Universal Health Care and the Continued Reliance on Custom in Determining Medical Malpractice

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The Clinton Administration’s quest to revamp the nation’s system of health care delivery has generated debate on many fronts. Cost, eligibility, scope of coverage, and financing are all vital concerns.1 We examine here a less visible, but no less important, issue: the impact of proposed health care reforms on the processes by which the tort system adjudicates medical malpractice claims.

This piece of the health care puzzle deserves attention because reforms of any significance will likely expose serious structural limitations in how the existing system deals with medical malpractice claims. These limitations stem both from tort law’s traditional reliance on professional custom as the determinant of the standard of care,2 and from its insistence that the standard thus established be both unitary—applicable to all health care providers and consumers regardless of resources, risk preferences, or knowledge3—and non-waivable by private arrangements between such providers and consumers.4

This approach may have functioned adequately under the simpler conditions of an earlier era,5 but it is increasingly untenable in today’s age of significant economic stratification among groups of

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5 See Siliciano, supra note 3, at 448-51.
health care consumers, a broadening social commitment to expanding access to health care, increasing reliance on complex and collective financing mechanisms, and the relentless growth of medical technologies. Indeed, confronted with these changes and the inherent limitations in its own approach, tort law has already been quietly forced to cede large areas of traditional medical practice to other modes of post hoc review, or to no review at all.\(^6\)

Comprehensive health care reform of an extent approaching the Clinton Administration’s ambitions is certain to make all too obvious the limitations of the current system. Expanding mainstream medical care to cover an additional thirty-five to forty million Americans is a daunting policy objective,\(^7\) but extending the corresponding legal protection against medical malpractice to this same degree is simply beyond the capacity of the tort system as currently structured.

The core difficulty is not that we lack sufficient courthouses, judges, or lawyers to accommodate such a throng. Rather, the problem is that tort doctrine itself is not structured to deal effectively with the legal problems that expansion will bring with it. Upon passage of comprehensive health care, this will become quickly and painfully clear.

Yet in this failure, we predict, lies seeds of great promise. Specifically, the kind of market-based reforms of the health care delivery system that are currently being debated are likely to have the salutary, if not wholly intended, effect of rehabilitating the medical malpractice system.

I
THE FAILED PROMISES OF OUR MEDICAL MALPRACTICE SYSTEM

Before assessing the impact of comprehensive health care reform on the malpractice system, it is important to understand how tort law currently seeks to police the delivery of medical care. Such an inquiry reveals a system that, because of its basic approach, is increasingly ill-suited to the task. As discussed below, these problems stem both from tort law’s effort to use customary practice as the sole means for setting the standard of care, and from its response to the tensions that differences in consumer resources, preferences, and knowledge create for the standard-setting process.

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\(^6\) See infra notes 55-61 and accompanying text.

\(^7\) See Emily Friedman, The Uninsured—From Dilemma to Crisis, 265 JAMA 2491 (1991).
A. Determining Reasonable Medical Care: The Role of Custom

The central legal task in any negligence action, including a medical malpractice suit, is to determine the standard of care against which the defendant's conduct is to be judged. Unlike some areas of negligence law where the jury's wisdom or the legislature's fiat define the standard of care, courts in medical malpractice cases have traditionally looked to the customary practices of the medical profession as the benchmark of acceptable behavior.

Judicial deference to professional custom spares the tort system the difficult and error-prone task of externally determining an appropriate standard of conduct for the medical profession. However, it places a premium on the ability of the profession itself to generate clear and consistent signals regarding its own standards, and assumes such standards can be trusted to reflect the interests of patients. Unfortunately, as discussed below, the process of formulating coherent medical customs has significantly broken down under the existing system of health care delivery, calling into question the wisdom of tort law's continued deference to such customs as proxies for reasonable care.

In order to understand the problems that now impair the formation of clear and coherent medical customs, it is first necessary to explore systematically the process of custom formation.

1. How Does Custom Arise?

We begin by defining "custom." In its simplest terms, custom is common practice. Custom develops over time when a group of actors, acting independently of, and often in competition with, each other, reach the same decisions regarding the manner in which their activities are carried out. It is a social construct that evolves through the repeated behavior of people in a particular context, thereby establishing a normative standard of conduct. Custom is recognized by courts as a reliable indicator of what is expected in a particular profession.

9 When a court gives a negligence case to the jury under a "reasonable care under the circumstances" instruction, the jury, in effect, fills in the substance of the standard. Id. at 207. But see Clinton v. Commonwealth Edison Co., 344 N.E.2d 509 (III. 1976) (court ruled as a matter of law that utility owed no duty to position transformer differently).
11 See generally supra note 2.
12 See Neil Meltzer, Hel ling v. Carey: Landmark or Exception in Medical Malpractice, 11 NEW ENG. L. REV. 301, 308 (1975) (complying with medical standard of care may not protect specialist from liability).
14 Judge Hand, writing in The T.J. Hooper, 60 F.2d 737, 740 (2d Cir.), cert. denied, 287 U.S. 662 (1932)—perhaps the most famous custom case in our jurisprudence—referred to custom as "the general practice of the calling."
activity should be conducted. In essence, custom represents an unconscious collective agreement on how an activity should be carried out.15

Such customs or common manners of practice may relate to many objectives: how to play a game, how to run a railroad, or how to make a movie. We focus here on the subset of customs that represent solutions to problems of how best to set about reducing risks of harm. These include the customary ways in which the medical profession seeks to reduce the risks of harm arising from the illnesses and injuries of the patient population. Two questions need to be addressed: First, what conditions give rise to the formation of customs? Second, under what circumstances should a court, in the context of a tort suit, defer to such customs in determining what constitutes reasonable care?

At the outset, a distinction should be drawn between what may be termed the "design" of a safety precaution and its "execution." As used in this analysis, "custom" relates exclusively to design—that is, the conscious decision to allocate resources in a particular manner to reduce risk. Thus defined, customs naturally vary depending on the conditions that give rise to the need for a safety precaution. In contrast, the universal response to how rational actors try to execute any given safety precaution is "as effectively as reasonably possible." Thus, the design of custom, not its manner of execution, is what is interesting in the present context.16

Turning to consider the conditions necessary for the formulation of custom, simple models drawn from actual cases prove useful.17 Let us suppose that a finite number of actors—barge operators, tug operators, dock operators, and cargo owners—operate collectively and competitively in a large harbor. One of the risks of life in the harbor is that of barges breaking loose from their moorings, threatening harm to themselves and the other interests in the harbor. We may assume, for purposes of analysis, that there are four basic ways in which to design precautions against the risk of breakaway: (1) moderately strong cables that can readily be replaced; (2) very strong cables that almost never break; (3) electronic alarm systems signaling break-

15 See Landes & Posner, supra note 13, at 136.
16 See generally Mark A. Hall, Health Care Cost Containment and the Stratification of Malpractice Law, 30 Jurimetrics J. 501 (1990) (distinguishing in malpractice context between standard of care and standard of carefulness). This same distinction can be observed in other areas of tort law. For example, in products liability, a suit alleging a design flaw involves a claim that the manufacturer's conscious design choices created an unreasonably risky product, while a manufacturing defect case is premised on a failure of the manufacturer to produce a product that meets its design specifications.
17 The examples used here are drawn primarily from two famous decisions by Learned Hand, The T.J. Hooper and United States v. Carroll Towing Co., 159 F.2d 169 (2d Cir. 1947).
away; and (4) maintenance of personnel on board to prevent breakaway.

Now, it stands to reason that any given barge operator will employ different combinations of these precautions, depending on the surrounding circumstances. Valuable cargoes during rough weather require a different response than do empty barges in a calm harbor. The question of interest here is whether, holding constant any given set of conditions, the various actors will respond uniformly with the same design. If they do, a careful observer of such response patterns could conceivably write a book "How to Operate in a Harbor." Moreover, a newcomer to the harbor could reasonably be advised, quite literally, to "go by the book."

What, then, are the necessary conditions for custom to develop to the point that such a book, based upon observed behavior, could be written about any given activity? We submit that the relevant participants in an activity must be similar in three respects for discernible custom to develop. First, the actors who directly affect the levels of risk generated by an activity must possess roughly the same knowledge of the real world in which their activity plays out. This knowledge would pertain not only to risks, but also to ways of dealing effectively with risk. Absent such uniformity of knowledge, actors lack the coherence of outlook necessary to engage in the kind of parallel decisionmaking that generates custom. They will see the same problems differently, and therefore will respond in diverse ways rather than in a uniform and customary manner.

Obviously, a wide array of considerations can affect the degree of uniformity of knowledge. For example, an activity that requires a specific kind of education, apprenticeship, or professional training will tend toward greater homogeneity of knowledge, and thus will be more conducive to the generation of custom, than one that imposes no such bar to entry. Similarly, a common base of knowledge is more likely to arise when the participants in an activity are confronted with relatively limited and stable sets of problems and solutions. If, in contrast, the activity is besieged by constant change and innovation, a shared base of understanding can easily erode as some participants lag behind others in their ability to keep abreast of new developments.

The second necessary condition for custom to develop is that the actors whose actions directly affect levels of risk must possess at least the minimum capacity to act effectively on the knowledge of the relevant facts. In the context of our harbor example, this mainly comes

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18 For custom to arise, such knowledge need only be uniformly held to be true by the actors; it need not be complete or accurate. Even fools can agree, so long as they are equally foolish. This does not ensure, however, that any resulting custom represents an optimal response to safety concerns. *See infra* notes 26-27 and accompanying text.
down to possessing adequate resources to make choices among possible precautionary options. If, for example, it is objectively reasonable to employ a bargee under some circumstances, but only a portion of barge owners or, more importantly, the cargo owners hiring barges, can afford to pay for this precaution, no stable consensus on the hiring of bargees will emerge from the behavior of barge owners. Some will employ bargees, while others will not, and therefore no single customary response will arise. Naturally, competitive pressures may eventually eliminate actors who lack the capacity to make adequate investments in safety. Until such a process has run its course, however, no unitary custom may be discernible.

Finally, for custom to emerge in our hypothetical harbor, the relevant actors’ attitudes toward risk, like their knowledge and their resources, must be sufficiently similar to allow their independent decisionmaking to proceed in a parallel fashion. Thus, if some barge owners and cargo owners are risk preferring, that is, willing to gamble on securing a barge with twine to avoid the cost of stronger cables, while others are obsessive in the precautions they take, no implicit consensus on the appropriate level of care will emerge from the process of individual decisionmaking.

Returning to our hypothetical harbor and applying the foregoing analysis on reasonable assumptions, customs will almost certainly

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19 Because cargo owners are the major consumers of barge operators’ services, cargo owners, presumed to be knowledgeable, will call the tune to which barge operators must dance.

20 Under such resource constraints, one might instead see the development of bifurcated customs: a “rich person’s custom” for those cargo owners with resources sufficient to allow full choice among the range of precautionary options, and a “poor person’s custom” representing the standard response of those whose capacity to choose is constrained by resource limitations. In our harbor example, assuming that what we refer to as our “rich person’s custom” is the efficient mode from a perspective of risk neutrality (see infra note 22), in the long run less efficient actors will be driven from the market. As discussed below, the law’s response to such bifurcated customs is particularly relevant in the medical malpractice context.

21 See supra note 20.

22 Attitudes toward risk are measured on a scale from risk preferring to risk averse. These measurements reflect the extent to which an actor does, or does not, equate receiving one dollar with a 50:50 chance of receiving two dollars. A rational actor who is a repeat player, facing the same choice hundreds of times each day, will almost certainly become risk neutral, treating the two opportunities as identical.

A risk-averse individual prefers receiving the one dollar over the risk of receiving nothing, and would even take less than one dollar to avoid such a risk. A risk-prefering individual prefers the chance of receiving two dollars over the certainty of receiving one dollar and would even take less than two dollars for the chance of receiving more than one.

Obviously, risk-prefering barge operators, left to their own devices, would choose at each juncture the precautionary option that increases the chance of winning the jackpot of escaping harm at a ridiculously low cost—even if such conduct also, to a greater degree, increases the chances of losing everything. Risk-averse and risk-prefering individuals are not repeat players because repeat players are driven to risk neutrality.
emerge over time.\textsuperscript{23} Knowledge of risks and precautionary measures is widely shared by those operating in the harbor. New inventions, which provide greater protection at lower cost, may give mavericks employing the new technology an edge in the short run. But in the longer run, because it represents an improvement, such new technology will come to be shared and a new equilibrium—a new custom—will emerge.\textsuperscript{24}

Moreover, capacity to act on knowledge will not present an impediment to standardization. Actors lacking resources to conform to custom will be driven from the marketplace—in our hypothetical, the harbor. Nor will divergence in risk preference defeat the development of custom. All successful competitors in the harbor are repeat players who confront the same choices over and over again. Such actors, over time, naturally tend towards risk neutrality.\textsuperscript{25} Given the homogeneity just described, our hypothetical harbor will, indeed, run itself "by the book." Those who deviate from custom will either turn out to be inventive trend setters for whom special rewards are due, or will be driven from the marketplace as misfit failures.

Having concluded on reasonable assumptions that the harbor will be teeming not only with tugs and barges but also with customary practices, what should lead a court to decide that such customs are worthy of judicial adoption as legal standards of care? Homogeneity of knowledge, resources, and attitudes toward risk helps generate custom, but these factors do not necessarily ensure that such customs will represent the kind of socially optimal responses to risk to which courts should defer.

Rather, the justification for such deference would depend on the extent to which all, or nearly all, of the interests at risk of harm from harbor activities are linked with each other by a network of contractual bargaining through which all interests, including those least able to affect risks directly—here, the cargo owners—are adequately taken into account. In our harbor, on reasonable assumptions, that is almost certain to be the case. Every major actor need not be linked

\textsuperscript{23} To the extent that custom reflects optimally efficient solutions to commonly encountered risks of loss, custom will inevitably emerge and actors in the long run will have no practical choice but to conform to it.

\textsuperscript{24} Indeed, Learned Hand's decision in The T.J. Hooper, 60 F.2d 737 (2d Cir.), cert. denied, 287 U.S. 662 (1952), has been criticized on the ground that it unnecessarily short-circuited the natural process by which a new custom supplants an old one. See Epstein, supra note 13, at 35.

\textsuperscript{25} Over the long run, a risk-neutral actor is at a competitive advantage compared to either a risk-averse or a risk-preferring actor in a hypothetical harbor. A risk-averse actor errs, quite literally, on the side of caution, by investing too many resources on care or by foregoing some objectively rational choices because of an irrational fear of choice. Conversely, a risk-preferring actor over the long run will suffer excessive losses by failing to make adequate investments in safety. See supra note 22.
contractually with every other. It will suffice if every actor is linked to
a sufficient number of other actors, including representatives from
other interest groups, so that no actor's decision affecting risk of harm
can afford to ignore, or undervalue, the interests of any other actor.26
Under such conditions, a court might readily conclude that the bal-
ance of risks and benefits reflected in the established custom repre-
sents the best approximation of reasonable care.27

It is important to bear in mind that we are speaking of common
patterns of precautionary behavior shaped by factors—knowledge of
risks and precautions, capacity to act on that knowledge, and attitudes
toward risk—that are exogenous to tort law. Stated somewhat differ-
ently, we are identifying elements that will drive reasonable, rational
actors to develop customary ways of acting, quite apart from threats of
legal liability aimed directly at forcing them so to act.

Of course, even if none of the elements we have identified were
present, imposing threats of tort liability could presumably produce
uniform patterns of behavior.28 No one doubts, at least theoretically,
that tort law could undertake the task of dictating what constitutes
good medical practice.29 Our inquiry here is precisely the opposite:
Can medicine itself define such customary practices in a way that will
command the respect of tort law? We now turn to that question.

2. Can Custom, Let Alone Reliable Custom, Develop in Today’s
Medical Marketplace?

Courts traditionally have been more willing to defer completely
to professional custom in the medical care context than they have in
other areas where customs may be available as guideposts for reason-
able behavior.30 Such deference makes sense if one assumes that
courts can easily identify medical custom,31 but becomes problematic
once one considers the impediments to the formation of any stable
custom, let alone reasonable custom, among health care providers.

First, the medical profession is increasingly confronted with sets of
problems and corresponding solutions that are vastly more compli-

26 See generally Epstein, supra note 13, at 19-20 (describing the origin and role of cus-
tom in determining reasonable care).
27 See, e.g., Spang Chalfant & Co. v. Dimon S.S. Corp., 57 F.2d 965, 967 (2d Cir. 1932)
(Hand,J.) (The "greater experience [of those engaged in custom-generating activity] gives
their estimates, even if no better than honest guesses, more weight than [judicial] specula-
tions."). See generally LANDES & POSNER, supra note 13, at 132-33.
28 See, e.g., The T.J. Hooper, 60 F.2d 737, 740 (2d Cir.), cert. denied, 287 U.S. 662
(1932) ("Courts must in the end say what is required . . . .").
29 One of the authors has expressed doubts in this regard. See James A. Henderson,
Jr., Expanding the Negligence Concept: Retreat from the Rule of Law, 51 Ind. L.J. 467, 494-95
(1976).
30 See DANZON, supra note 2, at 140-41.
31 See supra note 2.
cated than those of relatively simple settings, such as our hypothetical harbor, where custom typically arises. Perhaps because of the forces that shape custom, one barge is very much like another. In contrast, patients, even those with the "same" illness or injury, may require different approaches based on a host of individual conditions, including age, gender, weight, and other health-related criteria, none of which are susceptible to standardization by the forces that shape custom. Indeed, modern tort law implicitly recognizes the uniquely nuanced nature of medical problems in doctrines such as the "learned intermediary rule" for prescription drugs. The doctrine premises its traditional refusal to review the reasonableness of the "design" of a drug intervention primarily on the physician's need to make highly patient-specific determinations for proper drug therapy.

Of course, the highly differentiated nature of medical problems is not itself an absolute bar to the development of customary standards of care. Tort law could conceivably look for "micro-customs" applicable to limited subgroups of patients presenting a particular condition. It is far from clear, however, whether the tort system is well equipped to discern custom at this level of detail.

The variance within the patient population is matched by a diversity of therapeutic responses. Although health care providers of a generation ago may have had only a limited array of options in the diagnosis and treatment of illness and injury, the growth of technology in recent years has greatly added to the number of possible responses. Many medical conditions can now be treated in a wide variety of ways, each with different costs, risks, and benefits. Moreover, the relentless growth of medical care technologies during the last quarter-century expands this array of caretaking approaches on an

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32 This individualization is partly the consequence of technological proliferation. In a simpler age, when only one or two therapeutic responses to an illness or injury were possible, individual characteristics played a less influential role in medical decisionmaking. Of necessity, one size was forced to fit all. However, one effect of the proliferation of medical technologies has been the creation of an array of interstitial competing technologies, the marginal efficacy of which may be highly sensitive to patient characteristics.


34 In Helling v. Carey, 519 P.2d 981 (Wash. 1974), the court refused to recognize the customary distinction that ophthalmologists drew between patients under and over the age of 40 when determining the need to administer routine screening tests for glaucoma, even though the professional custom of not administering such tests to patients under 40 was reasonable on a risk-utility analysis.

While Helling was subsequently superseded by statute, see WASH. REV. CODE § 4.24.290 (1988), and has been both widely criticized and seldom followed, it does not instill confidence in the ability of courts to discern and validate customs applicable only to subgroups of the patient population.
almost daily basis.\textsuperscript{35} Even within specific treatment options for particular subgroups of the patient population—for example, joint replacement for arthritis in the elderly—the number of competing products and surgical approaches continues to proliferate.

In light of this plethora of caretaking technologies, the first factor essential to the formation of custom—a common base of knowledge among the relevant decisionmakers—may not emerge, even for simple and straightforward conditions. New technologies represent new ideas that take time to absorb and master, thus undermining the kind of informational homogeneity that permits custom formation. Some actors will quickly integrate new approaches while others will cling to old ways, creating a disparity of understanding and practice that is corrosive to custom.

Indeed, as reflected in the much-mooted decision in \textit{The T.J. Hooper},\textsuperscript{36} the advent of a single technological innovation in tugboat operations after the turn of the century—the receiving radio—so shifted the relevant safety equation that the court felt compelled to ignore industry practice and determine de novo what constituted reasonable precautions against coastal storms. With the rapid innovation that characterizes modern medicine, the problem is considerably more serious. Health care providers are confronted with an unending parade of new diagnostic and therapeutic tools, making it very difficult for the profession to reach a common understanding regarding appropriate precautionary measures.\textsuperscript{37}

In the medical context, the diversity of knowledge problem presents an additional wrinkle. To this point, we have considered the problem merely from the perspective of the expert health care providers. With respect to this group, a common professional training, ongoing education, and professional journals help bolster the necessary homogeneity of knowledge. For example, the \textit{New England Journal of Medicine} is a good antidote to the destabilizing impact of relentless technological innovation.

Medical professionals, however, must make health care decisions in consultation with the lay patients they treat. Traditionally, playing a role very much like that of the cargo owner in our earlier harbor hypothetical, the patient is viewed as the ultimate decisionmaker regarding the nature of any treatment. Thus, this group's level of knowledge also affects the likelihood of custom formation.


\textsuperscript{36} 60 F.2d 737 (2d Cir.), \textit{cert. denied}, 287 U.S. 662 (1932). For a detailed discussion of the case, see Epstein, \textit{supra} note 13.

\textsuperscript{37} See, \textit{e.g.}, Barak Gaster, \textit{The Learning Curve}, 270 JAMA 1280 (1993).
Using consumer choice as a touchstone for reasonable care is, however, highly problematic in the health care context. Unlike cargo owners, medical patients typically lack the kind of information necessary to make truly informed decisions. While the rise of informed consent may have partially ameliorated patient ignorance, the sophisticated nature of medical decisions and the emotional conditions under which such decisions are frequently made preclude meaningful comprehension by all but the most educated and ardent patients. Instead, patients typically rely heavily on their health care providers to identify, explain, and even decide among treatment choices.

Of course, if all patients were to defer completely to the judgments of the health care provider, patient ignorance would play no role in complicating the informational overload facing providers. However, total deferral is but one of the responses patients demonstrate. Some patients seek to participate actively in, or even to control, the provider's treatment decisions.

One suspects that most providers struggle to allow room for input from the patient, further reducing the chances that coherent, let alone appropriate, medical customs will emerge. In short, because highly complex medical decisions must ultimately pass through the portal of patient ignorance and fear, the kind of common understanding upon which custom depends is unlikely to arise.

As if the informational barriers discussed above were not sufficient to thwart the development of usable medical custom upon which tort law could rely, consider the chances of achieving the two other critical conditions in the process of custom formation: uniformity in risk preferences and economic capacity to act on choices and preferences.

With regard to risk preferences, it is a fair assumption that most patients are risk averse. Assuming that health care providers, as repeat players, tend to be risk neutral, nonuniformity once again threatens the emergence of custom; as a general matter, patients will be uncomfortable with risks their physicians regard as acceptable. To make matters worse, the widespread use of health care insurance tends to allow many patients leeway to play out their fantasies by

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38 See generally Donald A. Redelmeier, Understanding Patients' Decisions: Cognitive and Emotional Perspectives, 270 JAMA 72 (1993) (reviewing past studies from psychology literature to describe ways in which intuitive thought processes and feelings may lead patients to make suboptimal medical decisions); William M. Strull et al., Do Patients Want to Participate in Medical Decision Making?, 252 JAMA 2990 (1984) (detailing studies of patients' desire to participate in making medical decisions and for information relating to those decisions).

39 See generally supra note 38.

40 See Redelmeier, supra note 38, at 72-74.
overutilizing medical resources in the quest for eternal life. Such insurance partially frees health care consumers from cost constraints in choosing among treatments. With respect to any particular purchasing decision, an insured patient is likely to prefer the most efficacious, and therefore presumably the most expensive, course of treatment for which the patient's insurance will pay. Many of the changes in insurance during the last decade, such as raising deductibles and requiring co-payments, represent insurers' efforts to stem the overutilization of medical resources that insurance engenders. Yet medical insurance continues to enable patients and their physicians to choose treatments that may be above the socially optimal level of care.

Finally, and perhaps most importantly, even if patients were somehow adequately informed and sufficiently homogeneous in their risk preferences, the economic stratification of the patient population precludes formation of a stable unitary custom. Recall that the threshold capital requirements for barge ownership help ensure that all those who end up as barge owners possess the basic resources necessary to choose reasonably among the array of precautions against breakaway barges. There is no such entry barrier for those confronting medical problems. Entering the medical care harbor—getting sick—is free and largely involuntary. Once there, patient resources have an enormous impact on the individual's capacity to choose among remedies. The economically well-off are simply able to devote more financial resources than the "medically poor" to purchasing health care. For the latter, leaving the harbor—that is, going without any care whatever—is an unacceptable option. Even if both groups value health identically in relation to competing claims on their resources, the differing amounts of resources skew the patterns of choice. In this context, as in so many others, "Them's that has, gets."

Thus, with respect to illnesses and injuries that are amenable to an array of different treatment technologies, well-off health care con-

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42 Put differently, a would-be barge owner who lacks the resources to enter the market has no impact on the collective decisionmaking process that generates custom. In contrast, a lack of resources has no such preclusive impact on a patient seeking medical care. Through various avenues, the medically indigent do receive care. See Siliciano, supra note 3, at 447 n.31. However, their lack of resources often affects the amount and kind of care they receive, further undermining the homogeneity required for custom formation.

43 By medically poor, we mean those who, because of their lack of adequate insurance or offsetting financial resources, are unable to exercise any considerable degree of choice in the health care. This group is not completely coterminous with the economically poor, since many of the latter receive health care through government benefit programs such as Medicare. See generally Siliciano, supra note 3, at 440 nn.5-6 (describing various categories of "medically indigent" individuals).
sumers will naturally tend to purchase more expensive (and correspondingly more efficacious) treatments than will poor patients. The challenge for the tort system, then, becomes deciding which of these resource-dependent choices of treatment technologies represents the customary standard of care.

For a given medical condition, tort law may not observe a single customary response, but may instead find diverse responses by providers, ranging from folk remedies to experimental cures. Even among such micro-customs no particular solution may be trustworthy as a standard by which the tort system may measure due care; those without adequate resources are precluded from choosing optimal care, while those with insurance or wealth are prone to spend beyond that point. The other actors in the process, health care providers and insurers, may offset some of the decisionmaking deficiencies of patients, but there is no strong reason to believe they will do so to the necessary degree, and in the right direction, to yield appropriate customs.

In summary, modern medicine displays few of the features that tend to generate reliable customs in other contexts. The problems it confronts are complex and individualized, the solutions it offers are diverse and ever-changing, and the decisionmakers often lack the incentive or the ability to make appropriate choices among such solutions.

Of course, the common law is resilient and creative, and has the capacity to refine its approach to account for new and complex problems. Thus, even with the impediments to custom-formation noted above, it is possible to imagine some feasible, if only partial, solutions. The limited decisionmaking capacity of patients, for example, may be counterbalanced by the expertise of their physicians, and patients’ tendency towards risk aversion and consequent overconsumption of medical resources can be checked by cost constraints imposed by insurers. Even the problem of proliferation of medical

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44 Because of the informational deficiencies of patients, providers have a key role in deciding among competing modes of treatment. Yet, in making such choices for their patients, health care providers are influenced by many considerations other than determining what constitutes a reasonable level of care from a societal perspective. For example, professional pride and competition will cause some physicians to use new, cutting-edge technologies to treat conditions that are amenable to less exotic interventions.

This kind of frontier pushing is generally a good thing, but it can send a very confusing signal to the tort system unless the profession as a whole can agree upon what constitutes extraordinary, as opposed to ordinary, care. Unless this overinvestment in care is clearly acknowledged as such, the tort system can easily misidentify the behavior of such actors as representing a customary standard of care.

45 Insurance intermediaries also strongly influence the choice among available technologies. Although reimbursement decisions are not divorced from the issue of reasonable care, insurers still face strong incentives to preserve insurance pools by minimizing expenditures on costly treatments. This incentive may offset the less constrained decision-making of patients and their health care providers, but it is by no means clear that the
technologies might be tamed by an approach that insisted that a new device or procedure enjoy wide use before qualifying as a custom for liability purposes.

Nonetheless, any effort to breathe life back into the customary-practice rule must eventually confront the core problem created by the economic stratification of health care consumers. Even if sufficient homogeneity of knowledge and risk preference were somehow engineered back into the equation, the tort system would still be faced with groups of patients with significantly different capacities for purchasing medical care. We next examine tort law’s failed effort to address the fundamental challenge that wealth distinctions pose for a custom-based standard of care.

B. How Tort Law Has, Until Now, Reacted to the Wealth-Technology Dilemma

In attempting to resolve the deep tensions arising from the interplay of economic stratification and technological proliferation, the tort system has had several workable options. First, tort law could have explicitly acknowledged the direct impact that wealth has on the choice of available treatment technologies. Indeed, in other areas governed by negligence principles such an understanding almost goes without saying. In products liability, for example, the amount the consumer is willing to spend on a product is relevant in assessing a claim that the product should have had more expensive safety features; few courts would seriously entertain a claim that an economy car should have exactly the same level of safety features as a luxury car.46 Similarly, with claims of legal malpractice, the resources a client is willing to spend are directly relevant to whether the lawyer should do more.47

There is no theoretical impediment to configuring a medical malpractice standard that is similarly sensitive to available patient resources. Of course, if courts had adopted this alternative it would not be possible to think of a single customary standard of care for a given medical condition, any more than it makes sense to speak of a customary car or a customary lawsuit. Rather, if tort law had taken this path and explicitly accounted for patient resources in assessing medical malpractice claims, one might have expected to see the acceptance of multiple, stratified standards of care for the same illness or injury.

selection of technologies that results from the interplay of these forces represents a stable or coherent choice.

46 See Seattle-First Nat’l Bank v. Tabert, 542 P.2d 774, 779 (Wash. 1975) (“purchaser of a Volkswagen cannot reasonably expect the same degree of safety as would the buyer of the much more expensive Cadillac”).

47 Siliciano, supra note 3, at 440.
Wealthier patients would be protected by more comprehensive and demanding customs than those governing diagnosis and treatment of the same illness in patients with fewer resources.\textsuperscript{48}

Alternatively, tort law could have abandoned its ambition of providing legal protection to all economic groups and instead simply set a minimum standard of care below which no provider would be allowed to fall without incurring liability. Medical malpractice would have ensured the provision of basic care, but those patients seeking fancier and more expensive diagnostic and treatment technologies would no longer have been able to look to tort law to mandate such additional care. Rather, the degree of care owed those purchasing above tort law's minimum standard would be governed primarily by principles of contract law. In this sense, tort law would have assumed the role of a default remedy, similar to the role that it often plays when contracting is a permissible means of negotiating risk.\textsuperscript{49}

Under either the stratified custom or the minimum-standard-plus-contract approach, tort law would have explicitly acknowledged what is indisputably true regarding the quality of medical care: wealth matters. Unfortunately, however, tort law has taken a different course, one that denies rather than confronts the wealth-technology dilemma. Specifically, in the medical malpractice area, tort law has embraced two premises that largely inhibit either of the possible solutions outlined above.

First, tort law has traditionally refused to recognize formally the crucial role of patient resources in determining the kind and degree

\textsuperscript{48} Such customs would presumably have varied primarily with respect to the array of diagnostic and treatment technologies they employed. Of course, some aspects of the provision of medical care, primarily those that involve the investment of human effort, such as attentiveness, carefulness, and compliance with prescribed procedures, would probably have been universal across all sub-customs.

This is true in other contexts as well. In the products liability area, a court would find a defect due to human error—for example, failure to install a critical bolt—to be of equal significance regardless of the cost of the car. And a lawyer who fell asleep during trial would be potentially liable for malpractice regardless of the amount of resources the client was willing to spend. These kind of failings go to the "execution" of a particular "design," whether that design relates to building a car or trying a lawsuit. While it is possible to argue as a matter of pure theory that investments in human attentiveness should be as free to vary with consumer resources as investments in hard technology, it is difficult to imagine a court accepting such a view.

of medical treatment the patient receives.\textsuperscript{50} When reviewing malpractice claims, it has insisted on a unitary, wealth-blind standard of care. As one court noted, "Whether the patient be a pauper or a millionaire, whether he be treated gratuitously or for reward, the physician owes him precisely the same measure of duty, and the same degree of skill and care."\textsuperscript{51} This outlook, although comforting as a moral posture, has as a practical matter precluded refining and subdividing the standard of care to reflect available patient resources.\textsuperscript{52}

Second, tort law has, at least on the formal level, largely rejected the contract-based option. Except in unusual circumstances, efforts of patients and their health care providers to redefine duties of care through contract, independent of tort law, have been rejected as contrary to public policy.\textsuperscript{53} Because those seeking health care may have no other option but to agree to the provider's terms, and because such patients are at a significant informational disadvantage at the outset, courts have traditionally equated attempts by providers to modify contractually the standard of care with contracts of adhesion, and as a result have refused to enforce such bargains.\textsuperscript{54}

The sentiment of the no-contracting-out rule is arguably noble: it purports to correct the imbalances in bargaining power between the patient and the health care provider.\textsuperscript{55} Yet the ultimate effect of rejecting help from contract, while ignoring the impact of patient resources constraints, is to require tort law to identify a single, customary standard of care that applies to all comers. Given the existing degree of economic stratification and technological proliferation, this is, in our view, an impossible task. To the extent that tort law has appeared to succeed to date, it has done so only by ignoring the reality of medical care at the high and low ends of the wealth-technology spectrum.

\textsuperscript{50} Some aspects of tort doctrine, such as the charitable immunity doctrine and the locality rule, have de facto introduced some resource sensitivity into the tort standard. See Mark A. Hall, The Malpractice Standard Under Health Care Cost Containment, 17 J. Law, Med. & Health Care 347, 348-50 (1989). However, both doctrines are undergoing processes of abrogation, see W. Page Keeton et al., PROSSER AND KEETON ON THE LAW OF TORTS § 32, at 188, § 133, at 1070 (5th ed. 1984), further limiting tort law's ability to account for resource constraints.


\textsuperscript{52} See generally supra note 3.

\textsuperscript{53} See, e.g., Tunkl v. Regents of Univ. of Cal., 383 P.2d 441 (Cal. 1963). See generally Mehlan, supra note 4 (discussing impact of contracting on duties owed by health care providers).

\textsuperscript{54} Most modern commentators disagree with this strict anti-contractarian approach and tend to view private arrangements between patients and providers more favorably. See, e.g., Mehlan, supra note 4.

\textsuperscript{55} But see Alan Schwartz, A Reexamination of Nonsubstantive Unconscionability, 63 Va. L. Rev. 1053 (1977), for a critique of this view.
At the high end, a patient with substantial resources is generally free under the existing health care system to purchase the latest diagnostic and healing technologies. Because such technologies are being employed soon after their emergence, the tort system is generally unable to assess their reasonableness by its traditional reference to professional custom. Indeed, upper-end, high-technology medical care is almost by definition better than the standard of care upon which tort law, bound as it is by custom, is capable of insisting.

With high-technology care, the role of tort law is probably limited to policing the "execution," rather than the "design," of a medical intervention. Thus, poor technique during an experimental procedure, including sloppiness, inadvertence, and other forms of human error, might still be the subject of a malpractice claim. But the basic decision of the wealthy patient to buy extraordinary medical care is one that the tort system has little means of second-guessing. Despite the tort system's formal rejection of contract as a supplemental means of defining the duty of health care providers, patients at the uppermost economic strata remain free to design medical interventions that are more sophisticated and costly than what tort law might define as reasonable.56

At the other end of the wealth spectrum, contract plays a similar, though arguably more pernicious, role. As one of us has detailed elsewhere,57 tort law's refusal to acknowledge the influence of patient resources, and its consequent insistence on a unitary standard of care, do not have the intended effect of ensuring that the medically indigent receive the same care as everyone else. Instead, health care providers are actually discouraged from offering care to the poor because tort law still allows them the contractual freedom to refuse such patients in the first instance.58 By mandating a unitary standard of care that is more expensive than some patients can afford and that other actors in the health care system are increasingly unwilling to subsidize, tort law effectively encourages providers to choose the liability-free option of declining to treat a significant minority of the medically underprivileged population.59

Of course, many of the medically indigent do manage to receive some care, usually through emergency rooms, clinics, and charitable or public hospitals. In many cases, as the discussion above predicts,

56 Indeed, the main exception to tort law's refusal to recognize the validity of contractual waivers regards the use of new and experimental procedures. See, e.g., Colton v. New York Hosp., 414 N.Y.S.2d 866 (Sup. Ct. 1979).
57 See Siliciano, supra note 3, at 457-58.
58 Id. at 447.
59 Id. at 457.
the care thus provided is below the standard of care received by the medical middle class.\textsuperscript{60}

Tort law has been able to dodge the blunt challenge this de facto differentiation of care poses to its vision of a unitary standard. As a threshold matter, medically poor patients are considerably less likely to bring malpractice claims than are their middle class counterparts. In the rare instances that they do seek legal redress, they tend to do poorly relative to other malpractice plaintiffs, partly because judges and juries seem to accept what the tort system, on the level of doctrine, refuses to acknowledge: that money matters in deciding what care is due.\textsuperscript{61}

Thus, with the well-off able to contract out of ordinary medical care, and the poor unable to contract into such care, the tort system is left the more limited task of policing the delivery of care to the large middle class of health care consumers. Yet even here, the tort system is increasingly unable to implement its unitary, non-contractual, and resource-blind approach to determining the standard of care. Because significant resource distinctions are present even in this middle group, the propensity towards the fragmentation and disintegration of medical custom remains. And as health care financing continues to shift from its traditional, individualized, fee-for-service approach towards collective, pre-paid plans, such as Health Maintenance Organizations (HMOs), and fixed-payment reimbursements, such as Diagnostic Related Groups (DRGs), the influence of resource constraints has become increasingly difficult for tort law to ignore.

In HMOs, for example, individuals purchase, for a predetermined amount, the right to receive all reasonably necessary health care from the HMO. Because the upper limit of the HMO’s revenue is fixed ahead of time by the sum of membership payments, the profit-


\textsuperscript{61} See Helen Burstin et al., Do the Poor Sue More? A Case Control Study of Malpractice Claims and Socioeconomic Status, 270 JAMA 1697 (1993); Molly McNulty, Are Poor Patients Likely to Sue for Malpractice?, 262 JAMA 1391 (1989); Medical Care for All: Questions and Answers, 260 JAMA 3106 (1988).

Among other reasons, the poor are often the least sophisticated consumers of medical services and are therefore less likely to perceive and seek redress for shortcomings in the quality of care provided. Moreover, lawyers are generally more reluctant to pursue tort claims on behalf of poor plaintiffs because any award would typically be based largely on lost future earnings. Such earnings will be lower with the poor, reducing both the award and, critically, the lawyer’s contingency fee.
ability of the HMO depends on its ability to control the treatment costs of its members. Thus, the HMO may decline to make incremental investments in care, such as the use of certain diagnostic and treatment technologies or the extended use of inpatient care, that the health care provider dealing with a fully insured, fee-for-service patient might be inclined to order.

If these limitations on care later become the focus of a malpractice action, the HMO will naturally point to its need to marshal collective resources efficiently as a justification for not matching the level of care given to the non-HMO, fully-insured patient. In confronting such a tort claim, a court will again face the wealth-technology dilemma: as a practical matter, resources are directly affecting the level of patient care despite tort law's insistence that resources are irrelevant in determining the legal standard. In short, the hard realities of medical financing will collide head-on with the aspirations of tort law.62

II
LOOKING INTO THE FUTURE: THE IMPACT OF COMPREHENSIVE HEALTH CARE REFORM

A. The Short Term Impact of Health Care Reform

Any plan that remotely comports with the Administration's basic agenda would substantially increase the number of Americans who are legally entitled to demand treatment from health care providers. Whether the coverage goal is 100%, as the Administration had hoped, or something less than that, as now appears more likely, the health care system will be forced to provide care for millions of patients that it was previously free to ignore or divert to non-mainstream care.

These new arrivals will sorely exacerbate the wealth-technology dilemma that already bedevils the medical malpractice system's efforts to use custom as a standard-setting device. The bestowing of a right to medical care on this group will carry with it a corresponding entitlement to legal protection against medical malpractice. As previously noted, the tort system has traditionally provided such protection only in a unitary, resource-blind mode. Thus, any legislation that grants the right to health care coverage to those previously excluded from the system will, by operation of tort law if not in explicit statutory provisions, also require such coverage to be of the same quality as that provided to those already within the system.

As noted above, however, even with respect to the broad middle tier of health care, the tort system is experiencing increasing difficulty

in discerning what the appropriate level of quality should be. Different subgroups of the patient population, defined by the nature of their insurance coverage, make different tradeoffs in defining reasonable care, and thus generate what might be viewed as competing customs. Moreover, managed care alternatives, such as HMOs, are forcing courts to confront, albeit reluctantly, the inherent link between patient resources and access to diagnostic and healing technologies.

Attempting to relocate the medically indigent into the medical middle class will only heighten the confusion that prevails there now. Of course, if the current reform efforts promised to commit sufficient resources to put the newly insured on par with the bulk of mainstream health care consumers, such a problem might be avoided. Tort law would then simply be left with the task, daunting enough in itself, of determining what "ordinary" care should look like. Unfortunately, the same political sentiments that are threatening the goal of universal access also seem to preclude the expenditure of sufficient public and private funds to finance comprehensive levels of care for those who are granted access. In other words, Congress, when forced to economize on health care, is likely to limit benefits in its struggle to broaden access.

Whatever shape reform ultimately takes, then, it is almost certain not to provide the relatively unrestricted, fee-for-service care that has traditionally characterized mainstream American medicine. Instead, significant cost containment restrictions will likely be employed to limit the public and private expenditures engendered by increased access to health care. Access to health care for the newly covered will surely mean, as a practical matter, access to managed care, with pre-payment systems like HMOs and DRGs dominating the method of health care delivery.

Adverse selection will assure that these systems are structured so as to reflect the economic status of their participants. While the Administration's plan trumpets the retention of "choice" as an important and necessary characteristic, it is doubtful that those whose access to health care is solely through the grace of the reform effort will have any choice other than a carefully constrained, no-frills health care plan.

But this plan, or kind of plan, will be big and very visible. Although it will offer basic health care coverage, it will exist in open and obvious tension with a broad array of alternate, but more expensive group health care plans, each offering a different mix of health

63 In this context, adverse selection will take the form of wealthier participants leaving relatively bare-bones plans to join more generous plans to which like-minded consumers of health care will also turn.
care components at a different price. Courts will no longer be able to ignore the implications of cost containment.

The leading edge of cost-constraint cases are now reaching the courts. To date, such courts, saddled with tort law's vision of a unitary and global standard of care, have made a muddle of things. Attempts of tort law to police the middle levels of medical care can only grow more strained as collective, resource-sensitive financing mechanisms become dominant. With the advent of universal health care, we predict, things will quickly fall apart. Even the center that tort law now attempts to occupy will not hold.

B. The Long Term Impact of Health Care Reform

How will the tort system evaluate malpractice claims that arise within the various risk pools almost certain to be established under widespread health care reform? Undoubtedly courts will, at last, be forced to re-evaluate their traditional commitment to a unitary standard based on customary "good medicine." Until this era of mass health care reform, courts managed, barely, to cling to that tradition by ignoring not only the top, but more importantly the bottom, of the economic strata. With the advent of universal or near-universal health care coverage, self-imposed ignorance will no longer be possible.

We suggest two basic responses to this problem. First, the tort system might continue to purport to apply a unitary, custom-based standard to all care providers participating in health care groups. Given the new prominence of lower-end health care plans, courts would face an even more intractable problem in determining which particular group's practice constituted the "custom" that all groups would be required to observe.

Confronted with this dilemma, courts embracing this "head in the sand" option would probably cheat on their own approach, either by covertly jettisoning custom and making their own judicial determinations of reasonableness, or by making under-the-table, downward adjustments of the judicial response to medical malpractice claims by the poor. The latter approach would surely generate feelings of arbitrariness and injustice as standards that purport to be universal are adjusted downward for lower-end groups, in clear response to the groups' economic status.

In the alternative, courts could break with tradition and begin to rely openly on customary standards as they evolve in each individual group or subset of groups. This would not be nearly as difficult to

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achieve as it was in the pre-reform era. The impediments to the coherent formation of universal and unitary medical customs would presumably be lessened if customs were specific to types of group health care plans. For instance, both the medical problems presented and the medical technology available would be less diverse within a given group than in the population at large, because the group would be structured to reflect the economic status of its constituents.

Moreover, each group would tend to be more homogeneous regarding preferences for risk. The group will also have more information and be able to understand it more readily. Because care will be provided in a largely self-selected group setting, the differences in wealth within any given group will be less relevant, bringing about greater homogeneity in the capacity of participants to act on the information.

The same characteristics that will foster the formation of customs suitable to the particular needs and preferences of each health care group will also support contract-based solutions to the problems of standard-setting that have until now proven elusive. As noted earlier, courts have traditionally cast a jaundiced eye on contractual attempts to reduce legal standards of care. However, once health care groups have formed on a massive scale, and courts have become accustomed to the central role they play in providing health care, we believe it is inevitable that health care providers and patients within these groups will enter formal contracts setting forth the legal rights and duties among participants.

Some groups, for example, might rationally choose to devote fewer collective resources to legal review of medical care decisions and instead use such resources on health care itself. Although these need not necessarily be the poorest groups, such groups will be the hardest pressed for monetary cost savings and, within wide limits, courts should allow them to do so. Indeed, Congress might be well-advised to authorize such contracts in its enabling legislation.

66 See Mehlman, supra note 4, at 376-77 (discussing enhanced information handling ability of group, and resulting ability to make more cost-effective care decisions than individual patients).

67 See supra notes 53-54 and accompanying text.


69 See Clark C. Havighurst, Private Reform of Tort Law Dogma: Market Opportunities and Legal Obstacles, LAW & CONTEMP. PROBS., Spring 1986, at 143, 162 (detailing advantages to health care consumers of allowing contractual variation of legal obligations).

70 Advocates of the adoption by contract of various no-fault compensation plans have favored an approach wherein such contracts are, within certain limits, insulated from strict judicial scrutiny. See Jeff O'Connell, Neo-No-Fault Remedies for Medical Injuries: Coordinated Statutory and Contractual Alternatives, LAW & CONTEMP. PROBS., Spring 1986, at 125.
These contracts will presumably address not merely the standards by which health care will be judged for participants in the group, but also the appropriate measures of recovery and the processes and procedures whereby disputes will be resolved. For example, such agreements may commit care-related complaints to resolution by binding arbitration or by panels of experts. Courts will review these contracts for fundamental fairness to all sides, but in the main courts should, and we predict courts will, give them effect. At the juncture where courts can no longer review the adequacy of health care under traditional tort principles they will, by deferring to contract, get out of the business of such review.

**Conclusion**

This article has sketched how courts’ traditional deferral to professional custom when setting legal standards of care in the medical malpractice context has become more and more difficult over time. It traces the source of these difficulties to the disintegration over time of the conditions necessary for custom to develop in any group activity setting.

The most significant challenges to the development of custom have arisen as the growth of technology has exacerbated the effects of recipients’ wealth on the level of health care available to them. Tort law’s traditional commitment to a system-wide unitary standard of health care that is blind to the wealth of recipients has reached a crossroads. If and when universal health care reform admits thirty-five to forty million hitherto marginalized persons into the mainstream of health care, the traditional commitment to a unitary, wealth-blind legal standard will not hold.

Ironically, the same forces for change that doom the traditional approach to standard setting will very probably allow courts for the first time to adjust to the reality of wealth stratification as it affects health care delivery. As group health care plans proliferate, they will generally reflect the economic status of their participants. When reviewing the reasonableness of health care designs within such groups, courts might rationally rely on the designs explicitly adopted by contract.

Contracts establishing group plans will also reflect the preferences of their participants regarding the sorts of legal regimes for post-injury review and compensation that should apply. Again, within limits, courts should, and will, give legal effect to such contracts. Make no mistake: if and when the health care revolution arrives it will revolutionize not only the provision of health care in this country, but the tort-medical malpractice system as well.