct. 24, 2007, available at <http://www.washingtonpost.com/wp-dyn/content/article/2007/10/24/AR2007102402044.html>.

their overall care.”⁶² Some health-care systems that have adopted policies of full disclosure of medical errors and fair compensation to patients for medical errors have seen a decrease in medical-malpractice litigation.⁶³

III. THE NEED FOR A LEGAL DUTY TO DISCLOSE EMRS

The ethical obligation to disclose EMRs to patients and its practical value have not convinced all physicians.⁶⁴ Ethical codes are largely self-policing; thus, physicians and hospitals may succumb to their fears of litigation and loss of professional status without facing any commensurate sanctions for failing to disclose.⁶⁵ The standards issued by professional organizations also tend to promote systemic change to avoid future occurrences. While these efforts can dramatically improve health care, they tend not to ensure that useful—and sometimes vital—information is provided to individual patients about the risks they face.⁶⁶

As noted, the broad consensus that physicians should routinely disclose EMRs to patients tends to be cast in ethical rather than legal terms. With

62. Gallagher et al., *supra* note 11, at 1003.

63. See, e.g., Steve S. Kraman & Ginny Hamm, *Risk Management: Extreme Honesty May Be the Best Policy*, 131 ANNALS INTERNAL MED. 963 (1999) (describing the success of the Lexington Veterans Affairs [VA] Hospital's error-disclosure and patient-compensation program); S. Hall, *U-M Docs Say Sorry, Avert Suits*, DETROIT NEWS, May 12, 2004, at 1C (describing the success of the University of Michigan Health System's error-disclosure and patient-compensation program).

64. Nor are all scholars convinced that disclosure will have beneficial effects for physicians. Some scholars assert that error disclosure may increase the volume and costs of litigation. David M. Studdert et al., *Disclosure of Medical Injury to Patients: An Improbable Risk Management Strategy*, 26 HEALTH AFF. 215, 222 (2007); see also Gallagher et al., *supra* note 20, at 2716 (advocating a duty to disclose despite the potential for more litigation). And, indeed, until a patient “discovers” the existence of a medical error, it is relatively unlikely that the patient will file a medical-malpractice suit. Furthermore, regardless of assurances that disclosure of medical error and an accompanying apology will reduce the likelihood of a lawsuit, the mere specter of a malpractice lawsuit, with its attendant report in the National Practitioner's Database and other professional consequences, may lead some doctors to shun disclosure. But physicians can learn to share relevant information with patients in ways that help minimize the possibility of litigation. WACHTER & SHOJANIA, *supra* note 3, at 291 (suggesting “straightforward apologies, prompt and fair settlement offers, family involvement, and highly visible institutional commitments to preventing similar errors in the future”). Moreover, the physician has a fiduciary duty to disclose to patients. See *infra* Part V.

65. Joan Vogel & Richard Delgado, *To Tell the Truth: Physicians' Duty to Disclose Medical Mistakes*, 28 UCLA L. REV. 52, 55 (1980); see also *id.* at 58–60.

66. Only eight states require mandatory disclosure to the patient, rather than to an external organization. See *supra* note 27 and accompanying text; see also D. O. Farley et al., *Adverse-Event-Reporting Practices by US Hospitals: Results of a National Survey*, 17 QUALITY & SAFETY HEALTH CARE 416, 416 (2008) (finding that more than 94% of 1,652 responding hospitals from across the country have central systems for reporting and collecting data on adverse events, but only a third have established environments that support reporting, only “20–21% fully distribute and consider summary reports [of adverse] events,” and “only 13% have broad staff involvement in reporting adverse events,” with physicians appearing to be particularly averse to reporting errors).

the medical profession now recognizing the importance and value of these disclosures, defining a legal duty to disclose EMRs is both timely and appropriate.⁶⁷

A defined legal duty sends a clear message that physicians must not succumb to the fears that may breed silence among some physicians. A legal duty to disclose gives physicians a tangible, concrete requirement that undercuts any rationalizing of a need for concealment. If the law requires physicians to disclose EMRs to patients or face legal sanctions for a failure to do so, doctors will have a significant incentive to disclose that can counterbalance these fears. Because staying quiet can provide grounds for a lawsuit, physicians will be motivated to adhere to the consensus reached by their peers.⁶⁸ Moreover, while physicians accused of medical error will be vindicated if they adhered to the professional standard of care, physicians who fail to adequately disclose an EMR will have no such defense available to them.⁶⁹ The relevant issue will be a relatively straightforward question of whether an EMR was discovered by the physician in the course of treatment and whether the requisite disclosure occurred. Although some doctors may gamble that their patients will never learn of the emergent risk, the prospect of paying damages for a failure to disclose may shift the balance of their risk-benefit analysis, providing these physicians with a greater incentive to disclose.

Establishing a legal duty to disclose emergent medical risks will also convey a strong symbolic message to the medical profession.⁷⁰ A legal duty can animate ethical values such as a physician's obligation to disclose EMRs and a patient's right to know of these risks.⁷¹ Although the law often draws on behavioral norms when articulating legal duties, the law can also independently affect behavior when imposing liability for certain activities.⁷² Thus, physicians may take the duty to disclose more seriously

67. See Gallagher et al., *supra* note 20, at 2713 (asserting that “[e]xternal pressures for disclosure, coupled with some thawing of reluctance within the medical profession, have created an environment that is ripe for change”).

68. See Vogel & Delgado, *supra* note 65, at 60–61 (contending that a legal duty lessens some professional risks to physicians because “physicians could explain to colleagues and superiors that they were merely complying with the law in disclosing malpractice”).

69. See American College of Physicians, Ethics and Human Rights Committee, *Ethics Manual: Fourth Edition, Disclosure*, 128 ANNALS INTERNAL MED. 576 (1998), available at <http://www.annals.org/cgi/content/full/128/7/576> (observing that while medical errors are not necessarily unethical, failure to disclose them may be). What constitutes an “adequate” disclosure under the circumstances will be addressed *infra*, Part VI.

70. See Vogel & Delgado, *supra* note 65, at 88.

71. See CODE OF MEDICAL ETHICS, *supra* note 16, § 8.12.

72. See Charles D. Siegal, *Rule Formation in Non-Hierarchical Systems*, 16 TEMP. ENVTL. L. & TECH. J. 173, 174 (1998) (“[S]ome rules, while not generally controlling all or most behavior, do

when it is freighted with legal consequences. Similarly, as scholars have noted, “many physicians are idealistic, law-abiding citizens for whom a *legal* duty to disclose . . . would make a difference.”⁷³ Any reluctance to disclose may be outweighed by reinforcing the ethical principle that physicians must act in accord with their position of trust by sharing information of EMRs with their patients.

Moreover, appropriate consequences should flow from the breach of a responsibility that places patients directly at risk. Dr. Lucian Leape, who is widely perceived as the founder of America’s patient-safety movement, argues that when doctors fail to meet professional standards, “*something* has to happen. Today, nothing does, and you have a vicious cycle in which people have no real incentive to follow the rules because they know there are no consequences if they don’t.”⁷⁴ While doctors confront the prospect of sanctions from medical licensure boards and the possibility of being required to pay damages following a malpractice suit if medical error is discovered, the nondisclosure of an EMR by a physician should also result in specific and substantial consequences. Physicians generally agree that they should be personally responsible for the well-being of their patients because a “lack of accountability . . . *does* harm patient safety.”⁷⁵ Without a legal duty to disclose EMRs to patients and associated penalties, some doctors may continue to fail to disclose this important and often vital information to their patients.

A significant body of jurisprudence shows that courts have established a legal vehicle to mandate this disclosure: the fiduciary duty that physicians owe to their patients.⁷⁶ Especially when existing state law does not mandate this disclosure, and thus fails to provide adequate protection to patients, courts can apply this well-established judicial doctrine to remedy the failure to disclose an EMR.⁷⁷

influence some decisions; others may be ripening into norms in the traditional sense.”); Peter Tiersma, *The Language of Silence*, 48 RUTGERS L. REV. 1, 41–42 (1995) (describing the courts’ use of behavioral norms to establish legal duties).

73. Vogel & Delgado, *supra* note 65, at 86.

74. WACHTER & SHOJANIA, *supra* note 3, at 321 (quoting Wachter and Shojania’s interview with Dr. Lucian Leape, described by the authors as “the legendary surgeon who sounded the first alarms about medical errors back when few people were willing to listen”).

75. *Id.* at 380.

76. *Id.*

77. *Id.*

IV. THE NATURE OF THE PHYSICIAN-PATIENT RELATIONSHIP

An exploration of the physician-patient relationship lays the philosophical groundwork of a physician's duty to disclose EMRs. Underlying the relationship between patients and physicians are the bioethical principles of nonmaleficence, beneficence, autonomy, and justice.⁷⁸

The basic tenet "first, do no harm" encapsulates the idea of nonmaleficence. Physicians have an ethical obligation to avoid injuring patients.⁷⁹ If a doctor fails to provide a patient with complete information about the patient's medical condition, negative outcomes that the patient could have avoided may occur.⁸⁰ Further, if a patient has been injured by a medical error, disclosure of this occurrence is part of the physician's duty to help prevent future harm from occurring.⁸¹ To avoid doing harm, all EMRs—not just errors—need to be brought to the patient's attention, enabling the patient to monitor these risks and bring any materialized symptoms or harms to the attention of a physician.

The principle of beneficence recognizes that physicians have an affirmative obligation to help their patients "by doing what is best for them"⁸² and admonishes doctors who place their own interests over their patients' needs.⁸³ A beneficent physician offers full explanations of a patient's medical condition to a patient because providing that information, in and of itself, enables the patient to understand the existing medical circumstances and make related decisions.⁸⁴ While a physician may be tempted to withhold information that could trigger a medical-malpractice lawsuit, the principle of beneficence instead directs a physician to act in the patient's best interests. EMRs should be disclosed because that information may benefit the patient.

78. Albert W. Wu et al., *To Tell the Truth: Ethical and Practical Issues in Disclosing Medical Mistakes to Patients*, 12 J. GEN. INTERNAL MED. 770, 772 (1997); see also Kimberly G. Crone et al., *Between a Rock and a Hard Place: Disclosing Medical Errors*, 52 CLINICAL CHEMISTRY 1809, 1810 (2006); Joan Gibson, *Thinking About the "Ethics" in Bioethics*, in *BIOETHICS: HEALTH CARE LAW AND ETHICS* 4-5 (Barry Furrow et al. eds., 5th ed. 2004).

79. Wu et al., *supra* note 78, at 772.

80. Crone et al., *supra* note 78, at 1811.

81. *Id.*

82. Gibson, *supra* note 78, at 4 ("3. Beneficence. The principle that one has a duty to help others by doing what is best for them.").

83. Wu et al., *supra* note 78, at 772.

84. Crone et al., *supra* note 78, at 1810; see also WACHTER & SHOJANIA, *supra* note 3, at 291 (urging full disclosure because "professional ethics demand nothing less than candor").

The next bioethical tenet related to the physician-patient relationship is that patients are free to make their own decisions about their health-care treatment.⁸⁵ The principle of patient autonomy has been widely embraced.⁸⁶ As Justice Cardozo wrote, “[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body.”⁸⁷ This principle has also shaped the contemporary doctrine of informed consent, giving patients the ultimate authority to decide the course of their medical treatment.⁸⁸ Consent to medical treatment cannot be “informed” unless the physician has disclosed to the patient the material risks and benefits associated with a proposed treatment and reasonable alternatives to that treatment.⁸⁹ Likewise, patients deserve and need to have physicians tell them about medical risks that emerge over the course of treatment, thereby enabling patients to chart and monitor their future medical care. If unaware of these EMRs, patients may not fully grasp the implications of future medical treatment and may fail to make appropriate related medical decisions.⁹⁰ Disclosure may also enable patients to rid themselves of mistaken beliefs about their medical condition. For example, without disclosure patients may disregard pain they are currently experiencing because they believe that they were “successfully” treated for a given condition. Even if future health-care decisions are not at stake, “patients have a claim to know their own history and to be free of mistaken beliefs concerning their past, present, or future medical condition.”⁹¹ The principle of autonomy guarantees patients the right to know medical information that concerns their own bodies.

Justice—another bioethical principle associated with the physician-patient relationship—calls for giving patients services to which they are or

85. Crone et al., *supra* note 78, at 1810.

86. The American Medical Association’s Code of Medical Ethics declares that “[t]he principle of patient autonomy holds that an individual’s physical, emotional, and psychological integrity should be respected and upheld. This principle also recognizes the human capacity to self-govern and choose a course of action from among different alternative options.” CODE OF MEDICAL ETHICS, *supra* note 16, § 10.02.

87. *Schloendorff v. Soc’y of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914).

88. See Marshall B. Kapp, *Patient Autonomy in the Age of Consumer-Driven Health Care: Informed Consent and Informed Choice*, 28 J. LEGAL MED. 91, 117 (2007).

89. See *Canterbury v. Spence*, 464 F.2d 772, 782–83 (D.C. Cir. 1972).

90. Crone et al., *supra* note 78, at 1810; see also Thurman, *supra* note 11, at 150. Some may claim that patients cannot grasp the technicalities of medicine, but settled law and ethics view patients as capable of making informed medical decisions. Kapp, *supra* note 88, at 98–99 (contending that despite the doubts of some scholars, informed consent is an attainable goal). Patient decision-making capacity is generally presumed by the courts, unless incapacity is shown. FURROW ET AL., *supra* note 44, at 340.

91. Wu et al., *supra* note 78, at 772.

should be entitled.⁹² A quid pro quo exists between the patient and physician. For example, if a doctor receives payment to provide medical care to a patient, the physician must provide that care. Similarly, most members of the medical profession agree that a just physician who has committed medical error should provide the patient with an explanation, an apology, or an offer of compensation.⁹³ It is unjust to leave a patient at risk of harm when the physician knows information that will help the patient avoid or minimize that risk. In these circumstances, patients deserve candid disclosure of EMRs from their physicians.⁹⁴

These bioethical principles of nonmaleficence, beneficence, autonomy, and justice support a physician's duty to give patients information about EMRs. The unique relationship between physicians and patients, however, gives rise not only to bioethical principles, but also to fiduciary duties.

V. THE FIDUCIARY DUTY TO DISCLOSE

The nature of the physician-patient relationship creates special responsibilities for doctors. Because physicians have superior medical knowledge and skill and are the gatekeepers to medical services, patients are dependent on them.⁹⁵ Patients lack the knowledge or skill to assess their own health conditions. Instead, they must depend on their physicians to provide critical information about their medical well-being. Patients rely on doctors to assist and direct them in choosing necessary medical treatment. As noted in *Canterbury v. Spence*,⁹⁶ the now-classic case establishing that patients have a right to exercise informed consent before treatment begins, patients are almost totally dependent on doctors for medical information, with few reliable alternatives.⁹⁷ This dependence is enhanced by the anxiety that patients typically feel about their health, the vulnerability that they experience from a sickness or injury, and the challenge of finding a new doctor if a patient concludes that the present

92. See Gibson, *supra* note 82, at 4 (“5. Distributive Justice. The principle that benefits and burdens ought to be distributed equitably, that resources (especially scarce resources) ought to be allocated fairly, and that one ought to act in such a manner that no one person or group bears a disproportionate share of benefits or burdens.”).

93. Crone et al., *supra* note 78, at 1811; see also Wu et al., *supra* note 78, at 772–73 (contending that justice requires compensating patients who were seriously harmed by medical error).

94. See, e.g., BANJA, *supra* note 45, at ix (urging disclosure to respect “the patient’s right to the unvarnished truth about what happened”).

95. FURROW ET AL., *supra* note 44, at 327.

96. 464 F.2d 722 (D.C. Cir. 1972).

97. *Id.* at 782; see Hafemeister & Gulbrandsen, *supra* note 48, at 370–73.

doctor is providing inadequate services.⁹⁸ Because patients are so vulnerable and dependent on their physicians, the law imposes a “trust” on doctors—a fiduciary responsibility stemming from the dependence and vulnerability of the patient, and from the disparity between a patient’s and a physician’s knowledge and ability to act.⁹⁹

Fiduciary duties have deep roots in the common law. Within the law governing the administration of trusts—where a trustee has been appointed to administer a corpus or an estate on behalf of a beneficiary—courts developed the concept of fiduciary duty.¹⁰⁰ Originally an equitable remedy to correct the harm done by a disloyal trustee, fiduciary duties now apply to many relationships in which a party is entrusted with the welfare of someone who is relatively vulnerable.¹⁰¹ Typically, fiduciaries possess specialized knowledge¹⁰² and can deliver needed services that are not routinely available.¹⁰³ Fiduciary relationships arise when one party is justified in expecting loyal conduct from another.¹⁰⁴ Courts have recognized fiduciary relationships between attorneys and clients, guardians and wards, financial advisors and clients, and corporate officers and shareholders.¹⁰⁵ Among other things, fiduciaries are charged with a duty of loyalty¹⁰⁶ and must promote the beneficiary’s interest over the fiduciary’s own.¹⁰⁷ The duty of loyalty provides a check on the potential abuse of power by the fiduciary, who is in a predominant position with regard to the beneficiary.¹⁰⁸

98. Hafemeister & Gulbrandsen, *supra* note 48, at 370–73.

99. FURROW ET AL., *supra* note 44, at 327. *See generally* Thomas L. Hafemeister & Sarah P. Bryan, *Beware Those Bearing Gifts: Physicians’ Fiduciary Duty to Avoid Pharmaceutical Marketing*, 57 U. KAN. L. REV. 491, 519–28 (2009) (providing general overview and discussion of a physicians’ fiduciary duty to a patient); Hafemeister & Gulbrandsen, *supra* note 48, at 367–78 (providing general overview and discussion of a physicians’ fiduciary duty to a patient); Charity Scott, *Doctors as Advocates, Lawyers as Healers*, 29 HAMLIN J. PUB. L. & POL’Y 331, 337 (2008) (“This concept of the physician as fiduciary has become well accepted in both U.S. law and the ethical tenets of American professional medical associations.”).

100. Andrew Grubb, *The Doctor as Fiduciary*, 47 CURRENT LEGAL PROBS. 311, 311 (1994).

101. Maxwell J. Mehlman, *Dishonest Medical Mistakes*, 59 VAND. L. REV. 1137, 1147 (2006).

102. Marc A. Rodwin, *Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System*, 21 AM. J.L. & MED. 241, 244 (1995).

103. Tamar Frankel, *Fiduciary Law*, 71 CAL. L. REV. 795, 800 (1983).

104. Deborah A. DeMott, *Breach of Fiduciary Duty: On Justifiable Expectations of Loyalty and Their Consequences*, 48 ARIZ. L. REV. 925, 936 (2006).

105. Rodwin, *supra* note 102, at 243.

106. *Id.* at 244; *see also* Meinhard v. Salmon, 164 N.E. 545, 546 (N.Y. 1928) (charging fiduciaries with the duty of “undivided loyalty”).

107. 2 DAN B. DOBBS, *THE LAW OF TORTS* 1392–93 (2001); *see also* Rodwin, *supra* note 102, at 244.

108. Austin W. Scott, *The Fiduciary Principle*, 37 CAL. L. REV. 539, 541 (1949); Frankel, *supra* note 103, at 826; *see also* Mehlman, *supra* note 101, at 1147 n.44.

Courts have similarly recognized the fiduciary nature of the physician-patient relationship. Because patients generally seek the services of a physician when they are sick, injured, or concerned about their health, because doctors have unique access to a patient's medical information and superior insight into a patient's medical condition, and because physicians control patients' ability to obtain needed medical treatment, patients are highly dependent on their physicians and should be able to rely on their physicians to protect and promote their well-being.¹⁰⁹ For these reasons, the judiciary has routinely found a fiduciary relationship to exist between physicians and patients.¹¹⁰ As one court noted, "[t]here can be little dispute that a doctor occupies a condition of trust and confidence, a fiduciary relationship with [the] patient."¹¹¹ The medical profession acknowledges the physician's fiduciary duty in the AMA's Code of Ethics by stating "[t]he relationship between patient and physician is based on trust and gives rise to physicians' ethical obligations to place patients' welfare above their own self-interest."¹¹² The fiduciary's duty of loyalty is designed to ensure that the beneficiary can fully rely on the fiduciary to protect and promote the beneficiary's interests.¹¹³

Generally, fiduciaries have a duty to disclose to competent beneficiaries¹¹⁴ any information relevant to fulfilling their fiduciary obligations.¹¹⁵ The scope of the required communications vary somewhat,

109. See *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997) (noting that "trust . . . is essential to the doctor-patient relationship").

110. See, e.g., *Hahn v. Mirda*, 54 Cal. Rptr. 3d 527, 532 (Ct. App. 2007); *Tresemmer v. Barke*, 150 Cal. Rptr. 384, 394 (Ct. App. 1978); *Wohlgemuth v. Meyer*, 293 P.2d 816, 820 (Cal. Dist. Ct. App. 1956); *Mangoni v. Temkin*, 679 So. 2d 1286, 1288 (Fla. Dist. Ct. App. 1996); *Schmucking v. Mayo*, 235 N.W. 633, 633 (Minn. 1931); *Tracy v. Merrell Dow Pharm.*, 569 N.E.2d 875, 878 (Ohio 1991); *Borderlon v. Peck*, 661 S.W.2d 907, 908 (Tex. 1983); *Carson v. Fine*, 867 P.2d 610, 617-18 (Wash. 1994). Some courts have refused to extend a fiduciary framework to relationships that do not involve property, even when they exhibit all the classic indications of a fiduciary duty. Grubb, *supra* note 100, at 314. Arguably, these courts could view the patient's body as the "property" required to establish a fiduciary duty.

111. *Taber v. Riordan*, 403 N.E.2d 1349, 1353 (Ill. App. Ct. 1980).

112. CODE OF MEDICAL ETHICS, *supra* note 16, § 10.015.

113. William M. Barron & Mark G. Kuczewski, *Unanticipated Harm to Patients: Deciding When to Disclose Outcomes*, 29 JOINT COMMISSION J. QUALITY & SAFETY 551, 552 (2003).

114. Historically, full and open discussion was not expected when the beneficiary was incompetent, such as when the beneficiary was a minor or the subject of a guardianship or conservatorship. The underlying rationale was that these beneficiaries would not benefit from or meaningfully contribute to these discussions. Recently, however, it has been increasingly recognized that, to the extent possible, even these beneficiaries should be kept abreast of relevant activities by the fiduciary. See Sheryl L. Buske, *Foster Children and Pediatric Clinical Trials: Access Without Protection Is Not Enough*, 14 VA. J. SOC. POL'Y & L. 253, 281-87 (2007) (explaining that children's assent is generally required before pediatric treatment or research can commence and that this assent must follow an age-appropriate exchange of information regarding the treatment or research).

115. *Andrews*, *supra* note 44, at 373-74.

depending on the nature of the fiduciary relationship.¹¹⁶ Although many aspects of a physician's fiduciary duties have not been fully fleshed out by the courts,¹¹⁷ the duty to disclose EMRs fits squarely within existing legal doctrine.

Legal precedent supports the existence of a duty to disclose that is generally rooted in the fiduciary relationship between physicians and patients.¹¹⁸ Many cases have considered nondisclosure of medical error, for example, to constitute misrepresentation or fraud, often using this as a basis for tolling the statute of limitations that governs the filing of medical-malpractice claims.¹¹⁹ In addition, a failure to disclose an EMR to a patient—at least one involving an undisclosed medical error—has been the basis for directly imposing liability on a physician. Some courts have characterized a failure to disclose as misrepresentation by silence.¹²⁰ Deliberate nondisclosure has also been categorized as fraudulent concealment.¹²¹ In these cases, the failure to disclose is usually subordinated to a medical-malpractice claim, rather than standing alone as an independent cause of action.

Judicial rulings have also specifically indicated that a physician has a fiduciary duty to reveal EMRs to patients. These cases state that doctors have a fiduciary obligation to disclose to a patient whenever they become aware of adverse medical information about a patient's condition. A recent

116. See Mary Anne Bobinski, *Autonomy and Privacy: Protecting Patients from Their Physicians*, 55 U. PITT. L. REV. 291, 348–52; cf. Marshall B. Kapp, *Medical Error Versus Malpractice*, 1 DEPAUL J. HEALTH CARE L. 751, 762 (1997) (“[L]iability may be imposed on a physician specifically because that professional failed to reveal relevant information—i.e., the occurrence of the medical error—to the patient. The cause of action here could be based on the physician’s violation of fiduciary responsibilities, which encompass obligations to disclose the nature and scope of negligently caused injuries.”).

117. Mehlman, *supra* note 101, at 1172.

118. Theodore R. LeBlang & Jane L. King, *Tort Liability for Nondisclosure: The Physician’s Legal Obligations to Disclose Patient Illness and Injury*, 89 DICK. L. REV. 1, 36 (1984).

119. See, e.g., *Harrison v. United States*, 708 F.2d 1023, 1028 (5th Cir. 1983); *Pedersen v. Zielski*, 822 P.2d 903, 908 (Alaska 1991); *Walk v. Ring*, 44 P.3d 990, 999 (Ariz. 2002); *Brown v. Bleiberg*, 32 Cal. 3d 426, 439 (1982); *Tresemmer v. Barke*, 150 Cal. Rptr. 384, 394 (Ct. App. 1978); *Harvey v. Davis*, 432 So. 2d 1203, 1204 (La. Ct. App. 1983); *Schmucking v. Mayo*, 235 N.W. 633, 634 (Minn. 1931); *Reyes v. Anka Research, Ltd.*, 443 N.Y.S.2d 595, 597 (Sup. Ct. 1981); *Borderlon v. Peck*, 661 S.W.2d 907, 908 (Tex. 1983); see also *Andrews*, *supra* note 44, at 376; *LeBlang & King*, *supra* note 118, at 36–37.

120. See, e.g., *Stafford v. Shultz*, 270 P.2d 1, 7 (Cal. 1954); *Wohlgemuth v. Meyer*, 293 P.2d 816, 820 (Cal. Ct. App. 1956); *Adams v. Ison*, 249 S.W.2d 791, 794 (Ky. Ct. App. 1952); *Lopez v. Swyer*, 279 A.2d 116, 124 (N.J. Super. Ct. App. Div. 1971), *modified*, 300 A.2d 563 (N.J. 1973).

121. *Bohus v. Beloff*, 950 F.2d 919, 926 (3d Cir. 1991); *Roberts v. Francis*, 128 F.3d 647, 650 (8th Cir. 1997); *Morrison v. Acton*, 198 P.2d 590, 595 (Ariz. 1948); *Garcia v. Presbyterian Hosp. Ctr.*, 593 P.2d 487, 490 (N.M. Ct. App. 1979); *Earle v. Ratliff*, 998 S.W.2d 882, 888 (Tex. 1999); *Farmers’ State Bank of Newport v. Lamon*, 231 P. 952, 953 (Wash. 1925).

California case involved a patient who went through chemotherapy and a radical mastectomy, but who was not told that her cancer diagnosis was in error.¹²² The court asserted that, as a fiduciary, “the physician is prohibited from misrepresenting the nature of the patient’s medical condition.”¹²³ Similarly, the Eighth Circuit held that a physician violated his fiduciary duty by failing to inform his patient that he had removed her only remaining ovary during a bladder operation.¹²⁴ Because of the fiduciary relationship, the Fifth Circuit has also required doctors to disclose known facts about a patient’s adverse conditions, including “a cause [of the adverse condition] known by the doctor or discoverable by him through efficient diagnosis.”¹²⁵ In that case, a child’s parents were not told about the medical procedure that may have left their infant blind, comatose, and irreversibly brain damaged.¹²⁶

Courts have drawn heavily on the previously discussed bioethical tenet of patient autonomy to support a physician’s fiduciary duty to disclose to patients. For example, one court declared that each patient “has the right to chart his own destiny, and the doctor must supply the patient with the material facts the patient will need in order to intelligently chart that destiny.”¹²⁷ The principle of autonomy has special relevance for cases of medical error. Indeed, one court found it “unthinkable” that a physician could withhold information if “the patient was deprived of an opportunity for escape from a medical predicament which the physician by his own negligence had initially inflicted on the patient.”¹²⁸ A physician is usually the best—and often the only—means to avoid harm when a risk is discovered during the course of unrelated treatment. As courts place a high value on information that affects a patient’s autonomy, a physician must disclose all EMRs discovered in the course of treatment. One court stated that a doctor has a fiduciary duty to tell the patient all information

122. Hahn v. Mirda, 54 Cal. Rptr. 3d 527, 532 (Ct. App. 2007).

123. *Id.*

124. *Roberts*, 128 F.3d at 650.

125. *Nardone v. Reynolds*, 538 F.2d 1131, 1135 (5th Cir. 1976).

126. *See Nardone v. Reynolds*, 333 So. 2d 25, 28–29 (Fla. 1976) (providing factual background for *Nardone*, 538 F.2d at 1133).

127. *Nixdorf v. Hicken*, 612 P.2d 348, 354 n.19 (Utah 1980) (quoting *Miller v. Kennedy*, 522 P.2d 852, 860 (Wash. Ct. App. 1974), *aff’d*, 530 P.2d 334 (Wash. 1975)); *see also Gates v. Jensen*, 595 P.2d 919, 923 (Wash. 1979) (asserting that the physician must disclose all facts that “the patient needs in order to make the decision. To require less would be to deprive the patient of the capacity to choose the course his or her life will take”).

128. *Simcuski v. Saeli*, 377 N.E.2d 713, 719 (N.Y. 1978).

necessary for the patient to make informed decisions for future medical treatment.¹²⁹

It is also worth noting that a physician's fiduciary duty to disclose emergent adverse medical risks may extend beyond the termination of the physician-patient relationship. Courts have recognized that the timing of the emergent adverse medical condition does not mitigate the duty to disclose when the physician learns of information indicating that the patient's medical well-being is at significant risk.¹³⁰ Because of the potential gravity of medical information to patient health, the Fifth Circuit declared that the duty to disclose continues even after the physician-patient relationship has ended.¹³¹ As legal scholars have noted, "[w]hen a patient may be harmed because of prior treatment or when new information of critical importance is available concerning past care, a physician has a duty to reasonably notify those affected individuals. Only through such efforts can the physician fulfill the fiduciary responsibilities [created by] the physician-patient relationship."¹³² For example, one court recognized the existence of a cause of action when a physician failed to warn his former patient of the dangerous effects of the Dalkon Shield (an intrauterine device) after obtaining knowledge of these hazards.¹³³ Similarly, when a type of dye injected into patients was later discovered to be dangerous, the physicians who performed these injections were held to have a duty to seek out former patients and to disclose "that in the supposedly innocent treatment there had now been found to lurk the risk of devastating injury."¹³⁴

By requiring physicians to seek out former patients to disclose newly discovered medical risks, these decisions emphasize that physicians have a relatively extensive affirmative obligation linked to their fiduciary duties to their patients—one that does not automatically cease when the physician-patient relationship ends and that does not depend on a patient

129. Hahn v. Mirda, 54 Cal. Rptr. 3d 527, 532 (Ct. App. 2007).

130. See, e.g., Mink v. Univ. of Chicago, 460 F. Supp. 713, 720 (N.D. Ill. 1978); Schwartz v. United States, 230 F. Supp. 536, 540 (E.D. Pa. 1964).

131. Nardone v. Reynolds, 538 F.2d 1131, 1136 (5th Cir. 1976).

132. LeBlang & King, *supra* note 118, at 30.

133. Tresemer v. Barke, 150 Cal. Rptr. 384, 394 (Ct. App. 1978).

134. Schwartz, 230 F. Supp. at 540; see also Mink, 460 F. Supp. at 720 (finding that researchers who gave diethylstilbestrol (DES) to participants in a medical experiment had a duty to disclose a link between DES and cancer, even though that link was not known until after the experiment; the court explained that "[t]he fact the knowledge of the risk was obtained after the patient was treated does not alter the obligation. If the defendant fails to notify the patient when the risk becomes known, he has breached this duty.").

requesting this information.¹³⁵ In light of the constantly evolving nature of medical knowledge and the general mobility of patients, however, it is likely that courts would limit the duty of disclosure to EMRs that surface in the course of the physician-patient relationship or in a reasonable period of time after that relationship ceases.

VI. WHEN AND WHAT TO DISCLOSE

Beyond recognizing a duty to disclose EMRs, some courts have sketched parameters about the scope of the obligation. Generally, where recognized, the duty to disclose appears to be triggered as soon as the physician learns of the EMR, requiring the physician to share relevant information with the patient as soon as practicable.¹³⁶

In the words of the Fifth Circuit, the fiduciary relationship imposes on physicians the duty to disclose “known facts,” such as the discovery of an adverse condition afflicting a patient.¹³⁷ At least one court, however, has stated that a physician must disclose “those facts the physician knows or should know which the patient needs in order to make the decision.”¹³⁸ This ruling suggests that the test of the adequacy of the disclosure is what a reasonable physician would disclose with the same information about the patient’s medical condition and the emergent risk. Another court has indicated, however, that the test should be comparable to the “reasonable patient” test that a number of courts have adopted for determining whether a patient gave informed consent to medical treatment.¹³⁹ The latter

135. LeBlang & King, *supra* note 118, at 30 (concluding from case law that the duty to disclose “is not triggered by specific patient questions but rather exists independent of any such inquiry,” meaning that “[t]he physician must initiate the communication of pertinent information to the patient or risk liability for failing to comply with a recognized duty within the framework of the physician-patient relationship”). For example, a duty to disclose would likely arise when a physician, while looking at the records of a former patient, notices an undisclosed diagnostic result that indicates an EMR.

136. *See, e.g.*, Wohlgenuth v. Meyer, 293 P.2d 816, 820 (Cal. Ct. App. 1956); Gates v. Jenson, 595 P.2d 919, 923 (Wash. 1979); *see also* LeBlang & King, *supra* note 118, at 1.

137. Nardone v. Reynolds, 538 F.2d 1131, 1135 (5th Cir. 1976) (quoting Nardone v. Reynolds, 333 So. 2d 25, 39 (Fla. 1976)); *see also* Tetsone v. Adams, 373 So. 2d 362, 363 (Fla. Dist. Ct. App. 1979) (holding that physicians have a fiduciary duty to disclose known facts regarding the patient’s condition).

138. *Gates*, 595 P.2d at 923.

139. Nixdorf v. Hicken, 612 P.2d 348, 354 (Utah 1980) (stating that disclosure is required “[i]f a reasonable person in the position of the plaintiff would consider the information important in choosing a course of treatment”). For an example of the adoption of the “reasonable patient” standard in conjunction with assessing the nature of the disclosure needed to satisfy the requirements of informed consent, *see* Carr v. Strode, 904 P.2d 489 (Haw. 1995).

standard resonates with the notion that the fiduciary duty to disclose EMRs is linked to respect for patient autonomy.

Typically, courts have required disclosure only of material facts. For example, in a case where a doctor left a surgical cutting needle inside his patient's body, the court held that the fiduciary relationship "creates a duty in the physician to disclose to his patient any material information concerning the patient's physical condition."¹⁴⁰ Using the doctrine of informed consent as a model, the court defined "materiality" by stating that "[i]f a reasonable person in the position of the plaintiff would consider the information important in choosing a course of treatment then the information is material and disclosure required."¹⁴¹ Under this definition, the disclosed information should at least encompass the existence and extent of the patient's EMR.¹⁴²

As long as a physician adequately discloses the existence and extent of an EMR, a court will likely be relatively unconcerned about the specific content and manner of the disclosure. The purpose of the disclosure is to ensure that the patient receives information that is potentially vital to his or her medical well-being. In meeting this goal, the physician should be able to decide how to craft the disclosure. The best way of transmitting this information will vary somewhat from patient to patient. Doctors, exercising their medical expertise, can shape their disclosure accordingly. For example, some patients will have a relatively sophisticated understanding of their medical condition and risk, while other patients may need a detailed explanation of the risk they now face. But, similar to obtaining informed consent, a physician should not ignore any readily apparent special needs of a patient in making the necessary disclosure.¹⁴³

Some scholars have expressed concern that a disclosing physician may feel compelled to "choose words carefully," avoiding the word "error" or admissions of liability.¹⁴⁴ But a doctor need not focus on or admit error to

140. *Nixdorf*, 612 P.2d at 354; *see also Wohlgenuth*, 293 P.2d at 820 (requiring that the physician, as fiduciary, "make full and fair disclosure of all facts which materially affect the patient's rights and interests").

141. *Nixdorf*, 612 P.2d at 354; *see also Gates*, 595 P.2d at 922–23 (directing that physicians must disclose those facts to patients about their medical condition that patients need to make informed decisions about medical care).

142. An institution's ethics committee or quality review board could provide reliable guidance on the nature of the necessary disclosure. *See Wu et al.*, *supra* note 78, at 773.

143. *See generally Jacobo v. Binur*, 70 S.W.3d 330 (Tex. App. 2002) (ruling that plaintiff could proceed with her claim asserting that a physician did not obtain informed consent to a double mastectomy because the patient needed a more accurate description of her risk for breast cancer when her mother had just died from breast cancer, the patient was distressed, and she needed more consultation, support, and information).

144. *Gallagher et al.*, *supra* note 11, at 1001, 1003.

communicate an EMR. If a physician tells a patient all material information necessary to disclose an EMR, then the scope, content, and manner of the disclosure should be left to the physician's discretion. Indeed, the American College of Physicians urges doctors to consider each patient's individual needs when disclosing medical error, with variation permitted in the pace of disclosure to ensure that the information is understood.¹⁴⁵ Critical factors include providing disclosure in a setting and in a manner that allows the physician to share the information effectively, and ensuring that the patient adequately understands the meaning of the disclosed information.¹⁴⁶ Assuming the patient is capable of understanding this information,¹⁴⁷ concerns that a disclosure may be viewed as admitting error should not preclude a doctor from disclosing an EMR.¹⁴⁸

VII. A BREACH OF THE FIDUCIARY DUTY TO DISCLOSE AN EMR

A. *Elements*

A patient can seek damages if a physician fails to disclose a material EMR—a risk that materially endangers the medical condition of the patient—of which the physician was aware but the patient was not. The law entitles an individual to recover damages for a breach of fiduciary duty.¹⁴⁹ After establishing the existence of a physician-patient relationship,

145. American College of Physicians, *supra* note 19, at 950.

146. See Berman, *supra* note 11, at 202 (recording comments of leading health care quality expert Dr. Albert W. Wu, describing how best to disclose errors to patients); Kapp, *supra* note 116, at 766 (“[F]rank and open communication is more likely to maintain and renew than to harmfully rupture the therapeutic relationship between the physician and patient.”); cf. Thomas L. Hafemeister, *End-of-Life Decision Making, Therapeutic Jurisprudence, and Preventive Law: Hierarchical v. Consensus-Based Decision-Making Model*, 41 ARIZ. L. REV. 329, 360 (1999) (emphasizing the “importance of health care providers promoting the sharing of information and responsibility, enhancing communication, and providing support and counseling for those individuals involved in the decision-making process”).

147. If not, the physician should disclose the information to an appropriate surrogate.

148. Wu et al., *supra* note 78, at 773; see also Berman, *supra* note 11, at 199, 202. Indeed, a number of states have enacted “I’m Sorry” legislation to shield physicians and other health-care providers from potential malpractice liability based on their conversations with a patient following an adverse medical event. See *States Making It Safer for Doctors to Say ‘Sorry’: Apologizing Isn’t Always Allowed, but Can Defuse Anger, Avoid Lawsuits*, MSNBC, Apr. 11, 2007, <http://www.msnbc.msn.com/id/18059841/> (citing the American Medical Association for its finding that twenty-seven states have passed laws that “allow physicians to apologize when things go wrong without having to fear that their words will be used against them in court”). See generally Ebert, *supra* note 59, at 337; Robbenolt, *supra* note 59; Sack, *supra* note 59.

149. DOBBS, *supra* note 107, at 1392–93; see generally Meinhard v. Salmon, 164 N.E. 545 (N.Y. 1928); Moore v. Regents of the Univ. of Cal., 793 P.2d 479 (Cal. 1990); Mehlman, *supra* note 101; Forell & Sortun, *supra* note 29; RESTATEMENT (FIRST) OF RESTITUTION § 138, cmt. a (1937) (noting that “[a] fiduciary who commits a breach of his duty as fiduciary is guilty of tortious conduct and the

the patient must show that the physician became aware¹⁵⁰ of the EMR, either in the course of the physician-patient relationship or in a reasonable period of time after the relationship ended. Because it has been widely accepted that doctors have an ethical obligation to disclose a discovered EMR to a patient, the gist of this legal claim is that the physician favored a personal interest over the patient's interest and permitted this conflict of interest to impede the physician's fiduciary duty.¹⁵¹ The physician's conflict of interest may be financial or emotional. As discussed previously, the physician may have failed to disclose the EMR because of a fear of professional discipline, reputational damage, or litigation.¹⁵²

Moreover, a plaintiff must establish what information a physician needed to disclose under the existing circumstances to adequately inform the patient of the EMR, with the physician required to make a good faith disclosure reasonably calculated to inform the patient of this condition. This will generally be determined by assessing what a reasonable person in the patient's position would have considered to be material information under the circumstances. But to the extent that the plaintiff can show that the physician knew or should have known of special characteristics of the patient (e.g., impaired hearing) that required an alternative means of disclosure to ensure the nature of the EMR was adequately conveyed to the patient, the physician will be expected to use a reasonable alternative

beneficiary can obtain redress either at law or in equity for the harm done"). For a discussion of damages, see *infra* notes 167–76 and accompanying text.

150. As noted earlier, some jurisdictions appear to expand the basis for imposing liability by adding the equivalent of a "should have been aware" standard to the actual knowledge requirement. See *supra* note 138 and accompanying text. This has the effect of imposing liability on a physician for negligently failing to detect the EMR. Because the focus of the fiduciary duty is on loyalty rather than competence, this expansion seems unwarranted and is inconsistent with the majority of those rulings that have recognized a physician's fiduciary duty to disclose a discovered EMR.

151. Hafemeister & Bryan, *supra* note 99, at 522 ("Fiduciaries must act to protect and enhance the best interests of the beneficiary and cannot use their position to promote their own interests at the expense of the beneficiary. They are held to the highest level of loyalty and good faith, [and] are prohibited from putting themselves in positions where their interests and the beneficiary's interests conflict."); Hafemeister & Gulbrandsen, *supra* note 48, at 372 ("[P]atients—and society in general—must be able to trust physicians, rely on their loyalty, and rest assured that physicians will place the patient's best interests above all other potentially competing interests."); Mehlman, *supra* note 101, at 1150. While this cause of action could be formulated as a dignitary tort that permits recovery following the breach of a fiduciary duty, notwithstanding that the patient has not incurred damages from this breach, this formulation of this cause of action has not succeeded in parallel circumstances. *Id.* at 1152–53. In *Canterbury v. Spence* and other cases, courts have refused to allow patients to recover for a physician's failure to obtain informed consent—sometimes described as a fiduciary duty—when the patient incurred no harm or damages as the result of a failure to disclose the risks, benefits, and alternatives needed to acquire informed consent prior to the commencement of treatment. *Id.*

152. See *supra* notes 44–55 and accompanying text.

means of disclosure. The plaintiff must also show that any disclosure the physician made failed to meet this standard.¹⁵³

Further, a plaintiff must establish that a “reasonable patient” under these or similar circumstances would have pursued medical care or taken other related steps following the disclosure of the EMR that were significantly different from the course actually taken by the patient.¹⁵⁴ The plaintiff must also show that, as a result of the nondisclosure, the patient sustained injury—either from failing to obtain needed treatment or from failing to take other related steps in a timely manner to address the EMR. Finally, as discussed below, the patient must show damages from that injury.

B. Defenses

After a plaintiff establishes a prima facie case, the physician can rebut the allegation if the physician can show by a preponderance of the evidence that: (1) the physician did not owe a fiduciary duty to the patient (e.g., a physician-patient relationship did not exist at the time of discovery or the discovery was not made in a reasonable period of time after the relationship ended), (2) the physician did not have actual knowledge of an EMR, (3) what the physician discovered was not a material risk, (4) a reasonable patient who received disclosure would not have pursued a course of action significantly different from that followed by this patient, or (5) the patient was not harmed by the physician’s failure to provide timely disclosure.¹⁵⁵

Physicians may also attempt to counter these breach-of-fiduciary-duty suits through several affirmative defenses, but few circumstances excuse nondisclosure of a material EMR. First, a doctor may shift the blame to the patient for not discovering the EMR.¹⁵⁶ The physician may assert that a

153. As established earlier, the manner of disclosure is not usually relevant to this cause of action, as a fiduciary duty focuses on the failure to disclose—not the manner of disclosure—unless the manner of disclosure was so poorly done as to constitute a “non-disclosure.” See *supra* notes 142–48 and accompanying text.

154. This standard is modeled on the informed-consent requirement that patients must show that they would not have pursued the course they did (e.g., undergone medical treatment) if disclosure had been made. See FURROW ET AL., *supra* note 44, at 334 (noting that if the court finds a breach of the duty to disclose, before awarding damages, it must also conclude “that the operation would not have taken place if the risk had been disclosed”).

155. See Mehlman, *supra* note 101, at 1150–51.

156. Vogel & Delgado, *supra* note 65, at 81.

reasonable patient would have known of the EMR and taken appropriate steps to avoid or minimize related harm.¹⁵⁷

Second, physicians can claim that they could not reasonably locate the patient, thereby precluding them from disclosure.¹⁵⁸ But this defense should be available only under relatively rare and unusual circumstances.¹⁵⁹ Generally, disclosure of an EMR should occur as soon as practicable after the discovery, and a doctor will typically discover EMRs in the course of an ongoing physician-patient relationship. As a result, the physician should have little difficulty finding the patient to provide a disclosure.

A physician may also claim therapeutic privilege, a defense that allows doctors to withhold information about known risks from patients who may become so emotionally distraught by the information that they could endanger themselves.¹⁶⁰ Courts and scholars have castigated the therapeutic-privilege doctrine, in part because little evidence supports the notion that significant harm will result from disclosing a medical risk.¹⁶¹ In addition, the watershed ruling in *Canterbury v. Spence* sought to keep the therapeutic-privilege exception “carefully circumscribed” in the context of informed consent so as not to “devour the disclosure rule itself.”¹⁶² Further, recent studies discredit the defense’s rationale by showing that patients do not wish to be kept in the dark, but rather want full disclosure

157. As an extreme example, where a physician has amputated the wrong leg, this EMR will generally be obvious to the patient, and although the physician may face a lawsuit for medical malpractice, the physician should not be exposed to liability for a failure to disclose the EMR. The patient has sufficient notice of the EMR to enable the patient to take appropriate steps in response.

158. Vogel & Delgado, *supra* note 65, at 82. In some circumstances—such as where the patient lacks decision-making capacity—it may be appropriate to disclose the EMR to the patient’s surrogate.

159. The most likely circumstance where this would arise would involve a discovered EMR that pertains to a former patient. It may be difficult to locate a former patient. Nevertheless, reasonable efforts to locate and contact a former patient can be expected. *See, e.g.,* Tresemer v. Barke, 150 Cal. Rptr. 384, 393–94 (Ct. App. 1978) (recognizing the existence of a cause of action when a physician failed to warn his former patient of the dangerous effects of an intrauterine device after the physician learned of these hazards).

160. FURROW ET AL., *supra* note 44, at 336; *see also* Wu et al., *supra* note 78, at 771 (suggesting that a physician need not disclose if the information provided would actually undermine patient autonomy, such as in cases of severe depression or deliberate waiver); *Canterbury v. Spence*, 464 F.2d 772, 789 (D.C. Cir. 1972) (recognizing the therapeutic privilege as an exception to obtaining informed consent because “patients occasionally become so ill or emotionally distraught on disclosure as to foreclose a rational decision”).

161. FURROW ET AL., *supra* note 44, at 337. Even when given a poor prognosis, patients and their families generally appreciate full disclosure. *See, e.g.,* Robert Wood Johnson Foundation, Studies Suggest Cancer Patients, Families Respond Better to Frank Prognoses (July 13, 2007), <http://www.rwjf.org/programareas/features/digest.jsp?id=5955&pid=1142&c=EMC-ND142>.

162. 464 F.2d 772, 789 (D.C. Cir. 1972).

from their physicians.¹⁶³ While many statutes include therapeutic privilege as a possible exception to the duty to disclose a risk to a patient when seeking informed consent, only rarely is a therapeutic privilege cited as grounds for dismissing a cause of action that asserted a failure to obtain informed consent.¹⁶⁴

Further, few circumstances are appropriate for claiming therapeutic privilege as grounds for nondisclosure. Even patients who have been found incompetent may have some capacity to understand an EMR disclosure, although a family member or other guardian should be present to help the patient fully grasp the implications of the information shared. Certainly, the patient's surrogate should be given the relevant information. And when the patient stabilizes or regains decision-making capacity, a physician has no reason to withhold information about an EMR from the patient.¹⁶⁵ Thus, the defense of therapeutic privilege is significantly limited.¹⁶⁶

C. Damages

A patient who has not received adequate disclosure of an EMR merits both equitable relief¹⁶⁷ and compensatory damages for resulting economic and noneconomic injuries.¹⁶⁸ One equitable remedy is restitution, which entitles the beneficiary to the benefits derived by the fiduciary as a result of the breach of duty.¹⁶⁹ Courts also have broad discretion to fashion

163. See, e.g., Gallagher et al., *supra* note 11, at 1006; Wilkinson et al., *supra* note 30, at 97, 98.

164. FURROW ET AL., *supra* note 44, at 337.

165. Vogel & Delgado, *supra* note 65, at 82.

166. See also LeBlang & King, *supra* note 118, at 51 (noting that limitations like therapeutic privilege "lie at the periphery of an otherwise comprehensive duty").

167. Mehlman, *supra* note 101, at 1149. The Employee Retirement Income Security Act (ERISA) also allows an individual plan participant to seek equitable remedies for breach of fiduciary duty. See *Variety Corp. v. Howe*, 516 U.S. 489, 510–13, 515 (1996) (finding that 29 U.S.C. § 1132(a)(3) allows individual actions for equitable relief for breaches of fiduciary duty). Recovery seems limited, however, to "classic" equitable remedies. *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 257–58 (1993). These traditional equitable remedies include restitution, as well as injunctive and specific relief. *Knieriem v. Group Health Plan, Inc.*, 434 F.3d 1058, 1061 (8th Cir. 2006). See also Thomas R. McLean & Edward P. Richards, *Managed Care Liability for Breach of Fiduciary Duty After Pegram v. Herdrich: The End of ERISA Preemption for State Law Liability for Medical Care Decision Making*, 53 FLA. L. REV. 1, 44–46 (2001) (discussing equitable and compensatory relief for breach of fiduciary duty); Dante Figueroa, *Civil Law Trusts in Latin America: Is the Lack of Trusts an Impediment for Expanding Business Opportunities in Latin America?*, 24 ARIZ. J. INT'L & COMP. L. 701, 730 (2007) (observing that in common law jurisdictions, equitable remedies are broadly available to beneficiaries who allege breaches of fiduciary duty).

168. Mehlman, *supra* note 101, at 1153.

169. See *Mertens*, 508 U.S. at 255 (traditional equitable remedies include restitution); RESTATEMENT (FIRST) OF RESTITUTION § 138, cmt. a (1937) (noting that a beneficiary who suffers a

equitable remedies that meet the practical demands of the situation.¹⁷⁰ One scholar has proposed that in a managed-care setting, the remedy for a medical mistake should be the value the physician received from the patient's health plan when the patient's care was endangered.¹⁷¹ He argues that this value includes the reputational and seniority benefits of being a successful physician and any money that the doctor actually received from a managed-care organization as a result of withholding care from the patient (e.g., as part of a capitation plan).¹⁷²

For compensatory damages, a court's valuation should focus on the difference in medical costs between (1) what it would have cost to treat or otherwise address the medical condition in a timely manner, and (2) the cost to treat or otherwise address the harm when the patient discovered it. If the patient's condition has worsened, the court may take into account any lost wages that result from this deterioration of the patient's condition. Some pain and suffering damages attributed to the deterioration of the patient's condition may also be appropriate.

These equitable and compensatory remedies should serve to make the patient whole. They should redress the physical, financial, and emotional injury sustained by the patient as a result of the nondisclosure of the EMR.

While most courts and commentators agree that a patient who prevails in a fiduciary-duty lawsuit is eligible for punitive damages,¹⁷³ these will not be available or warranted in most EMR cases.¹⁷⁴ Because an award of punitive damages is not designed to compensate plaintiffs for their harm, but rather to punish or deter inappropriate conduct, these damages are generally limited to intentionally malicious conduct.¹⁷⁵ But in some cases of extreme physician disloyalty associated with a failure not to disclose an EMR, the required element of *malum in se* may be satisfied.¹⁷⁶ A physician's failure to disclose an EMR—especially if the doctor took affirmative steps to prevent the patient from discovering the EMR—

breach of fiduciary duty "is entitled to obtain the benefits derived by the fiduciary through the breach of duty").

170. *Lemon v. Kurtzman*, 411 U.S. 192, 200–01, (1973); *see also Amoco Prod. Co. v. Vill. of Gambell*, 480 U.S. 531, 541 (1987); *Franks v. Bowman Transp. Co.*, 424 U.S. 747, 763–64 (1976).

171. Mehlman, *supra* note 101, at 1153.

172. *Id.* at 1153 n.64.

173. *Id.* at 1149; *see also* E. Haavi Morreim, *Medicine Meets Resource Limits: Restructuring the Legal Standard of Care*, 59 U. PITT. L. REV. 1, 71–72 & 71 n.245 (1997) (citing scholarship, cases, and treatises in support of this contention).

174. BARRY R. FURROW ET AL., *LIABILITY AND QUALITY ISSUES IN HEALTH CARE* 243 (5th ed. 2004) ("In the normal malpractice case . . . [p]unitive damages are extremely rare.").

175. *See, e.g., State Farm Mut. Auto. Ins. Co. v. Campbell*, 538 U.S. 408, 409 (2003).

176. Mehlman, *supra* note 101, at 1153 & n.65.

involves not only a violation of the prevailing standard of medical care, but also a breach of the physician's ethical code of professional responsibility and the physician's legal fiduciary duty of loyalty to the patient. As a result, punitive damages are perhaps more apt here than in a medical-malpractice case. In egregious circumstances, awarding damages for a failure to disclose an EMR may appropriately send a message that will deter this behavior. To show the requisite malice, a plaintiff must prove that the doctor knew that serious injury would result from a failure to disclose the EMR, yet still failed to do so. For example, if a physician discovers a malignant tumor during a patient's unrelated surgery, but hides this information from the patient—fully realizing that the patient may die unless the tumor is immediately addressed—then the plaintiff may be able to show malice in the physician's decision not to disclose.

VIII. A BETTER APPROACH THAN A MEDICAL-MALPRACTICE OR INFORMED-CONSENT LAWSUIT

A claim for a breach of the fiduciary duty to disclose an EMR may parallel medical-malpractice or informed-consent claims. The former involves claims that a physician has failed to adhere to the medical standard of care, while the latter reflects a physician's failure to obtain the patient's informed consent before providing medical treatment. Fiduciary law, however, establishes a separate cause of action with a distinct focus and distinct remedies. Further, fiduciary law avoids some pitfalls of medical-malpractice actions and some limitations of informed-consent suits. As a result, claims based on a physician's fiduciary duty will help ensure and encourage the disclosure of EMRs.

A. *Medical Malpractice*

When learning that a physician did not disclose an EMR, a patient could file a medical-malpractice suit, alleging that the doctor breached the professional standard of care by failing to disclose. This approach has often dominated the discourse about a physician's failure to disclose a medical error to a patient. For example, many cases have recognized the failure to disclose as a basis for extending the statute of limitations for the filing of a medical-malpractice claim.¹⁷⁷

177. See, e.g., *Harrison v. United States*, 708 F.2d 1023, 1028 (5th Cir. 1983); *Pedersen v. Zielski*, 822 P.2d 903, 908 (Alaska 1991); *Walk v. Ring*, 44 P.3d 990, 999 (Ariz. 2002); *Brown v. Bleiberg*, 32 Cal. 3d 426, 439 (1982); *Tresemmer v. Barke*, 150 Cal. Rptr. 384, 389 (Ct. App. 1978); *Harvey v. Davis*,

Formulating nondisclosure of an EMR as a medical-malpractice claim, however, will find little support in the medical community. Put mildly, doctors have a very negative view of medical-malpractice claims,¹⁷⁸ in part because all adverse judgments and settlements must be reported to the National Practitioner Data Bank (NPDB).¹⁷⁹ Listing an event in the NPDB is a potential lifetime sanction that can have dramatic effects on a medical career. For example, it may preclude a doctor from being listed as a panel member approved to provide covered services under a managed-care plan or from obtaining staff privileges with a health-care facility, which are generally necessary to enable physicians to admit their patients and use the facility's resources.¹⁸⁰ Casting nondisclosure of an EMR as a cause of action for medical malpractice—thus mandating NPDB reports and threatening the livelihood of physicians—may be an extreme response when physicians fail to disclose the discovery of a medical condition unrelated to the course of treatment they provided or an error that poses little risk of harm.

Linking a failure to disclose medical risk to a medical-malpractice claim may also trigger a visceral reaction from physicians,¹⁸¹ possibly

432 So. 2d 1203, 1204 (La. Ct. App. 1983); *Schmucking v. Mayo*, 235 N.W. 633, 634 (Minn. 1931); *Reyes v. Anka Research, Ltd.*, 443 N.Y.S.2d 595, 597 (Sup. Ct. 1981); *Borderlon v. Peck*, 661 S.W.2d 907, 908 (Tex. 1983).

178. See *infra* note 181 and accompanying text; William M. Sage, *Medical Malpractice Insurance and the Emperor's Clothes*, 54 DEPAUL L. REV. 463, 464 (2005) ("For over a century, American physicians have regarded malpractice suits as unjustified affronts to medical professionalism."); see also Maxwell J. Mehlman, *The Shame of Medical Malpractice*, 27 J. LEGAL MED. 17, 17 (2006) (describing the various reasons why physicians deem the medical malpractice system to be unfair).

179. In 1986, Congress established the National Practitioner Data Bank (NPDB) to record malpractice payments and disciplinary actions involving physicians and other health-care professionals. 42 U.S.C. §§ 11101–11152 (2000). Hospitals and managed-care plans access the NPDB to determine whether a physician should be a staff or network member, and state medical boards can also access the information in the NPDB. DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF THE INSPECTOR GENERAL, MANAGED CARE ORGANIZATION NONREPORTING TO THE NATIONAL PRACTITIONER DATA BANK (May 2001), available at <http://oig.hhs.gov/oei/reports/oei-01-99-00690.pdf>. As noted, any entity (including an insurance company) that "makes payment under a policy of insurance, self-insurance, or otherwise in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical-malpractice action or claim," must report "information respecting the payment and circumstances thereof" to the NPDB. 42 U.S.C. § 11131.

180. Cynthia E. Boyd, *How Compliance Intersects with Medical Staff Issues: Credentialing*, J. HEALTH CARE COMPLIANCE, Mar.–Apr. 2008, at 11, 12 ("The NPDB represents the portion of law that was included to enhance professional review activities by making certain information concerning medical malpractice payments and adverse actions available to eligible entities and individuals. Data bank information is an important supplement to the credentialing process because of the information it contains."); Diane E. Hoffmann, *Are Health Care Conflicts All That Different? A Contrarian View*, 29 HAMLIN J. PUB. L. & POL'Y 235, 239 (2008) (noting that being listed in the NPDB "may affect a physician's future ability to be hired or obtain hospital privileges").

181. See David M. Studdert et al., *Medical Malpractice*, 350 NEW ENG. J. MED. 283, 283 (2004) ("Few issues in health care spark as much ire and angst as medical-malpractice litigation. Physicians

overriding what physicians generally accept as an ethical obligation to disclose.¹⁸² A legal sanction for breach of fiduciary duty that does not entail a potential medical-malpractice judgment may encourage physicians to disclose EMRs without awakening these deep-seated fears.¹⁸³ The threat of a fiduciary duty lawsuit could sufficiently change behavior while avoiding counterproductive effects.

Some scholars contend that causes of action for a medical breach of fiduciary duty have languished because they are virtually indistinguishable from medical-malpractice claims.¹⁸⁴ Although courts have widely cited the applicability of fiduciary law to the physician-patient relationship,¹⁸⁵ they routinely rely on the traditional negligence standard rather than fiduciary duty as a basis for awarding damages to an injured plaintiff.¹⁸⁶ Some courts have gone so far as to characterize the fiduciary duty claim as duplicative of a medical-malpractice claim.¹⁸⁷ Other courts have held that breaches of fiduciary duty amount to medical-malpractice claims and are not separate causes of action.¹⁸⁸ The United States Supreme Court ruling in *Pegram v. Herdrich*¹⁸⁹ may have inadvertently provided support for this position while holding that treatment decisions made by physician employees of a managed-care plan did not involve the fiduciary duties

revile malpractice claims as random events that visit unwarranted expense and emotional pain on competent, hardworking practitioners. Commentators lament the ‘lawsuit lottery,’ which provides windfalls for some patients, but no compensation for the vast majority of patients injured by medical care. Within the health care industry, there is a nearly universal belief that malpractice litigation has long since surpassed sensible levels.”) (internal citations omitted).

182. See *supra* notes 35–41, 50–55 and accompanying text.

183. Some commentators have asserted that the fear of medical-malpractice litigation by physicians is often times unfounded. See, e.g., TOM BAKER, *THE MEDICAL MALPRACTICE MYTH* 1 (2005).

184. See Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 504 (2002) (“[U]nder common law fiduciary principles, most courts have declined to allow suits for damages for breach of fiduciary duties based on financial incentives.”).

185. See *supra* notes 110–11 and accompanying text.

186. See *supra* notes 119–21 and accompanying text.

187. See, e.g., *Neade v. Portes*, 739 N.E.2d 496, 501–03 (Ill. 2000) (dismissing a suit alleging breach of fiduciary duty for nondisclosure of the physician’s financial conflict of interest as simply a medical-malpractice claim); *D.A.B. v. Brown*, 570 N.W.2d 168, 171 (Minn. Ct. App. 1997).

188. See, e.g., *Spoor v. Serota*, 852 P.2d 1292, 1294–95 (Colo. Ct. App. 1992) (finding that the breach of fiduciary claim replicated the plaintiffs’ malpractice claim); *Neade*, 739 N.E.2d at 503 (stating that because the plaintiff needed to prove the medical standard of care in order to show that the fiduciary breach was the proximate cause of injury—the same standard as for a medical-malpractice claim—it was unnecessary to recognize a new cause of action based on a breach of fiduciary duty); *D.A.B.*, 570 N.W.2d at 171 (holding that the breach of fiduciary duty claim was a mischaracterized malpractice claim); see also Mehlman, *supra* note 101, at 1154 (describing the attack by some legal scholars and jurists on a distinct claim for breach of medical fiduciary duty).

189. 530 U.S. 211 (2000).

imposed under the Employee Retirement Income Security Act (ERISA).¹⁹⁰ In dicta, the Court suggested that the fiduciary duty claims pursued against the managed-care plan were nothing more than malpractice claims.¹⁹¹

But even if breach of medical fiduciary duty and medical-malpractice claims may parallel one another or overlap, it does not follow that they are identical or redundant claims.¹⁹² For the two scenarios described at the beginning of this Article, most will readily agree that for the patient's well-being the doctor should disclose the EMR in both cases. But only the former—where the physician was the *source* of the EMR—would likely give rise to a medical-malpractice claim. Under the latter scenario—where the physician discovers an EMR that was not of his making and was unrelated to the treatment he was providing—a patient could not seek relief for medical malpractice because the physician did not make a medical “error.” Thus, relying solely on medical-malpractice doctrine will not address some types of critical undisclosed EMRs.

In addition, the two claims have distinct elements and remedies and serve different purposes.¹⁹³ As one court noted, “[p]rofessional negligence implicates a duty of care, while breach of a fiduciary duty implicates a duty of loyalty and honesty.”¹⁹⁴ A breach of medical fiduciary duty claim addresses a failure to act in a professionally responsible manner, assessed by examining the ethical standards of the profession.¹⁹⁵ In contrast, a medical-malpractice claim tends to focus on a medical mistake, assessed by considering the scientific and practice standards of the profession.¹⁹⁶ As research suggests that the practice of some members of the profession is to *not* disclose,¹⁹⁷ the appropriate benchmark for disclosure is the fiduciary standard of loyalty and honesty, not the professional standard of care.

In an era of “consumer-driven health care,” where patients—rather than employers, managed-care plans, or government-funded entitlement programs—are expected to bear greater responsibility and risk in choosing

190. *Id.* at 214. Under ERISA, the administrators of a managed-care plan owe a fiduciary duty to the plan. 29 U.S.C. §§ 1001–1461 (2000).

191. *Pegram v. Herdrich*, 530 U.S. 211, 235 (2000). The Supreme Court later clarified that medical-malpractice claims are completely preempted by ERISA. *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 200 (2004).

192. Mehlman, *supra* note 101, at 1157.

193. *Id.*

194. *Beverly Hills Concepts, Inc. v. Schatz & Schatz, Ribicoff & Kotkin*, 717 A.2d 724, 730 (Conn. 1998) (noting this distinction in a lawyer-as-fiduciary context).

195. Mehlman, *supra* note 101, at 1157 (asserting that “fiduciary breaches are far more immoral. . . . [A] simple malpractice error—an honest medical mistake—is not a moral error at all.”).

196. *Id.*

197. *See supra* notes 35–56 and accompanying text.

health plans and the course of their health care,¹⁹⁸ it has been noted that “if anything, fiduciary protections for patients need to be increased,” not eroded.¹⁹⁹ As a number of courts have ascertained that fiduciary law compels physicians to disclose EMRs,²⁰⁰ courts should generally recognize and reaffirm that a breach of fiduciary duty is an independent and appropriate cause of action that provides a crucial incentive to ensure that EMRs are disclosed to patients in a timely manner.²⁰¹ Fiduciary law enforces physicians’ duty of loyalty to their patients, an obligation that falls outside the assessment of professional competence that lies at the heart of a medical-malpractice claim.²⁰² Moreover, a fiduciary duty can accomplish this goal without alienating physicians. Because a breach of fiduciary duty does not necessarily signal medical malpractice, physicians will be sheltered from the severe effect of NPDB reporting and other consequences of a medical-malpractice suit.

Thus, fiduciary law provides advantages over medical malpractice as a unique legal vehicle to remedy the recognized harm of undisclosed EMRs. While a medical-malpractice claim—and, as discussed below, an informed-consent claim—may also be appropriate,²⁰³ a cause of action for breach of fiduciary duty provides an important vehicle to address failures to disclose.

198. Mehlman, *supra* note 101, at 1172.

199. *Id.*

200. *See supra* notes 118–29 and accompanying text.

201. *See Sherwood v. Danbury Hosp.*, 896 A.2d 777, 797 (Conn. 2006).

202. *See id.*

203. Indeed, although not as comprehensive as a fiduciary cause of action, some failures to disclose an EMR can be cast as medical-malpractice actions. The failure to disclose could be characterized as a breach of the applicable standard of care, established by current professional views regarding the necessity and appropriateness of such disclosures. Some courts have explicitly endorsed such a determination. *See, e.g., Mansmith v. Hameeduddin*, 860 N.E.2d 395, 406 (Ill. App. Ct. 2006) (finding that the physician breached the standard of care by not disclosing medical negligence to the patient); *Simon v. Biddle*, 946 So. 2d 733, 737 (La. Ct. App. 2006) (requiring a jury to decide whether a physician breached the standard of care by not disclosing that a tubal ligation was never performed on the patient). These suits require expert testimony to show that a failure to disclose violates the professional standard of care, unless a lay person would recognize that the failure to provide disclosure violates the professional standard of care, which may well be the case. *See Taber v. Riordan*, 403 N.E.2d 1349, 1353 (Ill. App. Ct. 1980) (requiring expert testimony to establish the standard of disclosure “unless the matters involved are common knowledge or within the experience of laymen”); *see also Nixdorf v. Hicken*, 612 P.2d 348, 352, 355 (Utah 1980) (not requiring expert testimony because even the “merest tyro” would know that nondisclosure breached the standard of care). While medical-malpractice exposure is not the optimal approach, it does have some benefit. The threat of a NPDB entry, although perhaps triggering irrational responses from some physicians, may encourage most doctors to take notice of this legal duty. Fear of NPDB reporting could also act as a counterbalance to professional pressures to hide medical errors, inciting physicians to disclose an EMR rather than face devastating consequences later.

B. Informed Consent

Another possible legal claim against a physician who failed to disclose an EMR involves a patient's right to exercise informed consent. Physicians must disclose sufficient information for patients to give their informed consent before beginning medical treatment—an obligation that is often cast in fiduciary terms.²⁰⁴ Propelled by emerging respect for patient autonomy, the doctrine of informed consent developed within the courts during the latter half of the twentieth century.²⁰⁵ As noted earlier, a patient's consent to medical treatment cannot be “informed” unless the physician has shared with the patient all material risks and benefits of a proposed treatment, plus any reasonable alternatives to that treatment.²⁰⁶ By requiring doctors to tell patients about the possible future course of their treatment, the informed-consent requirement can be read to imply that further disclosure is warranted if the patient's medical condition changes.²⁰⁷ Courts have indeed drawn an analogy between a physician's duty to inform patients of possible risks of treatment and a duty to inform patients of later EMRs, noting that these parallel duties both spring from the obligations of the physician-patient relationship.²⁰⁸

A cause of action based on informed consent, however, does not directly apply to EMRs. As one court noted in a failure-to-disclose case, “[w]hile analogy to the informed consent doctrine is helpful it is not dispositive.”²⁰⁹ Although the duty to disclose an EMR is similarly grounded in the fiduciary relationship, a distinct cause of action ensues from its breach.²¹⁰ Lawsuits asserting a failure to obtain informed consent focus on the period before treatment commences, addressing whether a patient would have still undergone treatment after learning about the undisclosed risk.²¹¹ By contrast, lawsuits targeting nondisclosure of an

204. See FURROW ET AL., *supra* note 44, at 315–31; see also *Canterbury v. Spence*, 464 F.2d 772, 782 (D.C. Cir. 1972) (establishing the informed-consent doctrine).

205. FURROW ET AL., *supra* note 44, at 311; see also Hafemeister & Gulbrandsen, *supra* note 48, at 361–62. The Centers for Medicare and Medicaid Services (CMS) has also issued regulations that require hospitals to establish policies and procedures that assure a patient's right to request or refuse treatment. 42 C.F.R. § 482.13(b)(2) (2007).

206. *Canterbury*, 464 F.2d at 782.

207. Andrews, *supra* note 44, at 374–75.

208. *Taber v. Riordan*, 403 N.E.2d 1349, 1353 (Ill. App. Ct. 1980); see also *Nixdorf v. Hicken*, 612 P.2d 348, 354 (Utah 1980); see also LeBlang & King, *supra* note 118, at 3 (“The scope of the legal trend toward full communication between physician and patient extends beyond the traditional doctrine of informed consent.”).

209. *Nixdorf*, 612 P.2d at 354 n.20.

210. See FURROW ET AL., *supra* note 44, at 315–31; see also *Canterbury*, 464 F.2d at 782.

211. See FURROW ET AL., *supra* note 44, at 334 (describing informed-consent lawsuits: “if the

EMR consider the period of treatment and its aftermath. The question of whether a patient would have undergone treatment does not arise.

Further, the duty to disclose EMRs is a freestanding obligation, independent of the duty to disclose the information needed to obtain informed consent. For example, in an analogous case involving experimental research, the court held that researchers had a duty to tell research participants that lead dust might contaminate their children's blood, notwithstanding that the researchers' awareness of this risk arose long after the subjects had given informed consent.²¹² The court held that this duty to disclose was "independent of consent" and in addition to this requirement.²¹³

A patient suing for breach of a physician's fiduciary duty to disclose an EMR also has a far better chance of recovery than a patient suing for breach of informed consent. The causation element is more readily satisfied: it is easier to show that harm resulted from nondisclosure of an actual medical risk than to demonstrate that the patient would have forgone treatment if alerted to a potential risk.²¹⁴ Moreover, a patient has a better chance of establishing damages from undisclosed EMRs than a patient who claims breach of informed consent.²¹⁵ In informed-consent cases, only rarely are patients better off by forgoing the proposed treatment. Damages are much easier to show when an EMR was hidden from a patient and resulted in a concrete injury that could have been prevented or treated.

IX. WHEN ANOTHER PHYSICIAN CAUSES THE EMR

Information regarding an EMR is so vital to a patient's well-being that disclosure should occur even if another physician was responsible for the

court finds that a physician has breached his duty to disclose a risk which a reasonable practitioner would have disclosed to a patient (or a reasonable patient would have found material), and further concludes that the operation would not have taken place if the risk had been disclosed, then if the risk materializes and the patient suffers harm, the physician is liable for resulting damages").

212. *Grimes v. Kennedy Krieger Inst., Inc.*, 782 A.2d 807, 850–51 (Md. 2001).

213. *Id.* at 850.

214. *See FURROW ET AL.*, *supra* note 44, at 333 ("Causation is established in an informed consent case if the plaintiff can prove a link between the failure of a doctor to disclose and the patient's injury—first that the risk not disclosed in fact materialized, and second that a patient would have declined treatment if he had received full information about that risk.").

215. *See id.* at 334 (noting damages arise in an informed-consent case "if the court finds that a physician has breached his duty to disclose a risk which a reasonable practitioner would have disclosed to a patient (or a reasonable patient would have found material), and further concludes that the operation would not have taken place if the risk had been disclosed, . . . the risk materializes and the patient suffers harm").

emergence of the medical risk.²¹⁶ Physicians may have a legal duty to disclose when they observe an EMR and learn that the physician responsible for the EMR does not plan to disclose this information to the patient.

One commentator posits a duty to disclose the clinical consequences of all medical errors, even those committed by other physicians, because a patient will need that information to provide informed consent to further treatment.²¹⁷ Indeed, the Fifth Circuit has declared that when several physicians are treating a patient and learn that one of them committed an error, the duty to disclose may apply to all of them—even if some of those doctors are unknown to the patient, like a radiologist examining the patient’s x-rays.²¹⁸ Accordingly, a physician who observes another physician failing to disclose an EMR in a timely manner may be held jointly liable for this nondisclosure. Similarly, a doctor who knowingly impedes a patient’s discovery of an EMR—notwithstanding that this physician was not responsible for the emergence of the risk—should be jointly liable for any nondisclosure.²¹⁹ When a physician is not responsible for creating the EMR, however, the doctor can satisfy “third-party” duties by urging the responsible physician to disclose, by notifying the relevant quality-assurance or risk-management staff of a failure to disclose, or by telling the patient directly about the EMR.²²⁰

X. BENEFITS OF DISCLOSURE

A duty to disclose EMRs benefits both patients and physicians.²²¹ Benefits to the patient include preventing or remedying harm, reducing the risk of any further harm, and enabling future informed decisions.²²² After disclosure, patients will be in a better position to monitor their health and fully explain their medical history to new doctors, who in turn will be better able to provide appropriate and needed treatment. Further, patients

216. For example, Dr. Albert Wu asserts that a doctor has “considerable duty to ensure that disclosure occurs when, in the care of his or her own patient, another physician makes a serious mistake.” Wu et al., *supra* note 78, at 775.

217. Thurman, *supra* note 11, at 150.

218. *Nardone v. Reynolds*, 538 F.2d 1131, 1136 (5th Cir. 1976).

219. *Sperandio v. Clymer*, 563 S.W.2d 88, 90–91 (Mo. Ct. App. 1978); *see also* LeBlang & King, *supra* note 118, at 2 (noting conspiracy as a possible cause of action against nondisclosing physicians).

220. Wu et al., *supra* note 78, at 774–75.

221. *Id.* at 771–72.

222. *Id.* at 771.

may place more trust in their doctors and the medical system following these disclosures.²²³

Physicians who disclose will benefit from knowing that they have fulfilled their ethical obligations, promoted their patients' health and well-being, and facilitated a level of communication that may quell possible future lawsuits.²²⁴ Likewise, doctors who provide services to these patients in the future will appreciate that their new patients are able to provide full and accurate information about their medical condition, which will help them provide appropriate and needed treatment. The duty to disclose EMRs—as opposed to a potentially more limited duty to disclose medical error—also shifts the purpose of disclosure from pointing fingers to sharing critical information with patients.

If litigation should arise in which a claim of medical error is posed, physicians may also benefit from having complied with their fiduciary duty to disclose an EMR. These doctors will likely be seen in a more positive light for having attempted to help, or at least warn, the patient than those who did not disclose an EMR. Physicians who have failed to disclose could face both a medical-malpractice lawsuit and a breach of fiduciary duty lawsuit—enhancing their exposure to liability. Further, because disclosure gives a patient actual knowledge of the risk and the possible harms that may result, the patient is on notice of this medical condition and the associated harms that can occur. After disclosure, the patient generally has an obligation to minimize any harm that has been incurred, and to seek treatment or take other steps to redress the EMR; a failure to act may offset any legal damages available to the patient.²²⁵ Also, EMR disclosure will prevent a patient from delaying pursuit of a lawsuit for any medical malpractice that may have occurred, as a plaintiff cannot toll the statute of limitations by claiming that the physician's failure to disclose prevented the patient from discovering the injury.²²⁶

223. Berman, *supra* note 11, at 198.

224. Wu et al., *supra* note 78, at 771–72.

225. *Burrell ex rel. Schatz v. O'Reilly Auto., Inc.*, 175 S.W.3d 642, 651 n.10 (Mo. Ct. App. 2005) (“Mitigation of damages is a well settled principle requiring that a party injured by breach of a tort duty make some reasonable effort to minimize the damages *after* breach and injury have been inflicted.”); *see also* W. PAGE KEETON ET AL., PROSSER AND KEETON ON TORTS § 65, at 458–59 (5th ed. 1984); *Ostrowski v. Azzara*, 545 A.2d 148, 151 (N.J. 1988) (“The doctrine [of avoidable consequences] proceeds on the theory that a plaintiff who has suffered an injury as the proximate result of a tort cannot recover for any portion of the harm that by the exercise of ordinary care he could have avoided.”); *Hanson v. Boeder*, 727 N.W.2d 280, 283 (N.D. 2007) (noting that a plaintiff injured by another's wrongful acts has a duty to mitigate or minimize the damages, which includes taking measures through reasonable exertion or at trifling expense, and can recover from the tortfeasor only the damages the plaintiff could not have avoided through reasonable effort).

226. *See, e.g., Harrison v. United States*, 708 F.2d 1023, 1028 (5th Cir. 1983); *Pedersen v. Zielski*,

Full disclosure also promotes shared decision making, an approach that permits a patient's insights to be coalesced with a physician's medical expertise. The value of this approach is now widely recognized and supported by the medical community. The Institute of Medicine defines the physician-patient relationship as a "sustained partnership,"²²⁷ while the AMA's Code of Medical Ethics asserts that "[i]t has long been recognized that successful medical care requires an ongoing collaborative effort between patients and physicians."²²⁸ This dynamic partnership helps both the physician and the patient actively pursue the goal of better health.²²⁹

The duty to disclose an EMR will advance shared decision making by expanding the knowledge base available to both parties and ultimately strengthening the relationship between physicians and patients. By disclosing known facts that are material to a patient's health, the doctor sends "a powerful message to the patient that he or she is a trusted member of the health-care team, not a potential adversary—a view that is much more likely to be reciprocated than if the patient is left in the dark."²³⁰ These conversations draw patients into the details of their current medical condition and help them chart their future health-care decisions. By improving communication and creating more realistic expectations about medical practice, disclosure strengthens the ties between physicians and patients.²³¹ These bonds may help restore public trust in the health-care system.²³²

Further, the fiduciary duty to disclose EMRs will help untangle many health-care problems at their most fundamental level. By making the

822 P.2d 903, 908 (Alaska 1991); *Walk v. Ring*, 44 P.3d 990, 999 (Ariz. 2002); *Brown v. Bleiberg*, 32 Cal. 3d 426, 439 (1982); *Tresemmer v. Barke*, 150 Cal. Rptr. 384, 389 (Ct. App. 1978); *Harvey v. Davis*, 432 So. 2d 1203, 1204 (La. Ct. App. 1983); *Schmucking v. Mayo*, 235 N.W. 633, 634 (Minn. 1931); *Reyes v. Anka Research, Ltd.*, 443 N.Y.S.2d 595, 597 (Sup. Ct. 1981); *Borderlon v. Peck*, 661 S.W.2d 907, 908 (Tex. 1983).

227. INSTITUTE OF MEDICINE, *PRIMARY CARE: AMERICAN'S HEALTH IN A NEW ERA* (Molla S. Donaldson et al. eds., 1996).

228. CODE OF MEDICAL ETHICS, *supra* note 16, § 10.02; *see also* Robert Kotler, *Let Patients Weigh in on Treatment Decisions*, L.A. TIMES, Mar. 31, 2008, available at <http://www.latimes.com/features/health/la-he-practice31mar31,1,5494907.story>.

229. *See* CODE OF MEDICAL ETHICS, *supra* note 16, § 10.02 ("Physician and patient are bound in a partnership that requires both individuals to take an active role in the healing process."); *see also* Cathy Charles et al., *Shared Decision-Making in the Medical Encounter: What Does It Mean? (Or It Takes at Least Two to Tango)*, 44 SOC. SCI. MED. 681, 688 (1997) (providing a model of shared decision making in which both parties work towards reaching an agreement on and share responsibility for the ultimate decision made).

230. Richard J. Croteau, *Editorial: All Outcomes Should Be Disclosed*, 29 JOINT COMMISSION J. QUALITY & SAFETY 556, 557 (2003).

231. Berman, *supra* note 11, at 198.

232. *Id.*

patient a knowledgeable sentinel for adverse developments, physicians can minimize further medical crises and expenses. Ultimately, this legal duty promotes the best interests of physicians and patients.

CONCLUSION

As a principle deeply entrenched in the medical community and the common law, the physician's fiduciary duty to disclose EMRs deserves legal prominence. Recognizing this duty to disclose—and enforcing a cause of action for fiduciary breaches—will ensure that physicians share crucial information with patients that allows them to avoid or mitigate potential harm. By routinely disclosing EMRs, physicians will deepen the trust of their patients and enhance their partnership in health care.