

Self-referral and kickbacks: fiduciary law and the regulation of “trafficking in patients”

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In this issue, Sujit Choudhry and colleagues argue persuasively for comprehensive regulation of the unsavoury practices of kickbacks and self-referrals involving physicians.¹ These practices are capable of corrupting clinical judgement by diverting physicians, wittingly or inadvertently, from what ought to be their exclusive preoccupation: the well-being of their patients.² There is some evidence that clinical judgement is affected by the practice of self-referral.^{3,4} Self-referral creates increased costs for the health care system,^{3,4} and suspicions have been raised that it can not only spawn unnecessary care but also lower the quality of care.⁵ As in other fields,⁶ kickbacks have long been regarded as improper within medicine; the 1938 revision of the CMA Code of Ethics declared the “trafficking in patients,” implied by “secret commissions” for patient referrals, to be “entirely unethical.”⁷

Given that there is no evidence that self-referral and kickbacks are beneficial to the health care system or to patients, the case for prohibiting them is compelling. The integrity of and public confidence in the medical profession is at stake. Regulators should take seriously Choudhry and colleagues’ specific recommendations to preclude physicians from both receiving and giving kickbacks, and to ban self-referrals to family-owned “independent” health facilities.¹ Interestingly, fiduciary law already precludes these practices, but Choudhry and colleagues assume that some physicians are deftly dodging this body of law.

The fiduciary duty of physicians is well established in law,^{8,9} but the underlying principles and legal content of this duty are anything but banal. Fiduciaries are “obligatory altruists.”¹⁰ They must selflessly, although not without remuneration, attend to their patients’ interests with single-minded attention.¹¹ In law, physicians are fiduciaries because they undertake to dedicate themselves to their patients, who have a reasonable expectation of such dedication, and patients rely on it implicitly.¹¹ Factors that give rise to the fiduciary duty of physicians include the power and influence of physicians,^{11,12} the vulnerability and dependence of patients¹¹ and the solemn pledge of physicians to act only in their patients’ interests.⁹ Fiduciary duty mandates exemplary relational behaviour and, unlike malpractice law, is not concerned with standard-of-care issues. As fiduciaries, physicians must discharge their responsibilities to patients with loyalty, honesty, candour and good faith, all the while avoiding conflict of interest.^{9,13} Material interests that compete with the interests of patients, including benefits of self-

referrals and kickbacks, must be avoided, for they give rise to a “reasonable possibility of mischief.”¹⁴ Given the comprehensive breadth of fiduciary law (even payers in kickback schemes are exposed to liability for “participating and benefiting from a breach of fiduciary duty”¹⁵), why is further regulation warranted?

Choudhry and colleagues’ explanation is that fiduciary duty can be sidestepped by virtue of the fact that Canadian courts accept that disclosure “fulfills” fiduciary duty.¹ Case law supports this assertion, although the courts also accept that caution should be exercised by physicians who are inclined toward the disclosure strategy.^{11,12} I have argued elsewhere that conflict of interest is “cured” by the free and informed consent of patients, not by the mere disclosure of conflicts to patients.¹¹ Disclosure can sometimes amount to consent in law, but the realities of disclosure are such that this ought rarely to be the case. Choudhry and colleagues doubt the “effectiveness” of disclosure: patients, they point out, might misconstrue disclosures as endorsements of referrals and, also, might acquiesce to referrals to avoid straining their relationship with their physicians.¹

There are other difficulties. Proper disclosure must be “full, frank and timely.”¹¹ This means that the full extent of the conflict — that is, the economic value to the physician of the entire impugned referral practice, and not just of the individual referral — must be divulged.¹¹ Disclosure must be sufficiently ample to permit patients to “realistically assess the risk posed to them by the divided loyalties of their fiduciaries.”¹¹ In addition, the core duties of loyalty and good faith may impel fiduciaries, who collaterally benefit from referrals, to provide alternative referrals. Courts take the requirements of proper disclosure seriously. In some cases, disclosure by fiduciaries have been rendered legally ineffectual because those receiving advice were not sent for an “independent” opinion.¹⁶ Hence, the disclosure strategy is a minefield of problems and might not be a practical or reliable basis for physicians to circumvent the strictures of fiduciary law.

Although fiduciary law remains relevant after disclosure of conflict of interest, self-referral and kickback practices should nonetheless be prohibited by regulation. This is because fiduciary law does not ordinarily provide patients who are subjected to these practices with sufficient incentive to initiate legal proceedings. Where patients suffer no harm from a referred service (and in most cases patients would not suffer harm) the economic benefit of a successful fidu-

ciary law suit is at best minimal, in the absence of unusual circumstances.¹⁷ In the absence of harm, punitive damages could be awarded for egregious behaviour; however, this would be extremely unusual.^{7,18} However, if patients suffer harm from the referred service, even without malpractice, it is possible that physicians could be liable for the harm.^{11,12,17} Fiduciary law is capable of responding harshly to the abuse of trust. Nevertheless, Choudhry and colleagues are right. Self-referral and kickback practices are ethically wrong, do a disservice to the medical system and to patients and, with few exceptions, should be banned outright.

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