

11-1976

In Search of a Standard of Care for the Medical Profession: The "Accepted Practice" Formula

Joseph H. King, Jr.

Follow this and additional works at: <https://scholarship.law.vanderbilt.edu/vlr>



Part of the [Medical Jurisprudence Commons](#)

Recommended Citation

Joseph H. King, Jr., In Search of a Standard of Care for the Medical Profession: The "Accepted Practice" Formula, 28 *Vanderbilt Law Review* 1213 (1975)

Available at: <https://scholarship.law.vanderbilt.edu/vlr/vol28/iss6/2>

This Article is brought to you for free and open access by Scholarship@Vanderbilt Law. It has been accepted for inclusion in Vanderbilt Law Review by an authorized editor of Scholarship@Vanderbilt Law. For more information, please contact mark.j.williams@vanderbilt.edu.

In Search of a Standard of Care for the Medical Profession: The "Accepted Practice" Formula

Joseph H. King, Jr.*

TABLE OF CONTENTS

	Page
I. INTRODUCTION	1214
II. PROSPECTS FOR CONTINUATION OF THE FAULT SYSTEM FOR MEDICAL MALPRACTICE	1218
A. <i>Administrative Costs</i>	1223
B. <i>Considerations of Fairness</i>	1227
C. <i>Effect on the Quality of Health Care</i>	1229
D. <i>Future Prospects</i>	1233
III. THE PROFESSIONALLY DEVELOPED STANDARD OF CARE	1234
A. <i>General Principles</i>	1234
B. <i>Professional Standard Redefined: The Accepted Practice Formulation</i>	1236
(1) Nature of the Accepted Practice Standard ..	1236
(2) Ascertaining the Accepted Practice Standard	1241
C. <i>The Case for a Professionally Developed Standard of Care</i>	1244
(1) Limitations of Trier of Fact	1248
(2) Cost- and Risk-Benefit Considerations	1251
(3) Impact on Professional Discretion	1255
(4) Inappropriateness of Malpractice Litigation as a Vehicle for No-Fault Loss Distribution ..	1256
(5) Fundamental Fairness	1256
D. <i>Potential Exceptions to the Professional Standard of Care</i>	1257
(1) The "Common Knowledge" Cases	1257
(2) Standard of Disclosure for "Informed Consent" Cases	1261

*Assistant Professor of Law, University of Tennessee. B.A. Pennsylvania State University, 1965; J.D. University of Pennsylvania, 1970. This article was made possible in part by a generous grant from the University of Tennessee Faculty Research Fellowship Fund.

E. Professional Standards Review Organizations and the Standard of Care	1266
(1) PSRO Norms and the Standard of Care	1267
(2) Reach of the Immunity Provision	1270
IV. CONCLUSION	1275

I. INTRODUCTION

The United States is in the midst of a medical malpractice "crisis." Claims asserted against physicians, hospitals, and other providers of health care have mushroomed dramatically in number¹ and magnitude.² Liability insurance premiums and the charges for medical services that defray them³ also have soared predictably.⁴

1. Current estimates are that more than 20,000 medical malpractice claims are asserted against doctors annually. NEWSWEEK, June 9, 1975, at 59. The number filed against physicians in New York alone rose from 564 in 1970 to 1200 four years later. *Id.*

2. In New York, for example, the average size of a medical malpractice recovery (whether judgment or settlement), grew from \$6000 to \$23,400 in the last decade. NEWSWEEK, *supra* note 1, at 59. Twenty years ago a \$100,000 verdict in a medical malpractice action was practically unheard of. Stetler, *The History of Reported Medical Professional Liability Cases*, 30 TEMPLE L.Q. 366, 381 (1957). This is in marked contrast to today's figures. California alone reports 19 settlements or awards in excess of \$1 million, 13 of which have come during the last 28 months. NEWSWEEK, *supra* note 1, at 59. *See, e.g.*, Niles v. City of San Rafael, 42 Cal. App. 3d 230, 116 Cal. Rptr. 733 (1974) (a total of \$4,025,000 was awarded to compensate for quadriplegic injuries to an 11 year old boy); Weaver v. Tucson Medical Center, No. 133796 (Ariz. Super. Ct., Dec. 31, 1973) (settlement of approximately \$2,000,000 in malpractice case in which 14-year old patient reportedly suffered quadrispasticity and blindness), noted in 17 AM. TRIAL LAW. ASS'N NEWSLETTER 103 (1974).

3. *See* Altman, *Malpractice Rates Drive Up Doctor Fees*, N.Y. Times, July 27, 1975, at 1, col. 4. One hospital has had to increase its room rates by \$12 a day in order to cover liability and malpractice premium rate increases. *Id.* at 24, cols. 2-3. Dr. Malcolm Todd, president of the American Medical Ass'n, estimates that some patients who paid an additional 10¢ a day in hospital charges to cover the cost of the liability insurance premiums in 1965 will now pay an extra \$3.65 per day for that purpose. Nat'l Observer, Feb. 15, 1975, at 10. Others estimate that the increase in malpractice rates could add \$2 or more to each office visit to a physician and \$4 a day to hospital bills. TIME, June 16, 1975, at 50.

The continuing ability of the medical profession to pass on all of the added costs of malpractice insurance to the consumer is also debatable. Consider, for example, that the annual income for anesthesiologists in the San Francisco area reportedly averages \$40,000 to \$45,000, and that proposed increases in insurance rates would demand an annual premium from the members of that specialty of \$18,184. U.S. NEWS & WORLD REP., May 26, 1975, at 34. One wonders whether the health care market is sufficiently inelastic to tolerate the marked increases in charges over such a short period of time that would be necessary to offset the proposed rate changes.

4. Medical malpractice insurance rates have increased roughly 600% in the past three or four years. U.S. NEWS & WORLD REP., *supra* note 3, at 33. Current estimates are that the cost of such insurance runs about \$1 billion a year (350 million paid by doctors and 650 million by hospitals) and could double in the next year. *Id.* One California hospital's insurance premium increased from \$14,000 in 1965 to \$820,000 in 1975. Nat'l Observer, *supra* note 3, at 10. Premiums for orthopedic surgeons in New York have been projected as high as \$40,000. Welch, *Medical Malpractice*, 292 N. ENG. J. MED. 1372, 1374 (1975).

The imminent or threatened departure of a number of insurance carriers from the business of providing professional liability protection⁵ in some states has further aggravated matters. As a result of these developments an epic and regrettably destructive encounter between two great professions, medicine and law, seems to be unfolding. One must ponder the curious etiology of the circumstance that pits one profession against the other; that at once, threatens the repose and integrity of one profession with the menace of criminalizing litigation while tying the economic sustenance of an appreciable segment of the other to the continued survival of those same legal processes; that indulges the untenable premise that the most highly schooled of our learned professions is also the most tortiously culpable; that condones a numerical growth of one profession out of proportion to societal demand⁶ and an unresponsiveness by the other to the calls for more doctors and health care professionals.⁷

5. See, e.g., Nat'l Observer, *supra* note 3, at 10; NEWSWEEK, *supra* note 1, at 63; TIME, *supra* note 3, at 49; TIME, May 5, 1975, at 82; TIME, March 24, 1975, at 62. In some instances the threatened loss of insurance has provoked physician-initiated antitrust litigation. *Now Doctors Charge Insurers With Malpractice*, BUS. WEEK, Aug. 4, 1975, at 40.

6. The current swell in the number of law graduates moving into the legal profession has been ominously noted in a recent study:

Despite exhortation that rewarding careers should be open to all law graduates, there seems little prospect that there will be a sizeable increase in demand in the near future to meet the rising supply. . . . Hence up to half of the graduates in the near future may have to seek employment in fields where traditionally legal training is not a prerequisite. York & Hale, *Too Many Lawyers? The Legal Services Industry: Its Structure and Outlook*, 26 J. LEGAL ED. 1, 30-31 (1973). A correlation between increases in the number of attorneys and the number of malpractice claims would be sheer speculation. It is interesting to note, however, that California, which is commonly regarded as the leader in medical malpractice claims, now has no fewer than 56 operating law schools. 28 L. SCHOOL NEWS, May 1975, at 3.

7. The shortage of physicians has been identified as an important factor in the rise in malpractice claims. SENATE SUBCOMM. ON EXECUTIVE REORGANIZATION, MEDICAL MALPRACTICE: THE PATIENT VERSUS THE PHYSICIAN, 91st Cong., 1st Sess., 4-5, 449-51 (Comm. Print 1969) [hereinafter cited as SENATE REPORT]. The Report of the Carnegie Commission on Higher Education has recognized acute manpower shortages in health services and has called for a significant increase in the number of medical personnel. CARNEGIE COMM'N ON HIGHER EDUCATION, HIGHER EDUCATION AND THE NATION'S HEALTH 13-22, 44-45 (1970). Recent reports indicate that there has been at least some improvement in this regard, although problems remain acute in terms of geographic maldistribution of manpower and overconcentration in some specialities and secondary care activities. Stimmel, *The Congress and Health Manpower: A Legislative Morass*, 293 N. ENG. J. MED., 68, 72 (1975).

Health care professionals, especially physicians, have, with the help of state licensing laws, reportedly established a virtual monopoly over access to their professions. Thorne, *Professional Education in Medicine*, in EDUCATION FOR THE PROFESSIONS OF MEDICINE, LAW, THEOLOGY, AND SOCIAL WELFARE 25 (1975). By setting exclusive standards for admission, the medical profession has regulated the number and type of people allowed to join its ranks sometimes in order to suit the economic advantage of physicians. *Id.* Until such time as a free market is more responsive to supply and demand, quality control will continue to be enforced, however imperfectly, by governmental intervention through malpractice litigation and direct quality control measures.

The members of the professions, however, are not the only protagonists in this conflict. The injured patient, if the size of the claim is sufficient to galvanize economy minded counsel,⁸ will assuredly face inordinate delays and indefinite prospects of recovery, both compounded by mercurial rules of law. Perhaps most aggrieved are the members of society who must finance through higher medical expenses this cost shifting apparatus. According to recent estimates, less than one-third of each dollar paid in insurance premiums accrues to the benefit of injured patients.⁹ The rest is siphoned off by plaintiff and defense counsel and insurance administrators. The practice of defensive medicine,¹⁰ an insidious outgrowth of the per-

8. It has been observed that it is not economically feasible to sue for medical malpractice where the total recovery will be less than \$25,000. See Lieberman, *Examining the Cases for Universal No Fault*, BUS. WEEK, April 28, 1975, at 56. Some have suggested a more flexible approach of evaluating the total case, including both damages and liability potential, before deciding whether to undertake representation. See L. CHARFOOS, *THE MEDICAL MALPRACTICE CASE: A COMPLETE HANDBOOK* 24-28 (1974).

In addition to the often enormous costs (for expert witnesses, discovery, protracted trials, and third party practice), some attorneys are reportedly also influenced by a commendable desire to avoid mere nuisance suits. *Id.* at 26. Arguably, since malpractice actions serve an admonitory function, they should be pursued however small their damage potential. This argument, however, runs afoul of the economic realities of litigation under a contingent fee arrangement. Moreover, the fact that the action does not proceed upon a contingent fee basis does not necessarily mean that the defendant is exculpated or that the plaintiff will be left remediless. Presumably the patient could retain counsel on a straight hourly basis. Also, direct disciplinary proceedings might be instituted in appropriate cases. As a general matter, one also wonders whether the ordeal of a criminalizing malpractice action, absent the need to redress a significant loss, is not normally more draconian than the allegedly negligent conduct warrants.

9. See SENATE REPORT, *supra* note 7, at 10, estimating that between 30% and 38% of the claims loss (the money paid out by the insurance company) goes to the patient. Since a portion of the premium dollar also goes for the nonlitigation costs of the insurance company, the actual amount paid to plaintiff out of the total premium dollar is even smaller. See, e.g., STAFF OF HOUSE COMM. ON INTERSTATE AND FOREIGN COMMERCE, *AN OVERVIEW OF MEDICAL MALPRACTICE*, 94th Cong., 1st Sess., 5, 8 (Comm. Print 1975) [hereinafter cited as OVERVIEW] (noting varying estimates that from 16% to 38% of the premium dollar reaches the patient); Bachman, *Doctors: Move Closer to Your Patient*, 11 TRIAL, May-June, 1975, at 25 (estimating that 18% of the premium dollar goes for patient benefits); Morris, *Medical Report: Malpractice Crisis — A View of Malpractice in the 1970's*, 38 INS. COUNSEL J. 521, 523 (1971) (summarizing a study putting patient recovery at 16% to 27% of the premium dollar).

10. Defensive medicine is essentially the management of a patient's care not only with an eye for the patient's welfare, but also in an effort preemptively to fashion an unassailable record in anticipation of potential malpractice litigation. In response to the threat of liability based on possibly specious allegations of negligence, a physician has asked perceptively, perhaps rhetorically, how practitioners can avoid the temptation of "treating the chart" along with the patient. Gorney, *A Doctor's Plea for Intelligent Compromise*, 7 TRIAL, May-June 1971, at 53. To the extent that the practice of defensive medicine diverts energy, attention, and resources from the immediate care of the patient to the chimera of litigation, the likelihood of an avoidable mistake and the misapplication of unnecessary, expensive, and even dangerous procedures are increased. Similarly, a fear of being sued no doubt discourages some physicians from undertaking particularly high risk procedures or from developing innovative

vasive threat of liability, has further increased the costs of health care. Perhaps most perverse, the costs of the malpractice system currently are not shared uniformly throughout society, but often are disproportionately borne by those who are inadequately covered by government health care programs or private health insurance and who, by reason of their infirmity, are least able to bear such inflated costs.

In light of increasing numbers of lawsuits and higher medical costs, it is not surprising that an unprecedented public expatiation on the causes¹¹ and cures for the malpractice crisis has flourished. The perceived need shared by some to overhaul the present system has sent reverberations running through the state and federal legislatures¹² and the medico-legal community. Unfortunately, in their apparent zeal, spokesmen for the various constituencies often have seemed to thrust past each other rather than to target their contentions in meaningful dialogue. The time may be ripe to retrench and survey the scene, not only with an eye toward possible change, but also to guard against what might prove an improvident rush to judgment.

As the conflict becomes clearer two fundamental questions will likely predominate. First, should a theory of strict liability or no-

techniques. See generally Bernzweig, *Defensive Medicine*, in HEW, REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE, Appendix at 38-40 (1973) [hereinafter cited as HEW REPORT]. Current estimates are that defensive medical practices cost between 2 and 7 billion dollars annually. Regier, *The View From HEW on Federal Involvement in the Malpractice Situation*, 3 J. LEGAL MED., June, 1975, at 19 (derived from speech by Dr. Roger O. Egeberg, Special Assistant to Secretary HEW for Health Policy). Others have suggested that the practice of defensive medicine is not so extensive, nor is it a significant contributing factor to the high costs of medical care. *The Medical Malpractice Threat: A Study of Defensive Medicine*, 1971 DUKE L.J. 939, 964-65. This difference of opinion probably in part reflects inherent difficulties in identifying and measuring defensive medical practices. See Hershey, *The Defensive Practice of Medicine*, 50 MILBANK MEM. FUND Q. 69 (1972).

11. Although the focus of this article will be upon legal aspects of medical malpractice, there are diverse nonlegal factors that have contributed to the increase in malpractice claims. They at least deserve mention. Foremost among them are: (1) the breakdown of physician-patient rapport; (2) the impersonalization of health care; (3) quantitative increases in the demand for and delivery of health care; (4) a negative public image of medical professionals; (5) an insufficient supply of medical personnel and resources; (6) the emerging consumerism among patients; (7) the growing litigiousness of society, fanned by contingent fee-minded attorneys; (8) an increased public understanding of medical facts; and (9) unrealistic public expectations regarding medical treatment. For a discussion of some of the foregoing items, see SENATE REPORT, *supra* note 7 at 2-5, 447-51. Dr. Kübler-Ross also tells of a growing public reluctance to accept the inevitability of death and pain. E. KÜBLER-ROSS, ON DEATH AND DYING 6, 14-15 (1969). This may have also played a significant role in the quickening of the malpractice crisis.

12. For a summary of some of the recently enacted or proposed state and federal legislation see OVERVIEW, *supra* note 9, at 36-193; Zimmerly & Smiley, *Legislators React to the Medical Malpractice Problem*, 3 J. LEGAL MED., May 1975, at 30-34.

fault displace the present system of fault based medical malpractice liability? Secondly, if fault is retained as an integral determinant in loss allocation for medical accidents, should a professionally defined standard of care provide the legal standard against which conduct normally should be evaluated?

On the first issue, it would seem that the adoption of a no-fault solution for all medical misadventures would be a mixed blessing, difficult to justify. The costs, even with a ceiling on recoveries, would be awesome. Definitional problems in identifying compensable events might largely nullify potential administrative savings. Serious egalitarian questions would also be raised. Should medical accidents be treated differently from insults from other causes? Would no-fault recoveries for economic losses not perpetuate social economic inequities at taxpayer or patient expense?¹³ Rather than a no-fault system, a social security type plan for reimbursement of medical expenses for all misfortunes, whatever their causes, seems a more credible prospect. If neither the collateral source rule¹⁴ nor a right of subrogation¹⁵ were applicable to such a plan, there would remain economic and perhaps other non-medical losses to be handled, if at all, under the fault system. As to the second issue, the appropriate standard of care when the fault system is retained, it is felt that deference to the collective judgment of the medical profession rather than to the ad hoc intuitions of lay jurists or triers of fact is the sounder course.

In the sections that follow, these issues will be examined in greater detail. First, the current fault system will be examined, and the prospects for its continued application will be discussed along with no-fault and social security type alternatives. Next, the concept of the professionally developed standard of care and the customary practice standard will be explained. The author's "accepted practice" formulation will be defined and analyzed, and some advantages of a professionally developed standard will be discussed. Finally, the relationship of the standard to the Professional Standards Review Organization of the Social Security Act will be examined.

II. PROSPECTS FOR CONTINUATION OF THE FAULT SYSTEM FOR MEDICAL MALPRACTICE

The popularity of the no-fault theory of loss allocation for auto-

13. See text accompanying notes 39-87 *infra*.

14. See note 50 *infra*.

15. See note 51 *infra*.

mobile accidents¹⁶ was inspired in large measure by onerous features of the traditional negligence approach. Automobile accident victims often were unevenly or arbitrarily treated, and the delay and other shortcomings of the fault system exacted a heavy administrative toll.¹⁷ Moreover, the validity of the deterrent effects of the threat of civil liability has been questioned in the automobile accident setting.¹⁸ The growing skepticism about the present system of loss allocation for medical malpractice has sparked interest in possible alternatives in this sphere as well. Most cases that have considered the question have, absent an express contract to produce a specified result, rejected an explicit adoption of strict liability for medical accidents arising out of professional services.¹⁹ Nevertheless, the ascendancy in malpractice litigation of such liability-producing concepts as informed consent,²⁰ *res ipsa loquitur*,²¹ *respondeat*

16. States with approximately 53% of the nation's population have enacted some form of no-fault automobile insurance. J. OF COMM., Jan. 27, 1975, § 2, at 6A, col. 4. See also Gouldin, *Countrywide Overview of Automobile No-Fault Insurance*, 23 DEFENSE L.J. 443 (1974). For an excellent analysis and overview of the characteristics of such plans, see Blum & Kalven, *Ceilings, Costs, and Compulsion in Auto Compensation Legislation*, 1973 UTAH L. REV. 341.

17. See generally, P. KEETON & R. KEETON, CASES AND MATERIALS ON THE LAW OF TORTS, 457 n.1, (and authorities cited therein), 457-539 (1971); REPORT OF THE SPECIAL COMMITTEE ON AUTOMOBILE ACCIDENT REPARATIONS, 94 A.B.A. REP. 559 (1969).

18. See note 67 *infra* and accompanying text.

19. For a sampling of cases refusing to extend strict liability to professional medical services, see e.g., *Johnson v. Sears, Roebuck & Co.*, 355 F. Supp. 1065, 1066-67 (E.D. Wis. 1973) (dictum without deciding); *Silverhart v. Mount Zion Hosp.*, 20 Cal. App. 3d 1022, 98 Cal. Rptr. 187 (1971) (strict liability held not applicable to hospital as user of allegedly defective needle); *Viland v. Winslow*, 34 Mich. App. 486, 191 N.W.2d 735 (1971) (physician not liable solely because of an alleged poor result of the treatment absent proof of substandard care); *Magner v. Beth Israel Hosp.*, 120 N.J. Super. 529, 535, 295 A.2d 363, 366 (1972) (strict liability not applicable to medical and dental professions); *Barbee v. Rogers*, 425 S.W.2d 342 (Tex. 1968) (strict liability not applicable to optometrist's professional acts). See generally Rubin, *Manufacturer and Professional User's Liability for Defective Medical Equipment*, 8 AKRON L. REV. 99, 103-05 (1974). The contaminated blood situation (in which there have been some strict liability decisions for the patient, usually involving transmission of hepatitis) has now largely been disposed of in almost all jurisdictions either by decisions or legislation favoring hospitals and blood banks. D. NOEL & J. PHILLIPS, *PRODUCTS LIABILITY IN A NUTSHELL* 132 (1974).

20. See text accompanying notes 199-221 *infra*.

21. See, e.g., *Clark v. Gibbons*, 66 Cal. 2d 399, 416, 426 P.2d 525, 537, 58 Cal. Rptr. 125, 137 (1967) (Tobriner, J., concurring, arguing in favor of strict liability in certain unexplained surgical accidents, commenting that if public policy demands liability without fault, responsibility should be fixed openly and uniformly and not under the guise of *res ipsa loquitur*). See generally Binder, *Res Ipsa Loquitur in Medical Malpractice*, 17 CLEV. MAR. L. REV. 218 (1968); Morris, *Res Ipsa Loquitur — Liability Without Fault*, 163 J.A.M.A. 1055 (1957); Rubsamens, *Res Ipsa Loquitur in California Medical Malpractice Law — Expansion of a Doctrine to the Bursting Point*, 14 STAN. L. REV. 251 (1962); Seavey, *Res Ipsa Loquitur: Tabula in Naufragio*, 63 HARV. L. REV. 643 (1950); Thode, *The Unconscious Patient: Who Should Bear the Risk of Unexplained Injuries to a Healthy Part of His Body?*, 1969 UTAH L. REV. 1.

superior,²² physician guarantees or warranties "to cure,"²³ and more recently, direct challenges to the professionally determined standard of care,²⁴ attests to the pressures on the courts to shift losses notwithstanding the absence of usual evidence of fault.²⁵ This tendency is undoubtedly symptomatic of an inherent perturbation that has always distressed fault based tort law. One writer has aptly characterized the problem as the "mutual hampering effect"²⁶ of attempting at once to compensate and to punish with a single money judgment. By forcing an accommodation between compensatory and admonitory objectives, this phenomenon unquestionably has distorted both goals. Despite this dissonance in fault based liability generally and the obvious plague that has beset the law of medical malpractice in particular, however, the wholesale repudiation of liability based upon fault for medical malpractice does not appear proximate or, for that matter, justified.

Commentators, while generally bemoaning the shortcomings of the fault based system, have differed in their recommendations for changes in the law's response to medical accidents. A general no-fault system for malpractice,²⁷ issuance of first party health and accident insurance to patients,²⁸ strict liability for at least certain

22. See generally Note, *Separation of Responsibility in the Operating Room: The Borrowed Servant, the Captain of the Ship, and the Scope of the Surgeons' Vicarious Liability*, 49 NOTRE DAME LAW. 933 (1974); Comment, *Hospital Liability for the Negligence of Physicians: Some Needed Legal Sutures*, 26 U. FLA. L. REV. 844 (1974).

23. See, e.g., Tierney, *Contractual Aspects of Malpractice*, 19 WAYNE L. REV. 1457 (1973); Note, *Establishing the Contractual Liability of Physicians*, 7 CALIF. (DAVIS) L. REV. 84 (1974); Note, *Express Contracts to Cure: The Nature of Contractual Malpractice*, 50 IND. L.J. 361 (1975); Comment, *Reassurance or Contract: The Physician Caught Between the Scylla and Charybdis*, 41 U.M.K.C.L. REV. 118 (1972); 41 TENN. L. REV. 964 (1974).

24. See, e.g., *Helling v. Carey*, 83 Wash. 2d 514, 520, 519 P.2d 981, 984 (1974) (Utter, J., concurring, urging in view of the court's rejection of the professional standard under the facts of the case, that the decision should rest on strict liability grounds rather than negligence principles).

25. On the trend in the direction of strict liability in medical malpractice generally, see Comment, *Medical Malpractice: A Move Toward Strict Liability*, 21 LOYOLA L. REV. 194 (1975).

26. Morris, *Rough Justice and Some Utopian Ideas*, 24 ILL. L. REV. 730, 733 (1930); see A. EHRENZWEIG, *NEGLIGENCE WITHOUT FAULT* 84 (1951).

27. See Carlson, *A Conceptualization of a No-Fault Compensation System for Medical Malpractice Injuries*, 7 LAW & SOC'Y REV. 329 (1973); Haines, *The Medical Profession and the Adversary Process*, 11 OSGOOD HALL L.J. 41, 52-53 (1973); Comment, *Continuing the Common Law Response to the New Industrial State: The Extension of Enterprise Liability to Consumer Services*, 22 U.C.L.A.L. REV. 401, 427-30 (1974).

28. See, e.g., Ehrenzweig, *Compulsory "Hospital Accident" Insurance: A Needed First Step Toward the Displacement of Liability for "Medical Malpractice"*, 31 U. CHI. L. REV. 279 (1964); Franklin, *Tort Liability for Hepatitis: An Analysis and a Proposal*, 24 STAN. L. REV. 439, 478-79 (1972) (recommends first party insurance coverage against transfusion-associated hepatitis); Morris, *supra* note 9, at 523 (advocating issuance of insurance against a "therapeutic misadventure" for hospital patients).

types of occurrences,²⁹ elective or limited no-fault systems,³⁰ some form of social security type compensation,³¹ as well as retention of the present system,³² all have been advocated.

29. See, e.g., Havighurst & Tancredi, "Medical Adversity Insurance" — A No-Fault Approach to Medical Malpractice and Quality Assurance, 1974 *INS. L.J.* 69 (proposing no-fault for specific types of iatrogenic injuries); Note, *Products and the Professional: Strict Liability in the Sale-Service Hybrid Transaction*, 24 *HAST. L.J.* 111 (1972) (urging strict liability of professional users of defective product); Comment, *Injuries Precipitated By Psychotherapy: Liability Without Fault As a Basis for Recovery*, 20 *S.D.L. REV.* 401 (1975) (suggests no-fault for iatrogenic injuries arising from psychotherapy). One writer seems to advocate the imposition of liability for medically induced injuries that are *humanly* avoidable under the current state of the art and that could have been prevented without unacceptable expense. Greenfield, *Consumer Protection in Service Transactions — Implied Warranties and Strict Liability in Tort*, 1974 *UTAH L. REV.* 661, 698-706. This inventive, though admittedly "fuzzy," standard does not appear to have fully shed the notion of negligence or at least the hint of arguably culpable conduct. As such, it would probably compound the definitional problems anticipated in no-fault approaches generally and would be extremely difficult, if not impossible, to administer.

30. See Note, *Comparative Approaches to Liability for Medical Maloccurrences*, 84 *YALE L.J.* 1141, 1158-60 (1975). This commentator has, *inter alia*, expressed an interest in an elective no-fault approach as typified in S. 215, 94th Cong., 1st Sess. (1975), at least prototypically as a means of testing the feasibility of a no-fault approach. This bill would permit election between fault and no-fault remedies after the injury.

An elective no-fault system involving election before an injury occurs has also been proposed. O'Connell, *Elective No-Fault Liability by Contract — With or Without an Enabling Statute*, 1975 *U. ILL. L.F.* 59, 65. For variations and ruminations on the elective no-fault theme, see J. O'CONNELL, *ENDING INSULT TO INJURY* (1975); O'Connell, *No-Fault Insurance for Injuries Arising From Medical Treatment: A Proposal for Elective Coverage*, 24 *EMORY L.J.* 21 (1975); O'Connell, *Elective No-Fault Insurance for Many Kinds of Accidents: A Proposal and An "Economic" Analysis*, 42 *TENN. L. REV.* 145 (1974).

31. Professor Keeton, while expressing reservations about the relative advantages and prospects for a no-fault system for medical injuries, seems to offer at least tacit support for a limited social security-type plan (perhaps a national health insurance plan) that would reimburse medical expenses regardless of the cause of the underlying injury and not merely those that were iatrogenically induced, i.e., injuries proximately induced or related to treatment. Keeton, *Compensation for Medical Accidents*, 121 *U. PA. L. REV.* 590, 612-17 (1973); see Silverstein, *Compensating Those Injured Through Experimentation*, 48 *CONN. B.J.* 398, 406-11 (1974) (recommends social security plan for injuries arising out of medical experimentation). Perhaps the most notably and far-reaching application of social security principles to accident law has been the New Zealand experiment. Palmer, *Compensation for Personal Injury: A Requiem for the Common Law in New Zealand*, 21 *AM. J. COMP. L.* 1 (1973); Palmer & Lemons, *Toward the Disappearance of Tort Law — New Zealand's New Compensation Plan*, 1972 *U. ILL. L.F.* 693.

32. See, e.g., Kretzmer, *The Malpractice Suit: Is It Needed?*, 11 *OSGOODE HALL L.J.* 55, 79 (1973) (recommending retention of the fault system for damages not recoverable under a compensation scheme); Lanzone, *A Defense Lawyer Views Products Liability and Professional Liability No-Fault*, 1975 *INS. L.J.* 82; Association of Trial Lawyers of America Position Paper — A Position of Responsibility, 11 *TRIAL*, May-June, 1975, at 49. In a recent comprehensive report on medical malpractice the Commission charged by the Secretary of HEW to study the problem cautioned, in the context of no-fault, against leaping "headlong from a system that works (with however many faults) into an untested one that may cause even more severe problems." HEW REPORT, *supra* note 10, at 101. Some commentators, recognizing the benefits of at least a limited social security health plan for injuries, have questioned the

Despite current interest in no-fault alternatives, the complete demise of the fault based system in medical malpractice does not, for both practical and political reasons, appear imminent.³³ A more likely development probably will be the enactment of a national health insurance plan³⁴ whereby medical expenses will be reimbursed without regard to their cause. Remaining losses (consisting primarily of economic loss and perhaps pain and suffering) would be handled under the fault system. With some of the pressure to find liability in order to compensate the victim removed by the prevalence of universal health insurance, the standard of care might also be clarified and applied with greater predictability even if more of the economic losses attributable to the health care enterprise were externalized as a result, that is, borne directly by the patient-consumer. In a jurisprudential world that often strives single-mindedly for ultimate solutions, the foregoing prospects undoubtedly will fall short of the apocalyptic vision of some. Yet, those prospects are not only reasonably foreseeable developments but ones that perhaps represent the most sensible compromise at this time.

To facilitate discussion, defined here is the terminology that will be used to refer to three basic system-types for loss redistribution—the fault, no-fault, and social security systems.³⁵ The *fault* system is premised on the notion that a defendant has engaged in conduct falling below socially acceptable standards and therefore must redress the losses caused. Liability insurance held by the defendant is a common, though not universal, feature of this system. A *no-fault* plan would provide compensation for certain losses, regardless of whether the causative agent was blameworthy, as long as those losses arose out of a predefined transaction or activity, such

advantages to be gained in redressing the remaining, nonmedical losses (economic, pain and suffering, etc.) under a no-fault as opposed to a fault system. Keeton, *supra* note 31, at 615-16.

33. A sampling of a few of the recent state statutes spawned by the current "malpractice crises" seems to suggest, as nearly as one can tell, the continued vitality of the fault system for medical malpractice. See, e.g., IND. ANN. STAT. §§ 16-9.5-1-1 *et seq.* (Supp. 1975); Tennessee Medical Malpractice Review Board and Claims Act of 1975, ch. 299, §§ 14(a)(1), 17(a), [1975] Tenn. Pub. Acts 662; Idaho Hospital-Medical Liability Act, S. 1186, 43d Leg., 1st Sess. § 10 (1975).

34. For some thinking on the subject of national health insurance, see, e.g., E. KENNEDY, IN CRITICAL CONDITION — THE CRISIS IN AMERICA'S HEALTH CARE (1972); *Hearings on H.R. 13870, 12684 Before the House Comm. on Ways and Means*, 93d Cong., 2d Sess. (1974). The diversity of the proposals suggested under the National Health Insurance rubric is well illustrated in Falk, *National Health Insurance: A Review of Policies and Proposals*, 35 LAW & CONTEMP. PROB. 669, 678-90 (1970). The private health insurance system is vigorously criticized in Bodenheimer, Cummings, & Harding, *Capitalizing on Illness: The Health Care Industry*, 4 INT'L J. HEALTH SERVICES 583 (1974).

35. The essential outlines of the three approaches are aptly described in Keeton, *supra* note 31, at 600-01. See generally G. CALABRESI, THE COSTS OF ACCIDENTS 3-16 (1970).

as the providing of medical care. Depending on the context, liability insurance may take the form either of first-party coverage (issued in advance to the injured party) as in some no-fault automobile insurance plans³⁶ or of liability insurance as found in many areas of tort law now governed by strict liability.³⁷ In either case, costs would be distributed through insurance premiums intramurally among the insured contributors participating in or affected by the enterprise in question. A *social security* system, as envisioned herein, would depart from the preceding models in at least two respects. First, a social security system would compensate those individuals in the class covered for specific losses without regard for either the identity (cause) or quality (culpability or innocence) of the force that produced the injury. Thus, the system would address all injuries and illnesses of individuals covered, rather than exclusively therapy related ones. Secondly, such a social security system would spread the costs of health care over most members of the taxpaying public, thereby accomplishing probably a broader loss distribution than under either of the other systems.

The future trends in society's response to medical accidents will be discussed in terms of three fundamental considerations: (1) the administrative costs of implementing the desired loss allocation; (2) the fundamental fairness of the allocation; and (3) the effects of the loss allocation on the quality of health care.³⁸

A. Administrative Costs

The administrative costs of the existing fault based system for allocating losses for medical malpractice include four components—the cost of administering the insurance agreement, the amount of plaintiff's recovery, and the fees for plaintiff's and defendant's counsel. In the absence of empirical data the relative administrative costs of the fault and no-fault options are difficult if not impossible to quantify. It is possible, however, to speculate on the general cost effect of each system.

Medical malpractice cases are extremely complex, time consuming, and costly to litigate because of the need for expert testimony and a personalizing of the lawsuit that discourages settlement. The relatively small portion of each malpractice insurance

36. See Blum & Kalven, *supra* note 16 at 344-45, 362-64.

37. For an overview of the turn toward strict liability in tort law generally, see Peck, *Negligence and Liability Without Fault in Tort Law*, 46 WASH. L. REV. 225 (1971).

38. For a more particularized exposition of the characteristics of what are perceived as good systems of compensation or accident law, see G. CALABRESI, *supra* note 33, at 24-33; 2 F. HARPER & F. JAMES, *THE LAW OF TORTS* §§ 11.5, 12.4 (1956); Keeton, *supra* note 31, at 603.

premium dollar that reaches an aggrieved litigant bears witness to this cost.³⁹ There is, therefore, a temptation to embrace a no-fault solution that hopefully would simplify the litigation process and thereby reduce administrative costs and ultimately malpractice insurance premiums. Even if the issue of personal fault were eliminated, however, the difficult causation question⁴⁰ with its concomitant costs would survive under no-fault.⁴¹ Unlike the situation involved in most personal injury lawsuits, in a medical accident a patient generally enters the professional relationship at issue *after* the onset of the original symptoms, which complicates the identification of the cause of the patient's ultimate condition. The causation issue might be especially abstruse under a no-fault system in which some form of compensable event other than a negligent act would be required as a causative antecedent. Presumably, a patient would recover even absent negligence as long as the injuries were iatrogenic (that is, proximately induced by or related to treatment). Determining whether an injury is iatrogenic for compensation purposes, however, is a difficult and imprecise endeavor. One commentator has aptly characterized it as "[p]erhaps the most troublesome problem"⁴² that perplexes no-fault proposals. Courts might lapse back into casuistic distinctions between commission and omission and other equally counter-productive exercises. Sorting out the causal dynamics of an inpatient's cardiac arrest,⁴³ post-surgical infection, or other arguably therapy induced injuries promises to be an expensive, enervating process with little chance of uniformity. Thus, the administrative savings likely to accrue from a no-fault system by elimination of the fault question may be largely offset by the added complexities in defining and proving causation.

It also is relevant to note that the administrative costs required to prove fault under the present system eventually may be mitigated, along with a simplification and expedition of the trial itself,

39. See note 9 *supra* and accompanying text. To the extent that a no-fault plan would be administered through private insurance, the percentage of the premium not returned in benefits would probably remain high. Blum & Kalven, *supra* note 16, at 344 n.6. The administrative "take" under no-fault, however, would still probably be less than under the existing fault-based system.

40. D. HARNEY, *MEDICAL MALPRACTICE* §§ 4.1-4.2 (1973).

41. Keeton, *supra* note 31, at 597.

42. *Id.* at 614.

43. The following hypothetical situation serves to illustrate the problem:

[A]ssume a patient has a heart condition which is difficult to diagnose. Under a no-fault system, would the patient be compensated if (a) he went to a hospital, suffered a cardiac arrest, and died while being treated; or (b) he went to a hospital, was given a complete physical, and then sent home where he died the same night; or (c) he never went to a hospital, but suffered a cardiac arrest and died?

Waxman, *Spiraling Costs: A Health Care Slide*, 11 TRIAL, May-June 1975, at 28.

by the use of screening panels and arbitration plans as alternate or complementary forums within the fault system.⁴⁴ Continued developments in this direction could render the present system less objectionable and remove some of the impetus from those advocating no-fault as an economy measure.

Even if the definitional obstacles of no-fault could be surmounted,⁴⁵ the added expense of compensating the additional numbers of injured patients probably would be staggering. It has been estimated that forty percent of the population has had a negative, but not necessarily negligent, health-impairing experience with health care.⁴⁶ The number of iatrogenic injuries sustained annually during the course of hospital care has been put in the two and one half to six million range.⁴⁷ When added to those iatrogenic injuries occurring outside of the hospital, the totals become even more inflated and certainly dwarf the estimated 18,000 to 20,000 medical malpractice claims currently asserted each year.⁴⁸ Some no-fault proposals, by providing for the payment of attorneys' fees in some

44. See generally Adams & Bell, *Alternatives to Litigation II: Constitutionality of Arbitration Statutes*, in HEW REPORT, *supra* note 10, App. at 314; Baird, Musterman & Stevens, *Alternatives to Litigation, I: Technical Analysis*, in HEW REPORT, *supra* note 10, App. at 214; Gibbs, *Malpractice Screening Panels and Arbitration in Medical Liability Disputes*, J. LEGAL MED., May-June, 1973 at 30; Henderson, *Contractual Problems in the Enforcement of Agreements to Arbitrate Medical Malpractice*, 58 VA. L. REV. 947 (1972); Wadlington, *Alternatives to Litigation, IV: The Arbitration Laws of the U.S.* in HEW REPORT, *supra* note 10, App. at 346; Comment, *The Medical Malpractice Mediation Panel in the First Judicial Department of New York: An Alternative to Litigation*, 2 HOFSTRA L. REV. 261 (1974); Note, *The New Mexico Medico-Legal Malpractice Panel—An Analysis*, 3 NEW MEX. L. REV. 311 (1973); Comment, *The Medical Malpractice Crisis: Is the Medical Review Committee a Viable and Legal Alternative?*, 15 SANTA CLARA LAW. 405 (1975). A number of states have enacted or are seriously considering screening panels or arbitration plans. Perhaps the most notable example to date has been Indiana, which on April 17, 1975, enacted a bill establishing, among other things, a medical review panel for malpractice claims. See IND. ANN. STAT. § 16-9.5-9-1 *et seq.* (Supp. 1975).

45. The no-fault plan that has perhaps come closest to providing a workable answer to the definitional problems for at least some types of medical accidents has been the selective compensation plan of Havighurst & Tancredi, *supra* note 29. These authors proposed the development of a catalogue of compensable events with a high iatrogenicity correlation in order to ease causation-proof requirements, regularize compensation, and strengthen quality-promoting incentives. *Id.* at 75-76.

46. Wolfe, *The Real Victim*, 11 TRIAL, May-June 1975, at 30. For general observations on the incidence of iatrogenic injuries, see R. MOSER, DISEASES OF MEDICAL PROGRESS (3d ed. 1969); Barr, *Hazards of Modern Diagnosis and Therapy — The Price We Pay*, 159 J.A.M.A. 1452 (1955); Kampmeier, *Diseases of Medical Progress*, 59 So. MED. J. 871 (1966); Pociński, Dogger, & Schwartz, *The Incidence of Iatrogenic Injuries*, in HEW REPORT, *supra* note 10, App. at 50; Schimmel, *The Hazards of Hospitalization*, 60 ANNALS OF INTERNAL MED. 100 (1964).

47. Regier, *supra* note 10, at 22. See Bernzweig, *Getting to the Root of the Problem*, 11 TRIAL May-June, 1975, at 59 (estimating the total number of iatrogenic injuries sustained during hospital care as in the 2 to 4 million range).

48. U.S. NEWS & WORLD REP. May 26, 1975, at 33.

cases regardless of whether payment was even due under the no-fault criteria,⁴⁹ could conceivably raise the costs much more. Admittedly, the use of an arbitrarily set ceiling on benefits might reduce the costs of a no-fault system. This would, however, afford incomplete compensation for many and would mean that the administrative costs would consume a greater proportion of the premium dollar. In any event, unless the ceiling reduced the level of compensation to a nominal sum, which would then certainly not justify the administrative costs of shifting the loss, the total costs of a no-fault system even with a ceiling probably would well exceed present costs.

A social security type national health plan appears to be a more likely and more defensible development than a no-fault plan, at least for present purposes. If neither the "collateral source" rule⁵⁰ nor a right of subrogation⁵¹ were applicable to such a plan, the fault system would then apply only to nonmedical losses such as economic loss and perhaps pain and suffering. Similarly, recovery in the absence of fault would be limited exclusively to reimbursement of medical expenses. Since all such losses, regardless of source, would be remedied, proof of causation and related definitional problems that plague no-fault proposals would be avoided under a national health plan for innocently caused injuries. At the same time, by limiting such a plan to the reimbursement of exclusively medical expenses, the costs would be more tolerable than those under a no-fault approach covering all damages. Additional administrative savings also may be anticipated since medical benefits, unlike no-fault

49. Kennedy-Inouye Bill, S. 215, 94th Cong., 1st Sess. § 1726(d) (1975).

50. The collateral source rule holds essentially that "benefits received by the plaintiff from a source collateral to the tortfeasor . . . may not be used to reduce the defendant's liability for damages." D. DOBBS, HANDBOOK ON THE LAW OF REMEDIES 185 (1973). See generally Fleming, *The Collateral Source Rule and Loss Allocation in Tort Law*, 54 CALIF. L. REV. 1478 (1966). Thus, if the collateral source rule applied to benefits under a national health insurance plan, the plaintiff who could prove fault might recover for his medical expenses from the defendant despite the fact that they were already reimbursable under the plan. This result would seem difficult to justify, at least if there were no right of subrogation vested in the agency providing the national health benefits, or there otherwise remained the probability of a double recovery by claimant.

51. If a national health insurance plan contained provisions subrogating the insurer, to the extent of its outlay for medical expenses, to any causes of action the patient may have had for malpractice, some of the administrative abuses of the fault system would reassert themselves. Perhaps such claims, which would essentially be among insurance carriers *inter se*, could be handled through a voluntary arbitration approach. In the final analysis, however, one may question whether there is sufficient justification for redistributing such losses (considering especially the inherent imponderables of medical science) to warrant the administrative expenses necessary to recapture the medical expenses. Cf. Keeton, *supra* note 31, at 616-17. On the subject of subrogation clauses generally, see Capwell & Greenwald, *Legal and Practical Problems Arising from Subrogation Clauses in Health and Accident Policies*, 22 FED. INST. COUNSEL Q., Winter 1972, at 23.

economic benefits, would be standardized, and the administrative costs of individualization of economic losses⁵² would be restricted to cases involving fault. In a consumer oriented public that increasingly regards good health as a matter of right,⁵³ the political climate also appears more conducive to a national health care plan than to a straight no-fault solution.

B. Considerations of Fairness

It is self-evident that the administrative costs of redistributing losses attributable to medical malpractice are reflected in higher medical charges.⁵⁴ The liability insurance premium pays everyone associated with the loss-redistribution process, and the funds for the premium are derived from the charges for medical services. A significant portion of the medical services are financed by the government⁵⁵ or through private health insurance,⁵⁶ and these institutions are capable of spreading administrative costs over a large portion of the general population. Such universal risk spreading does not occur when medical expenses are borne directly by the individual.⁵⁷ In that situation, members of society who, by reason of their infirmity, often are least able to withstand the high costs of medical care nevertheless are forced to pay not only the actual cost for these services, but also those additional charges that go for liability insurance premiums. Under a no-fault plan the burden probably would continue to fall most heavily upon those who, because of their medical condition, require more extensive health care. To be sure, by obviating the need to prove fault, a no-fault plan might produce administrative savings that would increase the percentage of the premium dollar currently reaching the victim.⁵⁸ That fact alone, however, would be of little consolation to patients who are afflicted

52. Keeton, *supra* note 31, at 609-10.

53. See Letter from Crawford Morris to Senator Abraham Ribicoff, Aug. 28, 1969, in SENATE REPORT, *supra* note 7, at 435, 447.

54. See, e.g., Andrew, *Malpractice Suits: The Increased Costs of Health Care*, 8 TULSA L.J. 223 (1972).

55. The total health bill in 1974 came to \$104 billion of which \$41 billion (or about 40%) was paid by government expenditures. *Washington Scene*, 3 J. LEGAL MED., June, 1975, at 52.

56. Government and private health insurance together cover about 65% of all health costs (90% of hospital bills and 61% of doctor bills). *BUS. WEEK*, May 26, 1975, at 72.

57. Estimates are that 20% of the American population have no private surgical or hospital insurance; 20% have no in-hospital physician insurance; 55% carry no insurance for visits to physicians; 49% have no insurance for prescribed drugs; and 93% do not have dental insurance. See Bodenheimer, Cummings, & Harding, *supra* note 34, at 585. Moreover, because of exclusions for coverage, deductibles, and policy limits, the average family of four is said to incur \$350 in medical bills annually that are not covered by its insurance. *See id.*

58. See generally note 9 *supra*.

with the higher medical costs that would assuredly materialize if all iatrogenic injuries were even incompletely redressed.

Even if a national health plan were adopted in conjunction with no-fault to redress economic losses so that the expense of health care, including the costs of no-fault, could be spread throughout the general population, the fairness of a no-fault alternative would remain open to question. Under a fault system individualization of economic benefits, such as loss of earnings or diminution of earning capacity, to reflect the pre-injury economic circumstances of the victim arguably can be justified by the time honored adage that the defendant takes the plaintiff as he finds him.⁵⁹ Not only are defendants supposedly deterred, but as between the innocent and the guilty parties, the latter purportedly should bear the loss as a matter of rough justice. To the extent that a no-fault system would continue to individualize economic losses, however, it becomes subject to challenge for preserving and reinforcing inequities in individual social and economic circumstances that antedated the medical accident at taxpayers' or patients' expense.⁶⁰ These problems would be absent in an exclusively social security plan that would reimburse only medical expenses, remedying essentially homogeneous risks. Thus, a no-fault system, more than either a fault or social security model, raises a serious "distributive justice"⁶¹ question, especially in our increasingly egalitarian society.

A no-fault system also is subject to what has been labeled the "bathtub argument."⁶² In the medical accident context proponents of this argument would question the justification for repairing losses from medical accidents but not from a slip and fall in the bathtub.⁶³ Once fault is removed from the picture, it is difficult, as a matter

59. See, e.g., W. PROSSER, *LAW OF TORTS* § 43, at 262 (4th ed. 1971).

60. Keeton, *supra* note 31, at 609. The effects of individualization in a no-fault system also can be viewed not simply as preservation of the economic status quo, but in terms of a transfer of wealth from poor patients to the rich ones. See Note, *supra* note 30, at 1156 n.80. On the subject of the resilience of class barriers in the society generally, see Parker, *Fact and Fancy About America's "Classless Society,"* *BUS. & SOC'Y REVIEW/INNOVATION*, Summer 1974, at 34-42.

61. The "distributive justice" problem is discussed from a slightly different perspective in the automobile no-fault context in Blum & Kalven, *supra* note 16 at 364. The authors observe that individualized recoveries exert pressure on policy makers either to differentiate premiums (with wealthier individuals paying more since they might recover more by way of economic loss) or to standardize certain risks by imposing a ceiling on recoveries. *Id.* For a conceptual analysis of the "distributive justice" notion, see Flynn & Ruffinengo, *Distributive Justice: Some Institutional Implications of Rawls' A Theory of Justice*, 1975 *UTAH L. REV.* 123.

62. See, e.g., Keeton, *supra* note 31, at 612-13; Marx, *Compensation Insurance for Automobile Accident Victims: The Case for Compulsory Automobile Insurance*, 15 *OHIO ST. L.J.* 134, 148 (1954).

63. See Kretzmer, *supra* note 32, at 76.

of fundamental fairness, to base one's right to compensation upon the fortuity of having received the injury at the innocent hands of a physician rather than from some other source.⁶⁴ If we assume, as we reasonably should, a present limit on the national willingness to socialize injury, then we must inquire whether our limited resources are better committed to plenary compensation for such things as medical and economic losses and pain and suffering solely for victims of medical misadventures, rather than to the financing of medical services for all who require them without regard to the source of the underlying condition. Again in terms of fairness, a national health insurance plan would appear to be the better alternative.

C. *Effect on the Quality of Health Care*

A central postulate of modern negligence law is that the imposition of liability is effective in deterring antisocial conduct.⁶⁵ Adoption of a no-fault or a strict liability system that would no longer distinguish innocent from blameworthy conduct would undermine that premise. Admittedly, the validity of the threat of liability as a deterrent against negligence has been questioned in recent years,⁶⁶ especially in the field of automobile accident law.⁶⁷ The automobile cases, however, are distinguishable from medical malpractice. In the former, the threat of civil liability adds little to the built-in deterrent inhering in the fact that the personal safety of a negligent driver is usually as imperiled as that of the victim.⁶⁸ Moreover, the

64. It has thus been reasoned:

So long as the personal responsibility of some individual . . . defendant is insisted on as a condition of entitlement to compensation, it naturally follows that only accidental injuries will (in general) be compensated. But when we get to the stage . . . in which the compensation is paid by the public in one way or another, and not by any individual, the justification for distinguishing between accident and natural disability or disease becomes less obvious.

P. ATIYAH, ACCIDENTS, COMPENSATION AND THE LAW 478 (1970); see generally W. BLUM & H. KALVEN, PUBLIC LAW PERSPECTIVES ON A PRIVATE LAW PROBLEM 37 (1965).

65. See 2 F. HARPER & F. JAMES, *supra* note 38, at § 12.3.

66. *Id.* § 12.4, at 755-57.

67. See, e.g., Conard, *The Economic Treatment of Automobile Injuries*, 63 MICH. L. REV. 279, 292-93 (1964); Cramton, *Driver Behavior and Legal Sanctions: A Study of Deterrence*, 67 MICH. L. REV. 421, 445 (1969). Professor Cramton, while doubting the efficacy of a threat of a money judgment as a deterrent in automobile cases, suggested that the experience rating of automobile liability insurance premiums may have a deterrent impact. *Id.*

68. See Lieberman, *supra* note 8, at 56. In addition to a deterrent influence of the driver's personal fear of injury, careless driving might also be deterred by a fear of criminal sanctions and loss of driving privileges. See P. KEETON & R. KEETON, *supra* note 17, at 525-26. Thus, one questions how much the threat of civil liability really adds to already existing deterrents to negligent vehicular operation. Moreover, there is some doubt whether substandard driving habits are really appreciated as such by the driver. *Id.* Others have been more

potential deterrent effect of the prospect of losing insurance coverage or of the experience-rating of premiums based on one's liability record, to the extent feasible and permitted by state law,⁶⁹ appears more significant in medical malpractice in terms of the money at stake and the effects of a loss of coverage.⁷⁰ Fear of liability exceeding coverage and dread of notoriety also may promote care.

Support also exists for the proposition that the current fault based system of liability does in fact encourage a higher quality of medical care.⁷¹ The absence of empirical evidence, however, makes attempts to quantify the positive consequences of civil liability problematic. At the very least, it would appear that the members of the medical professions are acutely aware of and have an abiding interest in their exposure to medical malpractice liability. This no doubt has inspired some circumspect medical practices. Conversely, the predisposition of the courts to distort malpractice law to compensate pathetic patients does little to foster confidence in capacity of the present system to discriminate on the basis of fault. By the same token, the purported dysfunctional effects and resource misallocation generated by the practice of defensive medicine⁷² also must be considered in any speculation about the overall effects of fault

reticent, less ready to concede the absence of meaningful deterrence in the threat of civil liability for automobile accidents. See W. BLUM & H. KALVEN, *supra* note 69, at 62-63.

69. The actual deterrent effect of threats of cancellation, nonrenewal, and experience rating of premiums has been eroded by a number of factors that were noted in Kendall & Haldi, *The Medical Malpractice Insurance Market*, in HEW REPORT, *supra* note 10, App. at 494. Carriers insuring through group plans have sometimes conditioned cancellation or nonrenewal upon action by a professional peer review committee. *Id.* at 508. Hospitals are often rated for their professional and premise liability together, a fact which obscures the effect of malpractice liability. Moreover, even where a practitioner's or institution's rate can legally deviate from the rate approved by the insurance commissioner, state approval through a "consent-to-rate" procedure may be required. While such a process might be feasible for large institutional insureds, the comparatively modest size of individual premiums may not be sufficient to justify the insurer's time. Ongoing evaluation of the quality of the individual's practice would also be difficult to maintain. *Id.* at 534.

70. See notes 1-2, 4-5 *supra*.

71. One authority on the subject of quality control in medical services has stated: From the viewpoint of quality controls, there is no question that the threat of malpractice suits is an inducement to elevate the diligence of medical performance. Since most such suits involve the management of serious cases in hospitals, the influence is felt strongly on the organization of medical staffs and other components of hospital operation. To some extent, the fear of malpractice actions may lead to extravagance . . . but, on the whole, it is a powerful stimulus to establishing rules for encouraging thorough work. It is also an inducement to careful medical record-keeping, which in turn helps to promote better continuity of medical care.

Roemer, *Controlling and Promoting Quality in Medical Care*, 35 LAW & CONTEMP. PROB. 284, 297 (1970). See generally Andenaes, *The General Preventive Effects of Punishment*, 114 U. PA. L. REV. 949 (1966). But see Carlson, *supra* note 27, at 353-54, where the author discusses such countervailing factors as professional commiseration and the insulating effect of liability insurance as mitigating the affects of civil liability on the quality of patient care.

72. See note 10 *supra*.

based liability on the quality of health care.

From an economic standpoint the existing health industry, especially its professional practitioner component, appears constitutionally unresponsive, in terms of accident avoidance, to the economic incentives and disincentives of strict liability. Because of uncertainty, perhaps inherent uncertainty, about the means of accident avoidance and the difficulties in organizing for research and information dissemination, the imposition of strict liability probably would not enhance risk avoidance through collective action by the physician-provider class.⁷³

The application of strict liability to non-negligent iatrogenic injuries as a means of reducing the costs of accidents also may be attacked on a more theoretical plane. According to Professor Calabresi one of the goals of accident law is to minimize accidents and accident avoidance costs, in other words to achieve "optimal deterrence."⁷⁴ To this end, Calabresi would have liability depend upon which party was best suited to make the decisive cost-benefit analysis.⁷⁵ The pivotal inquiry would not evaluate the cost-benefit decision itself, but rather would identify the most suitable cost-benefit analyst interested in the injury-producing transaction. Under such a test, the costs of a significant portion of non-negligent injuries might be borne by the patient rather than internalized by the health care provider. These cases involve injuries resulting from the realization of calculated risks of therapy.

When calculated or inherent risks are involved, the doctrine of informed consent⁷⁶ requires that the nature of the risks and alternative procedures be revealed to the patient. This doctrine emanates from the patient's paramount "right of self-decision"⁷⁷—the right to forego treatment and to make choices that might even be regarded as foolish ones.⁷⁸ One of the primary objectives of informed consent

73. See Note, *supra* note 30, at 1156-57.

74. Calabresi, *Optimal Deterrence and Accidents*, 84 YALE L.J. 656 (1975).

75. *Id.* at 666.

76. See text accompanying notes 199-221 *infra*.

77. *Canterbury v. Spence*, 464 F.2d 772, 786 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

78. 2 F. HARPER & F. JAMES, *supra* note 38, § 17.1 n.15, at 61 (Supp. 1968). The doctrine of informed consent has been restated in terms of the patient's nearly unqualified right to accept or reject diagnosis or treatment:

In ordinary malpractice cases the objectives of doctor and patient may be assumed to coincide. Both want the best result medical science can produce. . . . But no such assumption can safely be made on an issue of informed consent. The very foundation of the doctrine is every man's right to forego treatment or even cure if it entails what *for him* are intolerable consequences or risks, however warped or perverted his sense of values may be in the eyes of the medical profession, or even of the community, so long

has been "to promote individual autonomy,"⁷⁹ and with such autonomy comes a corresponding obligation of the patients to accept responsibility for the results of their informed decisions.⁸⁰ With the physician standing *sub potestate* on the question of whether to proceed with therapy, it would seem that the patient is by definition the more suitable party to perform the cost-benefit analysis and therefore to bear the loss from voluntarily encountered, calculated risks. One may question the assumption that patients can or do act on the basis of the material risk information⁸¹ or that they are really in a better position than the physician to weigh those risks. Once the decision on whether to proceed with specific treatment is legally vested in the patient as a matter of fundamental right, however, the patient perforce becomes the party who should "bear the incentive to *decide correctly*."⁸² Increasing patient access to medical information relevant to his case, typified by patient "bills of rights,"⁸³ may occasion even greater patient involvement in health care decisions and concomitant responsibility.

The positive effects of threatened liability, the profession's suspected unresponsiveness to strict liability incentives, and the decisive role accorded the patient in the decision to encounter calculated risks of treatment all militate against the imposition of strict liability on health care providers. Similarly, a mandatory first party no-fault insurance plan compelling patients to insure against medical accidents, if substituted for the present system, also might undermine deterrence and perhaps discourage patient accountability in terms of encountering known risks of treatment. One also senses a visceral public attitude that doctors and other providers should

as any distortion falls short of what the law regards as incompetency.

Id. at 60-61.

79. Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340, 364-65 (1974).

80. Professor Capron observed, in the context of informed consent, that:

The freedom to make decisions for oneself carries with it the obligation to answer for the consequences of those decisions. The requirement of consent for medical interventions thus serves to remind all the participants of their agreement concerning the procedure and their acceptance of those things which arise from its proper execution.

Id. at 365. See Note, *Informed Consent and the Dying Patient*, 83 YALE L.J. 1632, 1645-57 (1974). See also Greenfield, *supra* note 29, at 703-06.

81. Some have questioned whether patients really understand what they are consenting to, suggesting that the patient's primary protection rests with the physician. See Ingelfinger, *Informed (But Uneducated) Consent*, 287 N. ENG. J. MED. 465 (1972) (discussing experimental procedures). The solution for otherwise disenfranchised patients may lie in redoubled efforts to insure their comprehension. See generally Capron, *supra* note 79, at 413-16.

82. Calabresi, *supra* note 74, at 666; see Note *supra* note 80, at 1645-46.

83. See, e.g., W. CURRAN & E. SHAPIRO, LAW MEDICINE AND FORENSIC SCIENCE 126-34 (Supp. 1974) (containing a varied sampling of patient's bills of rights); HEW REPORT, *supra* note 10, at 71-77.

not completely escape the scrutiny of a fault based liability system.⁸⁴ This feeling is reinforced in several ways. Interaction between the physician and the patient is direct and personal, in marked contrast to the product liability case in which a product leaves an automated assembly line and reaches the consumer after passing through the stream of commerce, or an automobile collision in which a mechanical instrumentality is imposed between the parties before the damage is inflicted. Thus, the professional medical relationship promotes a more emotional, even moralistic, and less objective public attitude toward the allocation of the loss. Furthermore, direct governmental regulation and professional self-regulation have been spasmodic and historically ineffective,⁸⁵ inviting a perception of the fault system as the only means of insuring professional accountability.

D. Future Prospects

Whatever the merits of the deterrence argument, public opinion probably will continue to countenance some form of fault system until an effective or ostensibly effective means of policing the medical professional is demonstrated. Moreover, considering the costs, definitional problems, and potential class bias of a no-fault plan for medical accidents, the prospects for displacement of the present system by a no-fault model may well have to await society's willingness to commit the resources necessary to redress all types of injuries and afflictions rather than merely those that are therapy induced.

In the meantime, several less sweeping changes are foreseeable. A social security type national health insurance plan that would pay for medical expenses regardless of the source of the injury probably will be enacted. The existence of national health insurance should foster a greater willingness to externalize some of the remaining losses from medical accidents under the fault system. Thus, it would not be surprising if damages for pain and suffering were eliminated or significantly curtailed in the future.⁸⁶ In addition one might

84. See Lieberman, *supra* note 8, at 56.

85. The inadequacy of current governmental quality control measures has been frequently noted. See, e.g., Roemer, *supra* note 71; Worthington & Silver, *Regulation of Quality of Care in Hospitals: The Need for Change*, 35 LAW & CONTEMP. PROB. 305 (1970).

86. Classic articles on the subject of reform of torts rules governing recovery for pain and suffering include Morris, *Liability for Pain and Suffering*, 59 COLUM. L. REV. 476 (1959); Plant, *Damages for Pain and Suffering*, 19 OHIO ST. L.J. 200 (1958). More recently, the validity of damages for pain and suffering has been questioned on a more technical plane. The extent of the causal connection between the physical insult and the degree, duration, and existence of a claimant's pain has been reexamined, along with the "social" content (its

anticipate some overdue legislative revisions of the open ended "discovery rule"⁸⁷ in statutes of limitations. Legislators mindful of the costs of finding fault may also decide at least to supplement the traditional method of trial by employing screening panels of experts or arbitrators. Finally, the courts must eventually re-examine the substantive law of malpractice if the fault system is to be retained in any respect. Foremost in such a reappraisal will be the question of the appropriate standard of care for members of the medical profession and the role they should assume in formulating that standard.

III. THE PROFESSIONALLY DEVELOPED STANDARD OF CARE

A. *General Principles*

Once it is clear that a duty is owed by the defendant to the patient, a prima facie case of medical malpractice is made out by producing evidence "which establishes the applicable standard of care, demonstrates that this standard has been violated, and develops a causal relationship between the violation and the harm complained of."⁸⁸ It is the first element, the applicable standard of care, that animates the law of medical malpractice and that is most in need of a thoroughgoing examination.

The theory underlying fault based compensation systems in general and negligence law in particular presupposes some uniform standard of behavior against which defendant's conduct is to be tested.⁸⁹ It is not sufficient that the actor have performed at full potential with the utmost good faith. Rather, he must have con-

psychological and interpersonal aspect) of pain. See Peck, *Compensation for Pain: A Reappraisal in Light of New Medical Evidence*, 72 MICH. L. REV. 1355, 1360, 1367-68 (1974). See generally Nemiah, *The Psychological Aspects of Physical Injury*, 3 LAWYER'S MED. J. 269 (2d ed. 1975).

The inflationary effect of pain and suffering awards on the measure of recovery in medical malpractice is manifest. See, e.g., *Niles v. City of San Rafael*, 42 Cal. App. 3d 230, 116 Cal. Rptr. 733 (1974) (\$1,604,371 awarded for pain and suffering). See generally Holder, *Recent Decisions on Pain and Suffering*, 227 J.A.M.A. 1204 (1974).

87. There has been a decided judicial trend in medical malpractice cases in recent years toward the adoption of the so called "discovery rule" which, greatly oversimplified, often means that the statutory period commences to run when patient discovers or reasonably should have discovered the wrong. See generally D. HARNEY, *supra* note 40, § 8.5; A. HOLDER, *MEDICAL MALPRACTICE LAW* 322-24 (1975); 1 D. LOUISELL & H. WILLIAMS, *MEDICAL MALPRACTICE* ¶ 13.07, at 372-74 (Supp. 1974). The uncertainty the discovery rule insinuates into tort law may be compounded in the medical malpractice context by the probable displacement of occurrence-based liability insurance with a claims-based variety. See generally Comment, *The "Claims Made" Dilemma in Professional Liability Insurance*, 22 U.C.L.A.L. REV. 925 (1975).

88. *Kosberg v. Washington Hosp. Center, Inc.*, 394 F.2d 947, 949 (D.C. Cir. 1968).

89. W. PROSSER, *supra* note 59, § 32, at 149.

formed to the standard of the "reasonable man of ordinary prudence."⁹⁰ The standard of care of the medical profession traditionally has departed from this norm in several respects. As members of a learned profession doctors and other health care professionals, who were required to possess skill or knowledge beyond that of ordinary individuals, have been required to act in a manner consistent with that added capability.⁹¹ More significantly, it became⁹² and probably continues to be⁹³ the prevailing rule that such defendants' conduct is judged in terms of a professionally developed standard of care, sometimes expressed as the customary practice of other similarly situated members of the profession. Dean Prosser succinctly stated the rule when he equated "good medical practice" with "what is customary and usual in the profession."⁹⁴ By comparison, in negligence law generally compliance with the customary practice,⁹⁵ while typically admissible as *evidence*⁹⁶ that defendant exercised due care, rarely is conclusive.⁹⁷ Similarly, in the nonmedical

90. This standard was apparently first stated in *Vaughn v. Menlove*, 3 Bing. N.C. 468, 132 Eng. Rep. 490 (1738). W. PROSSER, *supra* note 59, § 32 at 150. Various other formulations of essentially the same standard have included the reasonable man, the prudent man, the man of average prudence, or a man of ordinary sense using ordinary care and skill. *Id.* The "reasonable man" standard has been expressly adopted by the Restatement. RESTATEMENT (SECOND) OF TORTS § 283 (1965).

91. RESTATEMENT (SECOND) OF TORTS § 289, comment *m*, § 290, comment *f*, § 299A, comment *b* (1965). Thus, the comments to the Restatement state:

If the actor has in fact more than the minimum of these qualities, he is required to exercise the superior qualities that he has in a manner reasonable under the circumstances. The standard becomes, in other words, that of a reasonable man with such superior attributes.

Id. § 289 comment *m*.

92. For a thorough although somewhat dated discussion of the customary practice standard of care for medical practitioners, see the late Professor McCoid's classic medical malpractice piece, McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 605-09 (1959).

93. See note 115 *infra* and accompanying text.

94. W. PROSSER, *supra* note 59, § 32, at 165. Prosser, however, is not entirely consistent. Compare *id.* at 165, 168 n.90 with *id.* at 165 n.63.

95. Stated simply, a customary practice is a relatively well-defined and regular usage or way of doing a specific thing followed by members of a trade, calling, or profession. 2 F. HARPER & F. JAMES, *supra* note 38, § 17.3, at 977; McCoid, *supra* note 92, at 605-07.

96. Professor Morris has explained the "three-fold relevancy" of evidence of conformity to custom as follows:

First. Evidence of conformity warns that liability may have far reaching effects on the fabric of business institutions . . .

Second. Evidence of conformity sharpens attention on the practicality of caution greater than the defendant used . . .

Third. Lack of opportunity to learn of safeguards from his calling is one of the "circumstances" to be taken into account in deciding whether the defendant acted reasonably.

Morris, *Custom and Negligence*, 42 COLUM. L. REV. 1147, 1147-49 (1942).

97. *E.g.*, 2 F. HARPER & F. JAMES, *supra* note 38, § 17.3, at 977-78; W. PROSSER, *supra* note 59, § 33, at 166-68; McCoid, *supra* note 92, at 610; see RESTATEMENT (SECOND) OF TORTS § 295A (1965).

cases expert testimony often will be necessary to afford guidance to the trier of fact, but rarely will be as conclusive with respect to the standard of care as it often is in medical malpractice cases.

B. Professional Standard Redefined: The Accepted Practice Formulation

A yawning need has existed for clarification and reappraisal of the appropriate province of the medical profession in the formulation of the standard of care. The present section examines the form a professionally developed standard of care might ideally assume. In the section that follows, the more elemental question of whether a standard fashioned by the profession should be controlling is considered.

(1) Nature of the Accepted Practice Standard

Historically, the medical profession has been instrumental in defining the standard of care for medical malpractice. The professional standard often has been enunciated in terms of *customary* medical practice,⁹⁸ emphasizing the typical conduct of the medical practitioner. Courts also have sometimes added a further qualification by stating the standard with reference to a particular locality or geographic setting.⁹⁹ A better approach would require conformity to the *accepted* professional standard. Practices approved by the profession, not necessarily those customarily followed by its members, would be controlling. This model would encourage a uniformly higher quality of care and at the same time preserve the essential attributes of a professional standard. The accepted practice standard rarely has been articulated adequately or analyzed as a distinct measure of performance, although nomenclature consistent with such a formula may be found in the case law,¹⁰⁰ in an occasional statute,¹⁰¹ and in some commentary.¹⁰² The following paragraphs will

98. See W. PROSSER, *supra* note 59, § 32, at 165; McCoid, *supra* note 92, at 605-09; Morris, *supra* note 96, at 1163-67; Note, *An Evolution of Changes in the Medical Standard of Care*, 23 VAND. L. REV., 721, 741-47 (1970); Note, *supra* note 30, at 1148-50; 28 VAND. L. REV. 441, 445-47.

99. See generally discussion of the locality rules at text accompanying notes 111-21 *infra*.

100. See generally notes 124-27 *infra* and accompanying text.

101. See Tennessee Medical Malpractice Review Board and Claims Act of 1975, ch. 299, §§ 14(a)(1), 17(a) [1975] Tenn. Pub. Acts 669, 671 (requiring, *inter alia*, that claimant in a medical malpractice action prove "the recognized standard of acceptable professional practice in the profession and specialty thereof, if any, that defendant practices in the community in which he practices or in a similar community . . ."). It remains to be seen whether the Tennessee courts will simply interpret the foregoing provision to require compliance with the professional custom, or will construe it in the broad "accepted practice" sense, with emphasis on professionally approved practices rather than focusing merely on the habitual ones. The

explore and explicate the essential nature of an accepted practice standard of care as envisioned by the author.

If the customary practice is construed literally to mean the medical custom, a customary practice standard of care might be relegated to little more than professional habit. The controlling standard thus would be defined exclusively in terms of medical procedures that have occurred with sufficient regularity in the past to become unmistakably etched into the practice of the profession. This raises the spectre of the past elevated to prologue in the scientifically dynamic and fluid field of medicine. Moreover, it is specious to imagine that the health care market effectively allocates medical resources so as to maximize the quality of health care.¹⁰³ Therefore, it is not certain that medical custom, responding to imperfect market dynamics, will produce optimal health care. It does not follow, however, that entirely jettisoning the professional standard of care is the wisest course;¹⁰⁴ rather, these realities militate in favor of refashioning the professional standard of care in order to foster a higher quality of health care. A reasonable step in this regard would be to articulate the standard in terms of the professionally accepted practice. This formulation would continue, with several possible exceptions,¹⁰⁵ the basic notion of a professionally developed standard of care. At the same time, such a rule would alleviate or at least mitigate several of the potential shortcomings of a professional standard based strictly on custom.

The standard as redefined offers three advantages. First, the accepted practice formulation would make it clear that the profession's standard might be applicable to potential malpractice situations that involved novel medical conditions as well as otherwise routine occurrences which take on an unprecedented aspect because

fact that the above statute retains a geographic limitation (same or similar community rule) suggests that even if an accepted practice standard is followed, its geographic scope and thus its potential for encouraging emulation of the highest state of the art will be limited to the relevant geographic frame of reference.

102. Even where medical custom has been rejected, apparently in favor of "good" or "acceptable medical practice," there is often little in the way of analysis of the nature of the professional standard that would presumably survive abrogation of the customary practice test. See D. HARNEY, *supra* note 40, § 3.1(A), at 89-90 & n.8, (B), at 90-91.

103. For a well-documented and persuasive analysis of the failure of the health care market to efficiently or optimally allocate resources, see Note, *supra* note 30, at 1144-46. See generally Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963). By contrast, Professor Posner's suggested justification for the customary practice standard seems, by implication, to be based somewhat simplistically and perhaps improvidently upon the existence of a market in which the customary practice would produce optimal care. See R. POSNER, *ECONOMIC ANALYSIS OF LAW* 72 (1972).

104. See text accompanying notes 128-78 *infra*.

105. See text accompanying notes 178-220 *infra*.

of the development of new medical techniques or treatment. The standard would guide health care providers who are called upon to respond to circumstances of first impression under the current state of the art. While the customary practice standard, taken literally, looks to the historical conduct of the profession, the accepted practice approach would focus on the "best standards of the day"¹⁰⁶—the reasonable expectations of the profession as to how its members should manage the care of a patient. By eclectic reference to approved practices the medical profession should be able to determine whether professional conduct for which no historical antecedents exist nevertheless falls within the broad ambit of what is generally perceived to be sound medical practice. Thus, the mere fact that a particular situation has not yet been unequivocally addressed by a settled custom should not prove fatal to a professional standard of care.

Secondly, in keeping with the basic precept in negligence law that the standard of care be based on an ideal paradigm,¹⁰⁷ the accepted practice formula would not necessarily be based upon what members of the profession customarily do. Instead the standard would depend upon what an ideal member would be expected to do in order to conform to the approved professional practice. Here again, the reasonable expectations of members of the profession would be the crucial inquiry. Moreover, the accepted practice formula also should be subject to the rule that a physician must act in a manner consistent with his best judgment.¹⁰⁸ Doubts about the relevance of the customary practice will no doubt continue to inhibit sound innovative departures from even undesirable customs as long as fear remains that such departures might establish a prima facie case of malpractice. Unequivocal adoption of an accepted practice standard should alleviate that problem, especially if it is made clear that failure to adhere to a customary approach that did not comport with sound medical practice would not be evidence of malpractice.¹⁰⁹

Thirdly, the accepted practice formula probably would be less dependent on a discernible professional consensus than the customary practice standard. The latter impliedly assumes the existence of a commonly practiced custom among a significant segment or at

106. Bradford, *A Unique Decision*, 2 J. LEGAL MED., Sept.-Oct. 1974, at 55.

107. W. PROSSER, *supra* note 59, § 32, at 151.

108. *Cf. Toth v. Community Hosp.*, 22 N.Y.2d 255, 262-63, 239 N.E.2d 368, 372-73, 292 N.Y.S.2d 440, 447 (1968) (physician must act with his best judgment even if it requires precautions in addition to those customarily followed or accepted in the community).

109. *Cf. id.* at 263 n.2, 239 N.E.2d at 373 n.2, 292 N.Y.S.2d at 448 n.2.

least a respectable minority¹¹⁰ of the profession. This leads to consideration of the geographic region from which a custom is to be derived and the degree of definiteness that must be demonstrated concerning a consensus as to the usual medical practice.

The demise of the so-called "locality rules" have compounded the problem of ascertaining a professional consensus. The locality rules are in essence corollaries of the professional standard of care. Many courts have defined the standard of care in terms of a specific geographical setting and have looked to the practice in defendant's community¹¹¹ or in more recent decisions to the practice in the same or similar communities.¹¹² The locality rules tended to reinforce the customary practice principle where it was otherwise controlling and greatly limited the experiential reference against which a defendant's conduct might be tested, thereby simplifying the determination of the customary practice. The locality rules proved objectionable because of their potential effect of insulating pockets of substandard medical practice and of severely restricting the pool of available expert witnesses, essential participants in most malpractice cases.¹¹³ Furthermore, this Balkanization of the profession was inconsistent with the recognition of an increasingly universal medical science. Despite harsh criticism by commentators,¹¹⁴ some varia-

110. See 1 D. LOUISELL & H. WILLIAMS, *supra* note 87, ¶ 8.04, at 204 (1973), where the authors comment that "it appears well settled that if a physician pursues a course followed by a 'respectable minority' of the profession, he is within the boundaries of permissible conduct." (footnote omitted).

111. What was perhaps the most widely cited statement of the strict "same locality" standard appears in *Pike v. Honsinger*, 155 N.Y. 201, 209, 49 N.E. 760, 762 (1898), in which the New York Court of Appeals stated:

A physician . . . by taking charge of a case, impliedly represents that he possesses, and the law places upon him the duty of possessing, that reasonable degree of learning and skill that is ordinarily possessed by physicians and surgeons in the locality where he practices.

The "same locality" rule is no longer the prevailing view in most jurisdictions. See Annot., 37 A.L.R.3d 420 (1971).

112. The "same or similar locality" standard has been the most prevalent version of the locality rules in recent years and continues to have substantial support. See, e.g., *Goeckede v. Price*, 19 Ariz. App. 320, 506 P.2d 1105, 1107 (1973); *Siirila v. Barrios*, 58 Mich. App. 721, 724, 228 N.W. 801, 803 (1975); *Bailey v. Williams*, 189 Neb. 484, 486, 203 N.W.2d 454, 456 (1973); RESTATEMENT (SECOND) OF TORTS § 299A (1965); Annot., 37 A.L.R.3d 420 (1971, Supp. 1974) (physicians).

113. See Annot., 81 A.L.R.2d 597 (1962).

114. See, e.g., D. HARNEY, *supra* note 40, § 3.3; A. HOLDER, *supra* note 87, at 52; 1 D. LOUISELL & H. WILLIAMS, *supra* note 87, ¶ 8.07; Linden, *The Negligent Doctor*, 11 OSGOODE HALL L.J. 31, 37 (1973); Waltz, *The Rise and Gradual Fall of the Locality Rule in Medical Malpractice Litigation*, 18 DEPAUL L. REV. 408 (1969); Comment, *Standard of Care for Medical Practitioners—Abandonment of the Locality Rule*, 60 KY. L.J. 209 (1971); Note, *Medical Malpractice: "Locality" Rule Abandoned in Massachusetts*, 23 S.W.L.J. 585, 589 (1969); Note, *An Evaluation of Changes in the Medical Standard of Care*, 23 VAND. L. REV. 729, 730-

tion of the locality rule (usually the "same or similar" locality) has been applied to general practitioners¹¹⁵ in many, and possibly the majority, of the jurisdictions that have addressed the issue. A goodly number of courts, however, have rejected the traditional locality rules for specialists¹¹⁶ and, in some cases, for general practitioners.¹¹⁷ Some of these courts have stated that geography and location are not determinative, but are merely factors that may be considered in arriving at the applicable standard of care.¹¹⁸

If the professionally developed standard of care were completely rejected, the locality rules and any other geographic restrictions on the standard of care probably would disappear as well.¹¹⁹ The converse is not true because the adoption of a national standard or at least the rejection of the traditional locality rules would not by itself preclude a professionally fashioned standard of care;¹²⁰ it

41 (1970); Note, *The Locality Doctrine and the Standard of Care of a Physician*, 8 WASHBURN L.J. 339 (1969).

115. See D. HARNEY, *supra* note 40, § 3.3, at 96; Deitz, Baird & Berul, *The Medical Malpractice Legal System*, in HEW REPORT, *supra* note 10, App. at 87, 134; Significant Court Decisions, *Medical Malpractice—Status of the Locality Rule*, 23 DEFENSE L.J. 178, 185 (1974); Annot., 37 A.L.R.3d 420 (1971, Supp. 1974) (physicians). See generally Annot., 36 A.L.R.3d 440 (1971, Supp. 1974) (hospitals).

116. See, e.g., *Kronke v. Danielson*, 108 Ariz. 400, 499 P.2d 156 (1972); *Naccarato v. Grob*, 384 Mich. 248, 254, 180 N.W.2d 788, 791 (1970). See generally Annot., 21 A.L.R.3d 953 (1968, Supp. 1974).

117. *Blair v. Eblen*, 461 S.W.2d 370 (Ky. 1970) (general practitioner); *Brune v. Belinkoff*, 354 Mass. 102, 235 N.E.2d 793 (1968) (specialist; dictum as to general practitioners); *Shier v. Freedman*, 58 Wis. 2d 269, 206 N.W.2d 166 (1973) (surgeon; dictum as to general practitioners).

118. See, e.g., *Blair v. Eblen*, 461 S.W.2d 370, 373 (Ky. 1970); *Shier v. Freedman*, 58 Wis. 2d 269, 284, 206 N.W.2d 166, 174 (1973).

119. Rejection of the conclusiveness of the professional standard of care would in all probability neutralize the locality rules, at least as they are currently employed. Nevertheless, it is conceivable, although unlikely, that some form of geographical orientation might survive. Since compliance with a professional standard probably still would be admissible as evidence of due care, a court might choose to accord greater weight to proof of conformity with a regional standard. Such an approach might be compared with the related principle advocated in some cases that have rejected the traditional locality rules but have allowed the particular circumstances in defendant's locality to be considered. See authorities cited note 118 *supra*. Other possibilities also come to mind. For example, in *Lejeune v. United States Cas. Co.*, 227 F. Supp. 191 (W.D. La. 1964) (see note 193 *infra* for later developments in Louisiana law), the court required that plaintiff initially prove the local professional standard of care. Then if it appeared that defendant had complied with that standard, plaintiff would be permitted to show that the customary practice was negligent. *Id.* at 194. Thus, here too, it is conceivable that a locality rule might survive when the court holds that the professional standard is no longer conclusive, though permitting it to retain a measure of probative vitality by its effect on the burden of going forward with the evidence.

120. In *Blair v. Eblen*, 461 S.W.2d 370 (Ky. 1970), for example, the court rejected a hard and fast locality rule yet at the same time expressly reaffirmed the professional standard of care, saying: "[W]e will not perpetuate a rule designed to protect country doctors in 1902, but we will leave determination of the standard to the medical profession and not the lay

would simply enlarge the professional frame of reference. Adoption of a national standard would, however, make the ascertainment of a consensus as to the medical custom an elusive goal if indeed a national consensus even existed. By contrast, the accepted practice variation of the professional standard would not depend on the existence of a demonstrable consensus on medical custom. It would emphasize the reasonable expectations of the medical profession nationally (or regionally if some geographic limitation on the standard survived). The existence of a consensus on medical custom, while perhaps taken into account, would be less crucial than the professional *sense* of what conduct was consistent with the collective expectations of the profession. A practitioner would continue to have the right to rely upon "one of several recognized courses of treatment."¹²¹ Under the accepted practice standard, however, this range of permissible courses of treatment would be confined to those *approved* by rather than those necessarily *followed* by the profession.

(2) Ascertaining the Accepted Practice Standard

In most situations there would probably be little significant difference between customary and accepted practice. When medical practitioners are plying their art in a manner that members of the profession would generally expect and desire, the custom would represent the professionally accepted practice. In actual fact, the difference between the two standards is more a matter of perspective and emphasis than of distinct medical systems separated by a discrete interface.

Proof of the accepted practice normally would require expert testimony, but experts would not be asked to survey only the medical tradition and habit; rather, they would offer their opinion about the reasonable expectations that the profession collectively holds for its members. The expert would draw upon his own educational and practical frame of reference as well as upon relevant medical thinking, as manifested by literature, educational resources

courts." *Id.* at 373. See, e.g., *Francois v. Mokrohisky*, 226 N.W.2d 470, 472 (Wis. 1975) (following a professional though not a geographically limited standard).

121. *Downer v. Veilleux*, 322 A.2d 82, 87 (Me. 1974); see *Chumbler v. McClure*, 505 F.2d 489, 492 (6th Cir. 1974) (stating that the standard of care is "not to be determined solely by a plebiscite"); *Dillmann v. Hellman*, 283 So. 2d 388, 389 (Fla. App. 1973). In *Tarasoff v. Regents of University of California*, 13 Cal. 3d 177, —, 529 P.2d 553, 560, 118 Cal. Rptr. 129, 136 (1974), noted in 28 VAND. L. REV. 631 (1975), the court stated that "within that broad range in which professional opinion and judgment may differ respecting the proper course of action, the psychotherapist is free to exercise his own best judgment free from liability. . . ."

and information available to practitioners,¹²² and experiences of similarly situated members of the profession. It may be argued that such an eclectic approach is too subjective, that it seeks to ascertain the unascertainable—namely, the brooding judgment of the medical collegium on the professionally acceptable level of performance of its members. The same can be said, however, of expert testimony generally. Indeed, the rationale for requiring expert witnesses is that the educated speculation of the experts will temper and guide the less informed speculation of the triers of fact. Disagreement among experts concerning the accepted practice would be resolved in the same way conflicts are resolved whenever expert opinions collide. The expert's background, qualifications, demeanor, and general persuasiveness, along with the degree to which the record consistently accommodates the various expert testimony, all would be relevant to the trier of fact in evaluating expert opinions.

An expert's opinion of the accepted practice need not be any more subjective or speculative than an attempt to identify the customary practice. It is doubtful whether the customary practice criterion, even with its historical perspective and therefore its ostensibly more empirical antecedents, produces a more uniform, predictable, or ascertainable standard. Certainly, as the geographic frame of reference enlarges with the demise of the locality rules, the likelihood of discovering a clearly defined medical custom becomes illusory. Even if a commonly held medical custom for a particular set of facts were static and could be assayed by plebiscite or some sampling technique, such procedures have seldom been attempted, and would hardly be economically feasible in any event. The expert's perception of accepted practice, by contrast, would not rely even in principle upon impossible head counts. Along with a sense of the custom among practitioners and of his own notion of profes-

122. This expansive source of the expert's opinion under the accepted practice standard is consistent with recent decisions holding that a medical expert may be competent to testify even though his familiarity with the applicable standards is not based on "occupational experience" as such. *See, e.g.,* *Cline v. Lund*, 31 Cal. App. 3d 755, 766, 107 Cal.Rptr. 629, 637 (1973). *See generally* Annot., 46 A.L.R.3d 275 (1972); Annot., 31 A.L.R.3d 1163 (1970). In the later case of *Brown v. Colm*, 11 Cal. 3d 639, 522 P.2d 688, 114 Cal. Rptr. 128 (1974) (en banc), the California supreme court held that it was prejudicial error to refuse to allow an expert to testify as to the standard of care applicable to a 1949 operation even though the expert had not yet been admitted to practice medicine in 1949. The court emphasized that the expert had experience as a practicing physician (although he acquired his experience about ten years after the alleged malpractice) and had made an exhaustive study of the medical literature. The court further observed that medical literature may sometimes be a more reliable guide for the standard of care for a 1949 operation than the testimony of one who had practiced medicine in that year. *Id.* at 645, 522 P.2d at 691, 114 Cal. Rptr. at 131.

sional responsibility, under the accepted practice approach, the expert would look to the best of available medical literature and to the increasingly standardized¹²³ educational outpourings from medical schools, professional associations, and elsewhere. These latter sources of information are in essence emanations of professionally accepted practice. Furthermore, they are often memorialized and thus offer greater accessibility than one would normally find by surveying the disparate therapeutic approaches of the practicing profession. Thus, the profession's customs would be cognizable under an accepted practice standard, but even time honored practices that were manifestly inconsistent with the reasonable expectations of the profession would not be condoned. Understood as such, the accepted practice standard is likely to encourage practitioners to stay abreast of sound medical technique. Additionally, it represents a more discernible and forward looking standard than is afforded by referring exclusively to habit or popular lore among practitioners.

The foregoing distinction between accepted and customary practice has seldom been articulated in the case law or elsewhere. It seems that the courts have been so preoccupied with alleviating the harshness of the locality rules that the gestalt of the professional standard rarely has been probed. The language employed in various decisions to express the standard of care has run the gamut; in some cases it seemingly is consistent with the customary practice standard,¹²⁴ in others with the accepted practice formulation,¹²⁵ and in still others language is used that perhaps is reconcilable with either standard.¹²⁶ Unfortunately, the full potential significance of the difference in terminology has largely eluded the courts. In some instances, the courts have chosen to regard the matter as one of

123. See Thorne, *supra* note 7, at 17-29. The training of physicians is probably the most standardized and centrally controlled of all of the professions. *Id.* at 82.

124. See, e.g., Downer v. Veilleux, 322 A.2d 82, 88 (Me. 1974) (plaintiff must prove a departure from the "general custom and practice in the profession"); Bailey v. Williams, 189 Neb. 484, 486, 203 N.W.2d 454, 456 (1973) (physician required to employ that degree of care and skill that physicians in the relevant geographic areas "would ordinarily exercise and devote to the benefit of their patients"); Siirila v. Barrios, 58 Mich. App. 721, 723, 228 N.W.2d 801, 802 (1975) (plaintiff must prove that defendant's conduct fell short of that "ordinarily done").

125. See, e.g., Francois v. Mokrohisky, 226 N.W.2d 470, 472 (Wis. 1975) (plaintiff required to prove that defendant's actions did not comport with the "approved medical practice under the circumstances").

126. Jury instructions approved in Hickman v. Employers' Fire Ins. Co., 311 So.2d 778, 779 (Fla. App. 1975), at one point emphasized "the course recognized as correct by his profession," implying an accepted practice approach. Later, however, the court approved a standard apparently based on what other similarly situated physicians "would have done," indicating more of a customary practice standard. *Id.* at 779.

semantic shadings, a tendency no doubt partly attributable to the fact that the difference between the trial court's instructions and those urged by counsel was not sufficiently discrete to appear potentially outcome-determinative or likely to influence significantly a jury.¹²⁷

In summary, the strict customary practice rule appears incompatible with a rapidly changing science and may glorify medical custom without due regard for advances in the state of the art. Moreover, a customary practice approach seems impliedly to assume a consensus regarding the medical custom, at least among a significant segment of the profession. Custom is an elusive standard at best, especially as the geographic perspective continues to expand with the erosion of the locality rules. By comparison, the accepted practice standard, emphasizing as it does the performance expectations of the profession rather than the professional habit of its members, avoids the more onerous limitations of the customary practice principle, and promises to foster a generally higher quality of medical care.

Once the anatomy of the professional standard is settled, the more critical question comes into sharper relief: whether a *professional* standard should constitute the standard of care in medical malpractice and thus be accorded conclusive weight by the courts. This question is explored in the following sections.

C. *The Case for a Professionally Developed Standard of Care*

A difficult and recurrent question facing courts and legislatures concerns the role that the medical profession should play in formulating the standard of care. Should conformity to the professional standard of conduct, based on the customary or, preferably, the accepted medical practice, conclusively establish the defendant's due care or simply constitute evidence that the finder of fact may accept or reject? Couched somewhat differently, the question becomes whether the testimony of expert medical witnesses should establish the standard of care, or whether it should merely afford guidance to the trier of fact on the feasibility of the various available courses of action, the trier of fact then applying a reasonable person standard. Conceptually, the professional standard of care and the

127. In *Massey v. Heine*, 497 S.W.2d 564, 566 (Ky. 1973), the trial court's instruction stated as the standard of care that "which ordinarily careful practitioners *ordinarily use*." Plaintiff's counsel urged that the court should have instructed that the defendant was obliged "to exercise that degree of care *as would be exercised* by a [sic] *ordinarily careful* physician." Despite plaintiff's express attack on the customary practice standard, due perhaps to the similarity of the language challenged to that urged by plaintiff, that underlying issue was not reached by the court. *Id.*

reasonable person standard potentially are mutually exclusive. Either the conduct of the medical practitioner is to be tested by the professionally accepted practice, when relevant, or it is not. To defer to the professional standard except when following that standard is perceived as negligence under a reasonable person test is not to defer to the medical profession at all, but to relegate it to something less than a standard of care in the traditional negligence sense.

Although commentators are divided on the issue,¹²⁸ the prevailing view in the courts seems to favor a professionally established standard of care. Cases adhering to some form of locality rule¹²⁹ usually should be viewed as embracing a professional standard of care. When the common knowledge¹³⁰ and informed consent¹³¹ cases as well as those cases holding simply that the physician must exercise his best judgment even in the face of a less rigorous community practice,¹³² are distinguished, few cases remain that have attacked

128. Many commentators have favored a professional standard of care for medical malpractice or at least have recognized it without dissent as the prevailing view. *See, e.g.*, D. HARNEY, *supra* note 40, § 3.1(A), (B) (opposing the customary practice standard but otherwise accepting the idea of a professional standard); W. PROSSER, *supra* note 59, § 32, at 165; Bradford, *A Unique Decision*, 2 J. LEGAL MED., Sept.-Oct. 1974, at 52; McCoid, *supra* note 92, at 605-09; Morris, *supra* note 96, at 1163-67; Comment, 6 TEX. TECH. L. REV. 279, 284 (1974); Comment, 28 VAND. L. REV. 441, 450-53 (1975). Others have opposed an unqualified, professionally-developed standard, at least one based exclusively upon customary practice. Note, 23 VAND. L. REV., *supra* note 98, at 741-47; Note, *supra* note 30, at 1149-50, *discussed at* note 159 *infra* and accompanying text.

In some instances the issue of the professional standard (especially when equated with customary practice) has inspired some uncertainty. Thus, the authors of one leading text have observed that ". . . [p]robably the conventional standard whereby reasonableness is measured by customary practice, has worked out fairly well on the whole." 1 D. LOUISELL & H. WILLIAMS, *supra* note 87, ¶ 8.04, at 203 (1973). In their supplement, however, the same authors equivocated that "practicing medicine according to the custom in the community does not, of itself, necessarily create immunity from tort liability." *Id.* at 89 n.632 (Supp. 1974). Then recanting somewhat (perhaps tacitly keeping the door ajar for the "accepted practice" version of the professional standard), the authors noted that the "[c]ourts have not clearly set forth the exact amount of weight to be accorded to custom." *Id.* Another text has exhibited similar dubiety. *See* A. HOLDER, *supra* note 87, at 50. Essentially this author opines that adherence to the local professional standard constitutes due care unless it is negligent. The crucial question — *negligent by what standards* — is passed over. Is negligence to be tested by a national professional standard of care or by a reasonable person standard, which would nullify a professional standard? The author's statement, without more, fails adequately to address the question. Even Prosser has evidenced such confusion. *See* note 94 *supra*.

129. *See* authorities cited note 112 *supra*. The locality rules essentially are statements of the professional standards of care in terms of a specific geographical frame of reference.

130. *See* text accompanying notes 178-97 *infra*.

131. *See* text accompanying notes 199-221 *infra*.

132. In *Toth v. Community Hosp.*, 22 N.Y.2d 255, 262, 239 N.E.2d 368, 372, 292 N.Y.S.2d 440, 447 (1968), the court stated that "evidence that a physician conformed to accepted community standards of practice usually insulates him from tort liability." However, the court went on to hold:

If a physician fails to employ his expertise or best judgment . . . he should not automati-

the professional standard of care. Most of these decisions seem to attack the customary practice variation,¹³³ and are not particularly overwhelming.¹³⁴ Indeed, the tendency to think of the professional standard exclusively in terms of the customary practice may help to explain the apparent willingness of most of these courts to question the professional standard so perceived.¹³⁵ Most of the decisions rejected the custom standard and did not really address the feasibility of an accepted practice approach. One wonders how they might have responded if counsel had urged that the medical custom test be replaced with the accepted practice variation of the professional standard.

With such sparse authority for an across the board rejection of the professional standard of care and with the courts' primary

cally be freed from liability because in fact he adhered to acceptable practice. There is no policy reason why a physician, who knows or believes there are unnecessary dangers in the community practice, should not be required to take whatever precautionary measures he deems appropriate.

Id. at 263, 239 N.E.2d at 373, 292 N.Y.S.2d at 447.

133. See note 135 *infra*. See also note 193 *infra*.

134. See, e.g., *Darling v. Charlestown Community Mem. Hosp.*, 33 Ill. 2d 326, 211 N.E.2d 253 (1965) (hospital defendant); *Lundahl v. Rockford Mem. Hosp. Ass'n*, 93 Ill. App. 2d 461, 235 N.E.2d 671 (1968) (dictum; physician defendant); *Morgan v. Sheppard*, 91 Ohio L. Abs. 579, 188 N.E.2d 808 (1963); *Incollingo v. Ewing*, 444 Pa. 263, 282 A.2d 206 (1971); *Helling v. Carey*, 83 Wash. 2d 514, 519 P.2d 981 (1974); *Favarola v. Aetna Cas. & Sur. Co.*, 144 So.2d 544 (La. App. 1962). See also notes 191, 193 and accompanying text.

135. Most of the cases cited in note 134 *supra*, that purport to limit the conclusiveness of the professional standard, couched their language in terms of the "customary practice" or "custom." Although none of the cases expressly opted for an "accepted practice" standard, at least one case, by emphasizing that a physician must give "due regard to the advanced state of the profession," came close to the spirit, if not the letter, of an accepted practice formulation. See *Incollingo v. Ewing*, 444 Pa. 263, 283, 282 A.2d 206, 217 (1971). The case of *Favarola v. Aetna Cas. & Sur. Co.*, 144 So. 2d 544 (La. App. 1962) (which rejected the customary practice relating to precautions to be taken to prevent patient from falling during an x-ray examination), has been narrowly construed. One case has limited it to situations involving negligence per se. See *Chapman v. Argonaut-Southwest Ins. Co.*, 290 So. 2d 779, 786 (La. App. 1974). Another case has construed *Favarola* as holding that conformity to the local custom will not relieve defendant of liability where that practice is contradicted by the accepted professional practice in accordance with the teaching in medical schools. See *Davis v. Duplantis*, 448 F.2d 918, 920 (5th Cir. 1971). In most cases cited in note 134 *supra*, it does not appear that the accepted practice alternative was even considered. Moreover, in subsequent decisions some courts have suggested that the professional standard of care may well have survived, at least to some extent, the earlier attacks on the customary practice formulation. See, e.g., *Ohligschlager v. Proctor Community Hosp.*, 55 Ill. 2d 411, 417, 303 N.E.2d 392, 396 (1973) (recognizing professional standard for physician without mentioning customary practice); *Richardson v. Doe*, 176 Ohio St. 370, 372, 199 N.E.2d 878, 879 (1964) (recognizing the professional standard but qualifying custom by requiring due regard for "the present state of medical science"). Of the cases cited in note 134 *supra*, only *Helling v. Carey*, 83 Wash. 2d 514, 519 P.2d 981 (1974), unequivocally rejected (under the facts presented) the professional standard of care without even ostensible concern over whether that standard was based on a customary or accepted practice or upon some other professional referent.

attention riveted on the locality rules, the vague ruminations about the place of the profession in the formulation of the standard of care might well have continued unabated. The situation changed abruptly in 1974 when the Washington Supreme Court decided *Helling v. Carey*¹³⁶ and addressed directly the conclusiveness of the professional standard of care without being distracted by peripheral questions of locality or custom.¹³⁷

Plaintiff in *Helling* while in her early twenties consulted defendant ophthalmologists with complaints of nearsightedness and was fitted with contact lenses. After several years plaintiff again consulted defendants to complain of irritation caused by the contact lenses. Five years later, after additional visits to the defendants, a test of plaintiff's intraocular eye pressure and field of vision revealed that plaintiff was afflicted with advanced glaucoma and had sustained severe irreversible damage to her eyes. It was estimated that the disease had been present for ten years or longer before it was diagnosed. The consensus of the testimony of both parties' medical experts established that the standards of the profession did not require *routine* glaucoma tests for patients under forty years of age.¹³⁸ According to some testimony, the incidence of glaucoma in persons under the age of forty was thought to be approximately one in 25,000.¹³⁹ The testimony also indicated that the professional standards do require pressure tests where the patient's complaints suggested possible glaucoma.¹⁴⁰ There was, however, no intimation from the opinion that the patient's complaints themselves called for a glaucoma test significantly earlier than the one actually performed. According to defendant's testimony, the pressure test was performed thirty days after plaintiff first complained of visual field problems. Based on essentially the above record, the jury rendered a verdict for the defendants, and the trial court entered a judgment accordingly, which was affirmed by the Court of Appeals.

On appeal, the Washington Supreme Court reversed, and held defendants liable as a matter of law for not having *routinely* administered the glaucoma test at a time when the disease might have been arrested, presumably years earlier. The court's conclu-

136. 83 Wash. 2d 514, 519 P.2d 981 (1974), noted in 10 GONZ. L. REV. 220 (1974); 20 N.Y.L.F. 669 (1975); 6 TEX. TECH. L. REV. 279 (1974); 28 VAND. L. REV. 441 (1975); 11 WILL. L.J. 152 (1974).

137. Rather than speak of the custom, the court expressly stated the issue in terms of the effect of defendants' "compliance with the standard of the profession of ophthalmology." 83 Wash. 2d at 517, 519 P.2d at 982.

138. *Id.* at 517, 519 P.2d at 982.

139. *Id.* at 518, 522, 519 P.2d at 983, 985.

140. *Id.* at 516, 519 P.2d at 982.

sion was based on its weighing of the cost, simplicity, and definitiveness of the glaucoma test, the incidence of the disease, and the gravity of the injury that may result when the disease is not detected and treated.

Helling is probably a classic case of hard facts making bad law. The plaintiff's plight no doubt evoked a great deal of sympathy. Under such circumstances, one might possibly have expected a reversal and new trial based upon some technical error or perhaps an especially creative characterization of the facts. Any real ambiguity as to the thrust of the court's holding as a matter of law, however, probably was dispelled by its express reliance on Judge Learned Hand's immortal opinion in *T.J. Hooper*,¹⁴¹ the leading case rejecting the conclusiveness of standards set by a single industry or enterprise. In the final analysis, *Helling* rejected the professional standard as applied to routine glaucoma testing and potentially rejected the professional standard for other medical procedures as well, especially if the procedures do not involve an extensive exercise of professional discretion or judgment.¹⁴² The *Helling* decision, with its unembarrassed examination of the professional standard question, takes on tremendous significance, and has already excited considerable comment.¹⁴³ The full impact of this terse opinion must await elaboration by the Washington courts and the reaction of other jurisdictions. It nevertheless serves as a useful foil for developing the following arguments that are urged in support of the professional standard of care.

(1) Limitations of Trier of Fact

A common justification for the professional standard of care is

141. 60 F.2d 737 (2d Cir. 1932). Judge Hand, speaking for the court, wrote:

[I]n most cases reasonable prudence is in fact common prudence; but strictly it is never its measure; a whole calling may have unduly lagged in the adoption of new and available devices. It never may set its own tests, however persuasive be its usages. Courts must in the end say what is required; there are precautions so imperative that even their universal disregard will not excuse their omission.

Id. at 740.

142. In *Helling* the court noted that there was "no judgment factor involved." 83 Wash. 2d at 518, 519 P.2d at 983. *But see* Bradford, *supra* note 128.

143. The case has elicited a wide range of negative commentary. *See* Letter from Lawrence S. Charfoos, 18 PER. INJURY NEWSLETTER 79 (1974) (member of the plaintiffs' bar, characterizing the decision as "a disaster"); Curran, *Glaucoma and Streptococcal Pharyngitis: Diagnostic Practices and Malpractice Liability*, 291 N. ENG. J. MED. 508 (1974) (describing *Helling* as an overly terse opinion that "leaves much to be desired"); Bradford, *supra* note 128; Comment, 28 VAND. L. REV. 441 (1975). Not all of the reaction, even by members of the medical profession, has been negative, however. *See, e.g.*, Dusinberre, *Diagnostic Screening and Malpractice*, 292 N. ENG. J. MED. 597 (1975); Note, YALE L.J., *supra* note 30, at 1149, 1163.

that lay jurors and judges are simply not equipped to wrestle with the complexities of medical science.¹⁴⁴ This argument, without more, may be an oversimplification. Judges and juries have always been called upon to decide difficult, complex questions. Additionally, the nonconclusiveness of the professional standard does not necessarily mean that the trier of fact would be without expert guidance.¹⁴⁵ Indeed, one would expect that cases rejecting the professional standard would nevertheless continue to require the testimony of expert witnesses to establish, under a reasonable person standard, what courses of action were scientifically feasible under the circumstances. The real question is not whether the scientific matter in controversy is or can be made comprehensible to laymen. Rather, it is the more fundamental issue of the proper allocation of medical decision-making responsibility. Should medical decisions that are not a matter of common knowledge be evaluated by the ad hoc judgment of a lay judge or lay jurors aided by hindsight¹⁴⁶ and an often unrealistic set of medical expectations?¹⁴⁷ Or, should such decisions depend on the collective judgment of the medical profession? The latter alternative manifestly appears to be the more defensible one. Deference to the professional standard is not simply a matter of inter-professional comity. It is a function, according to Prosser, of the "healthy respect which the courts have had for the learning of a fellow profession, and their reluctance to overburden it with liability based on uneducated judgment."¹⁴⁸

How then, should a case like *Helling v. Carey* be decided? Glaucoma is certainly an insidious and dreaded disease. The court apparently believed that if the pressure test had been routinely and timely administered the disease's destructive processes might have

144. See McCoid, *supra* note 92, at 607-08; Morris, *supra* note 96, at 1164.

145. Rejection of the conclusiveness of the professional standard does not necessarily affect the requirement for expert testimony. "Expert testimony could [still] be utilized to enlighten . . . laymen without allowing conformity to their testimony to become a conclusive defense." Note, 23 VAND. L. REV., *supra* note 98, at 743. Indeed, the court in *Helling* apparently relied on expert testimony regarding the simplicity, expense, and definiteness of the glaucoma test.

146. Retrospective lay evaluation of professional conduct is fraught with more than the usual risk of injustice where the science is as fluid and dynamic as the practice of medicine. The long delays before trial and the fact that many cases under recent statute of limitations decisions may have been based on conduct occurring years in the past under far different conditions threaten further to distort judge or jury objectivity and perspective. See note 87 *supra*.

147. Unrealistic public expectations of miraculous cures have been noted as a contributing factor in the continuing explosion in malpractice litigation. See, e.g., THE PATIENT VERSUS THE PHYSICIAN, *supra* note 7, at 447.

148. W. PROSSER, *supra* note 59, at 165.

been retarded. Weighing the evidence, the court made the following pronouncement:

The precaution of giving this test to detect the incidence of glaucoma to patients under 40 years of age is so imperative that irrespective of its disregard by the standards of the ophthalmology profession, it is the duty of the courts to say what is required to protect patients under 40 from the damaging results of glaucoma.¹⁴⁹

A relevant cost-benefit study¹⁵⁰ or independent medical opinion¹⁵¹ may subsequently validate or at least lend some support to the court's holding from the medical perspective. The decision as rendered by the court, however, is difficult to justify. The court did not allude either to an officially sanctioned study or to a respectable body of medical opinion that compelled the routine administration of the pressure test to persons under the age of forty. The danger in the court's apparent break with the medical profession lies not so much in the merits of the court's medical conclusion, which may even turn out to be medically sound, but in what the court's method may portend. The court unwisely has arrogated to itself medical decisions, superimposing its medical judgment upon the collective experience of the medical profession. Can it really be said that medical judgments of the courts will be "right" more often than those guided by approved medical practices? The case has provoked the following criticism from one physician:

Such matters must not be determined by common consumerist opinion, the press, presently popular medical copy, or even by the court. The best methods

149. 83 Wash. 2d at 519, 519 P.2d at 983.

150. If there were any extant cost-benefit studies that supported the court's medical decision, they were not expressly relied upon in the opinion. Parenthetically, it is interesting to contrast the court's decision not only with the professional standards, but also with the conclusion drawn in the somewhat different context of public screening for glaucoma. Despite the seriousness of the disease and the availability of diagnostic tests, one expert writing in a prestigious British medical journal commented that "[t]he prevalence of glaucoma is too low and the methods of detection such as to make population screening an uneconomic use of medical resources at present." Crick, *Chronic Glaucoma: A Preventable Cause of Blindness*, THE LANCET 205, at 207 (1974) (footnote omitted).

151. One physician has made the following general remark in support of the *Helling* decision: "The simplification and cheapening of many tests . . . have put an obligation on medicine to make them routine for special situations . . ." Dusinger, *supra* note 142, at 597; cf. Kaufman, *Questions and Answers — Maintenance of Tonometer Sterility in Glaucoma Screening*, 232 J.A.M.A. 849 (1975) ("Testing for glaucoma should be part of every routine thorough physical examination"). For a less enthusiastic, more specific scientific appraisal of the opinion, which raises some questions, *inter alia*, as to the conclusions of the majority and concurring opinions with respect to the simplicity and definitiveness of the glaucoma pressure tests, see Bradford, *supra* note 128. In this vein, in another case involving an ophthalmologist-defendant, expert testimony estimated that there were 40 or 50 different diseases all producing elevated intra-ocular pressure readings. See *Evans v. Sarrail*, 208 Cal. App. 2d 478, 480, 25 Cal. Rptr. 424, 425 (1962).

of discovery, diagnosis, and treatment for the best interest of the patient will ultimately evolve from the findings of the experts and professionals in the field and not from the court. The acceptable standard of care should be the best standard of the day, and it will only be determined by research and findings of the most knowledgeable in the field.¹⁵²

The medical profession in Washington may now have to assume that *Helling* has abruptly become a standard treatise for at least ophthalmology residents and practitioners. If the medicine practiced in *Helling* is safe and represents an optimal assignment of medical resources, will the court's future prescriptions be likewise? Will courts, impressed by often deceptive appearances of safety, diagnostic definitiveness, and in retrospect relative inexpensiveness, now routinely engage in all manner of major diagnostic and therapeutic intervention? Must every patient be solicited to undergo a comprehensive battery of tests to protect the doctor? Will revision of the *Helling* recipe or other judicially developed regimens of diagnosis or therapy have to await the indefinite prospect of future elaboration by the highest court of the state? The spectre thus rises of an improvident, legal-based science of medicine that could further petrify the healing arts¹⁵³ and strike at the very institutional integrity of the medical profession. Nor does it follow that if a court adheres to the professional standard, dangerous practices will go unchecked or required procedures will be ignored. When the negative aspects of a medical technique have been demonstrated by systematic and reliable studies, the *accepted* practice standard would probably compel repudiation of the untoward practice. In appropriate cases, specific medical procedures might even be required by statute or regulation.

(2) Cost- and Risk-Benefit Considerations

The use of a professionally developed standard of care, specifically a customary practice rule, in medical malpractice cases has been explained on the ground that the market dynamics of free

152. Bradford, *supra* note 128, at 55.

153. Even where an ophthalmologist responds to an elevated intra-ocular pressure reading by aggressively treating the patient for suspected glaucoma, he may still be sued. A patient who was treated for glaucoma after "borderline" pressure readings were noted, charged that she did not have glaucoma and that the treatment caused mental suffering and fear resulting from allegedly faulty advice to avoid pregnancy. See *Evans v. Sarrail*, 208 Cal. App. 2d 478, 480, 25 Cal. Rptr. 424, 425 (1962). This lawsuit ended in a directed verdict for the defendant (there being no evidence of negligence, the court applied a professional standard of care). It nevertheless serves to illustrate the potential "damned-if-you-do, damned-if-you-don't" syndrome facing doctors, if their decisions were permitted to be second-guessed by lay triers of fact. One wonders how a jury might have decided the *Evans* case had it been given a free hand to exercise its untutored medical judgment.

enterprise will operate to produce optimal health care consistent with a balancing of the costs and risks of therapy and the anticipated benefits that therapy offers.¹⁵⁴ It is implied that a customary practice may represent an acceptable, economically self-policing standard for activities when the party threatened by the enterprise is also the customer, which is usually the case with medical services,¹⁵⁵ though perhaps not with certain other professions.¹⁵⁶ Others have doubted the validity of the customary practice standard, persuasively challenging one of its underlying premises—that a health care market exists that effectively and optimally allocates medical resources¹⁵⁷ and have suggested that the conclusiveness of the customary practice standard be rejected unless it has been validated by a “systematic cost-benefit analysis.”¹⁵⁸ Neither of the foregoing views is really the answer. Customary practice insulates professional habit,¹⁵⁹ while the validation requirement seems overly narrow and probably goes too far toward the other extreme. It impliedly rejects the middle ground—the retention of the professional standard based upon the accepted rather than the customary medical practice.¹⁶⁰ The validation approach presumably would employ a reasonable person standard as in *Helling*, absent the existence of a systematic cost-benefit analysis, a proposition that is premised upon the

154. See R. POSNER, *supra* note 103, at 71-72.

155. See *id.* While the party generally threatened by medical procedures is the patient, a number of courts have found, in some circumstances, that a duty was owed to certain nonpatient third parties. See, e.g., *Tarasoff v. Regents of Univ. of Cal.*, 13 Cal. 3d 177, 529 P.2d 553, 118 Cal. Rptr. 129 (1974), noted in 28 VAND. L. REV. 631 (1975).

156. On this and other grounds, use of the customary practice standard has been questioned in the accounting field. See, e.g., Fifiis, *Current Problems of Accountants' Responsibilities to Third Parties*, 28 VAND. L. REV. 31, 84-86 (1975). The author went to some lengths to distinguish the medical from the accounting profession in terms of the possible feasibility of the customary practice standard. See *id.* With the exception of the greater relative danger posed to third parties by the activities of accountants as compared with physicians, the two professions are perhaps more akin from the standard of care perspective than Professor Fifiis is willing to concede. Though it is beyond the scope of the present inquiry, one wonders how an “accepted practice” standard of care, as advocated herein, might fare in the law governing the professional liability of accountants.

157. See note 103 *supra* and accompanying text.

158. Note, *supra* note 30, at 1150. For a discussion of the renewed interest of cost-benefit analysis theories as well as the difficulties involved in the use of such techniques, see BUS. WEEK, June 30, 1975, at 114.

159. See text accompanying notes 98-127 *supra*.

160. This middle ground may have been vaguely hinted at by the commentator's acknowledgement of a rule making custom a defense rebuttable by proof that defendant lagged behind the “new knowledge” of the profession. See Note, *supra* note 30, at 1150 n.49. This avenue, however, was apparently rejected (or at least not endorsed) as a solution for cases not covered by a systematic cost-benefit analysis. See *id.* at 1150. This observation is reinforced by the commentator's express approval of *Helling v. Carey*, a case clearly rejecting an accepted professional standard of care (as applied to the facts of the instant case). See *id.* at 1149.

groundless assumption that the courts are more likely to make optimal medical judgments than is the medical community.

Certainly, when a relevant systematic cost-benefit study has been undertaken, the results, if irrefutable, should be followed, as the accepted practice standard would clearly seem to dictate. The kind of analysis contemplated by the validation proposal would, however, minimally require the following: (1) that the incommensurables be capable of being valued or otherwise quantified with considerable definiteness;¹⁶¹ (2) that the effects of the medical procedure in question be isolated from other potentially causative influences;¹⁶² (3) that the necessary resources be committed to such an inquiry; (4) that the findings be demonstrated with minimal equivocation; and (5) that the results be disseminated in a timely fashion.¹⁶³ Experience has shown that in reality definitive cost-benefit studies which form the basis for important decisions are rare.¹⁶⁴ The existence of surveys that would, or reasonably should,¹⁶⁵ be outcome-determinative in a complex malpractice lawsuit would be even less likely. Indeed, while the cost-benefit or more accurately the "cost-

161. The problem of quantifying the elements of a cost-benefit calculus is a particularly complex one in which the inponderables of personal injuries — including death, pain and suffering, disability, and loss of earning capacity — are elements to be monetized. See generally BUS. WEEK, June 30, 1975, at 114-15.

162. Some of the difficulties in isolating the effects of a particular medical technique are explored in Dykes, *Uncritical Thinking in Medicine — The Confusion Between Hypothesis and Knowledge*, 227 J.A.M.A. 1275 (1974). Among other factors contributing to this uncertainty are basic ignorance, the fact that there are few true cures available, biological variability, and problems in differentiating the placebo effect from a specific pharmacological or therapeutic effect. *Id.* at 1276; cf. Benson & Epstein, *The Placebo Effect—A Neglected Asset in the Care of Patients*, 232 J.A.M.A. 1225 (1975).

163. It has been estimated that most research ideas in medical science are at least 4 years old (and a few are much older) when they appear in the journals. See Roland & Kirkpatrick, *Time Lapse Between Hypothesis and Publication in the Medical Sciences*, 292 N. ENG. J. MED. 1273, 1275 (1975). Where the collection of data extended over a prolonged period of time, the concept-to-publication interval would be much longer.

164. In a forum conducted in May 1973, Dr. Philip Handler, while president of the National Academy of Sciences, commented:

The ground rules for such analyses have not been spelled out, nor am I aware of an important decision outside the military which has really rested on what might be described as a formal, careful cost- and risk-benefit analysis.

Handler, *Introduction to National Academy of Sciences Forum on "How Safe is Safe?"* in Green, *The Risk-Benefit Calculus in Safety Determinations*, 43 GEO. WASH. L. REV. 791, 794, at 795 (1975).

165. Professor Posner has noted that "[t]he vogue of cost-benefit analysis has created inflated notions of the effectiveness of analytical techniques in resolving questions of cost and demand." R. POSNER, *supra* note 95, at 323. For a spirited dialogue that examines the roles of layman and scientist in the formulation of public policy through cost-benefit analyses, see Green, *supra* note 163; Handler, *A Rebuttal: The Need for a Sufficient Scientific Base for Government Regulation*, 43 GEO. WASH. L. REV. 808 (1975).

and risk-benefit"¹⁶⁶ analysis is a popular concept, it also has been described as a facile phrase that does not necessarily refer to a developed art or science.¹⁶⁷

Situations in which no relevant cost-benefit study exists will undoubtedly constitute the great majority of cases, and in such instances the better reasoned course would be to yield to the collective experience of the medical profession. Otherwise, the evaluation and formulation of medical decisions will be left to the case-by-case intuition of judge or jury while the development of future cost-benefit studies is awaited. Absent a definitive cost-benefit study, lay judges and jurors would be guided only by the desultory and fleeting wisdom that a few hired or at least interested experts could impart in a brief tender of less than unbiased testimony. It is specious to assume that from such a meager foundation a few laymen can construct all the premises needed to balance the costs and benefits. A court's oversimplified articulation of the medical facts is not necessarily self-fulfilling. In the *Helling* case the court's simplistic and conclusory method, devoid of all but the most superficial appraisals of the medical facts and costs, may ultimately stand as a monument to judicial paralogism. Furthermore, if practicing physicians are not normally able to organize into entities with a capacity for systematic cost-benefit research,¹⁶⁸ the refusal to recognize their professional standard would have little positive effect in encouraging basic research.

Not only is the traditional trier of fact inherently less capable than the medical profession of making optimal choices among competing therapeutic regimens, but without a determinative professional standard, the notorious penchant of plaintiff-oriented juries, and in recent years judges, to go for the deep pocket¹⁶⁹ might be exacerbated. Moreover, when a patient bent produces "hard" medical standards in the form of judicial rulings as a matter of law as in *Helling*, allocation of medical resources and courses of therapy might be obdurately skewed and the achievement of optimal patient care frustrated.

The uniquely obscure causation questions in malpractice cases also invite subjective judgments by judge and jury. The presence of some disease or injury that antedates the actionable event complicates the assignment of responsibility for the patient's ultimate con-

166. Handler, *supra* note 164, at 795.

167. *Id.*

168. See note 73 *supra* and accompanying text.

169. See, e.g., Morris, *supra* note 96, at 1165. See generally King, Book Review, 1974 DUKE L.J. 1000, at 1004-05.

dition. Moreover, since medicine is an inexact science, deciding whether an injury is the proximate result of substandard care or merely the realization of an unavoidable risk of therapy is a perplexing task. Without a professional standard for a benchmark, these added imponderables abet arbitrary judgments in malpractice cases.

Furthermore, the argument that industry standards may arise from economically motivated cost-cutting¹⁷⁰ appears less compelling in the medical malpractice setting. There is no indication of this kind of systemic disregard for the patient's welfare as a means of cost-cutting in the practice of medicine.¹⁷¹ The application of an accepted rather than customary practice standard, animated by the general dedication of the profession, should serve further to reduce the possibility that substandard procedures spawned by indifference or venality might be insulated from liability.

(3) Impact on Professional Discretion

The importance of preserving an unfettered exercise of professional judgment uninhibited by the constant presentiment of an unsympathetic jury applying an arbitrary standard of care cannot be overemphasized. No situation is comparable to that found in medical malpractice, where natural persons are made the primary defendants in civil litigation with such frequency. Even with a professional standard of care, no other legal milieu is less forgiving of human error than that in which the health care provider, and especially the physician, must perform.

A professionally determined standard offers a measure of forewarning of the legal effect of one's actions, without which there can be little predictability,¹⁷² uniformity, or repose¹⁷³ for the medical practitioner. Besides inspiring a chronic *Angst* that pervades and poisons the professional relationship, uncertainty over the law's expectations also promotes defensive medicine¹⁷⁴ with its attendant social exactions.

170. See W. PROSSER, *supra* note 59, at 167.

171. McCoid, *supra* note 92, at 609.

172. One commentator noted that without a professional standard of care, the practice of medicine would be condemned to "blind ignorance of what is right and wrong within the law," a framework in which no profession can function. Charfoos, *supra* note 143, at 79.

173. With the widespread adoption of the so-called "discovery rule" for statute of limitations purposes in medical malpractice cases, not only is the health care provider unsure of the substantive legal effects of his conduct, but he may not even rely on the usual repose that the passage of the applicable period of limitations once conferred. See note 87 *supra* and authorities cited therein.

174. See note 10 *supra*.

(4) Inappropriateness of Malpractice Litigation as a Vehicle for No-Fault Loss Distribution

When a duly licensed physician acts in strict accordance with the teaching of and in a manner acceptable to his profession, but nevertheless may be held liable as a matter of course, a situation exists that closely approximates liability without fault. Indeed, Justice Utter, concurring in *Helling*, said precisely that.¹⁷⁵ If such a characterization is accurate, at least a limited manifestation of no-fault is creeping *sub rosa* into an otherwise fault based system of liability. That situation promises to bring with it the unacceptable costs, definitional complications, uneven loss allocation, and class oriented individualization of benefits found in a formal no-fault approach.¹⁷⁶ The added insult also remains of moral reprehension associated with both the allegation and adjudication of professional liability under a traditional fault system.

(5) Fundamental Fairness

Tort litigation under a fault based system is oppressive, and when defendants are sued in their individual capacities and their professional competence is questioned *sub judice*, the procedure is even more damning. When, as in most cases, allegations address a failure to *exercise* rather than to *possess* the required skill or qualifications, the good reputation of the defendant is not normally at issue and may not even be admissible.¹⁷⁷ Thus, malpractice cases appear quite selective in their perception, usually focusing on isolated acts of alleged misfeasance. When a defendant's only wrong was to adhere faithfully to the course prescribed by his profession, the criminalizing impact of the litigation seems grossly out of proportion to the quality of the conduct challenged. Perhaps most lamentable of all is the fact that many malpractice cases assume a ubiquitous presence in the lives of the defendants that often cruelly haunts them throughout the protracted proceedings. Apart from the self-recriminating throes of those involved in active litigation, an *in*

175. Justice Utter stated:

[W]e are, in reality, imposing liability, because, in choosing between an innocent plaintiff and a doctor, who could have prevented the full effects of this disease by administering a simple, harmless test and treatment, the plaintiff should not have to bear the risk of loss. As such, imposition of liability approaches that of strict liability. *Helling v. Carey*, 83 Wash. 2d 514, 520, 519 P.2d 981, 984 (1974) (Utter, J., concurring).

176. See § II *supra*.

177. See, e.g., *Stauffer v. Karabin*, 30 Colo. App. 357, 364-65, 492 P.2d 862, 865-66 (1971) (evidence as to defendant's reputation in medical community inadmissible as hearsay); *French v. Brodsky*, 521 S.W.2d 670, 674 (Tex. Civ. App. 1975) (testimony as to the good reputation of the defendant in medical malpractice case not normally admissible).

terrorem temper also pervades the medical profession generally.

The counter argument, that the professional standard perpetuates the unfair "conspiracy of silence"¹⁷⁸ of the medical profession, is not persuasive. Even if the professional standard were not conclusive on the question of due care, it would not necessarily or even likely follow that expert medical testimony could be dispensed with. Expert testimony would still be needed in most cases not only to assist the finder of fact in determining what procedures were feasible, but also to afford guidance in deciding such related matters as medical causation and the nature and extent of the plaintiff's injuries.

As a general proposition, then, judicial deference to the standards developed by the medical profession seems well advised. Liberal application of the accepted rather than customary variant of the professional standard should mitigate any harshness in such an approach by liberating the profession from the normative force of the habitual. Moreover, the discretion of lay triers of fact would be preserved, as the following sections illustrate, with respect to matters that they are competent to decide.

D. Potential Exceptions to the Professional Standard of Care

(1) The "Common Knowledge" Cases

The requirement of expert testimony¹⁷⁹ is deeply ingrained in medical malpractice law and would, as previously noted, probably survive the abrogation of the professional standard of care. An important exception to the expert witness requirement, regardless of the standard of care employed, is the "common knowledge" doctrine,¹⁸⁰ which allows the finder of fact to rely exclusively on its fund

178. See, e.g., D. HARNEY, *supra*, note 40, § 5.1; 1 D. LOUISELL & H. WILLIAMS, *supra* note 87, ¶ 14.02-14.03; Belli, *An Ancient Therapy Still Applied: The Silent Medical Treatment*, 1 VILL. L. REV. 250 (1956); Kayajanian, *Confronting the Conspiracy of Silence: We Have the Tiger by the Tail*, 6 U. WEST L.A.L. REV. 40 (1974); Kelner, *The Silent Doctors—The Conspiracy of Silence*, 5 U. RICH. L. REV. 119 (1970); Seidelson, *Medical Malpractice Cases and the Reluctant Expert*, 16 CATH. U.L. REV. 158 (1966); Note, *Malpractice and Medical Testimony*, 77 HARV. L. REV. 333 (1963); Note, *Overcoming the "Conspiracy of Silence": Statutory and Commonlaw Innovations*, 45 MINN. L. REV. 1019 (1961). The reluctance of members of the medical profession to testify against each other has been duly noted by the judiciary, especially by such champions of plaintiffs' rights as Justice Tobriner and the late Justice Musmanno. See, e.g., *Clark v. Gibbons*, 66 Cal. 2d 399, 416 n.3, 426 P.2d 525, 537 n.3, 58 Cal. Rptr. 125, 137 n.3 (1967) (Tobriner, J., concurring); *Demchuk v. Bralow*, 404 Pa. 100, 107, 170 A.2d 868, 872 (1961) (Musmanno, J., dissenting).

179. See Annot., 40 A.L.R.3d 515 (1971) (hospitals); Annot., 81 A.L.R.2d 597 (1962) (physicians).

180. See *Sanzari v. Rosenfeld*, 34 N.J. 128, 141-42, 167 A.2d 625, 632 (1961).

of common knowledge to assay the feasibility of alternate courses of action and to evoke the appropriate standard of care.¹⁸¹ Because the issue of negligence in that context is not related to technical matters peculiarly within the knowledge of the medical profession, there is no need for expert testimony on the question of the standard of care.

The common knowledge principle finds its widest application in conjunction with the doctrine of *res ipsa loquitur*, which is based upon an assumption that the negligence may be circumstantially inferred from the nature of the resulting injury.¹⁸² In those *res ipsa* cases in which an inference of negligence may be drawn by laymen,¹⁸³ the standard of care is essentially the same as in the common knowledge cases. Only the quality of the proof is different—circumstantial evidence in the former and direct evidence of negligence in the latter.

The common knowledge cases, most of which seem to be of the *res ipsa* variant, typically have involved fairly perspicuous fact situations, such as the failure to remove a sponge or other foreign objects from the site of an incision,¹⁸⁴ injuries to portions of the body outside of the surgical field,¹⁸⁵ or whether a post-operative patient's acute condition required notification of patient's attending physician.¹⁸⁶ In recent years a tendency has developed to enlarge the scope of the common knowledge exception to reach ever more complex factual situations. Thus, expert testimony on the standard of care was not required when a patient's ureter allegedly was severed during a hysterectomy even though the operation was complicated, requiring

181. *Id.*

182. See generally W. PROSSER, *supra* note 59, § 39.

183. See 1 D. LOUISELL & H. WILLIAMS, *supra* note 87, ¶ 14.06, at 439-41, cataloging the more common examples; 2 S. SPEISER, *THE NEGLIGENCE CASE: RES IPSA LOQUITUR* § 24.8 (1972).

A number of cases have permitted a plaintiff to rely on *res ipsa loquitur* where an inference of negligence could be supported by expert medical testimony, in other words permitting an inference or presumption that such results do not normally occur absent a failure to follow the appropriate course of therapy. See 1 D. LOUISELL & H. WILLIAMS, *supra*, ¶ 14.06, at 438-39, 192-94 (Supp. 1974); 2 S. SPEISER, *supra*, ¶ 24.8, at 216 (1972). In such cases the professional standard of care should be as controlling as it would be in a straight negligence action in which the outcome depends on a professional standard.

184. See, e.g., *Hestbeck v. Hennepin County*, 297 Minn. 419, 212 N.W.2d 361 (1973) (expert testimony not required under a *res ipsa* claim when surgical sponge was allegedly lost during gallbladder surgery); cf. *Lipman v. Lustig*, 346 Mass. 182, 190 N.E.2d 675 (1963) (expert testimony not necessary and directed verdict for defendant improper where dentist allegedly permitted reamer to fall down patient's throat).

185. See, e.g., *Wiles v. Myerly*, 210 N.W.2d 619 (Iowa 1973) (burns discovered on patient's buttocks following vascular surgery involving another part of patient's body).

186. See, e.g., *Karrigan v. Nazareth Convent & Academy, Inc.*, 212 Kan. 44, 510 P.2d 190 (1973).

surgical invasion of the area near the ureter.¹⁸⁷

The apparent straightforwardness of the common knowledge cases is belied when a defendant responds to an allegation of negligence based on a purported common knowledge standard by introducing evidence of compliance with the professional standard of care. Although such a response has been infrequent in the past, the possibilities for collision between plaintiff's reliance upon the common knowledge doctrine and defendant's reliance upon conformity to an accepted professional practice should multiply as the catalogue of common knowledge situations keeps pace with growing public comprehension of medical matters.

Perhaps the most prevalent common knowledge cases have involved foreign objects left inside the patient, sometimes referred to generically as the "sponge" cases.¹⁸⁸ Legal theories employed to support liability based upon defendant's actual, as opposed to imputed, negligence have run the gamut, including straight negligence, *res ipsa loquitur*, negligence per se, and nondelegable duty theories.¹⁸⁹ This variousness attests to the doctrinal uncertainty with which the courts have dealt in such cases generally. When the jury's common knowledge sense of the standard of care is contradicted by evidence of compliance with a professionally recognized practice, this uncertainty is compounded. The results in such cases have been ambiguous and, especially in the older cases, divided.¹⁹⁰ The drift of authority ostensibly has been to reject the conclusiveness of at least the customary practice variation of the professional standard in these foreign object cases.¹⁹¹ Reportedly, the foreign object cases have been the only ones in which a few courts have even considered the inference of negligence nonrebuttable.¹⁹²

Upon closer scrutiny, the conflict in cases in which the common knowledge standard appears to run counter to the professional stan-

187. See *Pry v. Jones*, 253 Ark. 534, 487 S.W.2d 606 (1973).

188. *McCoid*, *supra* note 92, at 610.

189. See cases cited in Annot., 10 A.L.R.3d 9 (1966, Supp. 1974); Annot., 65 A.L.R. 1023 (1930).

190. See *McCoid*, *supra* note 92, at 611-14.

191. *Id.* For examples of cases rejecting the customary practice where a foreign object has been left in a wound, see *Leonard v. Watsonville Community Hosp.*, 47 Cal. 2d 509, 305 P.2d 36 (1957); *Grant v. Touro Infirmary*, 254 La. 204, 223 So. 2d 148 (1969). See generally 10 A.L.R.3d 9, § 3(d) (1966, Supp. 1974). Other courts have appeared more sympathetic to the professional standard in such cases. See *Dietze v. King*, 184 F. Supp. 944 (E.D. Va. 1960) (holding that in the absence of expert proof that sponge count was the customary practice, failure to make sponge count did not establish negligence); cf. *Hestbeck v. Hennepin County*, 297 Minn. 419, 212 N.W.2d 361 (1973) (implying that had conclusive evidence of compliance with the professional standard been forthcoming, the inference of negligence might have been rebutted).

192. See 1 D. LOUISELL & H. WILLIAMS, *supra* note 87, ¶ 14.07, at 441-42.

dard is often more apparent than real. In those situations, the following four observations may facilitate analysis. First, careful examination of the record may reveal that in fact no conflict exists. On the one hand, technical matters may fairly make the case unsuitable for lay evaluation. Conversely, the medical procedures involved may have been so readily cognizable that no recognized professional practice ever formally crystallized, or the court may have been unable to determine what the applicable professional practice was.¹⁹³

Secondly, the court's adherence to a common knowledge—"leave it to the jury"—approach in the sponge cases may simply signify underlying judicial incredulity.¹⁹⁴ Since the probability of losing a sponge, for example, is exceedingly remote if an approved technique is followed,¹⁹⁵ the presence of a sponge in the patient following surgery may permit a jury to conclude that the accepted practice was not as defendant asserted or was not followed, despite evidence to the contrary.¹⁹⁶ In such cases, however, a court probably would be on sounder analytical footing by stating the issue in terms of the persuasiveness of opposing testimony and evidence rather than impliedly rejecting the professional standard of care.

Thirdly, most cases based on the loss of foreign objects or injuries to remote portions of the body usually involve an unconscious or temporarily incapacitated patient. In these cases the courts have tended to base liability upon the special responsibility owed to patients,¹⁹⁷ as well as upon defendant's inability or unwillingness to

193. See *Chappetta v. Ciaravella*, 311 So. 2d 563 (La. App. 1975). In *Chappetta* a laparotomy pad had been left inside patient following a hysterectomy. In upholding liability, the court took great pains to state a caveat as to the effect of compliance with the customary practice in such cases. The court circumvented this issue because it was unable to ascertain what the applicable professional standard was. A number of Louisiana cases have purportedly rejected the conclusiveness of the customary practice standard in certain cases. See *Grant v. Touro Infirmary*, 254 La. 204, 223 So. 2d 148 (1969) (sponge left in incision was negligence per se notwithstanding compliance with the customary practice); *Favalora v. Aetna Cas. & Sur. Co.*, 144 So. 2d 544 (La. App. 1962) (rejected customary practice relating to precautions to be taken to prevent patients from falling during X-ray examinations). More recent Louisiana decisions, however, have suggested the continuing validity of the professional standard for many cases. See, e.g., *Chapman v. Argonaut-Southwest Ins. Co.*, 290 So. 2d 779, 786 (La. App. 1974); note 135 *supra*.

194. See *Morris*, *supra* note 96, at 1166-67.

195. *Id.* at 1166.

196. See *Burke v. Washington Hosp. Center*, 475 F.2d 364, 365-66 (D.C. Cir. 1973) (jury was free to disbelieve defendant's version of events, thus preserving the inference from *res ipsa*); cf. *Hiatt v. Groce*, 215 Kan. 14, 22, 523 P.2d 320, 326 (1974) (jury might not be bound by expert's conclusions that defendant had complied with professional standard if those conclusions were based upon records that the jury might have been persuaded were erroneous).

197. See W. PROSSER, *supra* note 59, § 39, at 223.

explain or account for plaintiff's injury. Therefore, such cases are probably *sui generis*.¹⁹⁸

Finally, the unwillingness of some courts to adhere to a relevant professionally determined standard in an apparent common knowledge situation may denote an adverse judicial reaction to the fact that the professional standard relied upon by defendant was bottomed on the customary rather than the professionally accepted practice. Adoption of the more flexible accepted practice criterion would probably reduce those occasions in which the common knowledge and professional standards diverge and also would make the courts less hesitant to adhere to the professionally determined norms in purported common knowledge cases.

When one of the foregoing considerations does not control, and when defendant's conformity to a relevant *accepted* practice of the profession has been satisfactorily demonstrated, the more judicious view would seem normally to dictate deference to the professional standard. This conclusion is consonant with the arguments favoring a professional standard of care generally and reflects the preferability of the collective judgment of the medical profession over the *ad hoc* and ill-informed supposition of lay jurors or a judge in medical matters, even ones that appear elementary to the technically naive observer.

(2) Standard of Disclosure for "Informed Consent" Cases

The debate over the weight to be accorded the professional standard has carried over into the doctrine of "informed consent."¹⁹⁹ This doctrine derives from the basic notion that "[e]very human being of adult years and sound mind has a right to determine what

198. See generally *Anderson v. Somberg*, 67 N.J. 291, 338 A.2d 1 (1975); Thode, *supra* note 21.

199. The doctrine of informed consent is a relatively recent development in the law of medical malpractice. *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093, *modified*, 187 Kan. 186, 354 P.2d 670 (1960), is commonly recognized as the bellwether case that presaged general acceptance of the doctrine. The theory has spawned a considerable literature. See, e.g., Alsobrook, *Informed Consent: A Right to Know*, 40 INS. COUNSEL J. 580 (1973); Capron, *supra* note 79; Karchmer, *Informed Consent: A Plaintiff's Medical Malpractice "Wonder Drug"*, 31 MD. L. REV. 29 (1966); Kessenick & Mankin, *Medical Malpractice: The Right to Be Informed*, 8 U.S.F.L. REV. 261 (1973); Plante, *An Analysis of "Informed Consent"*, 36 FORDHAM L. REV. 639 (1968); Ritts, *A Physician's View of Informed Consent in Human Experimentation*, 36 FORDHAM L. REV. 631 (1968); Shartsis, *Informed Consent: Some Problems Revisited*, 51 NEB. L. REV. 527 (1972); Waltz & Scheuneman, *Informed Consent to Therapy*, 64 NW. U.L. REV. 628 (1969); Note, *Informed Consent—A Proposed Standard for Medical Disclosure*, 48 N.Y.U.L. REV. 548 (1974); Note, *supra* note 80; Note, *Restructuring Informed Consent: Legal Therapy for the Doctor—Patient Relationship*, 79 YALE L.J. 1533 (1970).

shall be done with his body"²⁰⁰ Before he undergoes treatment, the patient first should have received information regarding the risks of and alternatives to the contemplated procedures and the prognoses if he goes untreated,²⁰¹ and then the patient's consent must be obtained.

A central issue in the informed consent cases relates to the nature of the physician's duty to disclose. While the matter is sometimes bifurcated analytically into questions of the existence of a duty and its scope,²⁰² for present purposes both will be referred to in terms of a single standard of disclosure. Until recently, the courts treated the standard of disclosure in the informed consent cases much the same as they did the standard of care in cases involving negligent malpractice. It generally was held that the extent of a physician's duty to disclose is determined by the professional standard for other similarly situated members of the profession.²⁰³ Then, in 1972 the landmark case of *Canterbury v. Spence*²⁰⁴ was decided by the Court of Appeals for the District of Columbia. Though it was not the first decision to reject the conclusiveness of the professional standard in informed consent cases,²⁰⁵ *Canterbury* has commonly been regarded as the leading exponent of that trend.²⁰⁶ The court expressly rejected the view "that the physician's obligation to disclose is either germinated or limited by medical practice."²⁰⁷ The court based its holding on four grounds. First, it observed that there was serious doubt that any discernible custom existed reflecting a professional consensus on the appropriate scope of disclosure.²⁰⁸ Secondly, the court argued that to bind the disclosure to medical usage would be to arrogate the decision on revelation to the physician, in possible derogation of the patient's right of self-determination.²⁰⁹ Thirdly, the court noted that the decision as to what should be disclosed oftentimes represents a nonmedical judgment.²¹⁰ And fi-

200. *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914) (Cardozo, J.).

201. *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

202. *See id.*

203. *See* Waltz & Scheuneman, *supra* note 199, at 636.

204. 464 F.2d 772 (D.C. Cir.) (Robinson, J.), *cert. denied*, 409 U.S. 1064 (1972).

205. *See, e.g.*, *Cooper v. Roberts*, 220 Pa. Super. 260, 286 A.2d 647 (1971) (duty to disclose what a reasonable person in plaintiff's apparent position would consider material to his decision to undergo treatment).

206. *E.g.*, Gough, *Recent Uses and Misuses of the Informed Consent Doctrine*, 10 THE FORUM 383, 389 (1974).

207. 464 F.2d at 783.

208. *Id.* at 783.

209. *Id.* at 784.

210. *Id.* at 785.

nally, the court rejected the view that the prevailing medical practice should define the standard of care for physicians generally.²¹¹ The court proceeded to adopt a test that would require disclosure when a reasonable person in patient's apparent position would likely attach significance to the risk in question.²¹²

While the professional standard of disclosure is still often referred to as the "majority rule"²¹³ in informed consent cases and has been reaffirmed in a number of recent opinions,²¹⁴ it has been vigorously challenged by other courts that have taken the *Canterbury* type approach to a varying extent.²¹⁵ It seems that more courts have specifically addressed the question of the weight to be accorded the profession's standards in the informed consent context than in the more frequent negligent treatment cases. This emphasis appears well deserved. The appropriate standard of disclosure is probably an even more inextricable issue in these cases than its counterpart is in the treatment cases. In addition to the usual arguments favoring abolition of the professional standard, especially the customary practice formulation, in malpractice cases generally, additional considerations arise that may be especially pertinent in informed consent cases. One such argument—that the nonexistence of a demonstrable custom for disclosure reflects a professional consensus—is not convincing. The absence of a medical consensus alone should not be dispositive when the *customary* practice formulation is replaced by the accepted practice construct. Under the latter, the absence of a clear consensus on the professional custom or usage should not prevent medical experts from deciding whether the challenged conduct falls within the broad ambit of what is commonly perceived to be sound medical practice.

The crucial argument for rejection of the professional standard

211. *Id.* (*semble*; prevailing practice may be *evidence* in negligent treatment cases).

212. *See id.* at 787; Waltz & Scheuneman, *supra* note 199, at 640.

213. *E.g.*, Butler v. Berkeley, 25 N.C. App. 325, 213 S.E.2d 571, 582 (1975); *see* D. HARNEY, *supra* note 40, § 24(A), at 61-62; Note, *Informed Consent—A Proposed Standard for Medical Disclosure*, 48 N.Y.U.L. Rev. 548, 551-52 (1973); Annot., 52 A.L.R.3d 1084, 1088 (1973).

214. *See, e.g.*, Karp v. Cooley, 493 F.2d 408 (5th Cir. 1974) (Texas law); Nishi v. Hartwell, 52 Hawaii 188, 473 P.2d 116 (1970); Charley v. Cameron, 215 Kan. 750, 528 P.2d 1205 (1974); Butler v. Berkeley, 25 N.C. App. 325, 213 S.E.2d 571 (1975); Annot., 52 A.L.R.3d 1084, 1091-92 (1973). Several decisions have adopted somewhat of a compromise position whereby the professional standard is still controlling, but once nondisclosure has been shown, the burden of showing compliance with the professional practice is placed on the defendant. *See* Stauffer v. Karabin, 30 Colo. App. 357, 492 P.2d 862 (1971).

215. *See, e.g.*, Cobbs v. Grant, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); Holland v. Sisters of St. Joseph, 522 P.2d 208 (Ore. 1974); Wilkinson v. Vesey, 110 R.I. 606, 295 A.2d 676 (1972); Miller v. Kennedy, 11 Wash. App. 272, 522 P.2d 852 (1974), *aff'd*, 85 Wash. 2d 151, 530 P.2d 334 (1975).

of disclosure in informed consent cases is based on the underlying objective of the doctrine. While the informed consent concept appears to have a number of functions,²¹⁶ foremost among them is the vindication of the patient's right of self-determination.²¹⁷ The patient's freedom to decide what shall be done with his person may be an even more paramount interest than the preservation of the patient's health. If the patient is the party vested with this near absolute veto power over medical intervention, it inevitably follows that the standard of disclosure must be dictated by the patient's informational needs as nearly as they can be perceived by the physician.²¹⁸ What information would apparently be significant to the patient is a decision that a layman normally is competent to make. In more doctrinal terms, once the existence of the risks and alternatives of the proposed therapy as well as other relevant medical facts are confirmed by medical experts,²¹⁹ the question of what risks and information would have been material to a person in the apparent position of the patient is a classic instance of a common knowledge situation. Under a rough division of labor, the physician is charged with preserving the patient's health, but not until the patient first has made the threshold decision of whether to proceed with the contemplated therapy. The standard of care should reflect this allocation of decision-making responsibilities.

Appealing arguments surely may be raised against the *Canterbury* solution. Under a *Canterbury* type analysis, a physician normally cannot rely with certainty upon his professional judgment or upon procedures approved by the profession. Moreover, the physician may be held liable even though the treatment itself was flawless by any reasonable standard because the essence of the informed consent theory is not the discovery of negligently inflicted injury, but the materialization of calculated risks about which the patient should have been forewarned.²²⁰ Sending the adequacy-of-the-disclosure issue to the jury, therefore, places the doctor in the utmost jeopardy unless he has a meaningful premonition of what dis-

216. Professor Capron has summarized the functions served by the informed consent doctrine to include the promotion of individual autonomy, the protection of the patient's status as a human being, the avoidance of fraud and duress, the encouragement of self-scrutiny by the physician, the fostering of rational decision making, and the involvement of the public in medical matters. Capron, *supra* note 79, at 364-76.

217. See *Canterbury v. Spence*, 464 F.2d 772, 786 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

218. See *id.* at 786-87.

219. The identification of the risks would have to be made by medical experts in most cases. This requirement for expert testimony would survive the adoption of the *Canterbury* standard of disclosure. See *id.* at 791-92.

220. See generally *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972).

closure will be legally sufficient.

Although it is a close question, on balance *Canterbury* probably expresses the more cogent approach for informed consent cases. To allow the medical profession to set the standard for disclosure may well disenfranchise patients with respect to a decision of paramount importance to them and one that lay patients normally are quite competent to make. The seeming incongruity of retaining the professional standard of care for treatment on the one hand, while rejecting the professional standard for disclosure on the other, is perhaps best explained by viewing the informed consent doctrine as a corollary to the common knowledge exception to the general requirement for expert testimony to determine the standard of care. The apparent harshness of this view may be ameliorated by recognizing certain justifications for nondisclosure. For example, when disclosure might seriously threaten the health of the patient, the withholding of the information from the patient should be excused. In these cases the emphasis shifts from the patient's interest in self-determination to the goal of averting serious injury. Under such circumstances, the judgment of the medical profession normally should be determinative in setting the standard for testing the medical justification for such nondisclosure.²²¹

221. With respect to the therapeutic privilege to withhold information, some commentators have rejected the *customary* practice standard as unworkable for appraisals of the psychological state of the patient. See Waltz & Scheuneman, *supra* note 199, at 642-43. These same writers, however, have recommended that the physician be permitted to establish the "medical propriety of his decision," and that the relevant test be whether his acts corresponded with "sound medical judgment." *Id.* at 642-43; cf. Smith, *Therapeutic Privilege to Withhold Specific Diagnosis From Patient Sick With Serious or Fatal Illness*, 19 TENN. L. REV. 349, 357 (1946). That test would appear consistent with the *accepted* practice formulation broadly construed, which would of course represent a professionally developed standard.

There has been fear expressed that unless the therapeutic privilege to withhold information is carefully circumscribed it may devour the disclosure rule itself. *Canterbury v. Spence*, 464 F.2d 772, 789 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972). This has led some to question the wisdom of the Waltz & Scheuneman formulation. See Capron, *supra* note 79, at 412-13 n.76. Others have been so perplexed by the question that they appear to have adopted both the professional and reasonable man standards coincidentally. See *Cobbs v. Grant*, 8 Cal. 3d 229, 246, 502 P.2d 1, 12, 104 Cal. Rptr. 505, 516 (1972) (holding that a disclosure need not be made beyond that required by the "medical community" when doctor can prove that the facts relied upon would demonstrate to a "reasonable man" that patient would have been so upset he could not have dispassionately weighed the risks). Still others have suggested that the goal should be one of "tactful disclosure" even if it proves distressing to the patient. Note, *supra* note 80, at 1655. Notwithstanding such criticism, considering the dilemma facing the physician, retention of the therapeutic privilege as tested by a professional standard would appear the best solution. If the burden of justifying the nondisclosure were placed upon the physician, as it probably should be, the jury would presumably be free to some extent to disregard expert testimony offered by defendant that lacked credibility or was otherwise unworthy of belief. This should afford an ample measure of protection to the patient without abandoning altogether the physician's therapeutic privilege.

E. Professional Standards Review Organizations and the Standard of Care

In 1972 Congress enacted the Professional Standard Review Organization [PSRO] Amendment²²² to the Social Security Act.²²³ Not only does this legislation augur basic changes in the delivery of medical care and in the physician-patient relationship,²²⁴ it also may affect the legal rules governing the standard of care for medical professionals. Inconsiderable if not cursory congressional attention to the PSRO Amendment²²⁵ has produced a rough, obscure statute, even considering that it essentially is enabling legislation. Nor has sufficient time elapsed since enactment for meaningful case law to have developed. Therefore, the examination of this legislation must be tentative and the conclusions reached speculative at best.²²⁶

According to its stated purpose, the PSRO Amendment was designed to promote effective, efficient, and economical delivery of health care of proper quality²²⁷ for patients under federally supported Medicare, Medicaid, and Maternal and Child Health Care programs. Its primary aim apparently was to reduce the spiraling costs for unnecessary medical services. The impetus behind these unnecessary services stemmed in part from the practice of defensive medicine,²²⁸ undisciplined medical practices generally, and a desire to accommodate patient expectations regardless of necessity or costs.²²⁹ Another possible contributing factor may have been the phenomenon that one writer in a somewhat different context has

222. 42 U.S.C. § 1320c (Supp. II, 1972). See generally McMahon, *PSROs . . . Implications for Hospitals*, 48 HOSPITALS, Jan. 1, 1974, at 53; Welch, *PSROs—Pros and Cons*, 290 N. ENG. J. MED. 1319 (1974); Note, *Professional Standards Review and the Limitation of Health Services: An Interpretation of the Effect of Statutory Immunity on Medical Malpractice Liability*, 54 B.U.L. REV. 931 (1974); Note, *Federally Imposed Self-Regulation of Medical Practice: A Critique of the Professional Standards Review Organization*, 42 GEO. WASH. L. REV. 822 (1974); Note, *PSRO: Malpractice Liability and the Impact of the Civil Immunity Clause*, 62 GEO. L.J. 1499 (1974); Note, *PSRO: A Status Report on Medical Peer Review Under the 1972 Social Security Act Amendments*, 6 LOYOLA (CHICAGO) U.L.J. 90 (1974).

223. 42 U.S.C. §§ 301-1396(i) (1970).

224. See Note, LOYOLA U.L.J., *supra* note 222, at 102-03 & nn.108-13.

225. Apparently the PSRO legislation reached the Senate from committee as part of a 989-page Social Security Act. Thus dwarfed, it gained relatively little attention. From the Senate it passed through a House-Senate Conference Committee, reaching the House on the final day of the 92d Congress, and passed without further amendment and with only one dissenting vote. See Segal, *A Hard Look at the PSRO Law*, 2 J.L. MED., Sept.-Oct., 1974, at 26; Note, GEO. WASH. L. REV., *supra* note 221, at 824 n.5.

226. For general background on the legislation, see S. REP. No. 1230, 92d Cong., 2d Sess. 267 (1972).

227. 42 U.S.C. § 1320c (Supp. II, 1972).

228. See note 10 *supra*.

229. See Note, GEO. WASH. L. REV., *supra* note 222, at 838.

termed "Funktionlust"²³⁰ or the "love of doing a thing"²³¹—practicing medicine—which is inherently self-perpetuating.

The legislation contemplates the establishment of area PSRO's throughout the nation. Certain norms are to be established and applied in the evaluation of the quality and necessity of health services. In addition to specific sanctions for noncompliance with the statute,²³² the Amendment also provides for civil immunity for certain conduct in conformity with applicable PSRO norms.²³³ Two general questions concerning the immunity provision immediately arise. First, how does the proffered grant of immunity affect traditional standard of care principles? Secondly, what is the likely reach of the immunity provision? These questions are considered in turn below.

(1) PSRO Norms and the Standard of Care

The PSRO norms are to be professionally developed standards. Rather than relying on the customary practice, the statutory language may imply a more flexible standard that is more akin to an *accepted* practice model.²³⁴ The statute states that the purpose of the review of medical services is to determine whether they are or were "medically necessary"²³⁵ and meet "professionally recognized standards,"²³⁶ and in the case of hospitalizations whether outpatient care or care at a different type of institution might be employed in lieu of contemplated in-patient care "consistent with the provision of appropriate medical care."²³⁷ The PSRO norms are to include a range of appropriate diagnosis and treatment for specific conditions consistent with "professionally recognized and accepted

230. This term was attributed to Konrad Lorenz in Crile, *The Surgeon's Dilemma*, HARPERS, May 1975, at 38.

231. *Id.* George Crile used the *Funktionlust* phenomenon to help explain the eagerness (even apart from economic incentives) of a surgeon to ply his trade.

232. See 42 U.S.C. § 1320c-7, -9(b)(1), (3) (Supp. II, 1972).

233. See 42 U.S.C. § 1320c-16(c) (Supp. II, 1972).

234. See notes 98-121 *supra* and accompanying text.

235. 42 U.S.C. § 1320c-4(a)(1)(A) (Supp. II, 1972). Similarly, health care practitioners and providers are obliged under the statute to assure that services ordered or provided by them are medically necessary. *Id.* § 1320c-9(a)(1)(A), (D).

236. *Id.* § 1320c-4(a)(1)(B). The provider or practitioner is likewise required to see that the services meet the "professionally recognized standards of health care." *Id.* § 1320c-9(a)(1)(B), (E).

237. *Id.* § 1320c-4(a)(1)(C). Health care practitioners and providers are also to assure that inpatient care, consistent with "professionally recognized health care standards," is both medically necessary and would not be available on a more economic basis at a facility of a different type. *Id.* § 1320c-9(a)(2)(A), (B).

patterns of care."²³⁸ The foregoing language seems to suggest that the emphasis will be on what the profession perceives to be acceptable practice rather than merely what the medical custom has been. This conclusion is undermined somewhat by the requirement that the PSRO norms be derived from "typical patterns of practice in its regions."²³⁹ Hopefully, the PSRO norms will reflect the latest state of the art in the profession and will not simply mimic professional custom.

Regardless of whether the norms are based upon the customary or the more liberal accepted practice construct, it seems that Congress has opted for a standard set by the medical profession by passing the PSRO Amendment. The legislation may thus represent at least a partial repudiation of decisions like *Helling v. Carey*²⁴⁰ and the judicial arrogation of medical decision-making that the case represents.

Another question relates to the appropriate geographic frame of reference from which the PSRO norms are to be derived. The primary reviewing unit in the administrative hierarchy is the "area" PSRO,²⁴¹ supplemented by Statewide Professional Standards Review Councils established for states with three or more area PSRO's²⁴² and a National Council.²⁴³ The Statewide Council appears to be envisioned essentially as a coordinating agency with little direct responsibility for review or formation of norms.²⁴⁴ The statute is ambiguous on the crucial question of the input the area and national organizations are to have in the creation of the norms. It says that the National Council shall provide for the preparation and distribution of materials indicating the "regional norms"²⁴⁵ to be used by the PSRO's as "a principal point of evaluation and review."²⁴⁶ Each PSRO is to "apply professionally developed norms of care, diagnosis, and treatment based upon typical patterns of practice in its regions."²⁴⁷ When the "actual norms" in a PSRO area are

238. *Id.* § 1320c-5(b)(1).

239. *Id.* § 1320c-5(a); *cf.* *Association of Am. Physicians & Surgeons v. Weinberger*, 395 F. Supp. 125, 139 (N.D. Ill. 1975).

240. 83 Wash. 2d 514, 519 P.2d 981 (1974). *See* notes 136-78 *supra* and accompanying text.

241. *See* 42 U.S.C. § 1320c-4(a) (Supp. II, 1972); S. REP., *supra* note 226, at 262.

242. *See* 42 U.S.C. § 1320c-11(a) (Supp. II, 1972).

243. *See id.* § 1320c-12.

244. *See id.* § 1320c-11(c).

245. *Id.* § 1320c-5(c)(1).

246. *Id.* § 1320c-5(c)(2).

247. *Id.* § 1320c-5(a). The PSRO PROGRAM MANUAL, ch. II, at 31 (1974), alludes to ten specific multi-state regions. The language of the statute, however, is confusing on this point. In one place, it refers to an area PSRO applying the norms of "its regions." 42 U.S.C. § 1320c-

significantly different from the regional norms, the area PSRO shall be informed by the National Council, and if the PSRO can demonstrate a reasonable basis for the difference, it may be permitted by the National Council to apply its own area-wide norms.²⁴⁸ From the foregoing provisions, at least a potential apparently exists for significant or even paramount involvement by the National Council in the creation of PSRO norms.²⁴⁹

The question of local responsibility for creation and application of the norms is further complicated by the area designations of the Secretary of Health, Education & Welfare [HEW]. Roughly thirty-one states (including some territories, commonwealths, or combinations thereof) have been designated single PSRO areas.²⁵⁰ Other states, such as California, boast as many as twenty-eight PSRO areas.²⁵¹ The guidelines for area designations state *inter alia* that generally PSRO areas should not cross state lines²⁵² and, when possible, should not divide a county.²⁵³ They further state that an area should as far as possible coincide with the appropriate "medical service area."²⁵⁴

It is difficult to predict what the geographical source of the PSRO norms ultimately will be. If the National Council is aggressive in its development of regional norms and sparing in its approval of area variances, the norms likely will mirror recent common law trends away from a locality perspective and in the direction of a national frame of reference. If the primary responsibility for the

5(a) (Supp. II, 1972). This seems to imply that the one area PSRO might contain multiple regions, whereas the converse appears to be the intended construction—regions should contain multiple area PSRO's.

248. See 42 U.S.C. § 1320c-5(a) (Supp. II, 1972).

249. The statute seems to suggest significant national input and perhaps direct control over area norms by the National Council. See *id.* This is clouded somewhat by the HEW manual, which appears to recognize the possibility that local PSRO Committees might select their own norms as an alternative to using the "sample sets" provided by the National Council. See PSRO PROGRAM MANUAL, ch. VII, at 17 (1974). This administrative gloss will no doubt further confuse the issue.

250. See 42 C.F.R. §§ 101.3 - .56 (1974). In such cases, a single PSRO area encompasses at least one complete state, territory, or commonwealth or combination thereof.

251. See *id.* § 101.7.

252. *Id.* § 101.2(a).

253. *Id.* § 101.2(b).

254. *Id.* § 101.2(d). This guideline is similar to an intermediate ground chosen in some cases that repudiated the traditional locality rules. Thus, in *Pederson v. Dumouchel*, 72 Wash. 2d 73, 79, 431 P.2d 973, 978 (1967), the court noted that the standard of care was "that established in an area coextensive with the medical and professional means available in those centers that are readily accessible for appropriate treatment of the patient." For more recent trends in Washington toward a national or in some cases reasonable person standard in malpractice, see respectively, *Sanderson v. Moline*, 7 Wash. App. 439, 499 P.2d 1281 (1972); and *Helling v. Carey*, 83 Wash. 2d 514, 519 P.2d 981 (1974).

development of the norms devolves to the area PSRO's, by the default or choice of the National Council or otherwise, a much different situation may result. When the PSRO area coincides with the state, responsibility for developing the norms would correspond with state responsibilities for licensing, regulation, and supervision of health care generally, but may still conflict with common law standards in states following the polar approaches of either a national or a community standard. On the other hand, the Balkanization of a single state into numerous PSRO areas that would be empowered to formulate PSRO norms may reanimate the strict locality rules with their accompanying vices and might conflict with some states' common law rules adhering to national standards.

Regardless of whether the PSRO norms are based on national, regional, or one of the manifold area-wide frames of reference, only by sheer coincidence would otherwise applicable common law rules governing malpractice correspond with the PSRO geographic orientation. Thus, to the extent its provisions displace the common law standards, the PSRO Amendment may have precipitously inaugurated dual or even multi-law rules, potentially affecting malpractice claims within a single state. Such a development should inspire interesting constitutional queries that, along with other questions, ultimately may affect the survival of the PSRO legislation.²⁵⁵ The imponderables of the PSRO standards added to the vagaries that have historically perplexed the common law standard of care may prove too much for the medical profession and sorely test the courts' adaptability. Perhaps the ultimate solution will come in the form of a unanimous acceptance of national standards regardless of where the treatment was administered. Certainly that is the incipient trend of the case law and seems at least to be consistent with the arguably broad powers conferred on the National Council by the PSRO Amendment.

(2) Reach of the Immunity Provision

The immunity provision of the PSRO Amendment²⁵⁶ applies in

255. Compare *Association of Am. Physicians & Surgeons v. Weinberger*, 395 F. Supp. 125 (N.D. Ill. 1975) (upholding the constitutionality, facially, of the PSRO Amendments as against challenges under the first, fourth, fifth, and ninth amendments to the Constitution), with *American Med. Ass'n v. Weinberger*, 395 F. Supp. 515 (N.D. Ill. 1975) (granting preliminary injunction enjoining enforcement of HEW regulations that condition Medicare and Medicaid reimbursement on the establishment by hospitals of "utilization review" committees to assess medical necessity within a certain time frame following patient's admission). See generally Note, *GEO. L.J.*, *supra* note 222, at 1509-13; Note, *LOYOLA U.L.J.*, *supra* note 222, at 102-06; *N.Y. Times*, May 28, 1975, at 24, col. 1.

256. See 42 U.S.C. § 1320c-16(c) (Supp. II, 1972).

appropriate circumstances to patient care financed by Medicare, Medicaid, or Maternal and Child Health Care programs. Thus, the potential applicability of the immunity clause is limited to less than one-half of all health care services provided in the United States.²⁵⁷ Apart from the distinction between federally funded health services and those financed in other ways, the reach of the immunity provision is not clear. As will be seen, it is difficult to forecast which health care services that are subject to the PSRO Amendment generally may fall also within the immunity clause.

The PSRO legislation was designed primarily as a means of reducing unnecessary government-sponsored health care services. Thus, one would expect the main PSRO emphasis to be upon facets of patient care that offer the most promise in terms of maximizing medical resource conservation. This tendency may, at least for a time, retard the applicability of the immunity clause.

Matters involving professional discretion and judgment as well as many complex, nonroutine medical procedures may not be amenable to the kind of explicit classification contemplated for PSRO norms. Bureaucratic delays in the creation and revision of PSRO norms also would render them incompatible with medical procedures based upon an especially fluid state of technology. Therefore, even if the necessary human and material resources are committed to the creation of PSRO norms, which is by no means assured, the practice of medicine by its very nature would seem to deny the feasibility of specific PSRO norms for many medical practices and thus deny potential immunity from civil liability.

The wording of the immunity clause²⁵⁸ raises a number of questions. It conditions immunity on, *inter alia*, compliance with professionally developed "norms" of care. According to the statute, the norms are to be utilized as a "principal point of evaluation and

257. See, e.g., Friedman, *Leonard Woodcock's Free Lunch*, NEWSWEEK, Apr. 21, 1975, at 84 (estimating that government spending accounted for 40% of all expenditures for health care). The prospects that PSRO norms will be extended to cover a greater portion of health care services appear especially good if a national health insurance plan is enacted. See Note, B.U.L. REV., *supra* note 222, at 932 n.4.

258. The immunity provision states in part:

No doctor of medicine or osteopathy and no provider . . . of health care services shall be civilly liable . . . on account of any action taken by him in compliance with or reliance upon professionally developed norms of care and treatment applied by a [PSRO] . . . operating in the area where such doctor of medicine or osteopathy or provider took such action but only if—

(2) he exercised due care in all professional conduct taken or directed by him and reasonably related to, and resulting from, the actions taken in compliance with or reliance upon such professionally accepted norms of care and treatment.

42 U.S.C. § 1320c-16(c) (Supp. II, 1972).

review."²⁵⁹ The term "norms," therefore, probably should encompass all standardized criteria upon which PSRO review is to be based.²⁶⁰ Confusion arises from Department of HEW recognition of three measures to assist in the objective evaluation of health care. These include not only "norms," but "standards" and "criteria"²⁶¹ as well. Since the Department of HEW states that all three of the foregoing yardsticks are to be used in PSRO review,²⁶² probably they all ultimately will be construed as falling within the purview of "norms" as the term is used in the immunity clause. Nevertheless, the potential difference in the meaning accorded "norms" under the statute and by the agency, until clarified, will probably engender some confusion.

Commentators have disagreed on whether actual PSRO approval of a defendant's conduct or merely the defendant's compliance with the prescribed norms is required for immunity. The immunity clause states in part that no doctor or provider of health care shall be civilly liable for action taken in compliance with or in reliance upon norms "applied"²⁶³ by PSRO's. Relying on this and other language, one writer has suggested that mere compliance with the PSRO norms will not insulate the physician from liability unless the physician also sought and was refused approval of the treatment that patient now alleges should have been administered.²⁶⁴ Another commentator has assumed that a grant of immunity does not require review of the facts of the specific case by the PSRO.²⁶⁵ This argument seems to consider the objective of the immunity clause to be the encouragement of compliance with the PSRO norms by the

259. *Id.* § 1320c-5(c)(2).

260. The Senate Report seems to support this broad construction by substituting "recommendations" for "norms" in its description of the immunity clause. *See* S. REP., *supra* note 226, at 267. It also identifies the purpose of the immunity provision as encouraging compliance with "standards and norms." *Id.* (emphasis added).

261. "Norms" are defined as "numerical or statistical measures of usual observed performance." PSRO PROGRAM MANUAL, ch. VII, at 16 (1974). "Standards" are "professionally developed expressions of the range of acceptable variation from a norm or criterion," and "criteria" are professionally developed "predetermined elements against which aspects of the quality of a medical service may be compared." *Id.*

262. *See* PSRO PROGRAM MANUAL, ch. VII, at 2 (1974).

263. 42 U.S.C. § 1320c-16(c) (Supp. II, 1972).

264. *See* Note, B.U.L. REV., *supra* Note 222, at 936-38. This commentator also suggested, *inter alia*, that blind compliance with the norms without seeking a variance when the patient's welfare so warranted would be inconsistent with one of the legislative purposes — that of providing medical services of acceptable quality. *See id.* at 937, n.48, relying on 42 U.S.C. § 1320c (Supp. II, 1972).

265. *See* Note, GEO. WASH. L. REV., *supra* note 222, at 820-30, 837-38. This construction of the statute seems to have at least tacit support in Senate Report No. 1230. It speaks in terms of compliance with norms without apparently mentioning a requirement of express PSRO approval of the action taken. *See* S. REP., *supra* note 226, at 267.

promise of immunity in advance.²⁶⁶ It is well established that legislation which operates in derogation of the common law, as does a grant of civil immunity, is to be strictly construed.²⁶⁷ Nevertheless, if the immunity clause is to fulfill its intended purpose of encouraging reliance on the collective judgment of the medical profession, immunity probably should be conferred when there has been either compliance with an applicable PSRO norm or express approval of the course followed under the PSRO norms. Until a definitive judicial or administrative clarification is provided, however, the safest way to attempt²⁶⁸ to avail oneself of the statutory grant of immunity probably would be to secure, through appropriate procedures,²⁶⁹ express "before the fact" PSRO approval of conduct complying with the applicable norms. Moreover, such approval also may reduce the likelihood that a claim of immunity could be challenged by the assertion that the PSRO norm relied upon was not applicable to the facts of the instant case.

The immunity provision is qualified by a proviso making it available to a defendant "only if [*inter alia*] . . . he exercised due care in all professional conduct . . . reasonably related to, and resulting from, the actions taken in compliance with or reliance upon such professionally accepted norms of care and treatment."²⁷⁰ A number of plausible interpretations of the qualifying language are conceivable. The "due care" requirement may qualify the threshold decision to rely on a PSRO norm as well as action taken incidental thereto.²⁷¹ The fact that one relied upon an applicable PSRO norm may thus create something approximating a presumption²⁷² that the defendant satisfied the relevant standard of care. Under such a view the decision to rely upon the applicable PSRO norm

266. See Note, GEO. WASH. L. REV., *supra* note 222, at 838.

267. See 3 J. SUTHERLAND, STATUTES AND STATUTORY CONSTRUCTION § 61.01 (4th ed. C. Sands 1973), where it has been stated that "[i]f a change is to be made in the common law . . . the legislative purpose to do so must be clearly expressed." *Id.* at 41.

268. One recent decision has expressly refused to decide, at this juncture, the threshold question of the authority of Congress to grant legal immunity under the PSRO legislation against common law tort liability. See *Association of Am. Physicians & Surgeons v. Weinberger*, 395 F. Supp. 125, 139 (N.D. Ill. 1975). Regrettably, the court was not moved to decision by the argument that physicians and other providers might be exposed to civil liability for complying with the law if the immunity clause is ultimately invalidated and if the PSRO norms depart from otherwise applicable standards of care. See *id.*

269. The legislative history suggests that immunity may be lost when the standards or norms are followed in an inappropriate manner or even when there has been express approval by the PSRO if it was induced through the provision of erroneous or incomplete information. See S. REP., *supra* note 226, at 267.

270. 42 U.S.C. § 1320c-16(c) (Supp. II, 1972).

271. See Note, GEO. WASH. L. REV., *supra* note 222, at 838-39.

272. See *id.*

might still be challenged as negligence, and the immunity clause would thus be largely nullified.

A second and perhaps more credible theory is that the due care requirement does not apply to the decision to rely upon applicable PSRO standards. It would, however, be relevant to acts "reasonably related to and resulting from" the application of the PSRO norms.²⁷³ This construction is probably the more reasonable one if the immunity clause is to have independent significance. It accords the PSRO norms conclusive weight. This interpretation, however, has drawbacks, not the least of which is its potential rigidity in encouraging unquestioning deference to prescribed norms whose authors may not have anticipated the specific situation presented. Perhaps in idiosyncratic cases or circumstances in which the inappropriateness of the PSRO norms is otherwise clear, the inflexible effect of the immunity clause could be mitigated simply by construing the norms as inapplicable to the question at hand.

A question also emerges over whether a failure to comply with applicable PSRO norms not only will deny to defendant the benefit of the immunity provision, but also may signify or imply malpractice. Legislative history suggests that noncompliance with the norms should create no presumption of malpractice.²⁷⁴ If there is to be no such presumption, would proof of noncompliance nevertheless be *evidence* of negligence? In other words, if noncompliance gave rise to no presumption, nor were deemed negligence per se generally, would the PSRO norms nevertheless be probative evidence of the standard of care for the purposes of evaluating a defendant's conduct? Presumably the legislature could have expressly provided for the imposition of civil liability as a means of insuring compliance with the norms had it chosen to do so. Thus, one could argue that as a matter of strict statutory construction—*inclusio unius est exclusio alterius*—noncompliance should not, without more, be evidence of negligence. The absence of an express provision for civil remedy *alone*, however, probably would not prevent the according of some weight to a violation. More significantly, however, it remains to be seen whether the PSRO norms will be sufficiently specific to be said to represent fairly a standard of care in the traditional sense.²⁷⁵ A fundamental question also arises concerning whether the statutory requirements of compliance with the norms are too conditional or qualified to mandate the imposition of tort

273. See *id.* at 839.

274. See S. REP., *supra* note 226, at 267.

275. See Note, GEO. L.J., *supra* note 222, at 1506.

liability for their breach.²⁷⁶ It is one thing to create a second standard of care, compliance with which is rewarded by relieving medical personnel from liability. It is a far different matter to key liability on noncompliance with that additional standard as well as the preexisting common law standards. To do so, it seems, would acutely aggravate problems that inhere in a situation involving co-existing standards of care within a single area. Until such time as the relevant state standards of care and PSRO norms coalesce into unified criteria governing medical performance, a construction limiting the legal effects of compliance or noncompliance with the PSRO norms to those expressly stated in the statute appears the wiser course. Until the question as to the full effect of noncompliance has been finally settled by the courts, however, those choosing to disregard the applicable norms may be doing so at their peril.

A sanguine outlook²⁷⁷ would anticipate a gradual move of both the common law rules and the PSRO norms toward an ultimate congress in the form of a national professionally developed standard of care for medical malpractice. The PSRO legislation might provide the impetus for developments in that direction. A less optimistic view might predict that an already confused, undividable area of the law will become hopelessly overburdened with a suffocating and pervasive bureaucracy to administer a second legal system for evaluating health care and adjusting grievances among patients and health care professionals.

IV. CONCLUSION

American lawmakers and jurists are or soon will be confronted with a number of vital decisions affecting the professional liability of members of the healing arts. At issue is the continuing validity of the present system of fault based liability for medical malprac-

276. One court has vaguely intimated that the statute should not create the occasion for the imposition of civil liability:

The "Profession Standards Review" Law does not prohibit a physician from performing any surgical operations he deems necessary in the exercise of his professional skill and judgment. It merely provides that if a practitioner wishes to be compensated for his services by the federal government, he is required to comply with certain guidelines and procedures enumerated in the statute.

. . .

. . . The risk of civil liability arises from common law standards of negligence, not from the statute.

Association of Am. Physicians & Surgeons v. Weinberger, 395 F. Supp. 125, 134, 139 (N.D. Ill. 1975).

277. It is to be hoped that chapters in the PSRO Program Manual to be issued as well as general HEW rules will help to clarify some of the questions ventilated in the foregoing discussion. Until the administrative regulations and guidelines, and a credible case law have evolved, however, the within statutory divination must be treated as provisional at best.

tice, as well as the essential nature such a system should assume if it survives. Though often divorced, the two issues are inextricably wedded. The survival of the fault based system will assuredly depend in large measure on whether it can be made to work more efficiently and more consistently while meeting its espoused goal of loss redistribution based both upon the existence of a medical accident and upon an unacceptable quality of performance.

The wholesale adoption of a no-fault scheme for medical accidents raises serious questions concerning its overall costs, definitional feasibility, egalitarian and distributive justice features, and basic fairness. These factors taken compositely militate strongly against a no-fault solution at this juncture. A social security type plan for financing health care needs poses fewer problems and would foster a more faithful administration of the fault system for those remaining economic losses by affording those stricken with misfortune a sure source of medical care outside of the fault based liability system. This would relieve some of the impetus behind suspect determinations of fault predominantly motivated by a desire to succor downtrodden plaintiffs.

An essential step in any revitalization of the fault system for medical malpractice lies in a reappraisal of the standard of care. It is probably no exaggeration to say that the basic integrity of fault based medical malpractice law and of the medical profession itself depends upon the retention of a professionally developed standard of care. This standard ideally should be based upon accepted practice, emphasizing the reasonable expectations of the profession.