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# The Role of the Jury in Modern Malpractice Law

Philip G. Peters, Jr.\*

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## INTRODUCTION

The health care industry has changed fundamentally since courts first gave physicians the power to set their own legal standard of care. Industry power has shifted away from physicians and toward managed care organizations. In an effort to keep costs down, these managed care organizations use a variety of strategies to influence the clinical practices of participating physicians. Under these circumstances, tort law's deference to medical customs is a quaint relic of a simpler time.

Although it is not widely appreciated, many states are abandoning their deference to medical customs and are empowering juries, with the help of experts, to decide what a reasonable physician would have done under the circumstances.<sup>1</sup> However, abandonment of the custom-based standard of care fundamentally alters the role of the jury. In states that have made this shift, the jury, not the medical profession, sets the standard of care. Although evidence of customary practices is still admissible, it no longer binds the jury.

The prospect of a widespread retreat from the custom-based standard of care has obvious policy implications. On the one hand, abandonment of the custom-based standard will enable judges and juries to police the practices of physicians facing intense pressure to cut costs. On the other hand, it may demand more of lay jurors than we can reasonably expect of them. And if, as some suspect, juries are unwilling to allow physicians and managed care organizations to be cost-conscious, then jury standard-setting could threaten efforts to keep health care affordable.

The choice between these two rival standards is made more difficult by the fact that each has serious shortcomings. Juries may misuse statistical proof evidence, may be susceptible to hindsight bias, and may penalize responsible efforts to keep health care costs under control. Sadly, the evidence regarding medical customs is no less disappointing. Research on physician behavior has revealed that physicians, like the rest of us, are vulnerable to self-interest, habit, and other competing influences. Customs vary inexplicably from one location to another. In addition, market imperfections so permeate health care delivery that competition cannot be trusted to discipline medical customs.

Under these circumstances, neither choice is especially appealing. Despite the imperfections associated with jury decision-making, however,

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1. See *infra* Part I (discussing the decline of deference to medical customs). Over the past several decades, nearly half of the states have quietly abandoned the custom-based standard of care. This migration away from the custom-based standard of care is described at much greater length in Philip G. Peters, Jr., *The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium*, 57 WASH. & LEE L. REV. 163, 166-68 (2000). Part I of this Article draws heavily from that prior work.

there are important justifications for assigning juries, rather than physicians, the power to set the medical standard of care. Juries are more likely than either physicians or insurance executives to strike a balance between cost and quality that reflects community values. Furthermore, the recent transformation of the health care industry has transferred considerable power from physicians to the health insurance industry, an industry that has not yet earned the privilege of self-regulation. Finally, the reasonable physician standard gives the health care industry an incentive to engage the community in a dialogue about health care resources. If the industry desires to lower the standard of care below levels that juries are demanding, the industry will need either to convince the public (i.e., future jurors) that frugality is socially responsible or to obtain the agreement of subscribers *ex ante* to a modification of the standard of care. By contrast, the custom-based standard allows health care professionals to decide unilaterally what is good for the community. For these reasons, it is worth taking the risk that juries will look skeptically at cost control measures.

This Article is organized in five Parts. Part I introduces the conventional understanding of medical malpractice doctrine and summarizes the evidence that state courts are retreating from a custom-based standard of care. Part II examines the fear that juries will reach unfair verdicts if left to determine the standard of care themselves. Part III evaluates the argument that medical customs constitute a more reliable barometer of reasonable care. Part IV then explores the advantages of assigning juries the power to set the standard of care using a reasonable physician standard. Finally, Part V synthesizes the arguments and concludes that courts should adopt the reasonable physician standard of care.

## I. DEFERENCE AND ITS DECLINE

For more than a century, courts have given physicians the power to set their own standard of care. This delegation of standard-setting authority to private parties dramatically distinguishes malpractice actions from other negligence litigation. In recent years, however, many state courts have been rethinking their deference to medical customs and have been returning to juries the power to set the standard of care.

### A. TRADITIONAL DEFERENCE TO MEDICAL CUSTOMS

In most negligence actions, the defendant's compliance with industry customs is simply one factor for the jury to consider.<sup>2</sup> While evidence of applicable customs is admissible, the jury is free to demand more

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2. Ordinary tort defendants are expected to exercise reasonable care under the circumstances. *See* RESTATEMENT (SECOND) OF TORTS § 295A (1965) (stating that custom is a factor but not controlling in the determination of whether an actor is negligent); W. PAGE KEETON ET AL., PROSSER AND KEETON ON TORTS § 33, at 193-96 (5th ed. 1984) (explaining the bearing of custom upon the standard of reasonable care).

precautions than industry norms require. As Learned Hand said in *The T.J. Hooper*, “[an industry] 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.”<sup>3</sup>

Since the late nineteenth century, however, courts have treated physicians quite differently. Medical customs are not merely admissible, they define the physician’s legal standard of care.<sup>4</sup> In the words of Dean Prosser, the custom-based standard of care “gives the medical profession . . . the privilege, which is usually emphatically denied to other groups, of setting their own legal standards of conduct, merely by adopting their own practices.”<sup>5</sup>

By deferring conclusively to medical customs, courts materially changed the jury’s function in malpractice actions. In an ordinary negligence action, the jury must consider all of the evidence adduced and then determine whether the defendant behaved reasonably under the circumstances. To do so, the jury must make important judgments about the value of life and personal safety and about the proper level of safety precautions. In a malpractice action, at least in theory, the jury does not make these value judgments—the medical profession does. The jury’s job is merely to determine whether the defendant has complied with the industry norms.

#### B. THE RECENT RETREAT FROM A CUSTOM-BASED STANDARD

Gradually, quietly, and relentlessly, state courts are abandoning the custom-based standard of care. Thus far, eleven states and the District of Columbia have expressly refused to equate reasonable care with customary

3. 60 F.2d 737, 740 (2d Cir. 1932).

4. See, e.g., *Osborn v. Irwin Mem’l Blood Bank*, 7 Cal. Rptr. 2d 101, 125 (Cal. Ct. App. 1992) (describing custom as the majority rule); PATRICIA M. DANZON, *MEDICAL MALPRACTICE: THEORY, EVIDENCE AND PUBLIC POLICY* 16, 139-40 (1985) (stating that deviations from reliance on custom standard are “rare”); BARRY R. FURROW ET AL., *HEALTH LAW* § 6-2, at 238 (1995) (same); DAVID M. HARNEY, *MEDICAL MALPRACTICE* 89 (1973) (stating that custom defines the standard of care); KEETON ET AL., *supra* note 2, § 32, at 189 (same); SYLVIA LAW & STEVEN POLAN, *PAIN AND PROFIT: THE POLITICS OF MALPRACTICE* 7, 101 (1978) (same); CLARENCE MORRIS & C. ROBERT MORRIS, JR., *MORRIS ON TORTS* 55 (2d ed. 1980) (stating that custom is the rule in medical malpractice); James A. Henderson, Jr. & John A. Siliciano, *Universal Health Care and the Continued Reliance on Custom in Determining Medical Malpractice*, 79 CORNELL L. REV. 1382, 1384 (1994) (same); Alan H. McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 560, 605-06 (1959) (same); Clarence Morris, *Custom and Negligence*, 42 COLUM. L. REV. 1147, 1147, 1158 (1942) (stating custom normally should define standard of care); Theodore Silver, *One Hundred Years of Harmful Error: The Historical Jurisprudence of Medical Malpractice*, 1992 WIS. L. REV. 1193, 1212 (stating custom determines standard of care). Similarly, the *Second Restatement of Torts* states that the physician must “exercise the skill and knowledge normally possessed” by other physicians. RESTATEMENT (SECOND) OF TORTS § 299A (1965) (emphasis added).

5. KEETON ET AL., *supra* note 2, § 32, at 89.

practices.<sup>6</sup> The most famous of these cases is *Helling v. Carey*,<sup>7</sup> a Washington Supreme Court decision. However, custom has also been abandoned in Colorado,<sup>8</sup> the District of Columbia,<sup>9</sup> Florida,<sup>10</sup> Illinois,<sup>11</sup> Louisiana,<sup>12</sup> Minnesota,<sup>13</sup> Mississippi,<sup>14</sup> Nevada,<sup>15</sup> Texas,<sup>16</sup> Wisconsin,<sup>17</sup> and Wyoming.<sup>18</sup> These states now use a “reasonable physician” test.

Another nine states, although not explicitly addressing the role of custom, have also endorsed the “reasonable physician” test. These states are Indiana,<sup>19</sup> Kentucky,<sup>20</sup> Maryland,<sup>21</sup> Montana (for non-board certified general

6. In addition to these jurisdictions, four additional states have appellate decisions expressly rejecting customary standards: Pennsylvania, Ohio, California, and Oklahoma. However, the current law in these states is unclear. See Peters, *supra* note 1, at 175-79 (discussing the cases in these states at length).

7. 519 P.2d 981 (Wash. 1974).

8. See *State Bd. of Med. Exam'rs v. McCroskey*, 880 P.2d 1188, 1194 (Colo. 1994) (citing *United Blood Servs. v. Quintana*, 827 P.2d 509, 520 (Colo. 1992)) (finding that presumption that adherence to customary practices provides a reasonable standard of care is rebuttable with proof to the contrary).

9. See *Ray v. Am. Nat'l Red Cross*, 696 A.2d 399, 404 (D.C. 1996) (upholding reasonably prudent professional standard); see also *Cleary v. Group Health Ass'n, Inc.*, 691 A.2d 148, 156 (D.C. 1997) (stating that the duty owed is that of a “reasonably prudent physician”).

10. See *Doctors Mem'l Hosp., Inc. v. Evans*, 543 So. 2d 809, 812 (Fla. Dist. Ct. App. 1989) (citing *Nesbitt v. Comm. Health*, 467 So. 2d 711, 715 (Fla. Dist. Ct. App. 1985)) (disregarding the customary methods test and emphasizing the prudent person standard).

11. See *Advincula v. United Blood Servs.*, 678 N.E.2d 1009, 1027-28 (Ill. 1996) (stating, in an action against a blood bank, that custom was not conclusive even for medical professionals and favoring citing *Chiero* and *Lundahl* on this point); *Chiero v. Chi. Osteopathic Hosp.*, 392 N.E.2d 203, 209 (Ill. App. Ct. 1979) (“[G]eneral custom is . . . not, however, conclusive.”); *Lundahl v. Rockford Mem'l Hosp. Ass'n*, 235 N.E.2d 671, 674 (Ill. App. Ct. 1968) (“It is entirely possible, as pointed out by the Supreme Court in the case of *Darling v. Charleston Community Memorial Hospital* . . . that what is the usual or customary procedure might itself be negligence.”).

12. See *Favalora v. Aetna Cas. & Sur. Co.*, 144 So. 2d 544, 550 (La. Ct. App. 1962). The law in Louisiana is complex and is reviewed in more detail in Peters, *supra* note 1, at 173 n.55.

13. See *Kalsbeck v. Westview Clinic, P.A.*, 375 N.W.2d 861, 868 (Minn. Ct. App. 1985) (upholding a reasonable care standard). *But see* *Ogle v. Bassett Creek Dental, P.A.*, No. C6-96-2060, 1997 WL 292163, at \*2 (Minn. June 3, 1997) (unpublished opinion) (assuming that a medical standard of care is customary).

14. See *McCarty v. Mladineo*, 636 So. 2d 377, 381 (Miss. 1994) (stating that a physician must be minimally competent and act in a reasonably prudent manner); *Hall v. Hilburn*, 466 So. 2d 856, 873 (Miss. 1985) (same).

15. See *Brown v. United Blood Servs.*, 858 P.2d 391, 396 n.5 (Nev. 1993) (agreeing with the Colorado Supreme Court that customary practices may be deficient).

16. See *Hood v. Phillips*, 554 S.W.2d 160, 165 (Tex. 1977) (applying a reasonably prudent doctor standard).

17. See *Nowatske v. Osterloh*, 543 N.W.2d 265, 272 (Wis. 1996) (stating that the standard of care applicable to physicians is what is reasonable given the state of medical knowledge at time of treatment).

18. See *Vassos v. Roussalis*, 625 P.2d 768, 772 (Wyo. 1981) (articulating the standard as “that which is required of a reasonable person in light of all the circumstances”).

19. See *Vergara v. Doan*, 593 N.E.2d 185, 187 (Ind. 1992) (requiring a physician to

practitioners),<sup>22</sup> Oregon,<sup>23</sup> Vermont,<sup>24</sup> Virginia,<sup>25</sup> West Virginia,<sup>26</sup> and, less clearly, New Hampshire.<sup>27</sup> In these states, like the states that have expressly rejected deference to custom, the jury decides whether the physician

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“exercise that degree of care, skill, proficiency exercised by reasonably careful, skillful, and prudent practitioners in the same class to which he belongs, acting under the same or similar circumstances”); *see also* Oelling v. Rao, 593 N.E.2d 189, 191 (Ind. 1992) (holding that a plaintiff’s expert must establish what reasonable doctors similarly situated would have done).

20. *See* Blair v. Eblen, 461 S.W.2d 370, 373 (Ky. 1970) (requiring the “degree of skill which is expected of a reasonably competent practitioner”). Some ambiguity arguably remains because Blair, in 1970, said that “we will leave determination of the standard to the medical profession and not the lay courts.” Blair, 461 S.W.2d at 373. The more recent cases, however, use a reasonability test. When I practiced in Kentucky, it was commonplace to ask experts whether the defendants had violated “the standard of care” without further defining the standard.

21. *See* Shilkret v. Annapolis Emergency Hosp. Ass’n, 349 A.2d 245, 255 (Md. 1975) (holding that “a hospital is required to use that degree of care and skill which is expected of a reasonably competent hospital in the same or similar circumstances”).

22. *See* Chapel v. Allison, 785 P.2d 204, 210 (Mont. 1990) (requiring “the standard of care of a ‘reasonably competent general practitioner acting in the same or similar community . . . in the same or similar circumstances’”).

23. *See* OR. REV. STAT. § 677.095 (1999) (defining degree of care as “that degree of care, skill and diligence that is used by ordinarily careful physicians . . . in the same or similar circumstances in the community . . . or a similar community”); Rogers v. Meridian Park Hosp., 772 P.2d 929, 933 (Or. 1989) (“[A] physician must *always* exercise reasonable care.”).

24. *See* Rooney v. Med. Ctr. Hosp., 649 A.2d 756, 760 (Vt. 1994) (holding doctors to the standard of what a reasonable doctor would have done under similar circumstances); *accord* Short v. United States, 908 F. Supp. 227, 236 (D. Vt. 1995) (applying the Rooney standard).

25. *See* VA. CODE ANN. § 8.01-581.20 (Michie 2000) (“[T]he standard of care by which the acts or omissions are to be judged shall be that degree of skill and diligence practiced by a reasonably prudent practitioner in the field of practice or speciality in this Commonwealth.”); Raines v. Lutz, 341 S.E.2d 194, 196 (Va. 1986) (“Health care providers are required by law to possess and exercise only that degree of skill and diligence practiced by a reasonably prudent practitioner in the same field of practice or specialty in Virginia.”); *accord* Bryan v. Burt, 486 S.E.2d 536 (Va. 1997) (stating that a physician must demonstrate the degree of skill and diligence employed by a reasonably prudent practitioner).

26. *See* W. VA. CODE ANN § 55-7B-3 (2000) (requiring proof that the “care provider failed to exercise that degree of care, skill, and learning required or expected of a reasonable, prudent health care provider . . . in the same or similar circumstances”). *But see* Tennant v. Marion Health Care Found., Inc., 459 S.E.2d 374, 393 (W. Va. 1995) (finding that an erroneous instruction applying a standard of care of the “average doctor” engaged in the field was not prejudicial); Howe v. Thompson, 412 S.E.2d 212, 215-17 (W. Va. 1991) (allowing a jury instruction of a standard of care containing elements of both reasonability and custom). In 1994, a federal court concluded that West Virginia would reject a custom-based standard of care. Doe v. Am. Nat’l Red Cross, 848 F. Supp. 1228, 1233-34 (S.D. W. Va. 1994).

27. *See* N.H. REV. STAT. ANN. § 508:13 (1997) (considering whether a practitioner has “acted with due care having in mind the standards and recommended practices and procedures of his profession, and the training, experience and professed degree of skill of the average practitioner of such profession, and all other relevant circumstances”); N.H. REV. STAT. ANN. § 507-C:2 (1997) (explaining plaintiff has burden of proving “standard of acceptable professional practice in the medical care provider’s profession or specialty”); Morrill v. Tilney, 519 A.2d 293, 296-97 (N.H. 1986) (citing N.H. REV. STAT. ANN. § 508:13 (1997), establishing the standard of medical malpractice).



behaved reasonably, not whether she complied with custom.<sup>28</sup> Although experts still battle in the courtroom, they argue about what physicians *should* do, not what physicians *ordinarily* do.

In addition to the states that have moved to a reasonability standard, several other states have case law that is too ambiguous, inconsistent, or conflicting to classify confidently.<sup>29</sup> As a consequence, the fraction of states that unambiguously endorse the custom-based standard of care has fallen from a clear majority to a shrinking plurality.

Finally, courts in states that purportedly endorse the custom-based standard often allow plaintiffs more latitude than this standard of care would imply.<sup>30</sup> Plaintiffs in these states commonly reach a jury even when their experts have stated only that the defendant's conduct is not "acceptable," not "appropriate," or fails to meet the "standard of care."<sup>31</sup> The experts in these cases have not been required to testify that the defendant deviated from customary practice. Nor is the admission of respected clinical practice guidelines premised on proof that they describe actual rather than recommended practice.<sup>32</sup>

In theory, of course, the "respectable minority" rule should protect physician defendants from liability in cases where physicians simply disagree.<sup>33</sup> However, as Mark Hall correctly points out, courts typically give

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28. See *supra* text accompanying note 4 (discussing the case law).

29. These states are Arizona, California, Georgia, Iowa, Michigan, Ohio, and Pennsylvania. See Peters, *supra* note 1, at 175-79, 181-82, 190 (discussing the cases from these jurisdictions).

30. See *id.* at 185 (discussing the cases).

31. See *Sanders v. Ramo*, 416 S.E.2d 333, 335 (Ga. Ct. App. 1992) (noting that experts' affidavits may give the opinion of the failure to exercise due care without reciting the proper legal standard of care); *Lyu v. Shinn*, 40 Haw. 198, 206 (1953) (finding expert's testimony of hypothetical patient's medical reaction sufficient to establish a standard of care); *McGrady v. Wright*, 729 P.2d 338, 341 (Ariz. Ct. App. 1986) (concluding that plaintiff's expert created a prima facie case by testifying that a reasonable and prudent doctor would have taken a biopsy); *Heirs v. Lemley*, 834 S.W.2d 729, 733 (Mo. 1992) (accepting testimony about defendant's failure to "exercise that degree of skill and learning that an ordinarily careful and prudent physician would have exercised"); *McCourt v. Abernathy*, 457 S.E.2d 603, 605 (S.C. 1995) (affirming judgment based on expert's testimony that defendant had deviated from "the standard of care"). Some courts are more strict; see, e.g., *Downer v. Veilleux*, 322 A.2d 82, 86-88 (Me. 1974) (rejecting testimony that defendant's conduct was "bad practice"); *Kortus v. Jensen*, 237 N.W.2d 845, 851 (Neb. 1976) (rejecting testimony that plaintiff's expert would have acted differently).

32. See Michelle M. Mello, *Of Swords and Shields: The Role of Clinical Practice Guidelines in Medical Malpractice Litigation*, 149 U. PA. L. REV. 645, 663-65, 677-84 (2001) (arguing that clinical practice guidelines do not indicate customary uses).

33. The "respectable minority" or "two schools of thought" rule permits physicians to choose among respectable schools of medical thought without fear of liability. See, e.g., *Downer*, 322 A.2d at 87 ("[A] physician does not incur liability merely by electing to pursue one of several recognized courses of treatment."); *Haase v. Garfinkel*, 418 S.W.2d 108, 114 (Mo. 1967) (stating there can be "difference of opinion among competent physicians"); *FURROW ET AL.*, *supra* note 4 at 382-84 (describing the "respectable minority" defense). This rule arises out of judicial unwillingness to choose among conflicting schools of thought when physicians

these cases to the jury.<sup>34</sup> The jury then applies a de facto reasonability test in order to determine whether the defendant's school of thought was "respectable." As a consequence, contemporary support for the custom-based standard of care is far weaker than previously supposed.<sup>35</sup>

### C. JUDICIAL RATIONALES FOR THE SHIFT

Courts abandoning the custom-based standard of care have shared Judge Hand's view that "[c]ourts in the end must say what is required."<sup>36</sup> "Negligence," said the Wyoming Supreme Court, "cannot be excused on the grounds that others practice the same kind of negligence."<sup>37</sup> Otherwise, said the Colorado Supreme Court, "the profession itself would be permitted to set the measure of its own legal liability, even though that measure might be far below a level of care readily attainable."<sup>38</sup> The unstated conclusion in these opinions is that deference to customary standards would place the profession above the law.<sup>39</sup>

The courts have not, however, explained why the once-persuasive arguments made in favor of a custom-based standard are no longer convincing.<sup>40</sup> Perhaps courts were influenced by the consumerism of the

themselves cannot reach a consensus. See RESTATEMENT (SECOND) OF TORTS § 299A cmt. f (1965) ("The law cannot undertake to decide technical questions of proper practice over which experts reasonably disagree. . . ."). As a result, physicians are theoretically insulated from liability both when they comply with an established custom and when respectable medical opinion is divided on which medical practice is best.

34. See Mark A. Hall, *The Defensive Effect of Medical Practice Policies in Malpractice Litigation*, LAW & CONTEMP. PROBS., Spring 1991, at 119, 128-29 (noting the failure of the "respectable minority" rule to keep these cases from the jury); see also Peters, *supra* note 1, at 186 (same).

35. Moreover, the movement away from the custom-based standard has not run out of momentum. In the 1980s, four states expressly rejected customs and three adopted a reasonable-physician standard. In the 1990s, four more jurisdictions rejected conclusive reliance on a custom-based standard and Indiana adopted a reasonable-physician standard. If this trend continues, the states that assign standard-setting to the jury will soon constitute a majority. However, it is also possible that some of the states that have adopted the reasonable-physician test without explicitly addressing the role of custom will ultimately end up deferring to customs. See Peters, *supra* note 1, at 184 (discussing the facts that support this possibility).

36. *The T.J. Hooper*, 60 F.2d 737, 740 (2d Cir. 1932), cert. denied, 287 U.S. 662 (1932); see, e.g., *Advincula v. United Blood Servs.*, 678 N.E.2d 1009, 1027 (Ill. 1996) (noting that custom is not conclusive of proper care (citing *Darling v. Charleston Cmty. Mem'l Hosp.*, 211 N.E.2d 253, 257 (Ill. 1965) (quoting *The T.J. Hooper*, 60 F.2d 737, 740 (2d Cir. 1932), cert. denied, 287 U.S. 662 (1932))); *Nowatske v. Osterloh*, 543 N.W.2d 265, 272 (Wis. 1996) (noting that customary conduct is not dispositive of reasonable care).

37. *Vassos v. Roussalis*, 625 P.2d 768, 772 (Wyo. 1981).

38. *United Blood Servs. v. Quintana*, 827 P.2d 509, 520 (Colo. 1992) (en banc).

39. See, e.g., *id.* (noting that courts, not professions, decide due care (quoting *The T.J. Hooper*, 60 F.2d at 740)); *Darling v. Charleston Cmty. Mem'l Hosp.*, 211 N.E.2d at 257 (same).

40. Interestingly, however, the timing and text of the opinions abandoning the custom-based standard of care suggest that the trend was not, at least initially, triggered by a reaction against the growth of managed care delivery systems. The trend began in the 1970s, well before managed care companies had gained a significant market share or become the target of public

1970s.<sup>41</sup> Or perhaps they may have lost their faith that physicians are sufficiently different from engineers, truck drivers, product manufacturers, and other tort defendants to justify the legal privileges previously accorded to them.<sup>42</sup>

Whatever the explanation, it is clear today that courts defer less to physicians than they once did and are less willing to erect special rules for health care providers. For example, physicians are no longer exempt from antitrust laws.<sup>43</sup> In many states, physicians no longer enjoy the protection from corporate competition once provided by the corporate practice prohibitions.<sup>44</sup> In tort law, physicians have lost the protection of the strict locality rule<sup>45</sup> and are also required to obtain informed consent.<sup>46</sup> In addition, courts appear to be retreating from some of the special “no duty” rules that once typified medical malpractice law, such as the rule that pharmacists have no duty to warn patients about incompatible prescriptions and the rule that “on call” doctors have no duty to emergency patients until they establish a physician-patient relationship.<sup>47</sup> Abandonment of the custom-based standard of care is consistent with this trend away from special rules for health care providers.

The weakening of support for the custom-based standard of care is also consistent with the gradual movement of twentieth-century tort law away from special duties tailored for specific social contexts and toward a general obligation of reasonable care. Throughout the twentieth century, early tort law’s complex matrix of immunities and special duty rules has been giving way to a more simple regime in which more people are exposed to tort liability and their duty is simply to behave reasonably.<sup>48</sup> For example, many

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controversy. Furthermore, the more recent opinions make no reference to the emergence of managed care systems or the need for greater judicial scrutiny of an increasingly commercialized health care delivery system.

41. See WILLIAM CURRAN ET AL., *HEALTH CARE LAW AND ETHICS* 213 (5th ed. 1998) (noting that consumerism eroded the “authority and supremacy” of the physician and may have made possible the rise of the informed consent cause of action).

42. See Peters, *supra* note 1, at 196-99 (discussing the evidence that public trust is declining).

43. MARK A. HALL & IRA MARK ELLMAN, *HEALTH CARE LAW AND ETHICS IN A NUTSHELL* 186 (1990).

44. See *People v. Pac. Health Corp.*, 82 P.2d 429, 430 (Cal. 1938) (stating that corporations may not engage in the practice of medicine); PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 198-234 (1982) (describing the struggle of physicians to avoid corporate dominance).

45. See, e.g., *Hall v. Hilbur*, 466 So. 2d 865, 871 (Miss. 1985) (requiring doctors to follow national standards of care, not local ones); FURROW ET AL., *supra* note 4, at 239-40.

46. See, e.g., *Salgo v. Leland Stanford Jr. Univ. Bd. of Trs.*, 317 P.2d 170, 181 (Cal. Ct. App. 1957); FURROW ET AL., *supra* note 4, at 265-87.

47. Philip G. Peters, Jr., *Breaking Down the Boundaries of Malpractice Law*, 65 MO. L. REV. 1047, 1047 (2000).

48. See Gary T. Schwartz, *The Vitality of Negligence and the Ethics of Strict Liability*, 15 GA. L. REV. 963, 963-77 (1981) (discussing the growth of negligence principles and the abrogation of

states have simplified the obligations of possessors of land, replacing the tripartite status-based duty rules with a single duty of reasonable care.<sup>49</sup> Similarly, many states have expanded recovery for emotional distress<sup>50</sup> and for failure to warn.<sup>51</sup> In addition, the charitable, family, and governmental immunities have all been partially or completely abrogated.<sup>52</sup> Overall, these changes suggest that tort law is evolving toward a general duty of reasonable care. Malpractice law's movement away from a custom-based standard of care is consistent with this trend.

#### D. IMPLICATIONS

Whether de jure or de facto, the shift away from the customary standard and toward a reasonable physician standard takes the task of standard-setting away from the profession and assigns it to the jury.<sup>53</sup> The centrality of this

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special classifications and immunities).

49. See, e.g., *Rowland v. Christian*, 443 P.2d 561, 566-69 (Cal. 1968) (discarding the common-law classifications of trespasser, licensee, and invitee in favor of a simple, unified negligence standard).

50. See, e.g., *Dillon v. Legg*, 441 P.2d 912, 921 (Cal. 1968) (allowing emotional distress recovery to a mother who witnessed her child's death, but was in no danger herself); *Bass v. Nooney Co.*, 646 S.W.2d 765, 768-73 (Mo. 1983) (abandoning the impact rule in emotional distress cases).

51. See, e.g., *Tarasoff v. Regents of Univ. of Cal.*, 551 P.2d 334, 339-48 (Cal. 1976) (finding that a psychiatrist has duty to warn potential victims of dangerous patients when a "special relationship" exists between the doctor and either the patient or victim); *Madden v. C & K Barbecue Carryout, Inc.*, 758 S.W.2d 59, 63 (Mo. 1988) (finding that a business owner has a duty to protect invitees from foreseeable torts of third parties).

52. See KEETON ET AL., *supra* note 2, § 131-35, at 1032-73 (surveying immunities).

53. The switch to a reasonable physician standard also has at least three practical consequences. First, judges will permit plaintiffs to reach a jury without proving that the defendant failed to do what most physicians do. Page Keeton, *Medical Negligence—The Standard of Care*, 10 TEX. TECH L. REV. 351, 363 (1979). Second, juries will hear instructions describing the standard of care in terms of reasonability rather than compliance with custom. In Indiana, for example, the courts have approved jury instructions using a reasonable-physician standard. See *Miller v. Ryan*, 706 N.E.2d 244, 248 n.4 (Ind. Ct. App. 1999) (approving a trial court instruction using the reasonable physician test). In Vermont, too, the state supreme court has endorsed the use of the reasonable physician standard in jury instructions. See *Rooney v. Med. Ctr. Hosp.* 649 A.2d 756, 760 (Vt. 1994) (disapproving of "error in judgment" language, but approving reasonable care language in a challenged jury instruction). Oregon's supreme court has not directly faced the issue, but its discussion of improper jury instructions in a 1989 case strongly suggests that the jury is to be given the issue of reasonable care. See *Rogers v. Meridian Park Hosp.* 772 P.2d 929, 933 (Or. 1989) (overturning a verdict for a defendant anesthesiologist because the jury instruction wrongly suggested that a physician's duty to "exercise reasonable judgment" depended on existence of "reasonable differences of opinion"). Third, courts will expect the parties to explain why the defendant's actions were (or were not) reasonable, just as they do in all other negligence litigation. That means that evidence of the costs and benefits of any untaken precautions will now be admissible.

These changes are occurring not only in states that have expressly rejected deference to custom, but also in states that have quietly adopted a reasonable physician test. In Indiana, for example, the plaintiff's expert must state "what other reasonable doctors similarly situated would have done under the circumstances." *Oelling v. Rao*, 593 N.E.2d 189, 191 (Ind. 1992).

doctrinal shift cannot be overstated. The delegation of standard-setting authority to the professions is unique in tort law. It is the foundation upon which the field of medical malpractice law has been built.<sup>54</sup>

Under the custom-based standard of care, the relevant inquiry is not whether the defendant behaved like a reasonable person or even whether she behaved as a reasonable physician. Instead, the jury must determine whether the defendant conformed with customary practices. Consequently, the jury's inquiry is positive, rather than normative.<sup>55</sup> The jury determines what the customary practice *is*; it does not decide what the custom *ought* to be.<sup>56</sup> The law assigns the normative judgment to the medical profession.

Because the question for the jury is what physicians do not why they do it, evidence of the ineffectiveness of customary practices often is excluded from evidence at trial.<sup>57</sup> Under the custom-based standard of care, that evidence is irrelevant. As one court explained, "professional prudence is defined by actual or accepted practice within a profession, rather than theories about what 'should' have been done."<sup>58</sup> By the same logic, evidence of authoritative clinical practice guidelines also ought to be excluded (although typically it is not).<sup>59</sup>

Under the jury-applied reasonable physician standard, by contrast, the *jury*, not the profession, determines what a reasonable physician would have done under similar circumstances. Medical customs, to the extent that they

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Michigan law appears to operate in a similar fashion. *See* *Locke v. Pachtman*, 521 N.W.2d 786, 791 (Mich. 1994) (stating that expert must explain "what a reasonably prudent surgeon would do, in keeping with the standards of professional practice"). Furthermore, in West Virginia, a federal district court, applying the professional standard of care, refused to grant a summary judgment against a plaintiff whose experts challenged the customary practices of the blood-banking industry as dilatory. *Doe v. Am. Nat'l Red Cross*, 848 F. Supp. 1228, 1234 (S.D. W. Va. 1994). The West Virginia law on jury instructions is less clear. *See* *Tennant v. Marion Health Care Found., Inc.*, 459 S.E.2d 374, 393 (W. Va. 1995) (finding that jury instruction with erroneous language on standard of care was not prejudicial). In addition, anecdotal evidence from Kentucky and New Hampshire suggests that their courts do not require a plaintiff's expert to prove that the defendant failed to do what most physicians do. In Kentucky, where I practiced for several years, plaintiffs' experts commonly testified only that the defendant's conduct had not met the "standard of care." Lawyers in New Hampshire report a similar experience.

54. *See* Peters, *supra* note 1, at 166-68 (describing the array of subsidiary doctrines accompanying the custom-based standard of care).

55. *See* James F. Blumstein, *Rationing Medical Resources: A Constitutional, Legal, and Policy Analysis*, 59 TEX. L. REV. 1345, 1396 (1981) (noting that the custom-based standard requires no normative judgment).

56. *See id.* (noting that the custom-based standard requires no normative judgment).

57. *See*, *Schneider*, 817 F.2d at 990 (stating that evidence of effectiveness of treatment is irrelevant); *cf.* FURROW ET AL., *supra* note 4, at 238-39 (noting that defendants normally do not offer evidence of effectiveness of customary practices).

58. *Osborn v. Irwin Mem'l Blood Bank*, 7 Cal. Rptr. 2d 101, 128 (Cal. Ct. App. 1992).

59. *See* Mello, *supra* note 32, at 663-65, 677-84 (arguing that clinical practice guidelines are typically inaccurate evidence of customary practice and discussing the admissibility of clinical practice guidelines as evidence of the standard of care).

exist, are admissible but not binding on the jury. Several important policy consequences flow from this transfer of authority. Most obviously, the abandonment of a custom-based standard of care will make adherence to outmoded customs more dangerous and innovation less risky. More importantly, the change in standards will empower the jury to set a floor below which cost containment practices cannot descend absent an enforceable agreement to modify the standard of care.<sup>60</sup> The crucial unanswered question is whether jurors can handle that task responsibly.

## II. JURY COMPETENCE

Over the past century, the justification most frequently offered for taking the power of standard-setting away from the jury is that lay people cannot be trusted to determine what reasonable medical care requires. The fabric of this argument has five related threads. The first and most obvious concern is that lay jurors lack the training needed to evaluate complex medical treatment decisions. The second thread is a fear that juries will be sympathetic to injured plaintiffs and biased against wealthy defendants. A third and more recent concern is that juries will not permit defendants to take costs into account, even though the balancing of costs against benefits is an integral part of modern negligence law. The fourth concern is that jury verdicts will be distorted by two cognitive biases that apply to hindsight judgments: hindsight bias and outcome bias. The final concern is that malpractice disputes, especially those involving resource allocation, are “polycentric” and, therefore, not capable of resolution without adopting some concrete benchmark, such as compliance with medical customs.

Each of these concerns identifies an important potential limit on the jury’s ability to apply a reasonable care standard fairly. Happily, the empirical research on jury behavior is more favorable than this list of concerns would suggest.

### A. JURY CAPACITY

Many proponents of a custom-based standard of care doubt that lay jurors have the technical expertise or intellectual ability to evaluate the conduct of skilled professionals.<sup>61</sup> Critics fear that juries will be confused by

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60. In theory, cost conscious providers will also be freer to deviate from wasteful standards set by fee-for-service medicine. In practice, however, it is far from clear that juries will be receptive to cost-based explanations. See *infra* Part II.C (discussing jury willingness to consider costs).

61. See, e.g., *Doe v. Am. Red Cross Blood Servs.*, 377 S.E.2d 323, 326 (S.C. 1989) (noting a preference toward a professionally generated standard of care); KEETON ET AL., *supra* note 2, at 189 (discussing “the layman’s ignorance of medical matters”); Richard E. Leahy, *Rational Health Policy and the Legal Standard of Care: A Call for Judicial Deference to Medical Malpractice Guidelines* 77 CAL. L. REV. 1483, 1496-98 (1989) (expressing doubt over jurors’ ability to comprehend complex expert witness testimony on the medical standard of care); Morris, *supra* note 4, at 1164 (suggesting that neither judges nor juries are able to reasonably assess medical evidence).

scientific evidence and, in their confusion, will be vulnerable to manipulation by plaintiffs' attorneys and their hired-gun experts, who will elicit sympathy for injured plaintiffs<sup>62</sup> and antipathy toward wealthy defendants.<sup>63</sup> In his much-cited article on the malpractice standard of care, Allan McCoid concluded that juries were not technically competent to understand the issues in a malpractice case.<sup>64</sup> Clarence Morris, in his classic 1942 article *Custom and Negligence*, theorized that neither the judge nor the jury is "competent to judge whether or not a doctor has acted reasonably."<sup>65</sup> Joseph King opined that medical error should not be "evaluated by the ad hoc judgment of a lay judge or lay jurors aided by hindsight . . . ."<sup>66</sup> These critics doubt the ability of the jury to assess the credibility of the conflicting experts accurately.<sup>67</sup>

Unfortunately, there are no empirical studies that test these fears directly. No research has compared the outcomes reached under a custom-based standard with those obtained under a reasonable physician standard. Nevertheless, the existing body of empirical research on jury decision-making does provide a useful background against which to form educated hypotheses about the jury's capacity to reach fair verdicts while applying a reasonable care standard.

### 1. Evidence of Judge-Jury Concordance

One method commonly used by social scientists to evaluate jury performance is to compare the outcomes reached by juries with those reached by judges. Researchers have repeatedly found that juries and judges reach extremely similar conclusions about tort liability. As a consequence, these studies do not provide support for the contention that juries are especially sympathetic to plaintiffs and vulnerable to manipulation by plaintiffs' attorneys.

That finding has been confirmed using two very different

62. See, e.g., STEPHEN DANIELS & JOANNE MARTIN, CIVIL JURIES AND THE POLITICS OF REFORM 127-28 (1995) (discussing fears about pro-plaintiff bias); Joseph H. King, Jr., *In Search of a Standard of Care for the Medical Profession: The "Accepted Practice" Formula*, 28 VAND. L. REV. 1213, 1254 (1975) (noting the pro-plaintiff bias of lay juries); NEIL VIDMAR, MEDICAL MALPRACTICE AND THE AMERICAN JURY 4 (1995) (quoting the North Carolina Hospital Association).

63. See, e.g., James K. Hammit, et al., *Tort Standards and Jury Decisions*, 14 J. LEGAL STUD. 751, 754 n.8 (1985) (discussing the perception that the defendants wealth matters); CLARK C. HAVIGHURST, HEALTH CARE LAW AND POLICY 778 (1988) (noting the danger of bias against wealthy defendants); King, *supra* note 62, at 1254 (noting "the notorious penchant . . . to go for the deep pockets"); VIDMAR, *supra* note 62, at 4 (quoting the North Carolina Plastic Surgery Society) and 21 (quoting former U.S. Surgeon General C. Everett Koop).

64. See McCoid, *supra* note 4, at 607-08 (discussing the inadequacy of lay juries to properly evaluate the conduct of medical experts).

65. Morris, *supra* note 4, at 1164.

66. King, *supra* note 62, at 1249.

67. See DANZON, *supra* note 4, at 140 (describing this view).

methodologies. One approach compares plaintiff win rates in bench trials and jury trials, and the other asks both judges and jurors to evaluate the same evidence. Researchers comparing bench trials with jury trials have found that plaintiffs in malpractice and product liability actions win significantly more often in front of judges than in front of juries.<sup>68</sup> However, it is possible that plaintiffs' success in front of judges may have more to do with the routing of certain kinds of cases to juries and other types to judges than with the decision-making tendencies of judges and juries themselves.<sup>69</sup> To eliminate this confounding variable, researchers have employed a second methodology for comparing the decisions of judges and juries.

An alternative methodology compares the reactions of judges and jurors to the same evidence. The most famous of these studies was undertaken by Kalven and Zeisel in the 1960s.<sup>70</sup> They reviewed 4000 civil trials.<sup>71</sup> In nearly four out of five cases (78%), the judge and jury agreed, thus refuting fears about jury unpredictability and incompetence.<sup>72</sup> As Clermont and Eisenberg observed, "[t]his 78% agreement rate is better than the rate of agreement between scientists doing peer review, employment interviewers ranking applicants, and psychiatrists and physicians diagnosing patients."<sup>73</sup> In fact, it compares favorably to the rate of agreement among physicians evaluating the conduct of their peers. A study by Farber and White, for example, found that internal reviewers examining claims filed against a self-insured hospital disagreed or filed ambiguous reports over thirty percent of the time.<sup>74</sup>

The Kalven and Zeisel study also contained a second interesting finding. When the judge and jury disagreed, the disagreements did not reflect a jury bias in favor of plaintiffs. Instead, disagreements were nearly evenly split between plaintiffs and defendants.<sup>75</sup> Thus, no significant

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68. See Kevin M. Clermont & Theodore Eisenberg, *Trial by Jury or Judge: Transcending Empiricism*, 77 CORNELL L. REV. 1124, 1137, 1174 (1992) (discussing findings). Jurors were also slightly tougher on plaintiffs in automobile accident cases. They were only more favorable to plaintiffs in marine and FELA cases, and the pro-plaintiff tendency was slight. *Id.* at 1137. Another study found a significant pro-defendant bias in product liability cases. See Steven Landsman et al., *Be Careful What You Wish For: The Paradoxical Effects of Bifurcating Claims for Punitive Damages*, 1998 WIS. L. REV. 297, 334 (discussing findings).

69. See Clermont & Eisenberg, *supra* note 68, at 1174 (suggesting alternative ways of interpreting studies comparing judge and jury verdicts).

70. HARRY KALVEN, JR. & HANS ZEISEL, *THE AMERICAN JURY* (1966).

71. *Id.* at 63-65.

72. KALVEN & ZEISEL, *supra* note 70, at 63. Personal injury cases had the same rate of agreement. *Id.* at 64 n.12.

73. Clermont & Eisenberg, *supra* note 68, at 1153.

74. See Henry Farber & Michelle White, *Medical Malpractice: An Empirical Examination of the Litigation Process*, 22 RAND J. ECON. 199, 204-05 (1991) (discussing findings).

75. KALVEN & ZEISEL, *supra* note 70, at 63-65. Ten percent of the time, the jury favored the defendant when the judge would have found for the plaintiff, and twelve percent of the time the jury found for the plaintiff when the judge would have found for the defendant. *Id.*



evidence of pro-plaintiff bias was found.

Other more recent studies have also found an absence of pro-plaintiff bias. A study by Heuer and Penrod involving 160 complex civil and criminal cases found judge-jury agreement 63% of the time and found that the cases of disagreement were split about evenly in favor of plaintiffs and defendants.<sup>76</sup> Another recent study of judge-juror agreement in civil cases reportedly found that judges are more likely to find for plaintiffs than juries.<sup>77</sup>

In addition, recent research has shown that judges continue to give strong positive evaluations to juries. In the Kalven and Zeisel study, for example, when judge and jury disagreed, judges usually indicated that the jury's verdict was reasonable.<sup>78</sup> In another survey of state and federal judges in Georgia, 94% of the judges felt that juries understood the evidence, and 87% felt that the juries were not pro-plaintiff.<sup>79</sup> Fully 100% of the federal judges and 89% of the state judges agreed that the jury adhered to the judge's instructions.<sup>80</sup> Over 97% of both groups said that they agreed with jury verdicts more often than was reported in the Kalven and Zeisel study.<sup>81</sup>

This evidence of judge-jury concordance rebuts the assumption that juries are unfairly sympathetic to injured patients and vulnerable to manipulation by plaintiffs' attorneys.

## 2. Research on Complex Cases

Despite the evidence that juries perform well in tort trials generally, some critics doubt that juries perform equally well in complex cases, such as those involving antitrust, toxic torts, and medical malpractice.<sup>82</sup> However,

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76. See Larry Heuer & Steven Penrod, *Trial Complexity: A Field Investigation of Its Meaning and Effects*, 18 LAW & HUM. BEHAV. 29, 48 tbl.13 (1994).

77. See Richard Lempert, *Civil Juries and Complex Cases: Taking Stock After Twelve Years*, in VERDICT: ASSESSING THE CIVIL JURY SYSTEM 181, 222-23 (Robert E. Litan ed., 1993) (reporting on research by Heuer and Penrod). Heuer and Penrod found that judges were considerably more likely to disagree with jury defense verdicts (52% percent disagreement) than with plaintiffs' verdicts (29%). *Id.*

78. See Neil Vidmar, *The Performance of the American Civil Jury: An Empirical Perspective*, 40 ARIZ. L. REV. 849, 853 (1998).

79. Perry Sentell, *The Georgia Jury and Negligence: The View from the (Federal) Bench*, 27 GA. L. REV. 59, 116 (1992) [hereinafter Sentell, *Federal Bench*]. All the federal judges and 98% of the state judges felt that jury performance was satisfactory or would be if some procedural reforms were adopted. *Id.* at 117. See generally Perry Sentell, *The Georgia Jury and Negligence: The View from the Bench*, 26 GA. L. REV. 85 (1991).

80. See Sentell, *Federal Bench*, *supra* note 79, at 117. A 1987 Louis Harris survey of 1000 judges found nearly complete support for this proposition. Louis Harris & Assocs., *Judges Opinions on Procedural Issues: A Survey of State and Federal Trial Judges Who Spend at Least Half of Their Time on General Civil Cases*, 69 B.U. L. REV. 731, 746 (1989) (noting that nearly all judges believed jurors attempted to apply the law as instructed).

81. See Sentell, *Federal Bench*, *supra* note 79, at 115.

82. See, e.g., Douglas Ell, *The Right to an Incompetent Jury: Protracted Commercial Litigation and the Seventh Amendment*, 10 CONN. L. REV. 775, 775-76 (1978) (questioning jury competence in a

the evidence on judge-jury concordance in complex cases is very favorable. In one study of malpractice trials, for example, juries were harder on plaintiffs than judges were.<sup>83</sup> Likewise, the Heuer and Penrod study of complex cases found that judge-jury disagreement was not related to trial complexity.<sup>84</sup>

In their famous study of criminal trials, Kalven and Zeisel found not only that judges and juries agreed most of the time, but also that this agreement rate was *not* affected by the difficulty of the case.<sup>85</sup> When judge and jury did disagree, the judges did not attribute this disagreement to the jury's misunderstanding of complex cases.<sup>86</sup> Instead, disagreements appeared most often in cases where community values were important.<sup>87</sup> Kalven and Zeisel thus concluded that jurors generally comprehend complex evidence.<sup>88</sup>

Thus, judges seem satisfied by the performance of jurors, even in complex cases. In addition to the Kalven and Zeisel study, the Federal Judicial Center undertook a study of judicial satisfaction with juries. In the lengthy, difficult trials examined by that study, the trial judges believed that the jury had almost always made the correct decision or applied the law ably to the facts.<sup>89</sup>

However, evidence that judges and juries agree does not rule out the possibility that both judges and juries have misunderstood complex evidence. Efforts to study jury comprehension more directly have yielded inconsistent results. Several experimental studies indicate that mock jurors tend both to underuse probabilistic evidence<sup>90</sup> and to overestimate the odds

complex commercial case); Kirk Johnson et al., *A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims*, 42 VAND. L. REV. 1365, 1366 (1989) (arguing for a nonjury system for medical malpractice cases); Stephen Sugarman, *The Need to Reform Personal Injury Law Leaving Scientific Disputes to Scientists*, 248 SCI. 823 (1990) (questioning jury competence to evaluate complex scientific concepts in personal injury cases).

83. Clermont & Eisenberg, *supra* note 68.

84. See Heuer & Penrod, *supra* note 76, at 49. Another study found that mock jurors relied primarily on the content of expert testimony in less complex cases but that they were more persuaded in more complex cases by testimony from a more highly expert than from a less expert witness. See Joel Cooper et al., *Complex Scientific Testimony: How Do Jurors Make Decisions?*, 20 LAW & HUM. BEHAV. 379, 379 (1996).

85. See KALVEN & ZEISEL, *supra* note 70, at 157-58.

86. See Kalven, *supra* note 71, at 1066-67 (finding that judges did not doubt jury understanding); see also Heuer & Penrod, *supra* note 76, at 49 (finding that "judicial satisfaction with the jury's performance did not vary with the complexity of the case").

87. See KALVEN & ZEISEL, *supra* note 70, at 116-17.

88. *Id.* at 158.

89. GORDON BERMANT ET AL., *PROTRACTED CIVIL TRIALS: VIEWS FROM THE BENCH AND THE BAR* 26 (1981).

90. See Joe S. Cecil et al., *Citizen Comprehension of Difficult Issues: Lessons from Civil Jury Trials*, 40 A.M. U.L. REV. 727, 757-69 (1991) (reviewing the empirical literature); David L. Faigman & A.J. Baglioni, Jr., *Bayes' Theorem in the Trial Process: Instructing Jurors on the Value of Statistical Evidence*, 12 LAW & HUM. BEHAV. 1, 1 (1988) (finding that mock jurors underestimated the

of low probability hazards.<sup>91</sup> Yet, researchers have also found that people “can freely use statistical information when its situational applicability is made apparent.”<sup>92</sup> In actual litigation, therefore, a presentation by an expert witness may adequately clarify the use to which applicable statistics should be put. The authors concluded that “it does not appear particularly difficult to arrange the conditions under which various statistical notions are perceived as situationally applicable and consequently are used as the basis for judgments.”<sup>93</sup> That finding is consistent with the results in other studies,<sup>94</sup> one of which found that jurors are more likely to use the probability testimony if it contains hypothetical examples linked directly to the case.<sup>95</sup>

Other small studies have criticized juror comprehension. One study interviewed jurors who had heard a complicated antitrust case and concluded that jurors have difficulty understanding economic testimony involving concepts such as “market power” and “natural monopoly.”<sup>96</sup> Other interviewers have concluded that jurors need assistance with esoteric evidence.<sup>97</sup> However, these conclusions have usually been reached in studies that had very small samples (some interviewing jurors from only one or two trials), and some were reported by journalists not trained in the scientific method.<sup>98</sup>

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Bayesian significance of statistical evidence about blood typing and that testimony from a statistician describing the Bayesian significance did not alter this); William C. Thompson, *Are Juries Competent to Evaluate Statistical Evidence?*, 52 LAW & CONTEMP. PROBS., Autumn 1989, at 9, 33 (stating that “most subjects . . . give less weight to evidence of a match than Bayes’ theorem says they should”).

91. See Faigman & Baglioni, *supra* note 90, at 7-13 (discussing study results); Brian C. Smith et al., *Jurors’ Use of Probabilistic Evidence*, 20 LAW & HUM. BEHAV. 49, 60-70 (1996) (discussing study results). See generally Cecil et al., *supra* note 90, at 756-60 (reviewing the literature).

92. Arie W. Kruglanski et al., *Lay Persons’ Sensitivity to Statistical Information: The Case of High Perceived Applicability*, 46 J. PERSONALITY & SOC. PSYCHOL. 503, 503 (1984). When the testimony was more abstract, jurors were less able or willing to use it in their decision making. *Id.*

93. *Id.* at 516.

94. See *id.* at 515 (reviewing other studies).

95. See Nancy Brekke & Eugene Borgida, *Expert Psychological Testimony in Rape Trials: A Social-Cognitive Analysis*, 55 J. PERSONALITY & SOC. PSYCHOL. 372, 381 (1988) (discussing study results).

96. See ARTHUR D. AUSTIN, COMPLEX LITIGATION CONFRONTS THE JURY SYSTEM: A CASE STUDY 82, 85-86 (1984).

97. See STEPHEN J. ADLER, THE JURY: TRIAL AND ERROR IN THE AMERICAN COURTROOM 218-42 (1994) (discussing factors that would lead to better juries); MOLLY SELVIN & LARRY PICUS, THE DEBATE OVER JURY PERFORMANCE: OBSERVATIONS FROM A RECENT ASBESTOS CASE 24-26 (1987) (describing juror confusion in several cases); see also Joseph Sanders, *Jury Deliberation in a Complex Case: Havener v. Merrell Dow Pharmaceuticals*, 16 JUST. SYS. J. 45, 57-58, 65 (1993) (concluding that juror comprehension fell short of ideal but attributing this to problems with the judge’s instructions and the defense lawyers’ presentation of the case). But see Vidmar, *supra* note 78, at 857-58 (critiquing these criticisms).

98. See Richard Lempert, *Juries, Hindsight, and Punitive Damage Awards: Failures of a Social Science Case for Change*, 48 DEPAUL L. REV. 867, 888 (1999) [hereinafter Lempert, *Failures of a*

In addition, these unfavorable reports have not considered the possibility that the jury's group deliberations can cure the problems found in individual juror comprehension. Researchers have discovered that mock jurors can and do correct each other's factual mistakes.<sup>99</sup> One study found that, although individual juror recollection of facts and instructions was rather weak, pooled recollections resulted in 90% recall of facts and 80% recall of instructions.<sup>100</sup> Other studies have found that juror comprehension varies significantly among individuals, but that the most able jurors take leadership roles and tutor the others.<sup>101</sup> Consequently, group deliberations appear to improve the ability of juries to adjudicate complex cases fairly.<sup>102</sup>

Others studies of criminal and civil trials have found that juries have mechanisms for managing complex evidence.<sup>103</sup> In an ABA study of four extremely complex cases, for example, the researchers found that while juror comprehension varied widely among individual jurors, the most capable jurors helped other jurors by explaining the evidence and legal rules and leading the discussion.<sup>104</sup> The jurors were not overly influenced by experts, recognizing conflicts and rejecting those experts who most seemed like "hired guns."<sup>105</sup> Jurors gave greatest weight to those experts, like treating physicians, who had a personal relationship with the parties, and to those whose testimony was most understandable.<sup>106</sup> This study also uncovered several ways that lawyers and judges can improve jury comprehension, including organizing the evidence conscientiously, demonstrating the relevance of key evidence more clearly, and explaining complex legal issues more completely.<sup>107</sup>

Overall, therefore, the evidence on complex trials is reassuring. The most rigorous studies have failed to find any evidence that failures of

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*Social Science*] (stating that one study was "partly grounded in empirical research"); Vidmar, *supra* note 78, at 857 (describing the statistics).

99. Phoebe C. Ellworth, *Are Twelve Head Better Than One?*, 52 LAW & CONTEMP. PROBS. Autumn 1989, at 225; cf. REID HASTIE ET AL., *INSIDE THE JURY* 88 (1983).

100. See HASTIE ET AL., *supra* note 99, at 81.

101. See ABA, *infra* note 104 at 16, 22.

102. Cf. VIDMAR, *supra* note 62, at 275 (expressing confidence in jury verdicts, at least if the jury has twelve members).

103. See Lempert, *supra* note 77, at 183-90 (reporting on thirteen complex cases in which there no clear evidence of jury confusion).

104. See ABA SPECIAL COMM. ON JURY COMPREHENSION, ABA LITIGATION SEC., *JURY COMPREHENSION IN COMPLEX CASES* 16, 22 (1989).

105. *Id.* at 40; Vidmar, *supra* note 78, at 863-64 (reviewing the literature); see also VIDMAR, *supra* note 62, at 171-73 (noting research evidence that jurors take experts with a grain of salt). One experimental study found that jurors relied on the content of the testimony except in highly complex cases, where they gave more weight to the experts' credentials. See Cooper et al., *supra* note 84, at 379.

106. See ABA, *supra* note 104, at 42-43.

107. See Cecil et al., *supra* note 90, at 754 (suggesting several ways to "improve the presentation of evidence in complex cases").

comprehension distort actual jury verdicts. Group deliberations and the leadership of the most competent jurors appear to cure many of the problems of understanding experienced by individual jurors. In addition, judges and attorneys can further improve jury comprehension by better presentation of the evidence and the law. Finally, difficulties with comprehension have not been shown to systematically favor one party over another.<sup>108</sup> For these reasons, most researchers believe that juries are capable of handling complex civil cases.<sup>109</sup>

One researcher who studied nine complex trials concluded as follows:

Throughout this review, strengths of the jury emerge. A close look at a number of cases, including several in which the jury verdicts appear mistaken, does not show juries that are befuddled by complexity. Even when juries do not fully understand technical issues, they can usually make enough sense of what is going on to deliberate rationally, and they usually reach defensible decisions. To the extent that juries make identifiable mistakes, their mistakes seem most often attributable not to conditions uniquely associated with complexity, but to mistakes of judges and lawyers, to such systemic deficiencies of the trial process as battles of experts and the prevalence of hard-to-understand jury instruction, and to the kinds of human errors that affect simple trials as well.<sup>110</sup>

The most troubling remaining doubt about jury capacity in complex cases arises out of the evidence that lay people have difficulty comprehending and applying statistical and probabilistic evidence.<sup>111</sup> The tendency to overestimate low probability risk could lead jurors to overestimate the riskiness of the defendant's clinical decisions. However, studies demonstrating this human tendency may be of limited relevance to jury performance because the study instruments have given the respondents far less information than jurors will get at trial.<sup>112</sup> Experimental evidence suggests that the tendency of lay persons to overestimate the probability of low-probability events can be cured by educating them about the actual

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108. See Gary L. Wells, *Naked Statistical Evidence of Liability: Is Subjective Probability Enough?*, 62 J. PERSONALITY & SOC. PSYCHOL. 739, 748 (1992) (experimentally finding that people are reluctant to find in favor of plaintiffs who rely on purely probabilistic evidence).

109. See, e.g., JOHN GUINTEHER, *THE JURY IN AMERICA*, 208-13 (1988) (expressing confidence in jury judgments); VALERIE P. HANS & NEIL VIDMAR, *JUDGING THE JURY* 250-51 (1986) (same); SAUL M. KASSIN & LAWRENCE S. WRIGHTSMAN, *THE AMERICAN JURY ON TRIAL: PSYCHOLOGICAL PERSPECTIVES* 125-27 (1988) (same); Cecil et al., *supra* note 90, at 733-36, 750-64 (same).

110. Lempert, *supra* note 77, at 234.

111. This finding is also consistent with the findings of cognitive psychologists in nontrial settings. See Reid Hastie & W. Kip Viscusi, *What Juries Can't Do Well: The Jury's Performance as Risk Manager*, 40 ARIZ. L.J. 901, 909-10 (1998) (reviewing the literature).

112. Lempert, *Failures of a Social Science*, *supra* note 98, at 888.

probabilities.<sup>113</sup> Defense counsel can provide that education in malpractice actions.

A remaining issue is the tendency of jurors to underutilize probabilistic evidence in favor of nonstatistical evidence. There is no evidence that the human propensity to favor nonstatistical proof plays a significant role in medical malpractice cases or leads to inappropriate or systematically biased verdicts. Most of the research to date has involved scientific evidence offered against the accused in a criminal trial. However, there is some evidence that jurors are less skeptical of scientific evidence when it is used in a civil trial.<sup>114</sup> In addition, researchers have found that jurors are more likely to use expert testimony if it contains hypothetical examples linked directly to the case, rather than abstract examples.<sup>115</sup> Good tort lawyers know that intuitively. Thus, the tendency for juries to underuse probabilistic evidence can be mitigated by explanations or analogies offered during trial to make the probabilities more salient.<sup>116</sup> This tendency may also be ameliorated by group deliberations thereafter. More research is badly needed to provide a clearer picture of jury use of probabilistic evidence in realistic settings. Until then, the case against jury decision-making lacks convincing evidence.

### 3. Evidence of Jury-Physician Agreement

Another source of information for evaluating the ability of juries to understand medical malpractice trials and to resolve them fairly is provided by studies comparing the outcomes reached by juries with those reached by physician reviewers. Surprisingly, researchers have found that jury verdicts are surprisingly consistent and predictable. Where their judgments differ from those of physicians, juries are consistently more lenient toward

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113. See Robert MacCoun, *Inside the Black Box: What Empirical Research Tells Us about Decisionmaking by Civil Juries*, in VERDICT, *supra* note 77, at 261 (citing the studies). Any remaining discrepancies may reflect lay consideration of factors other than mortality that are not taken into account by risk experts, such as perceived control over the risk, the potential for catastrophe, likelihood of fatality, inequitable distribution of the risk, and benefits and the extent to which the activity generates “unknown risks.” See Cecil et al., *supra* note 90, at 762. The departures, therefore, do not necessarily indicate a failure to comprehend the genuine risks.

114. Jane Goodman, *Jurors’ Comprehension and Assessment of Probabilistic Evidence*, 16 AM. J. TRIAL ADVOCACY 361, 382 (1992).

115. See Brekke & Borgida, *supra* note 95, at 372.

116. See Peter H. Schuck, *Judicial Avoidance of Juries in Mass Tort Litigation*, 48 DEPAUL L. REV. 479, 502 (1998) (suggesting that trial lawyers can “humanize and simplify even the most technical scientific evidence”); Dale A. Nance, *Bayesian Rationality and Jury-Decision-Making: Toward an Optimal Presentation Method for Trace Evidence with Relatively Large and Quantifiable Random Match Probability* 57 (2000) (unpublished manuscript on file with author) (studying the responses of jurors called for service in Kane County, Illinois that “careful use of Bayesian methods in the courtroom can indeed assist the jury in reaching more accurate verdicts and it can do so without improper manipulation or deception of the jury”). However, studies have found that efforts to explain the Bayesian significance of probabilistic evidence does not tend to increase the weight assigned to the evidence. See generally Faigman & Baglioni, *supra* note 90.

malpractice defendants than other physicians would be.<sup>117</sup>

In the most widely cited study of medical malpractice claims, Mark I. Taragin and his colleagues reviewed 8231 closed files of one New Jersey insurance company dating from 1977 to 1992.<sup>118</sup> Each claim had been reviewed upon receipt by physician consultants and labeled “defensible,” “indefensible,” or “unclear.” Juries were much more likely to excuse physicians in “indefensible” cases than to find against them in “defensible” cases.<sup>119</sup> In the study, juries were even tougher on plaintiffs than physician reviewers had been.

Another study reached similarly favorable conclusions about jury-physician agreement. Faber and White reviewed 465 malpractice cases, of which twenty-six went to trial.<sup>120</sup> Plaintiffs won only four of the trials.<sup>121</sup> The plaintiffs won two of the four cases in which the defendant’s conduct had been classified as “bad” by the insurer’s private reviewers and won only two of the eleven cases that had been rated as “ambiguous.”<sup>122</sup> Plaintiffs lost all of the thirteen cases in which the medical care was rated as “good.”<sup>123</sup> Two other smaller studies also found that juries are no harder on physicians than other physicians are.<sup>124</sup>

117. See VIDMAR, *supra* note 62, at 161-69, 175-82 (reviewing the literature).

118. Mark I. Taragin et al., *The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims*, 117 ANN. INT. MED. 780, 780-81 (1992).

119. In the cases labeled “indefensible” that went to trial, the plaintiffs won only 42% of the time. Taragin et al., *supra* note 118, at 781. They also won 30% of the “unclear” cases. *Id.* Although plaintiffs won 21% of the “defensible” cases, *id.*, that finding is consistent with the authors’ hypothesis that the review process missed some indefensible cases. *Id.* The authors of the study felt that these classifications were probably biased in favor of the defendant physicians and understated the amount of negligence because this internal review was undertaken by fellow physicians and because it was based on limited information. *Id.* at 782. As a result, the researchers concluded that “unjustified payments are probably uncommon.” *Id.*

120. Henry Farber & Michelle White, *A Comparison of Formal and Informal Dispute Resolution in Medical Malpractice*, 23 J. LEGAL STUD. 777, 802 (1994); see also Farber & White, *supra* note 74, at 204-05, 204 tbl.1 (finding that the hospital won all thirteen trials, including one labeled “bad” and three labeled “ambiguous”).

121. Farber & White, *supra* note 120, at 802.

122. *Id.*

123. *Id.*

124. FRANK SLOAN ET AL., *SUING FOR MEDICAL MALPRACTICE* 17-30 (1993). See Vidmar, *supra* note 62, at 859 (deducing from the Sloan tables that the rating given to the case by physicians hired by the researchers was twice as likely to have been “negligent” in cases that the plaintiff won at trial as in cases that the plaintiff lost and, when plaintiffs lost, that the rating was twice as likely to have been favorable as when the plaintiff won). In the Liang study, anesthesiologists practicing in an academic medical center were asked to review twelve scenarios based on actual jury trials. Bryan A. Liang, *Assessing Medical Malpractice Jury Verdicts: A Case Study of an Anesthesiology Department*, 7 CORNELL J.L. & PUB. POL’Y 121, 129 (1997). In five of these cases, there was significant disagreement between the physicians and the actual jury verdict. *Id.* In four of those five instances, the jury had exonerated a physician whom the reviewers felt had given medically inappropriate care. *Id.* As in the Taragin study, jurors exonerated physician defendants more readily than other physicians did. *Id.* at 136.

When Stephen Daniels and Lori Andrews conducted a similar study in conjunction with the American Bar Foundation, they evaluated twenty-three cases involving alleged misuse of oxytocin, they found that plaintiffs won fourteen of sixteen cases in which evidence of contraindications was presented at trial and lost six of the seven cases in which evidence of contraindication was absent.<sup>125</sup>

This evidence of jury-physician agreement has important implications. First, it provides reassurance that juries are not systematically biased against physicians. Because physicians are reluctant to label the errors of their peers as negligent,<sup>126</sup> one would expect juries to find physician defendants negligent more frequently than other physicians do. They, however, do not, a fact that suggests that jurors commonly give the benefit of the doubt to physician defendants. Thus, juries appear to take the burden of proof seriously. If they do not feel comfortable choosing between opposing experts, they find for the defendant. If the complexity of some malpractice cases helps anyone, it helps defendants.

#### 4. Summary of the Evidence Regarding Jury Capacity

The existing data provide a basis for cautious optimism about jury capacity. Juries and judges usually agree on liability, even in complex cases. Juries and physicians also tend to agree, although juries tend to exonerate defendants more readily than physicians do. The evidence, therefore, indicates that juries do a reasonably competent job.

That optimism must be tempered by the evidence that ordinary people have problems estimating risks and using probabilities. There are several reasons not to overreact to this evidence, however. Most importantly, educating jurors about actual risk can significantly improve jury comprehension. In addition, the tendency of lay persons to underuse probabilistic evidence is mitigated by explanations and analogies offered during trial and, perhaps, by the jury's own deliberations.<sup>127</sup> Furthermore, the lay propensity to favor nonstatistical proof does not appear to lead juries to reach inappropriate verdicts; jury verdicts closely match the conclusions reached by judges and physicians. Moreover, many malpractice cases are not technically complicated (e.g., wrong dosage cases) and others turn on

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125. Stephen Daniels & Lori Andrews, *The Shadow of the Law: Jury Decisions in Obstetrics and Gynecology Cases*, in 3 *MEDICAL PROFESSIONAL LIABILITY AND THE DELIVERY OF OBSTETRICAL CARE* (Victoria P. Rostow & Roger J. Bulger eds., 1989), cited in Neil Vidmar, *Are Juries Competent to Decide Liability in Tort Cases Involving Scientific Medical Issues?*, 43 *EMORY L.J.* 885, 906 n.72 (1994) [hereinafter Vidmar, *Competent*].

126. See HARVARD MEDICAL MALPRACTICE STUDY GROUP, *MEDICAL CARE AND MEDICAL INJURIES IN THE STATE OF NEW YORK: A PILOT STUDY 10* (1982) (making this observation); PAUL C. WEILER ET AL., *A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION AND PATIENT COMPENSATION 125* (1993) (same); Taragin et al., *supra* note 118, at 782 (same).

127. See *supra* text accompanying notes 105-07 (discussing jury use of probabilistic evidence).



crucial issues of credibility (e.g., what was said or done).<sup>128</sup> In all states, the jury will be assisted by witnesses who tell the jury what the customary clinical practices are and why they are customary. In reasonable care states, they will also hear what respected medical bodies recommend in their clinical practice guidelines. These recommendations are likely to carry great weight unless a convincing reason for departure is offered. Thus, the argument that juries lack the tools with which to decide malpractice cases fairly seems misplaced.

### B. BIAS AGAINST PHYSICIANS

Conventional wisdom assumes that juries will sympathize with injured plaintiffs and will penalize wealthy physician defendants. In fact, jurors sympathize more with the physicians who are sued than with the patients who sue them.

#### 1. Survey Evidence of Pro-Physician Bias

An expanding body of evidence suggests that jurors begin their deliberations favoring physician-defendants and doubting the motives of plaintiffs in medical malpractice cases.<sup>129</sup> Ellen L. Leggett found that one-third of the potential jurors she studied believed that malpractice plaintiffs are looking for easy money.<sup>130</sup> She found that potential jurors are even more distrustful of plaintiff's lawyers than they are of plaintiffs; two-thirds believe that plaintiff's lawyers have pressured dissatisfied plaintiffs into filing suit.<sup>131</sup> Many of her respondents believed that medical malpractice suits ruin the health care system by driving up costs.<sup>132</sup>

Neil Vidmar has also found that potential jurors are concerned about plaintiff motives and excessive litigation.<sup>133</sup> In his study of North Carolina juries, Vidmar noted that voir dire often produced remarks like "too many people sue their doctors" and "it is just going to raise the health insurance rates for the rest of us."<sup>134</sup> Although researchers have not yet explored the role that cognitive dissonance plays in this phenomenon, the need to trust

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128. Vidmar, *Competent*, *supra* note 62, at 898-99.

129. In addition to the studies described in the text, an interesting study of Ohio jury verdicts found that physicians were treated more favorably than other health care workers, even after controlling for injury severity and type of malpractice alleged. Deborah Jones Merritt & Kathryn Ann Barry, *Is the Tort System in Crisis? New Empirical Evidence*, 60 OHIO ST. L.J. 315, 392 (1999).

130. Ellen L. Leggett, *Identifying Juror Bias and Their Impact on Cases*, available at <http://www.jri-inc.com/articles.htm> (last modified Sept. 7, 1999).

131. *Id.*; see Edith Greene et al., *Jurors' Attitudes About Civil Litigation and the Size of Damage Awards*, 40 AM. U. L. REV. 805, 817 (1991) (finding that most jurors believed attorneys encouraged people to file frivolous lawsuits).

132. See Leggett, *supra* note 130 (discussing the findings).

133. VIDMAR, *supra* note 62, at 169-70.

134. *Id.* at 169.

physicians with one's own life certainly gives each of us a powerful motive to assume that physicians are rarely careless.

Skepticism about plaintiffs is not confined to people who sue their doctors. Valerie Hans and William Lofquist found the same anti-plaintiff skepticism in their study of Delaware jurors in cases involving tort claims against business defendants.<sup>135</sup> Four of five jurors surveyed agreed that "people are too quick to sue" and that "there are far too many frivolous lawsuits today."<sup>136</sup> Only one-third felt that "most people who sue others in court have legitimate grievances."<sup>137</sup> The researchers were surprised by these findings, concluding:

Rather than revealing jurors willing or eager to impose on business the costs of plaintiffs' injuries, our findings show that jurors were suspicious of the legitimacy of plaintiffs' claims and concerned about the personal and social costs of large jury awards . . . [J]urors were generally favorable toward business, skeptical more about the profit motives of individual plaintiffs than of business defendants, and committed to holding down awards.<sup>138</sup>

These findings are consistent with other studies that have found widespread public concern about overeagerness to sue.<sup>139</sup> Publicity about the tort crisis has made citizens deeply concerned about excessive litigation and insurance costs.<sup>140</sup> People who start a decision-making process with pro-defendant biases of this kind may find it difficult to abandon their preconceptions when presented with contrary evidence.

## 2. Plaintiff Win Rates

The fear of pro-plaintiff bias is also not substantiated by the data on plaintiff win rates. The empirical literature on tort win rates is exhaustively summarized in Hans and Vidmar's book *Judging the Jury*. According to their

135. Valerie P. Hans & William Lofquist, *Jurors' Judgments of Business Liability in Tort Cases: Implications for the Litigation Explosion Debate*, 26 LAW & SOC'Y REV. 85, 85 (1992) [hereinafter Hans & Lofquist, *Jurors' Judgments*]; see also Valerie P. Hans & William S. Lofquist, *Perceptions of Civil Justice: The Litigation Crisis Attitudes of Civil Jurors*, 12 BEHAV. SCI. & L. 181, 187 [hereinafter Hans & Lofquist, *Civil Justice*] (1994) (reporting on a larger sample).

136. Hans & Lofquist, *Jurors' Judgments*, *supra* note 135, at 93.

137. *Id.*

138. *Id.*

139. See, e.g., David M. Engel, *The Oven Bird's Song: Insiders, Outsiders and Personal Injuries in an American Community*, 18 LAW & SOC'Y. REV. 551, 553, 559-61 (1984) (finding that citizens in a rural Illinois county disapproved of "cashing in" via personal injury lawsuits and characterized those who did sue as "people looking for the easy buck"). Not all jurors will share these beliefs. Hans & Lofquist, *Jurors' Judgments*, *supra* note 135, at 96.

140. Greene et al., *supra* note 131, at 809; Hans & Lofquist, *Civil Justice*, *supra* note 135, at 213; VIDMAR, *supra* note 62, at 171. This concern is associated with lower jury awards. See Hans & Lofquist, *Jurors' Judgments*, *supra* note 135, at 97 (1992); see also Greene et al., *supra* note 131, at 816 (noting that jurors who favored tort reform gave lower awards).

meta-analysis of the empirical data, malpractice plaintiffs have a considerably lower win rate (roughly 30%) than automobile accident victims (60-70%).<sup>141</sup> In other studies the difference is even greater.<sup>142</sup> In fact, malpractice cases typically have the lowest success rate of any category of torts. Although this pattern could be explained by many factors—such as unique settlement patterns in malpractice actions or the custom-based standard of care itself—the pattern certainly does not provide any evidence of pro-plaintiff bias.

### 3. The Absence of Evidence of Deep Pockets Bias

Although the research on this subject is thin, the existing data also fails to confirm a jury bias against “deep pocket” defendants.<sup>143</sup> That finding is consistent with the low win rate of plaintiffs in medical malpractice cases,<sup>144</sup> where the defendant is presumptively wealthy and insured.<sup>145</sup>

### 4. Summary

There is simply no evidence that juries are prejudiced against physician defendants or that their verdicts are distorted by their sympathy for injured plaintiffs. Instead, the existing evidence strongly indicates that jurors begin their task harboring sympathy for the defendant physician and skepticism about the plaintiff. This survey data is consistent with the evidence, discussed in the previous subsection, that juries treat physicians more favorably than other physicians do.<sup>146</sup> Although it is possible that growing public antagonism toward managed care practices will reverse these sympathies, no evidence of backlash against individual physicians has surfaced to date.

141. HANS & VIDMAR, *supra* note 109, at 251 (summarizing empirical evidence); *see also* DANIELS & MARTIN, *supra* note 62, at 12 (stating a 32% win rate); Robert MacCoun, *supra* note 113, at 137, 148 (noting a 33% win rate); Michael J. Saks, *Do We Really Know Anything About the Behavior of the Tort Litigation System—and Why Not?*, 140 U. PA. L. REV. 1147, 1240 (1992) (finding a 34% win rate). One major study of state tort judgments found that, overall, tort plaintiffs succeeded 49% of the time. Brian J. Ostrom et al., *A Step Above Anecdote: A Profile of the Civil Jury in the 1990's*, 79 JUDICATURE 233, 235 (1996) (describing the study results).

142. *See* DANIELS & MARTIN, *supra* note 62, at 127 (stating that the national win rate of plaintiffs was 30.4% from 1988-90, but varied considerably between states); VIDMAR, *supra* note 62, at 20, 43-44; *see also* Vidmar, *Competent*, *supra*, note 125, at 892-93 (collecting studies on jury outcomes).

143. *See* Merritt & Barry, *supra* note 129, at 359 (reporting on a study of Ohio cases); *see also id.* at 393-94 (concluding that at the very least, a bias would depend on a huge interplay of factors).

144. *See supra* text accompanying notes 141-42.

145. However, there is evidence that juries hold corporations to a higher standard of responsibility than individuals. For a review of this literature, see Vidmar, *supra* note 78, at 870-71.

146. *See supra* text accompanying notes 117-26 (reviewing the studies).

### C. JURY UNWILLINGNESS TO CONSIDER COSTS

A more recent concern about jury decision-making is that jurors will refuse to take costs into account. If they are unwilling to do so, jurors may insist on socially unwarranted safety precautions.

This issue has surfaced most prominently in academic discussions of punitive damage awards in product liability actions. Gary Schwartz and Kip Viscusi both concluded that juries have a distaste for explicit cost-benefit analysis by automobile manufacturers.<sup>147</sup> Schwartz concluded that “juries have often proved hostile to the core public-policy idea that high monetary costs can justify a reduction in health or safety.”<sup>148</sup> Commenting on the possibility, Schwartz observed, “[I]t seems sensible to recognize in all of this an instance of the ‘two cultures’ problem. A culture has developed around public policy analysts that sees the risk-benefit criterion as obviously acceptable; but the culture of public opinion itself tends to regard that criterion as distressing.”<sup>149</sup>

If juries are unwilling to allow physicians and health plans to take costs into account, then giving them power to set medical standards could also thwart responsible efforts to contain health care costs and make health insurance more affordable.<sup>150</sup> If jurors cannot be trusted to apply a reasonable physician standard with sensitivity to the cost implications, then courts may want to continue to delegate the power to determine the legally required standard of care to the medical profession.

At present, we know virtually nothing about the jury’s willingness to consider costs when making decisions about reasonable care. The clues are contradictory. Viscusi has conducted two experimental studies of punitive damages in which he found that explicit risk-benefit analysis by corporate defendants slightly increased the incidence of punitive damage awards (by eight percent<sup>151</sup> and five percent<sup>152</sup>). He concluded that risk-benefit analysis

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147. See Gary T. Schwartz, *The Myth of the Ford Pinto Case*, 43 RUTGERS L. REV. 1013, 1035 (1991) (contending that the public has considerable ambivalence about risk-benefit balancing, especially by private corporations); W. Kip Viscusi, *Corporate Risk Analysis: A Reckless Act?*, 52 STAN. L. REV., 547, 588 (2000) (concluding that risk-benefit analysis is penalized by juries).

148. See Gary Schwartz, *A National Health Care Program: What Its Effect Would be on American Tort Law and Malpractice Law*, 79 CORNELL L. REV. 1339, 1373 (1994) [hereinafter Schwartz, *National Care Program*].

149. Schwartz, *supra* note 147, at 1041.

150. See, e.g., Peter D. Jacobson & Matthew L. Kanna, *Cost-Effectiveness Analysis in the Courts: Recent Trends and Future Prospects*, 26 J. HEALTH, POL., POL’Y & L. 291 (discussing the willingness of juries to tolerate explicitly cost-conscious medical treatment decisions); Schwartz, *National Care Program*, *supra* note 148, at 1373. If the health care industry is to strike a reasonable balance between quality and affordability and is to allocate the available resources rationally, then jurors need to consider the overall population’s interest in access, not just the interests of the injured party before the court. Jacobson & Kanna, *supra* at 13, 25.

151. Viscusi, *supra* note 147, at 557. Risk-benefit analysis also increased the magnitude of the awards. Viscusi also found that mock jurors do not appear to use traditional risk-utility analysis when asked to sit in the shoes of a corporate CEO and make decisions about safety

is penalized even when it is consistent with the risk analysis used by government agencies. However, the significance of these findings is clouded by the failure of the survey instruments to instruct the jurors about the legal status of risk-utility analysis and the absence of explanations of defendant's methods by defense counsel. In addition, both studies interviewed individual subjects. Thus, they lacked the deliberations that characterize actual trials.<sup>153</sup>

Some view the large punitive damages verdicts recently awarded against managed care organizations as evidence that juries will not tolerate cost-conscious medicine. However, several other clues point to a contrary conclusion. First, the jurisdictions that have abandoned the custom-based standard of care do not appear to have experienced any unique crises as a result. Second, many malpractice cases involve underlying resource allocation issues, such as whether more tests or treatments should have been offered.<sup>154</sup> Yet, defendants win two-thirds of the malpractice trials.<sup>155</sup>

Third, resource allocation questions are implicit in all negligence cases. When, for example, a jury decides that a grocery store employee should have patrolled and cleaned the aisles more frequently or that a reasonable grocer would have installed non-slip plastic mats in front of produce counters, the jury is deciding that these safety precautions are more important than a lower price for groceries and more important than the other goods and services that could have been purchased with the additional money now devoted to groceries. Yet, there is no evidence that juries ignore costs in these cases; to the contrary, they resolve these cases just as judges would.<sup>156</sup>

Fourth and finally, a little-known 1968 study by Edward Green found that mock juries appropriately consider both risks and costs.<sup>157</sup> Furthermore, his findings suggest that the current failure of trial courts to instruct juries in risk-utility calculus probably does not matter. His subjects took risk-utility

precautions. However, they were not asked whether they would find that the CEO who failed to do so was negligent. They were not given a legal standard of care to apply. Instead, they used their own personal norms to make an *ex ante* safety decision. *Id.*

152. See Kip Viscusi, *Jurors, Judges, and the Mistreatment of Risk by the Courts*, 30 J. LEG. STUD. 107, 123 (2001) (finding that undertaking a risk analysis increased the probability of a punitive damages award by 0.05).

153. See Lempert, *supra* note 112, at 877.

154. This fact is relevant even in jurisdictions using a custom-based standard of care, for it indicates that juries will respect a resources-based custom.

155. *Supra* text accompanying notes 141-42.

156. *Supra* text accompanying notes 68-81. In jurisdictions that give a risk-utility jury instruction, the resource implications of the negligence standard are made even more patent for the jury. See, e.g., *United States v. Carroll Towing Co.*, 159 F.2d 169, 173 (2d Cir. 1947) (suggesting that reasonableness requires balancing of risk and utility); *RESTATEMENT (SECOND) OF TORTS* § 291 (1975) (same). There is no evidence that the juries ignore this instruction in either malpractice cases or ordinary tort cases. In fact, the concordance of jury verdicts with the conclusions of judges strongly suggests that jurors do not ignore costs.

157. See Edward Green, *The Reasonable Man: Legal Fiction or Psychosocial Reality?*, 2 LAW & SOC'Y REV. 241, 245 (1968) (describing the "calculus of risk formula" applied by most juries).

most clearly into account when they were given no instructions about risk-utility calculus.<sup>158</sup>

None of these clues completely allay the suspicion that juries will be uncomfortable with medical decisions that take costs into account.<sup>159</sup> However, neither the existence nor the magnitude of this discomfort has been demonstrated.

#### D. HINDSIGHT BIAS

In negligence litigation, defendants are supposed to be judged by the reasonableness of their conduct, not by its outcome.<sup>160</sup> Yet, cognitive psychologists know that judgments made in hindsight are routinely distorted by two cognitive heuristics. The first, *hindsight bias*, makes bad outcomes seem more predictable in hindsight than they were *ex ante*.<sup>161</sup> The second, *outcome bias*, leads people to assume that individuals who cause accidents have been careless.<sup>162</sup> Because of these biases (which are commonly referred to collectively as “hindsight bias”), jurors may treat tort defendants unfairly.<sup>163</sup> One potential solution is to rely on an *ex ante* standard of care—

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158. See *id.* at 248, 255 (analyzing the effect of a jury instruction on mock juries). He speculated that the risk-utility instructions that he used had been confusing. *Id.* at 255.

159. David Eddy has described the unwillingness to consider health care costs as the “cost taboo.” David M. Eddy, *Balancing Cost and Quality in Fee-for-Service Versus Managed Care*, HEALTH AFF., May-June 1997, at 162, 169. Richard Epstein and Alan Sykes argue that the public is unable to reconcile its inconsistent demands for low premiums *ex ante* with its desire for comprehensive coverage *ex post*. Richard A. Epstein & Alan O. Sykes, *The Assault on Managed Care: Vicarious Liability, Class Actions and the Patient’s Bill of Rights*, Social Science Research Network Electronic Library, at [http://papers.ssrn.com/paper.taf?abstract\\_id=253328](http://papers.ssrn.com/paper.taf?abstract_id=253328) (last visited FEB. 6, 2002).

160. See RESTATEMENT (SECOND) OF TORTS § 282 (1965) (“Negligence is conduct which falls below the standard established by law for the protection of others against unrealistic risk of harm.”).

161. See Baruch Fischhoff, *Hindsight ≠ Foresight: The Effect of Outcome Knowledge on Judgment Under Uncertainty*, 1 J. EXPERIMENTAL PSYCHOL.: HUM. PERCEPTION & PERFORMANCE 288, 288 (1975) (reporting that once an outcome is known, its probability seems higher).

162. See Jonathan Baron & John C. Hershey, *Outcome Bias in Decision Evaluation*, 54 J. PERSONALITY & SOC. PSYCHOL. 569, 570 (1988) (describing as experiment in which an actor was adjudged more “responsible” when the outcome was severe); Robert A. Caplan et al., *Effect of Outcome on Physician Judgments of Appropriateness of Care*, 265 JAMA 1957, 1960 (1991) (outlining results from a study); Jeffrey J. Rachlinski, *A Positive Psychological Theory of Judging in Hindsight*, 65 U. CHI. L. REV. 571, 581 n.36 (1998) (collecting studies on outcome bias); Dan Zakay, *The Evaluation of Managerial Decisions’ Quality by Managers*, 56 ACTA PSYCHOLOGICA 49, 52 tbl.1, 55 (1984) (stating that outcome is the most important indicator of decision quality in the eyes of professional managers).

163. Individuals who know that a bad outcome has occurred tend to evaluate prior conduct more harshly than they would if they were unaware of the actual outcome. See Kim A. Kamin & Jeffrey J. Rachlinski, *Ex Post ≠ Ex Ante: Determining Liability in Hindsight*, 19 LAW & HUM. BEHAV. 89, 90 (1995) (“In making such judgments, people overestimate both probability of the known outcome and the ability of decision makers to foresee the outcome.”); D. Jordan Lowe & Philip M.J. Reckers, *The Effects of Hindsight Bias on Jurors’ Evaluations of Auditor Decisions*, 25 DECISION SCI. 401, 403 (reviewing the literature).

such as adherence to industry custom—that has been set before the bad outcome occurred and, thus, is insulated from these biases.<sup>164</sup> Some courts have justified their deference to medical customs on this basis.<sup>165</sup>

Although hindsight bias does constitute a potentially serious obstacle to fair verdicts, the readiness to transfer standard-setting power from the courts to the regulated industry may be premature. Several factors are likely to reduce the risk of hindsight bias in actual jury trials. In addition, any advantage conferred upon plaintiffs by hindsight bias may be offset by other aspects of the judicial process that favor defendants.

### 1. Factors that May Reduce Hindsight Bias in Actual Trials

The litigation process differs in important respects from the experimental studies that have directly observed the effect of hindsight bias. Actual jury trials have higher stakes,<sup>166</sup> more robust facts,<sup>167</sup> individual accountability<sup>168</sup> and group deliberations.<sup>169</sup> Each of these differences has

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164. See Rachlinski, *supra* note 162, at 608. Although Rachlinski acknowledged that industry customs would sometimes be a poor proxy for reasonability, he concluded that medical customs were likely to reflect an efficient level of safety precautions. *Id.* at 610-12.

165. See *Osborn v. Irwin Mem'l Blood Bank*, 7 Cal. Rptr. 2d 101, 125 (Cal. Ct. App. 1992); *Hall v. Hilbun*, 466 So. 2d 856, 871 (Miss. 1985).

166. Two experimental studies suggest that people can reduce their susceptibility to their biases when it is important enough for them to do so. See Jennifer D. Campbell & Abraham Tesser, *Motivational Interpretations of Hindsight Bias: An Individual Difference Analysis*, 51 J. PERSONALITY 605, 616 (1983); Elizabeth Creyer & William T. Ross, Jr., *Hindsight Bias and Inferences in Choice: The Mediating Effect of Cognitive Effort*, 55 ORGANIZATIONAL BEHAV. & HUM. DECISION PROCESSES 61, 71-75 (1993); see also Merrie Jo Stallard & Debra L. Worthington, *Reducing the Hindsight Bias Utilizing Attorney Closing Arguments*, 22 LAW & HUM. BEHAV. 671, 680-81 (1998) (finding that appeals to justice removed the bias). This is consistent with other studies which have found that “people tend to listen to contrary evidence and to people unlike themselves when motivation is high to reach a correct answer or an answer they will need to defend to others.” Michael J. Saks, *What Do Jury Experiments Tell Us About How Juries (Should) Make Decisions?*, 6 S. CAL. INTERDISC. L.J. 1, 30 (1997); see also Russell H. Fazio, *Motives for Social Comparison: The Construction-Validation Distinction*, 37 J. PERSONALITY & SOC. PSYCHOL. 1683, 1683 (1979) (noting that information comparisons occur more when the judgment is important); Arie W. Kruglanski & Ofra Maysel, *Motivational Effects in the Social Comparison of Opinions*, 53 J. PERSONALITY & SOC. PSYCHOL. 834, 837 (1987) (finding that persons with a high fear of invalidity compare their views more with people who disagree).

167. Given a shortage of facts with which study subjects must make judgments about probabilities or reasonability, researchers have hypothesized that the subjects may place an undue emphasis on outcome information. At a trial, by contrast, jurors will hear a much richer version of the facts, including exculpatory evidence from the defendant. See, e.g., Baron & Hershey, *supra* note 162, at 578 (reporting results of a study in which subjects displayed outcome bias); Lempert, *supra* note 77, at 192-94 (discussing the complex fact scenarios that juries hear); Lowe & Reckers, *supra* note 163, at 404 (discussing the difference between studies and trials).

168. Significant experimental evidence suggests that people who feel personally accountable for their decisions put substantially more cognitive work into their decisions. Cvetkovitch, for example, concluded that accountability produced less “intuitive” and more “analytic” modes of thought. See George Cvetkovitch, *Cognitive Accommodation, Language, and*

the potential to reduce hindsight bias.<sup>170</sup>

A number of procedural reforms also have the potential to reduce hindsight bias. These strategies include bifurcating the trial of liability and damages,<sup>171</sup> reinstating unanimous verdicts,<sup>172</sup> and permitting jurors to take notes and ask questions.<sup>173</sup> Bifurcation, in particular, is a promising option,<sup>174</sup> even though the bifurcation of liability and damages is not yet

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*Social Responsibility*, 41 SOC. PSYCHOL. 149, 149-50 (1978) (reviewing the literature). Tetlock found that accountability caused his subjects to think about issues in a "more integratively complex" way. See Philip E. Tetlock, *Accountability and Complexity of Thought*, 45 J. PERSONALITY & SOC. PSYCHOL. 74, 81 (1983) (reviewing the literature). Jurors are likely to resist cognitive shortcuts to the extent that they feel accountable to others. See *id.* at 82 (analyzing study results).

169. Group deliberations have the potential to reduce the impact of the hindsight biases. See Rachlinski, *supra* note 162, at 587 n.76 (analyzing group decision making). Jurors must explain their conclusions to their peers during deliberations and must also listen to the contrary thoughts of other jurors, including alternative theories about the alleged negligence of the defendants. Thus, the group deliberations that occur in actual jury trials actively engage individual jurors in a "consider the opposite" debiasing exercise that resembles the most successful debiasing experiments. See Philip G. Peters, Jr., *Hindsight Bias and Tort Liability: Avoiding Premature Conclusions*, 31 ARIZ. ST. L.J. 1277, 1286-89 (1999) (reviewing the literature on cognitive debiasing strategies). The few studies done thus far have found that deliberations by groups of three to five slightly reduce the hindsight bias. See Ed Bukszar & Terry Connolly, *Hindsight Bias and Strategic Choice: Some Problems in Learning from Experience*, 31 ACAD. MGMT. J. 628, 631 (1988); Dagmar Stahlberg et al., *We Knew It All Along: Hindsight Bias in Groups*, 63 ORGANIZATIONAL BEHAV. & HUM. DECISION PROCESSES 46, 55-56 (1995) ("[G]roups were less likely than individuals to fall prey to hindsight distortions."). Larger groups might increase that effect.

170. See Peters, *supra* note 169, at 1300-03 (discussing the "distinguishing characteristics of actual jury trials" and how these characteristics—gravity of the proceedings, accountability, robust facts, and group deliberations—help to minimize hindsight bias).

171. See Hal R. Arkes & Cindy A. Schipani, *Medical Malpractice v. The Business Judgment Rule: Differences in Hindsight Bias*, 73 OR. L. REV. 587, 633 (1994) (discussing bifurcation process); Christine Jolls et al., *A Behavioral Approach to Law and Economics*, 50 STAN. L. REV. 1471, 1528-29 (1998) (same); David Wexler & Robert F. Schopp, *How and When to Correct for Juror Hindsight Bias in Mental Health Malpractice Litigation: Some Preliminary Observations*, 7 BEHAV. SCI. & L. 485, 503 (1989) (making the first recommendation of bifurcation). But see Rachlinski, *supra* note 162, at 605 (concluding that the debiasing potential is limited). Bifurcation will not eliminate the bias, since the jury will be aware that the plaintiff has been injured, but it might reduce the bias by minimizing the extent to which the jury learns of the severity of the plaintiff's injuries.

172. See Peters, *supra* note 169, at 1306-07 (discussing how unanimity forces more deliberation). Jurors deliberate differently when they know that their verdict need not be unanimous. See HASTIE ET AL., *supra* note 99, at 184-85 (finding that deliberations were longer and more robust under a unanimity rule). Hans and Vidmar concluded that "[u]nanimity juries were more thorough in their evaluation of the evidence and the law; [and] jurors in the minority participated more actively in the discussion." HANS & VIDMAR, *supra* note 109, at 175; see also MacCoun, *supra* note 113, at 161 (discussing unanimous verdicts). This is precisely the kind of active deliberation process necessary to reorient jurors to a foresight perspective.

173. See Peters, *supra* note 169, at 1308-09 (reviewing these proposals).

174. Zeisel and Callahan reported in 1963 that defense verdicts rose from 34% to 56% when trials were bifurcated. Hans Zeisel & Thomas Callahan, *Split Trials and Time Saving: A Statistical Analysis*, 76 HARV. L. REV. 1606, 1612 tbl.3 (1963). In addition, a 1992 simulation study



common in ordinary negligence actions.<sup>175</sup>

In addition, judges have other tools for disarming pro-plaintiff biases.<sup>176</sup> For example, judges can inform jurors about the burden of proof early in the trial<sup>177</sup> and instruct them to deliberate before voting.<sup>178</sup> Each has the potential to reduce hindsight bias.

Finally and most importantly, defense counsel can and do attempt to reduce hindsight bias. They use voir dire, an opening statement, expert witnesses, evidence of customary norms, and a closing argument to persuade the jury that the defendant's action was reasonable at the time that it was undertaken. There is some reason to believe that they can be at least partially successful.

Until recently, the most successful experimental strategies for reducing hindsight bias had been designed to weaken the causal link that people prematurely construct between the known outcome and the antecedent behavior.<sup>179</sup> In particular, subjects were encouraged to consider seriously the

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by Horowitz and Bordens found that plaintiffs won less often when liability and damages were bifurcated (62.5% v. 87.5%). Irwin A. Horowitz & Kenneth S. Bordens, *An Experimental Investigation of Procedural Issues in Complex Tort Trials*, 14 LAW & HUM. BEHAV. 269, 281-85 (1990). However, plaintiffs' awards were higher. *Id.*; see also VIDMAR, *supra* note 62, at 275 (discussing bifurcation). The Federal Rules of Civil Procedure authorize bifurcated trials. FED. R. CIV. P. 42(b).

175. Louis Harris & Assocs., Inc., *Judges' Opinions on Procedural Issues: A Survey of State and Federal Trial Judges Who Spend at Least Half Their Time on General Civil Cases*, 69 B.U. L. REV. 731, 744 tbls.5.2 & 5.4 (1989) (referring to judges' bifurcated trials).

176. However, jury instructions that warn the jury not to use hindsight, standing alone, are unlikely to have a significant impact on the bias. See Peters, *supra* note 169, at 1305 (describing studies showing that instructions from a mock judge did not reduce hindsight bias). In addition to the tools described in the text, judges can improve the chances that accountability will reduce hindsight bias by admonishing jurors not to discuss the case prior to submission or to vote on the case before discussing the facts. *Id.* at 1301. Accountability is most likely to reduce bias if the accountable individual is unaware of the views of the person to whom she is accountable. Tetlock, *supra* note 168, at 81.

177. Early instruction on the burden of proof has been shown to produce more not guilty verdicts in criminal trials. See Jonathan D. Casper, *Restructuring the Traditional Civil Jury: The Effects of Changes in Composition and Procedures*, in VERDICT: ASSESSING THE CIVIL JURY SYSTEM, *supra* note 77, at 414, 445 (citing Saul W. Kassin & Lawrence S. Wrightsman, *On the Requirements of Proof: The Timing of Judicial Instruction and Mock Juror Verdicts*, 37 J. PERSONALITY & SOC. PSYCHOL. 1877, 1877-87 (1979)). It doubles the time that jurors spend discussing the burden of proof. See *id.* (citing REID HASTIE, FINAL REPORT TO NATIONAL INSTITUTE LAW ENFORCEMENT AND CRIMINAL JUSTICE (1983) (unpublished manuscript, Northwestern University)). And it increases the odds that jurors will defer their verdict decisions until the evidence is complete. See *id.* at 446.

178. Early voting can lock jurors into positions and reduce the debiasing power of group deliberations. See Peters, *supra* note 169, at 1308 (discussing the disadvantages of early voting).

179. Individuals who are given outcome information are believed to assimilate it with the limited information that they already know to build a coherent story. See Fischhoff, *supra* note 161, at 297 (referring to experimental strategies for reducing hindsight bias); Lowe & Reckers, *supra* note 163, at 405 (same). When they are given information about a bad outcome, they "rewrite the story" so that the beginning and middle provide a causal explanation for what they

evidence suggesting that other outcomes were also possible.<sup>180</sup> For example, researchers have reduced or eliminated hindsight bias by informing their subjects that positive outcomes were possible and then asking the subjects to explain these positive outcomes.<sup>181</sup> This exercise moves individuals from a hindsight to a foresight perspective, i.e., from a perspective that merely requires the explanation of one outcome to one that requires consideration of multiple possible outcomes.<sup>182</sup> Cognitive strategies of this kind have had considerable, although not uniform, success in reducing hindsight bias.<sup>183</sup>

Defense counsel can employ similar tactics to prevent the jury from greasing only one causal pathway. By helping the jury see the alternatives that seemed possible *ex ante* and by explaining why the defendant felt her choice was reasonable at the time, defense counsel can involve the jury in precisely the same kind of “consider the opposite” exercise that has proven successful in experimental settings.<sup>184</sup>

So far, however, very little research has been undertaken to explore whether the efforts of defense counsel can fulfill this promise. Two important studies using cognitive strategies in simulated trial settings have had mixed results.<sup>185</sup> A study by Stallard and Worthington eliminated two-thirds of the hindsight bias by having defense counsel remind mock jurors in closing argument that the plaintiff wanted them to be a “Monday morning quarterback” and warning the jurors not to use hindsight or second-guess the defendants.<sup>186</sup> However, a study by Kamin and Rachlinski found no reduction in bias after having the judge warn mock jurors about the danger of hindsight judgments and having both judge and defense

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now know to be the end. Lowe & Reckers, *supra* note 163, at 405-06; David A. Schkade & Lynda M. Kilbourne, *Expectation-Outcome Consistency and Hindsight Bias*, 49 ORGANIZATIONAL BEHAV. & HUM. DECISION PROCESSES 105, 107 (1991). Thus, they build a story from back to front. Thereafter, they view the actual outcome as natural and find it difficult to see how alternative outcomes could have occurred.

180. See Peters, *supra* note 169, at 1286-89 (reviewing the literature).

181. See, e.g., Hal R. Arkes et al., *Eliminating the Hindsight Bias*, 73 J. APPLIED PSYCHOL. 305, 305 (1988) (attacking hindsight bias by asking subjects to think concretely about alternative outcomes); Lowe & Reckers, *supra* note 163, at 414 (providing subjects with alternative positive outcomes to consider); Michelle R. Nario & Nyla R. Branscombe, *Comparison Processes in Hindsight and Causal Attribution*, 21 PERSONALITY & SOC. PSYCHOL. BULL. 1244, 1249 (1995) (asking subjects to explain alternative outcomes); Peters, *supra* note 169, at 1286-89; Paul Slovic & Baruch Fischhoff, *On the Psychology of Experimental Surprises*, 3 J. EXPERIMENTAL PSYCHOL.: HUM. PERCEPTION & PERFORMANCE 544, 544 (1977) (same).

182. See Lowe & Reckers, *supra* note 163, at 406 (making this point).

183. See Peters, *supra* note 169, at 1286-89 (discussing cognitive strategies).

184. To help make these efforts successful, judges can prepare jurors by giving them instructions that explain both the dangers of hindsight bias and how it operates. Wexler & Schopp, *supra* note 171, at 492.

185. See Kamin & Rachlinski, *supra* note 163, at 94-98 (finding little impact). *But see* Stallard & Worthington, *supra* note 166, at 679 (finding a substantial reduction in hindsight bias).

186. See Stallard & Worthington, *supra* note 166, at 679 tbl.3 (finding that their strategy reduced the increase attributable to hindsight from 28% to 8%, a reduction of over 70%).

counsel encourage the jury to “think of all the ways” that the accident could have happened.<sup>187</sup> Consequently, the research testing this debiasing strategy is inconclusive.

More intriguing is a very recent study by Kathryn Kadous.<sup>188</sup> She hypothesized that hindsight bias was a product of affect, rather than cognition, and that negative outcomes cause people to feel both increased levels of negative affect and increased motivation to lay blame.<sup>189</sup> She therefore attempted to eliminate hindsight bias by reducing juror reliance on affect as a basis for laying blame. Her strategy was stunningly simple: she merely told her mock jurors that they might feel anxious and tense, as actual jurors do, because they are making difficult decisions.<sup>190</sup> This maneuver completely eliminated the hindsight bias, even though it was unobtrusive and did not drive the jurors in a particular direction. Although this line of research is still in its infancy, it is extraordinarily promising and its lessons could easily be transferred to the courtroom.

## 2. Aspects of the Civil Justice System that Favor Defendants

*The General Theory of the Second Best* instructs us that fixing some imperfections in a system while others remain in operation can actually produce a new situation that is worse than the old.<sup>191</sup> Correcting biases that favor plaintiffs without correcting biases that favor defendants could actually make the situation worse, rather than better.<sup>192</sup>

The civil justice system favors malpractice defendants in two important respects. First, as discussed earlier, jurors sympathize with physicians and distrust the motives of plaintiffs who sue them.<sup>193</sup> Second, malpractice

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187. Kamin & Rachlinski, *supra* note 163, at 94-98; see also Ronnie Janoff-Bulman et al., *Cognitive Biases in Blaming the Victim*, 21 J. EXPERIMENTAL SOC. PSYCHOL. 161, 161, 169-73 (finding that requesting subjects to explain a neutral outcome did not reduce victim blaming).

188. Kathryn Kadous, *Improving Jurors' Evaluations of Auditors in Negligence Cases*, 18 CONTEMP. ACCT. RES. 425 (2001). This paper is based on data from her dissertation at the University of Illinois.

189. *Id.* at 439. She found that negative outcome information did cause higher levels of motivation to lay blame. *Id.* She apparently did not attempt to measure affect directly, however.

190. *Id.* at 432.

191. See R.G. Lipsey & Kevin Lancaster, *The General Theory of the Second Best*, 24 REV. ECON. STUD. 11, 12-13 (1956-1957).

192. The neatness with which pro-defendant access bias offsets or corrects pro-plaintiff process bias should not be overstated. Gillette and Krier appear to have assumed, for purposes of simplifying their basic model, that the process and access biases would equally affect all risk producers. If, however, the access bias (false negatives) were concentrated in one subset of injurers (say, obstetricians) and the erroneous verdicts (the false positives) in another, then one group of defendants (say, family physicians) could remain insulated from an adequate deterrent signal while the compensating deterrent signal produced by pro-plaintiff process bias would be concentrated on another subset of physicians.

193. See *supra* text accompanying notes 129-40.

defendants benefit from the obstacles that victims face in bringing their claims to court.

Most victims of medical negligence never make a claim. A California study found only one claim for every ten negligently injured patients.<sup>194</sup> Even more remarkably, only one in six of those who suffered major, permanent injuries filed suit.<sup>195</sup> A later New York study found only one claim for every 7.6 negligent injuries.<sup>196</sup> Most recently, a study of hospital negligence in Utah and Colorado had similar findings.<sup>197</sup> Under these circumstances, the deterrent signal sent to injurers is likely to be tragically inadequate.<sup>198</sup>

Advantages like these may offset the benefit, if any, conferred upon plaintiffs by hindsight bias. According to *The General Theory of the Second Best*, the elimination or reduction of one system of imperfection (such as hindsight bias) will not necessarily improve overall allocative efficiency as long as other imperfections (such as access bias) remain.<sup>199</sup> Because two imperfections can counteract each other, the reduction of one, but not the other, can actually reduce efficiency. In tort litigation, therefore, the defendant's fear of hindsight bias may partially offset the potential for underdeterrence posed by access bias.

### 3. Concluding Thoughts About Hindsight Bias

Unfortunately, we know very little about the operation of hindsight bias in actual litigation. Actual jury trials differ from experimental studies in material respects that may reduce the presence of hindsight bias. In addition, judges and attorneys have the power to reduce the likelihood of a biased verdict. Studies designed to test this hypothesis have had mixed results. However, social scientists have barely begun to explore the full array of tools, ranging from voir dire to summation, that defense counsel and defense witnesses can employ to shrink the hindsight bias. Nor have they tested whether plaintiff's counsel can successfully employ tactics that will preserve or even enhance hindsight bias. Many important questions, therefore, remain unanswered. In the interim, it seems reasonable to speculate that the trial process can reduce, but not eliminate, hindsight bias.

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194. DANZON, *supra* note 4, at 19; Saks, *supra* note 141, at 1183 (citing CAL. MED. ASS'N & CAL. HOSP. ASS'N, REPORT ON THE MEDICAL INSURANCE FEASIBILITY STUDY 101 (Don H. Mills ed., 1977)).

195. Saks, *supra* note 141, at 1183.

196. WEILER ET AL., *supra* note 126, at 70 tbl.4.1.

197. See David M. Studdert et al., *Negligent Care and Malpractice Claiming Behavior in Utah and Colorado*, 38 MED. CARE 250, 254 (2000) (finding that only 3% of the patients who suffered negligent injury filed suit).

198. See Clayton P. Gillette & James E. Krier, *Risk, Courts, and Agencies*, 138 U. PA. L. REV. 1027, 1044-45 (1990) (arguing that pro-plaintiff biases in the judicial process ("process bias") may be outweighed by factors that limit access to the courts ("access bias")).

199. Richard S. Markovits, *Second-Best Theory and Law & Economics: An Introduction*, 73 CHI-KENT L. REV. 3, 3 (1998).

Before deciding on measures to correct any residual hindsight bias, courts also need to consider whether any advantage conferred upon malpractice plaintiffs by uncorrected hindsight bias is offset by aspects of the civil justice system that favor malpractice defendants. These factors include juror skepticism toward malpractice plaintiffs and the barriers that exist to bringing a lawsuit. It may not be fair to take significant measures to reduce hindsight bias (such as deference to medical customs) without taking similar measures to reduce the biases that benefit defendants.

### E. POLYCENTRICITY

In an article entitled *Process Constraints in Tort*, Professor James Henderson offered a quite different reason for retaining the custom-based standard of care.<sup>200</sup> Building on the work of Lon Fuller, Henderson argued that medical malpractice actions are “polycentric” and that resolving them using a reasonable care test “would exceed the limits of adjudication.”<sup>201</sup>

#### 1. The Problem Posed by Polycentric Disputes

Polycentric disputes are those that require the simultaneous “weighing and balancing of interrelated . . . considerations.”<sup>202</sup> They raise issues that cannot be resolved in a linear, step-by-step fashion and, instead, require simultaneous assessment of many choices.<sup>203</sup> Building a bridge was an example used by Lon Fuller:<sup>204</sup>

There are rational principles for building bridges of structural steel. But there is no rational principle which states, for example, that the angle between girder A and girder B must always be 45 degrees. This depends on the bridge as a whole. One cannot construct a bridge by conducting successive separate arguments concerning the proper angle for every pair of intersecting girders. One must deal with the whole structure.<sup>205</sup>

Fuller felt that questions about how to build a bridge were not well suited to resolution by adjudication. Family disputes about where to go on vacation

200. James A. Henderson, Jr., *Process Constraints in Tort*, 67 CORNELL L. REV. 901 (1982) [hereinafter Henderson, *Process Constraints*]; see also James A. Henderson, Jr., *Expanding the Negligence Concept: Retreat from the Rule of Law*, 51 IND. L.J. 467, 494 (1976) [hereinafter Henderson, *Retreat from the Rule of Law*] (discussing the dangers of “independent judicial review of medical custom”). Keeton also had made a brief mention of polycentricity in malpractice disputes in 1979. Keeton, *supra* note 53, at 359.

201. Henderson, *Process Constraints*, *supra* note 200, at 923-24.

202. *Id.* at 907.

203. See *id.* at 908-911 (using a hypothetical problem to illustrate the concept).

204. See Lon L. Fuller, *The Forms and Limits of Adjudication*, 92 HARV. L. REV. 353, 394-404 (1978) (using multiple illustrations to explain polycentric decision making).

205. *Id.* at 403.

provide another example of a polycentric dispute.<sup>206</sup> Fuller also believed that disputes over the allocation of resources were polycentric. “Generally speaking, it may be said that problems in the allocation of economic resources present too strong a polycentric aspect to be suitable for adjudication.”<sup>207</sup>

Extending Fuller’s reasoning, Henderson concluded that the tort standard of reasonable care is so open-ended that it, too, is polycentric.<sup>208</sup> As a result, he favored the retention of tort doctrines that make tort duties less open-ended, such as the traditional status rules in landowner cases and judicial deference to custom in malpractice cases.<sup>209</sup>

Malpractice disputes have an especially strong air of polycentricity when they involve resource allocation issues. When a plaintiff contends that her condition should have been treated more aggressively, for example, she is suggesting that more resources should have been devoted to her care. Jurors cannot make a wise decision about her claim to resources without some sense of the implications that their decision will have for the allocation of resources to other competing medical and social uses. In Henderson’s view, asking judges or juries to do this “clearly would exceed the limits of adjudication.”<sup>210</sup>

Deference to custom appealed to Henderson because it cured the circularity of the underlying allocation decision. Instead of making an allocation decision, the jury would have the more manageable task of deciding “whether the conduct of the individual physician conformed to the established standards of his profession.”<sup>211</sup> Although Henderson conceded that a custom-based standard may not be the fairest test of culpability, he felt that deference to custom is one of “[t]he concessions that substantive tort law must make to the realities of process.”<sup>212</sup>

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206. See Henderson, *Retreat from the Rule of Law*, *supra* note 200, at 472 (imagining the difficulties a court would face in resolving this issue).

207. Fuller, *supra* note 204, at 400. Imagine, for example, a dispute over how to allocate a city’s revenues.

208. See Henderson, *Process Constraints*, *supra* note 200, at 922 (discussing the difficulties of applying a reasonable standard of care); Henderson, *Retreat from the Rule of Law*, *supra* note 200, at 478-79 (discussing judicial approaches to dealing with problems of negligence).

209. See Henderson, *Process Constraints*, *supra* note 200, at 923-25 (discussing alternative approaches to determining liability). He also includes the no-duty-to-rescue rule. *Id.* at 928-43.

210. *Id.* at 923-24. Richard Pearson briefly made a similar point in 1976 in support of his assertion that “[c]ourts are not well suited institutionally to the making of evaluations of industry custom.” Richard N. Pearson, *The Role of Custom in Medical Malpractice Cases*, 51 *IND. L.J.* 528, 534 n.40 (1976).

211. Henderson, *Process Constraints*, *supra* note 200, at 924. Courts can escape the problem of polycentricity by delegating “the open-ended task of planning reasonable medical care” to the “collective managerial authority of the medical profession.” Henderson, *Retreat from the Rule of Law*, *supra* note 200, at 480.

212. Henderson, *Process Constraints*, *supra* note 200, at 902; accord CLARK C. HAVIGHURST ET AL., *HEALTH CARE LAW AND POLICY: READINGS, NOTES, AND QUESTIONS* 1010-13 (2d ed. 1998)

Henderson is not alone in his pessimism about judicial efforts to make health care allocation decisions. Writing about health care rationing decisions in the context of health insurance contract interpretation, Mark Hall has concluded that “the cost/benefit trade-offs . . . that underlie medical spending decisions partake heavily of these . . . aspects of polycentrism.”<sup>213</sup>

## 2. Critique

The polycentricity argument in favor of a custom-based standard of care turns on two fundamental assumptions. One is that medical customs will be readily ascertainable, thus curing the problem of polycentricity without producing equivalent problems of indeterminacy. In reality, however, medical practices rarely provide the stable, ascertainable benchmark that Henderson desired. As a result, Henderson himself has now concluded that courts cannot rely on the presence of medical customs to serve as the basis for their decisions.<sup>214</sup> The second assumption is that tort disputes—at least those involving resource allocation issues—cannot be resolved by the jury in a principled manner. That assumption is also questionable.

### a. *The Absence of Stable Customs*

In the past few decades, medical researchers have learned that clinical practices vary dramatically and inexplicably. A number of studies, starting with the classic work of John Wennberg,<sup>215</sup> have demonstrated that physician practices vary widely, even within narrow geographic areas. In Vermont, for example, eight percent of the people in one community had their tonsils taken out while seventy percent of the residents of a different community

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(noting that custom might be chosen as the legal benchmark for administrative reasons that do not imply that customs are optimal or right). Henderson recommends that we “strive to achieve . . . reasonable accommodations of substantive objectives within process constraints.” *Henderson, Process Constraints*, *supra* note 200, at 948.

213. MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS 72 (1997). In addition, Havighurst, Blumstein, and Brennan, although not relying on the concept of polycentricity, have suggested that reference to professional standards may be necessary to make the legal standard of care manageable. See HAVIGHURST ET AL., *supra* note 212, at 1010-13 (suggesting that reference to professional standards is necessary to make the legal standard of care manageable in length and enforceable in court); CLARK C. HAVIGHURST ET AL., HEALTH CARE LAW AND POLICY: READINGS, NOTES, AND QUESTIONS, TEACHER’S MANUAL CHAPTER 7, 5 (1999) (“custom is probably the only feasible starting point.”); *id.* at 7 (“It is very unlikely that the courts, with their limited resources and dependence on lawyers and lay juries, can ever arrive at and administer an efficient standard for governing all medical care.”).

214. See James A. Henderson, Jr. & John A. Siliciano, *Universal Health Care and the Continued Reliance on Custom in Determining Medical Malpractice*, 79 CORNELL L. REV. 1382, 1383 (1994) (discussing the changing fare of health care litigation). As an alternative, he seems to advocate an increased role for contractually-specified standards. *Id.* at 1404.

215. John Wennberg, *Dealing with Medical Malpractice Variations: A Proposal for Action*, HEALTH AFF., Summer 1984, at 6, 7.

had the surgery.<sup>216</sup> In Iowa, the rate of prostate removal ranged from 15% to 60%.<sup>217</sup> A Medicare study found that procedure rates varied by more than three hundred percent for more than one-half of the procedures studied.<sup>218</sup>

In addition to the geographic variation that permeates clinical medicine, the highly differentiated nature of medical problems is also a barrier to the formation of medical customs.<sup>219</sup> Patients vary in ways that resist standardization.<sup>220</sup> This variation is matched by a similar variety in possible therapeutic responses, each with its own mix of benefits, risks, and costs.<sup>221</sup> At the same time, physicians vary in their preferences and in their knowledge of medical literature and practices.<sup>222</sup> Finally, the movement of many employers away from fee-for-service health plans and toward managed care plans has produced significant differences among health plans in their resources and their cost-containment philosophies.<sup>223</sup> Under these circumstances, there will rarely be a “custom” that provides a clear rule of decision.

In theory, of course, the respectable minority rule of malpractice law should solve this problem by eliminating the need to identify a single professional norm. However, courts have not applied the respectable minority rule in this fashion; instead, they give these cases to the jury. As Mark Hall has noted, “[T]his breakdown between theory and practice essentially allows the jury to impose, based on its own independent judgment, the governing standard of care—the very result malpractice law attempts to avoid.”<sup>224</sup> In practice, therefore, the custom-based standard of care routinely fails to provide an external benchmark to displace the jury’s independent determination of reasonability.

There is an additional erroneous assumption underlying the idea that a custom-based standard will provide a more ascertainable and predictable standard. In truth, few trial experts can be expected to have an accurate

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216. *Id.* at 9.

217. *Id.*

218. CURRAN ET AL., *supra* note 41, at 36.

219. See Henderson & Siliciano, *supra* note 214, at 1390 (noting the problems the differential nature of medical problems pose in forming medical customs).

220. See HALL, *supra* note 213, at 84-88 (concluding that individual treatment decisions are complex and individualized); Henderson & Siliciano, *supra* note 214, at 1390 (concluding that the “highly differentiated nature of medical problems” is an obstacle to the formation of useful medical customs); McCoid, *supra* note 4, at 584 (stating that “there is no standard patient”).

221. Henderson & Siliciano, *supra* note 214, at 1390.

222. *Id.* at 1391.

223. See *id.* at 1399-400 (noting the heterogeneity of modern health plans); E. Haavi Morreim, *Medicine Meets Resource Limits: Restructuring the Legal Standard of Care*, 59 U. PITT. L. REV. 1, 8-20, 94-95 (1997) (same).

224. Mark A. Hall, *The Defensive Effect of Medical Practice Policies in Malpractice Litigation*, 54 LAW & CONTEMP. PROBS. 119, 128-29 (1991); see Peters, *supra* note 1, at 186 (noting the failure of the respectable minority rule to keep these cases from the jury).



sense of what most physicians are doing. As David Eddy notes, “[I]t is a major research task to figure out what practitioners in a community are doing.”<sup>225</sup> As a consequence, experts who are asked questions about the standard of care are unlikely to have a reliable understanding of customary norms across the nation or even in similar communities. Instead, their testimony is more likely to be a barometer of their own practices.

Recognizing that customs are illusory, Henderson has now retreated from his undivided support for deference to custom. Instead, he and his coauthor John Siliciano have recommended greater reliance on contractually-based standards of care.<sup>226</sup> But that solution will only work if the parties enter into an enforceable agreement governing the standard of care. Absent such an agreement, the courts still must provide a default standard of care. When courts choose this standard, they need to take into account that the custom-based standard of care rarely lives up to its promise of providing a bright-line rule of decision.

*b. The Adjudicability of Negligence Actions*

A second reason for doubting the polycentricity argument is that it proves too much. As Henderson uses the term, all tort actions decided under a “reasonable care” standard are polycentric.<sup>227</sup> Yet, juries routinely make competent decisions in these cases. The empiricists who study jury decision-making regularly and convincingly reassure us of this.<sup>228</sup>

The manner in which most negligence cases are pleaded and proven may explain why tort actions are more manageable than critics anticipated. Plaintiffs typically narrow the scope of the jury’s inquiry by focusing upon an “untaken precaution” and alleging that a reasonable person would have undertaken it.<sup>229</sup> With the task so confined, the jury need not determine the precise combination of safety precautions that would optimize social welfare.<sup>230</sup> Instead, jurors examine the defendant’s failure to take the specific precaution recommended by the plaintiff. This focus on specific untaken precautions narrows the jury’s assignment and, thus, removes its ostensibly polycentric parameters.

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225. David M. Eddy, *The Use of Evidence and Cost Effectiveness by the Courts: How Can It Help Improve Health Care?*, 26 J. HEALTH, POL., POL’Y & L. 387, 396 (2001).

226. See Henderson & Siliciano, *supra* note 214, at 1391 (noting that variations in practice destroy much of custom’s potential for clarity and simplicity).

227. See Henderson, *Process Constraints*, *supra* note 200, at 923-24 (suggesting that juries cope with these simpler cases by relying on empathy and intuition).

228. See *supra* text accompanying notes 61-81 (reviewing studies of jury verdicts).

229. Mark F. Grady, *Untaken Precautions*, 18 J. LEGAL STUD. 139 (1989).

230. Grady, *Untaken Precautions*, *supra* note 229, at 147. In addition, most medically adverse events occurring during hospitalization involve surgery or adverse drug events. Eric J. Thomas et al., *Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado*, 38 MED. CARE 261, 268 (2000). These mishaps are likely to involve a lack of skill rather than a faulty allocation of scarce resources.

In some jurisdictions, the jury's task will be structured even further by a jury instruction explaining that reasonability is determined by balancing the risks of the defendant's conduct against its utility.<sup>231</sup> So confined, a negligence action differs materially from open-ended disputes.

Of course, these solutions to the problem of polycentricity do not guarantee that the jury will reach sound conclusions. The jury may, for example, be influenced by hindsight, be confused by the evidence, or give too little weight to the cost implications of its decision. Those, however, are different objections which have been evaluated above.

To summarize, the polycentricity argument for taking the responsibility of standard-setting away from the jury is vulnerable to two important criticisms. First, it overestimates the extent to which malpractice actions and other tort actions are open-ended. Second, it seeks to cure the problem of polycentricity by relying on an external benchmark—customary medical standards—that itself is often indeterminate.

#### F. EVALUATING DOUBTS ABOUT THE JURY

Juries and judges usually agree. So do juries and physicians. Together, these findings strongly rebut the widely-shared misconception that juries are biased in favor of injured patients. They also provide a credible basis for concluding that juries understand the evidence in tort cases in general and in malpractice actions in particular. Although social scientists have found that lay people are prone to certain errors using statistical proof, they have also found that these tendencies are correctable.

However, jurors may be vulnerable to hindsight bias. We do not know whether the trial process can neutralize this danger. In addition, jurors may be resistant to the explicit balancing of cost against safety. If so, they may penalize responsible cost-control in health care delivery. At present, however, we can only speculate about this risk as the scant research data is conflicting. Furthermore, it is quite possible that any advantage conferred upon plaintiffs by these tendencies is offset both by the sympathy that jurors have for physicians and by the barriers to litigation that favor defendants.

Overall, the jury receives a good but not perfect report card. However, none of the credible doubts expressed about jury competence are unique to medical malpractice litigation.<sup>232</sup> Hindsight bias and resistance to risk-utility calculus are threats to all tort litigation. The same can be said for worries about complexity. In modern jury trials, complexity abounds. Product liability actions, toxic tort cases, airplane accidents, and highway design cases

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231. See, e.g., *United States v. Carroll Towing Co.*, 159 F.2d 169 (2d Cir. 1947) (suggesting that reasonableness requires a balancing of risk and utility); RESTATEMENT (SECOND) OF TORTS § 291 (1975) (same).

232. See, e.g., John Kimbrough Johnson, Jr., *An Evaluation of Changes in the Medical Standard of Care*, 23 VAND. L. REV. 729, 743 (1970) (pointing out that these concerns are applicable to all negligence actions); Silver, *supra* note 4, at 1217 (same).

are just a few of the tort actions in which juries listen to experts and then determine whether the defendant has behaved like a reasonable person with similar training. Only in professional malpractice actions have courts taken the task of setting the legal standard of care away from the jury and given it to the regulated industry. As a result, the case for taking standard setting away from the jury in malpractice actions seems to turn on something special about medical or professional negligence actions.

In malpractice actions, it seems likely that professionals benefit from judicial confidence that their customs provide a reliable barometer of reasonable behavior. This confidence is not reposed in the customs of other industries, such as trucking or product manufacturing. It has two likely explanations: (1) faith in the *professionalism* of physicians, and (2) faith in the discipline of the *medical market*. Each of these possibilities is explored further in Part III

### III. CONFIDENCE IN MEDICAL CUSTOMS

Scholars and courts have articulated two quite distinct rationales for trusting clinical practices. The first is faith in the professionalism of physicians. The second is faith in the power of the market to make medical practices efficient. In the real world, however, medical practices live up to neither ideal.

#### A. FAITH IN PHYSICIANS

Historically, both courts and scholars have trusted physicians to put the welfare of patients above all other interests.

##### 1. A History of Trust

Faith in physicians resonates throughout the early legal commentary explaining the customary standard of care. Allan McCoid's classic 1959 article on the medical standard of care contended that physicians "should be free to operate in the best interests of the patient."<sup>233</sup> Post-hoc judicial supervision, he feared, would interfere with that freedom and prevent doctors from practicing sound medicine.<sup>234</sup> Richard Pearson summarized the underlying logic of the custom-based standard of care as follows: "There is no need for courts to act as a source of pressure to compel the medical profession to give adequate consideration to patient safety and well-being, since the forces that operate within the medical profession make such extra-

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233. McCoid, *supra* note 4, at 608.

234. *Id.* at 608. In an earlier piece, McCoid had concluded "that the doctor is exercising his skill for the benefit of the patient [and] inasmuch as this assumption is a basic tenet of medical science it seems a proper one." Allan H. McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 MINN. L. REV. 381, 431-32 (1957).

professional pressure unnecessary.”<sup>235</sup> Dean Prosser, too, believed that the custom-based standard of care rested on “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.”<sup>236</sup> Another scholar, James Henderson, concluded that “[a]n important reason for allowing the medical profession to set its own standards is that courts can assume these standards are adequate to protect the interests of patients.”<sup>237</sup>

Even today, courts retaining a custom-based standard of care emphasize their respect for their fellow professionals. “[W]e defer,” said the South Carolina Supreme Court, “to the collective wisdom” of physicians.<sup>238</sup> Likewise, the Kansas Supreme Court based its ruling on its faith in “the medical profession’s own recognition of its obligations to maintain its standards.”<sup>239</sup>

The most interesting statement of this rationale appears in a 1985 Arizona products liability decision. In *Rossel v. Volkswagen of America*,<sup>240</sup> Volkswagen contended that its automobile designers were professionals, like physicians, and that their conduct should therefore be judged against professional customs. Unpersuaded, the Arizona Supreme Court explained that it would delegate its standard-setting power “only when the nature of the group and its special relationship with its clients assure society that those standards will be set *with primary regard to protection of the public* rather than to such considerations as increased profitability.”<sup>241</sup>

## 2. The Limits of Professionalism

Regrettably, much of this confidence in physician norms is misplaced. Recent research demonstrates that physicians, like the rest of us, are driven not only by science and fidelity to patient interests, but also by habit, self-interest, and other competing considerations. In the understated words of Clarence Morris, “doctors as a class may be more likely to exert their best efforts than drovers, railroads, and merchants; but they are human and subject to temptations of laziness and unthinking acceptance of traditions.”<sup>242</sup>

235. Pearson, *supra* note 210, at 537.

236. KEETON ET AL., *supra* note 4, § 32, at 189.

237. Henderson, *Process Constraints*, *supra* note 200, at 926.

238. Doe v. Am. Red Cross Blood Serv., 377 S.E.2d 323, 326 (S.C. 1989).

239. Natanson v. Kline, 350 P.2d 1093, 1107 (Kan. 1960).

240. 709 P.2d 517 (Ariz. 1985).

241. *Id.* at 523 (emphasis added). Physicians did not always enjoy this special trust. One hundred and fifty years ago, physicians enjoyed neither exalted social status nor legal privilege. See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 81-92 (1982) (providing a historical analysis of physicians’ status and privileges). In tort law, they were held to the same standard of reasonable care applied in other negligence actions. See Silver, *supra* note 4, at 1205-11.

242. MORRIS & MORRIS, *supra* note 4, at 56.

Realistic skepticism about physician loyalty is consistent with the findings of researchers who have studied physician self-referral practices. They have learned that a physician is far more likely to order a procedure like a lab test or x-ray if the physician owns the facility that will perform the procedure.<sup>243</sup> In his important review of the literature on physician practices, Timothy Jost reported that physician referral practice “is less influenced by evaluations of technical competence than it is by factors such as affability of the consultant, patient preferences, previous use of the consultant by the referring physician, personal familiarity with the consultant, reciprocal referrals from the consultant and eschewal of patient ‘stealing’ by consultants.”<sup>244</sup>

Cardiologists who do invasive procedures are much more likely to recommend these procedures than primary care physicians and cardiologists who do not perform these procedures.<sup>245</sup> Physicians who have been coddled by pharmaceutical sales representatives are more likely to prescribe the drugs made by that company.<sup>246</sup> Physicians are professionals, but they are also humans with their own financial and professional interests. As a consequence, they are imperfect agents.<sup>247</sup>

In addition, surprisingly few clinical practices are actually based on scientific evidence.<sup>248</sup> In fact, current research provides definitive

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243. See RICHARD P. KUSSEROW, U.S. DEP'T. OF HEALTH & HUMAN SERVS., FINANCIAL ARRANGEMENTS BETWEEN PHYSICIANS AND HEALTH CARE BUSINESSES: REPORT TO CONGRESS 18 (1989) (documenting the higher incidence of treatment for patients that are self-referred). That practice was tolerated by the profession until Congress intervened. See Thomas L. Greaney, *How Many Libertarians Does it Take to Fix the Health Care System?*, 96 MICH. L. REV. 1825, 1831 (1997) (reviewing RICHARD A. EPSTEIN, MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE? (1997)).

244. Timothy S. Jost, *The Necessary and Proper Role of Regulation to Assure the Quality of Health Care*, 25 HOUS. L. REV. 525, 570 (1988); see HALL, *supra* note 213, at 46 (listing factors that lead physicians to make decisions that fully informed patients would not make); Henderson & Siliciano, *supra* note 214, at 1394 n.44 (noting that “professional pride and competition will cause some physicians to use new, cutting edge technologies to treat conditions that are amenable to less exotic interventions”).

245. See John X. Ayanian et al., *Rating the Appropriateness of Coronary Angiography—Do Practicing Physicians Agree with an Expert Panel and with Each Other?*, 338 NEW ENG. J. MED. 1896, 1901 (1998) (finding that beliefs about appropriateness of coronary angiography varied by groups).

246. See Jost, *supra* note 244, at 571; *cf.*, E. HAAVI MORREIM, HOLDING HEALTH CARE ACCOUNTABLE: LAW AND THE NEW MEDICAL MARKETPLACE 71 (2001) (describing physician susceptibility to drug advertisements).

247. See DANZON, *supra* note 4, at 221 (noting the imperfection).

248. See E. HAAVI MORREIM, BALANCING ACT: THE NEW MEDICAL ETHICS OF MEDICINE'S NEW ECONOMICS 51 (1995) (stating that customs are sometimes based on “habit, hunch, current fashion, and the profession’s folk wisdom”); Sara Rosenbaum et al., *Who Should Determine When Health Care Is Medically Necessary?*, 340 NEW ENG. J. MED. 229, 231 (1999) (“Much of medical practice is the result of tradition and collective experience. Many basic medieval interventions have not been studied rigorously.”).

information about only a small percentage of all clinical decisions.<sup>249</sup> And when clinical evidence is available, physicians often are slow to act upon it. In 1980, for example, a major study established that rigorous glucose control significantly reduced long-term complications from diabetes.<sup>250</sup> Yet, a study of clinical practices in 1995 discovered that only one out of four diabetic patients was receiving the recommended number of annual tests.<sup>251</sup> That finding was not aberrant.<sup>252</sup> Physicians commonly fail to follow the guidelines recommended by their professional organizations.<sup>253</sup>

As Haavi Morreim observes, clinical “routines are based not just on clear data and careful reasoning, but also on habit, hunch, current fashion, and the profession’s folk wisdom.”<sup>254</sup> As a result, medical customs have a veneer of scientific validity that is too often undeserved. This conclusion was confirmed by the recent findings of the National Institutes of Health, which concluded that tens of thousands of Americans lose their lives every year due to medical error.<sup>255</sup> As a result, Lawrence Gostin, a respected law professor and policy analyst, summarizes the disappointing state of health care quality this way:

The quality of health care is, by most accounts, a serious problem. Research has demonstrated that physicians overuse health care services by employing unnecessary interventions that are costly and place patients at risk; underuse services by failing to afford standard care that would produce favorable outcomes; and misuse services by devising the wrong treatment plan or improperly executing the correct plan.<sup>256</sup>

Medicine has also undergone a recent structural transformation that

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249. See M. Gregg Bloche, *Medical Care and the Enigma of Efficiency* 166, 174 (1999), available at [http://papers.ssrn.com/paper.taf?abstract\\_id=184275](http://papers.ssrn.com/paper.taf?abstract_id=184275).

250. DCCT Research Group, *The Absence of Glycemic Threshold for the Development of Long-Term Complication: The Perspective of the Diabetes Control and Complications Trial*, 38 *DIABETES* 1289 (1989).

251. See Lee N. Newcomer, *Physician, Measure Thyself*, *HEALTH AFF.*, Jul-Aug. 1998 at 32, 33. Another example of belated response is provided by the widespread failure of physicians to use beta-blockers to prevent recurrence of myocardial infarctions. Even though the American College of Cardiology had adopted a guideline recommending the administration of beta-blockers, two studies found that roughly half of the eligible patients were not receiving the treatment. See *id.* (reviewing the studies).

252. See MORREIM, *supra* note 248, at 70 (reviewing the findings of the failure to follow practices widely agreed to be appropriate).

253. See Mello, *supra* note 32, at 680-82 (discussing the incomplete compliance).

254. MORREIM, *supra* note 248, at 51.

255. See COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 2* (Linda T. Kohn et al. eds., 1999).

256. Lawrence O. Gostin, *A Public Health Approach to Reducing Error: Medical Malpractice as a Barrier*, 282 *JAMA* 1742-43 (2000).

accentuates the danger that patient interests will suffer.<sup>257</sup> Control of the insurance market has shifted from not-for-profit insurers like Blue Cross & Blue Shield to profit-oriented commercial insurers. These insurers are using a variety of strategies to make physicians more cost-conscious and responsive to plan preferences, including proprietary treatment guidelines, financial incentives for reducing utilization, and the threat of termination without cause (politely called “deselection”).<sup>258</sup> Understandably, commentators fear that the loyalty of physicians is now divided between their patients and their plans.<sup>259</sup>

Under these circumstances, it seems reasonable to revisit the assumption that medical customs are uniquely reliable. The unwavering faith that the law once placed in physicians was probably naive from the outset and predictably has weakened in a more realistic and cynical age. In the words of noted physician and policy analyst David Eddy,

[G]iven the very high rates of inappropriate care that can prevail in communities, if we actually measured what practitioners were doing and used that to define the standard of care, we would run a high risk of installing an inappropriate practice as the standard of care. The well-documented overuses of hysterectomies, antibiotics, bypasses, and C-sections are examples.<sup>260</sup>

In the real world, physicians are not immune from conflicting interests. In addition, health care delivery is increasingly controlled by for-profit organizations concerned more with cost than with quality. As a consequence, it is far less obvious than it once was that medicine should set its own standard of care.

#### B. MARKET DISCIPLINE

The second justification offered for trusting customs is an economic one. Scholars like Judge Richard Posner, Patricia Danzon, and Richard Epstein have argued that customary practices are a good proxy for reasonable care because the marketplace will force medical practices to be

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257. Between 1988 and 1994, membership in nonprofit HMOs increased by 24.9% while membership in for-profit HMOs increased by 91.6%. See Jon Gabel, *Ten Ways HMOs Have Changed During the 1990s*, HEALTH AFF., May-June 1997, at 134, 135; see also Daniel M. Fox, *The Politics of Explicit Rationing*, HEALTH AFF., May-June 2000, at 279, 280 (noting that consumers are “increasingly aware that their relationship with physicians has business as well as fiduciary aspects”). By 1997, most HMO members were enrolled in for-profit plans. Gabel, *supra* at 135.

258. See Joan H. Krause, *Reconceptualizing Informed Consent in an Era of Health Care Cost Containment*, 85 IOWA L. REV. 261, 286, 298-300 (1999) (discussing how physicians may not refer patients for “ancillary services” and HMOs restrict patient care through economic disincentives for physicians).

259. See Michael H. Bailit, *Ominous Signs and Portents: A Purchaser’s View of Health Care Market Trends*, HEALTH AFF., Nov.-Dec. 1997, at 85, 86 (discussing how compensation systems do not adequately take into account physician’s ethics).

260. Eddy, *supra* note 225, at 396.

efficient.<sup>261</sup>

Under traditional economic theory, customs ought to be efficient whenever transaction costs are low.<sup>262</sup> If transaction costs are low, sellers, like physicians, have an incentive independent of tort law to provide the level of care for which their customers are willing to pay.<sup>263</sup> Transaction costs tend to be low whenever injurers and victims have a preexisting contractual relationship through which they can negotiate their respective obligations. Under these circumstances, law and economics scholars reason that the market will produce efficient customs.<sup>264</sup> Because the relationship between patients and physicians appears to satisfy these requirements, several scholars have concluded that physicians will adopt customs that reflect the level of safety precautions desired by the public.

However, this conclusion assumes that the market for medical services is substantially free of market imperfections such as information and bargaining power asymmetries.<sup>265</sup> That assumption is unrealistic. There are several reasons why market forces cannot ensure that customary practices are economically ideal.

First, consumers lack sufficient choice to manifest their preferences. Most individuals obtain insurance from their employers. In 1996, employees in 80% of the small businesses offering health benefits did not have any choice of health plan.<sup>266</sup> Managed care plans, in turn, limit the employee's choice of physician, and then influence the physician's options and incentives. As a result, patients lack the choices necessary to insure that medical practices reflect their preferences.

Second, to the extent that patients have a choice, they lack the medical training necessary to evaluate alternative treatments and providers.<sup>267</sup> In fact,

261. RICHARD A. POSNER, *ECONOMIC ANALYSIS OF LAW* 168-69 (4th ed. 1992); see DANZON, *supra* note 4, at 141 (arguing for a customary standard); Richard A. Epstein, *Medical Malpractice, Imperfect Information, and the Contractual Foundation for Medical Services*, 49 *LAW & CONTEMP. PROBS.* 201, 203-05 (1986) (advocating customary standards if the contract sets no other one).

262. See WILLIAM M. LANDES & RICHARD A. POSNER, *THE ECONOMIC STRUCTURE OF TORT LAW* 132 (1987); POSNER, *supra* note 261, at 168.

263. See POSNER, *supra* note 261, at 168-69.

264. See DON DEWEES ET AL., *EXPLORING THE DOMAIN OF ACCIDENT LAW* 96 (1996); POSNER, *supra* note 261, at 168; RICHARD POSNER, *TORT LAW: CASES AND ECONOMIC ANALYSIS* 673 (1982).

265. See Rachlinski, *supra* note 162, at 611 (stating that an efficient custom must not have market imperfections like lack of information or bargaining power).

266. Jon R. Gabel et al., *Small Employers and Their Health Benefits, 1988-1996: An Awkward Adolescence*, *HEALTH AFF.*, Sept-Oct. 1997, at 103, 105. Nearly half of all Americans have no choice of plan. Norman Daniels & James Sabin, *The Ethics of Accountability in Managed Care Reform*, *HEALTH AFF.*, Sept-Oct. 1998, at 50, 54; Lynn Etheredge et al., *What is Driving Health System Change?*, *Health Aff.*, Winter 1996, at 93, 94 (stating that 48% of employees only have one plan).

267. See Greaney, *supra* note 243, at 1834 (discussing the inability of consumers to successfully evaluate health care quality); Clark C. Havighurst, *Vicarious Liability: Relocating Responsibility for the Quality of Medical Care*, 26 *AM. J.L. & MED.* 7, 14-15 (2000) (same).



they may not even be able to evaluate the quality of treatments they have actually received.<sup>268</sup> Third, even if they had the education and sophistication to manage complex medical information, too little outcome data is available for patients to pick either providers or medical plans based on quality.<sup>269</sup> In fact, physicians and health plans aggressively resist consumer access to this data.<sup>270</sup> And unlike consumers of food and clothing, most consumers of medical care are not repeat purchasers<sup>271</sup> and cannot learn by trial and error about cost-quality trade-offs.<sup>272</sup> Finally, patients make many of their medical consumption decisions under stressful and emotionally charged conditions inconsistent with informed reflection.<sup>273</sup>

Researchers have found that hundreds of thousands of Americans consent to unnecessary medical procedures annually.<sup>274</sup> Other studies have found that patients who fund their own care make poor medical choices, cutting back equally on both effective and ineffective care.<sup>275</sup> Preliminary reports also indicate that consumers do not use health care “report cards” because the information is too complex.<sup>276</sup>

268. See Jost, *supra* note 244, at 560 (discussing the inability of consumers to successfully evaluate health care quality). Much health care, therefore, qualifies as a “credence good” for which the consumer must ultimately trust the provider. *Id.*

269. See DANZON, *supra* note 4, at 110 (noting scarcity of data); Greaney, *supra* note 243, at 1833-34 (same); Henderson & Siliciano, *supra* note 4, at 1392 (same).

270. See Ellyn E. Spragins, *What Are They Hiding? HMOs Are Getting More Secretive About Quality*, NEWSWEEK, Mar. 1, 1999, at 74 (discussing resistance to consumer access to data).

271. See DANZON, *supra* note 4, at 141 (discussing the nature of medical care); HALL, *supra* note 213, at 45 (1997) (describing procedures like bypass and cancer surgery).

272. HALL, *supra* note 213, at 45.

273. See Greaney, *supra* note 243, at 1837; Henderson & Siliciano, *supra* note 4, at 1392.

274. SYLVIA LAW & STEVE POLAN, PAIN AND PROFIT: THE POLITICS OF MALPRACTICE 18-19, 61-62, 251-52 (1978); Mark R. Chassin et al., *Does Inappropriate Use Explain Geographic Variations in the Use of Health Care Services?*, 258 JAMA 2533, 2536 (1987).

275. See HALL, *supra* note 213, at 49 (reviewing the literature). Absent an efficient market, the customary practices of an industry are likely to favor the interests of that industry and to discount the interests of the people it puts at risk. POSNER, *supra* note 261, at 168.

276. See Judith H. Hibbard et al., *Informing Consumer Decisions in Health Care: Implications from Decision-Making Research*, 75 MILBANK Q. 395, 412 (1997) (finding that more than half of the Medicare population has difficulty using comparative health plan information); Stephen T. Mennemeyer et al., *Death and Reputation: How Consumers Acted Upon HCFA Mortality Information*, 34 INQUIRY 117, 118-19, 125-26 (1997); see also James A. Schuttinga et al., *Health Plan Selection in the Federal Employees Health Benefits Program*, 10 J. HEALTH, POL., POL'Y & L. 119, 132, 134 (1985) (discussing complexity of choosing health care and health care plans). Even though pregnant women constitute a group of patients believed to be highly motivated to search for providers on the basis of quality, a recent study found that they rarely do so. See Thomas J. Hoerger & Leslie Z. Howard, *Search Behavior and Choice of Physician in the Market for Prenatal Care*, 33 MED. CARE 332, 333, 341, 348 (1995). In Pennsylvania, researchers studying consumer report cards concluded that “public reporting of mortality outcomes in Pennsylvania has had virtually no direct impact on patients’ selection of hospitals or surgeons.” Eric Schneider & Arnold Epstein, *Use of Public Performance Reports: A Survey of Patients Undergoing Cardiac Surgery*, 279 JAMA 1638, 1642 (1998).

Patients clearly need assistance policing the market. Unassisted, they simply cannot accurately monitor the quality of many of the medical services that they receive. As Mark Hall correctly observes, it is “not feasible to expect a viable consumer-driven market to develop for discrete treatment decisions.”<sup>277</sup> These market flaws are likely to favor providers at the expense of patients. In the words of one commentator, “[W]hen quality is hard to measure, there are many ways to increase return on equity by lowering quality.”<sup>278</sup> In an imperfect market, patients are likely to receive less quality and more risk than they would have been willing to purchase if fully informed and able to choose.<sup>279</sup>

Because of these barriers to intelligent choice, patients typically rely on the judgment of their physicians.<sup>280</sup> Yet, as explained above, physicians are imperfect agents. They are vulnerable to an array of conflicting interests.<sup>281</sup> Tim Jost describes the prescribing and admitting practices of physicians this way:

Physicians prescribing a particular drug are often responding more to the fawning solicitations of pharmaceutical company detail men or to the demands of their patients than to their own experience with the pharmaceutical. A doctor may admit a patient to a particular hospital because it is the only hospital that will give him staff privileges, or because it is most convenient to his office, rather than because it is the hospital most suited to the patient’s needs . . . . Whatever the doctor’s motives may be for a particular referral or lack of referral, the patient is, for all the reasons already given, seldom in a position independently to evaluate that judgment, or even its results . . . . Because consumers lack reliable sources of information, the market cannot be counted on to assure quality.<sup>282</sup>

As an alternative, employers could conceivably act as fiduciaries for their employees. However, their primary interest is cost, not quality.<sup>283</sup>

277. HALL, *supra* note 213, at 46.

278. R. Adams Dudley et al., *The Impact of Financial Incentives on Quality of Care*, 76 MILBANK Q. 649, 655 (1998).

279. See DANZON, *supra* note 4, at 221.

280. See Greaney, *supra* note 243 (noting this reliance); HALL, *supra* note 213, at 45 (same); Henderson & Siliciano, *supra* note 4, at 1392 & n.38 (same).

281. *Supra* text accompanying notes 242-60.

282. Jost, *supra* note 244, at 571.

283. See *id.* at 576; Gary T. Schwartz, *A National Health Care Program: What Its Effect Would Be on American Tort Law and Malpractice Law*, 79 CORNELL L. REV. 1333, 1369 (1994). As a consequence, plans compete on cost rather than quality. See also Mark A. Hall, *The Competitive Impact of Small Group Health Insurance Reform Laws*, 32 U. MICH. J.L. REFORM 685, 685 (1999) (reporting that small group health insurers compete on the basis of risk selection rather than quality of care). Few large employers reward high quality plans with more business. See Bailit, *supra* note 259, at 87.

Moreover, they too lack the capacity for gathering and evaluating information about the quality of various providers.<sup>284</sup> Furthermore, they could not feasibly supervise all of the individual treatment decisions affecting their employees. As a consequence, they cannot insure that clinical medical practices adequately reflect the interests and preferences of their employees.

### C. SIZING UP MEDICAL NORMS

Regrettably, much of the confidence that courts have placed in physician norms is misplaced. As Clark Havighurst notes, medical custom is "almost certainly a poor guide to efficiency in medical practice."<sup>285</sup> Physicians are influenced not only by scientific advances and concern for patient welfare, but also by habit, self-interest, and other competing considerations. As a consequence, medical customs differ widely and inexplicably from one location to another. Indeed, many academics have concluded that the search for customs is illusory.<sup>286</sup> In addition, health care delivery is increasingly controlled by for-profit organizations which may weigh cost more heavily than quality. Under these circumstances, courts can no longer assume that medical customs are a reliable barometer of reasonable care.

## IV. THE POTENTIAL ADVANTAGES OF JURY STANDARD-SETTING

Jury decision-making is imperfect. So, too, are medical customs. If the choice between deferring to physicians and relying on juries had to be made exclusively on this basis, the choice would be difficult and highly speculative. However, there are important policy reasons for resolving this uncertainty in favor of the jury.

### A. LEGAL ACCOUNTABILITY

Under a custom-based standard, said one court, "the profession itself would be permitted to set the measure of its own legal liability, even though that measure might be far below a level of care readily attainable. . . ."<sup>287</sup> "Negligence," said another, "cannot be excused on the grounds that others practice the same kind of negligence."<sup>288</sup> The unstated conclusion in these opinions is that deference to customary standards would place the

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284. See Jost, *supra* note 244, at 567-68 (noting the cost and the freerider problems associated with this task).

285. HAVIGHURST ET AL., *supra* note 213, at 5.

286. *E.g.*, Keeton, *supra* note 53, at 365, 368; Henderson & Siliciano, *supra* note 214, at 1390.

287. *United Blood Servs. v. Quintana*, 827 P.2d 509, 520 (Colo. 1992), *aff'd*, 827 P.2d 509 (Colo. 1992) (noting that courts, not professions, decide due care); *Darling v. Charleston Cmty. Mem'l Hosp.*, 211 N.E.2d 253, 257 (Ill. 1965) (same).

288. *Vassos v. Roussalis*, 625 P.2d 768, 772 (Wyo. 1981).

profession above the law. By contrast, the reasonable physician test assigns the task of standard-setting to the jury—citizens chosen by the courts to represent the community.<sup>289</sup>

### B. INCORPORATING COMMUNITY VALUES

The reasonable physician standard will allow the jury, as a representative of the community, to apply community standards to the determination of liability. Juries make a crucial value judgment when they decide whether a defendant has met the standard of reasonable care. To decide, for example, whether an automobile manufacturer should have spent more money to reduce the risk of fatality in frontal collisions, jurors must place a value on the preservation of life and on the avoidance of personal injury. In malpractice cases, it seems reasonable to assume that a citizen jury will reflect community values better than physicians and insurance executives.<sup>290</sup> Making this value judgment is a quintessential jury function. It is assigned to them because their value judgment is likely to parallel the values of the community. It is no coincidence that both state and federal constitutions guarantee the right to a trial by jury.<sup>291</sup> The assignment of standard-setting power to the jury gives substance to that right.<sup>292</sup> The burden of persuasion certainly rests on those who would take this power away from the jury.

### C. ENCOURAGING INNOVATION AND QUALITY IMPROVEMENT

The custom-based standard, while providing immunity to physicians who continue to adhere to obsolete customs, exposes innovators to

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289. See, e.g., JEFFREY ABRAMSON, WE, THE JURY 2-13 (1994) (making a thoughtful defense of the jury as an institution of deliberative democracy); Leon Green, *Jury Trial and Mr. Justice Black*, 65 YALE L.J. 482, 483 (1956) ("It offers an assurance of judgment by neighbors who understand the community climate of values . . ."); see also Catherine Pierce Wells, *Tort Law as Corrective Justice: A Pragmatic Justification for Jury Adjudication*, 88 MICH. L. REV. 2348, 2386-90 (1990) (articulating a theory of negligence law in which the jury is crucial). P.S. Atiyah attributes the large responsibility given to U.S. juries to distrust of central power, fear of rule by elites, and anti-statism. P.S. Atiyah, *Tort Law and the Alternatives: Some Anglo-American Comparisons*, 1987 DUKE L.J. 1002, 1017-18, 1043-44.

290. Researchers have found that lay people give weight to factors that are not taken into account by risk experts, such as perceived control over the risk, the potential for catastrophe, likelihood of fatality, inequitable distribution of the risk and benefits and the extent to which the activity generates "unknown risks." See Cecil et al., *supra* note 90, at 762.

291. See Mark Curriden, *Putting the Squeeze on Juries*, ABA J., Aug. 2000, at 52, 54.

292. Ideally, of course, elected legislatures would make decisions about fundamental and recurrent policy choices. Occasionally, they do. However, neither legislatures nor administrative agencies could hope to fashion ex ante rules of decision for even a tiny fraction of the many treatment disputes that arise every day. The civil justice system is expected to perform this task. Absent guidance from the legislatures, courts must decide whether the standard for these disputes will be set by physicians or juries. Jury verdicts are more likely to reflect community values and in this sense are the democratic choice.

liability.<sup>293</sup> It is safer to stay with the pack than to keep up with best practices. The reasonable physician test escapes this shortcoming. "A emphasis on reasonable rather than customary practices . . . insures that custom will not shelter physicians who fail to adopt advances in their respective fields . . . ."<sup>294</sup>

#### D. HONESTY

The reasonable physician standard is also more honest. In jurisdictions that purport to employ a custom-based standard of care, courts routinely allow plaintiffs to reach the jury without proof that the defendant departed from customary practice.<sup>295</sup> Their doing so is inevitable. Custom could not hope to provide an ex ante standard of care for every medical decision required by the literally limitless variety of patients and their presentations.<sup>296</sup>

Similarly, courts often allow parties to introduce evidence of clinical practice guidelines even though these standards typically are not meant to describe customary practices.<sup>297</sup> Instead, they are intended to raise the level of existing practice.<sup>298</sup> Judges understandably admit these guidelines because they believe authoritative standards are relevant. Yet, courts which accede to these realities are effectively abandoning the custom-based standard of care without admitting it. Formal adoption of the reasonable physician standard of care would end this charade.

#### E. FREEDOM TO TAKE COSTS INTO ACCOUNT

Under the custom-based standard of care, many physicians feel obliged to offer costly treatments or tests that confer little or no proven benefit simply because their colleagues do.<sup>299</sup> The reasonable physician test would free physicians to abandon costly practices produced by habit, ignorance, or

293. See HAVIGHURST ET AL., *supra* note 212, at 1014-15 (noting this effect). An exception exists for formal clinical trials in which the patient expressly consents to participation in an experiment treatment. See, e.g., Karp v. Cooley, 493 F.2d 408, 423-24 (5th Cir. 1974) (involving a clinical trial); FURROW ET AL., *supra* note 4, at 206 (describing the exception).

294. Nowatske v. Osterloh, 543 N.W.2d 265, 272 (Wis. 1996).

295. See Peters, *supra* note 1, at 185-87 (demonstrating that many "customs-based" jurisdictions also allow experts to evaluate the reasonableness of care given).

296. See, e.g., RICHARD A. EPSTEIN, TORTS 137 (1999) (noting that custom is not fine-grained). Although a potential disadvantage of this individualization is the loss of guidance and predictability that ex ante rules, like industry custom, could theoretically provide, the custom-based standard of care simply does not provide the predictability that it promises. See *supra* text accompanying notes 215-26 (noting that geographic variation and the difference in medical problems prevents medical custom formation).

297. See Mello, *supra* note 32, at 677-84 (arguing that the guidelines are often not intended to reflect current clinical practice).

298. *Id.*

299. I have heard this complaint in many conversations with physicians at our teaching hospital.

fee-for-service reimbursement.<sup>300</sup> And it would permit their attorneys to offer evidence that supports their conclusions about lack of effectiveness and cost. Custom would not govern. Whether juries will be receptive to these departures from custom, especially if costs played a major role in the decision, is not yet known.

#### F. POLICING MANAGED CARE

A jury-determined reasonability standard would permit the courts to set a floor below which cost-cutting practices could not fall.<sup>301</sup> Both health policy analysts and the public worry that managed care organizations place too much emphasis on cost and too little emphasis on effectiveness.<sup>302</sup> For reasons discussed above,<sup>303</sup> market forces alone are unlikely to insure a reasonable trade-off between cost and quality. When quality is hard to measure, companies have an incentive to cut quality unduly in order to increase profits. The result could be a race to the bottom. A custom-based standard would permit this race as long as other health plans and their providers were responding to the market in a similar fashion. A reasonability standard would not.

Because "physicians' decisions control 75% of health care spending,"<sup>304</sup> health plans know that they must enlist the physicians' help to control health care costs.<sup>305</sup> Thus, they are paying physicians in a way that penalizes a physician's use of expensive services like diagnostic tests, referrals to specialists, and hospital admissions.<sup>306</sup> Some plans are developing their own proprietary treatment protocols in order to shape physician behavior at the bedside.<sup>307</sup> In addition, many plans have purchased software that permits

300. Courts allow risk-utility evidence in cases governed by a reasonable care standard. *See, e.g.,* *Bodin v. City of Stanwood*, 927 P.2d 240, 248 (Wash. 1997); Stephen G. Gilles, *The Invisible Hand Formula*, 80 VA. L. REV. 1015, 1024 n.23 (1994).

301. Courts have not yet decided whether this standard of care can be modified by contractual agreement. For a thoughtful discussion of the role of contract, see generally CLARK C. HAVIGHURST, *HEALTH CARE CHOICES* (1995) and MORREIM, *supra* note 248.

302. *See, e.g.,* Bailit, *supra* note 259, at 86-87; Mark A. Hall, *supra* note 283, at 704 (1999); Havighurst, *supra* note 267, at 8-9, 13, 26 (noting that "corporate health plans have assumed extensive responsibility for the cost of care, without accepting more than nominal responsibility for its quality").

303. *See supra* text accompanying notes 261-84 (stating that due to market imperfections, economic forces alone cannot be relied on in making medical practices efficient).

304. Ezekiel J. Emanuel & Lee Goldman, *Protecting Patient Welfare in Managed Care: Six Safeguards*, 23 J. HEALTH POL., POL'Y & L. 635, 635 (1998).

305. *See* Schwartz, *supra* note 147, at 1364 (describing the methods in which HMOs persuade doctors to control costs, including paying them "on a 'capitation' basis" or adjusting their annual salaries if their costs rise above a certain level).

306. *See id.* at 1364-65 (same).

307. *See* MORREIM, *supra* note 248, at 19-20 (describing the efforts to draft managed care guidelines).

them to monitor the costs generated by each physician.<sup>308</sup> Because physicians depend upon plan participation for their access to patients, the threat of termination provides the plan with powerful leverage over physician behavior.<sup>309</sup>

These efforts to place physicians at risk make the threat of undertreatment both more pervasive and more insidious. The threat of undertreatment is more pervasive because the risk of improper denial of care is no longer limited to the prospective utilization process; instead this risk of denial affects every decision physicians make about a patient's treatment. It is more insidious because bedside rationing by physicians is far less apparent to patients than an insurer's utilization review denial.<sup>310</sup> This invisibility is, of course, part of bedside rationing's appeal to health plans. In fact, United Healthcare has dropped its prospective utilization process for physical illnesses entirely, preferring instead to rely on rationing by its physicians.<sup>311</sup>

The impact of these incentives on physicians is real. Gary Schwartz recounts the experience of one medical group that was concerned about the impact of these financial incentives on its income. Said one of the physicians, "[W]e don't get paid if we go over budget."<sup>312</sup> The group held discussions to develop informal norms to keep costs down. Examples of the resulting norms included prescribing Prozac to depressed patients for six weeks before seriously considering a psychiatric consult and dissuading women under fifty from having mammography.<sup>313</sup> The reasonable physician standard of care allows courts to monitor such practices.

Perhaps an even better strategy would be for states to regulate the policies and payment practices of managed care organizations directly. However, ERISA places serious barriers on the use of tort law or other state laws to do so.<sup>314</sup> As a result, courts must settle for supervising the impact of

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308. See John J. Jacobi, *Patients at a Loss: Protecting Health Care Consumers Through Data Driven Quality Assurance*, 45 U. KAN. L. REV. 705, 771 (1997) (describing various programs enabling them to evaluate costs).

309. Finally, health plans typically reserve the contractual right to "deselect" plan physicians without cause. See Schwartz, *supra* note 147, at 1363 (noting that physicians who order too many tests may be "purged" from the preferred provider organization).

310. See, e.g., Troyen A. Brennan, *Moral Imperatives Versus Market Solutions: Is Health Care a Right?*, 65 U. CHI. L. REV. 345, 360 (1998) (calling it "hidden" rationing); Havighurst, *supra* note 267, at 12 (calling it "secret" rationing).

311. See, e.g., Peter A. Ubel & Robert M. Arnold, *The Unbearable Rightness of Bedside Rationing: Physician Duties in a Climate of Cost Containment*, 155 ARCHIVE OF INTERNAL MED. 1837, 1841 (1995) (noting that it is easier for plans not to ration themselves and to delegate this task to physicians).

312. Schwartz, *supra* note 147, at 1365.

313. *Id.*

314. See *Pegram v. Herdrich*, 530 U.S. 211, 219 (2000) (holding that employee benefit plans may reward providers for limiting medical care without violating ERISA).

these managed care policies at the bedside.<sup>315</sup>

Of course, asking juries to supervise managed care norms presents an obvious risk. Juries may resent health care decision-making that takes cost into account. In that event, jury verdicts could undermine progress on cost-control and push providers back toward the “spare no expense” habits of fee-for-service medicine. At present, we do not have the data needed to quantify this risk.

Does managed care pose a sufficient threat to patient welfare to warrant the unquantifiable risk that juries will penalize reasonable cost-consciousness? The evidence is mixed. On the one hand, the available data does not substantiate fears that managed care results in a lower quality of care for the general public. Studies comparing HMO outcomes with fee-for-service outcomes have found that HMO outcomes are better in some circumstances, worse in others, and roughly equivalent overall.<sup>316</sup>

On the other hand, there are several important reasons to view these preliminary findings with some skepticism. First, most studies have found that HMOs do have worse outcomes for high-risk groups, such as the seriously ill, the poor, and the mentally ill.<sup>317</sup> Second, the studies have focused on relatively narrow measures of quality and were not designed to rule out types of harm that were not measured.<sup>318</sup> Third, the existing literature largely relies on data that predates several important changes in the managed care industry.

The recent changes are particularly troubling. For example, the two major literature reviews undertaken by Miller and Luft in 1994 and 1997 cover studies whose data were actually collected prior to 1992.<sup>319</sup> At that time, physician practices only had to cut the “fat” and not the “lean.”<sup>320</sup> In addition, the HMOs of the 1980s were very different from those of today. In 1985, for example, only 26% of HMO members were in for-profit plans; by

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315. *Id.* (“The check on this influence . . . is the professional obligation to provide covered services with a reasonable degree of skill and judgment in the patient’s interests.”).

316. *See, e.g.,* David U. Himmelstein et al., *Quality of Care in Investor-Owned vs. Not-for-Profit HMOs*, 282 JAMA 159, 159-61 (1999) (reviewing the data); Robert H. Miller & Harold S. Luft, *Does Managed Care Lead to Better or Worse Quality of Care?*, HEALTH AFF., Sept.-Oct. 1997, at 7, 10 (same).

317. *See, e.g.,* Himmelstein et al., *supra* note 316, at 159 (reviewing the literature); Miller and Luft, *supra* note 316, at 14 (same); John E. Ware Jr., et al., *Differences in 4-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-for-Service Systems*, 276 JAMA 1039, 1039-42 (1996).

318. *See* David Orentlicher, *Health Care Reform and the Patient-Physician Relationship*, 5 HEALTH MATRIX 141, 166 (1995) (“The studies also are not rigorous enough to exclude the possibility of undetected harmful consequences.”).

319. *See generally* Miller & Luft, *supra* note 316. A smaller study using 1993-95 data also found that outcomes differed little. *See* David M. Cutler et al., *How Does Managed Care Do It?*, 31 RAND J. ECON. 526, 533-35, 541 (2000).

320. *See* Orentlicher, *supra* note 318, at 166.



1998, that proportion had increased to 62%.<sup>321</sup> A major 1999 study by Himmelstein and colleagues found that for-profit HMOs had uniformly worse quality of care than not-for-profit HMOs.<sup>322</sup> The outcomes were worse both for preventive measures, like breast cancer screening and immunizations, and for therapeutic measures, such as the use of beta-blockers for patients discharged after a myocardial infarction.<sup>323</sup> Surprisingly, in both types of plans, overall expenses were the same. However, the not-for-profit plans spent a greater percentage of their premium dollars on patient care and less on profit and overhead.<sup>324</sup> These results are consistent with other studies exploring the relationship between HMO ownership and quality of care.<sup>325</sup>

The early HMOs also used staff and group models that have now been replaced by network and independent practice association (IPA) models.<sup>326</sup> Here, too, the change is material. The 1999 Himmelstein study found that staff and group models had higher scores on nearly all quality-of-care indicators than network and IPA models.<sup>327</sup>

Furthermore, early HMOs paid their physicians a salary; today, most managed care plans use reimbursement schemes that provide a greater incentive for economy, such as capitation and bonuses for reduced utilization.<sup>328</sup> Once again, this change may be significant; methods of reimbursement do affect physician behavior.<sup>329</sup>

321. Himmelstein et al., *supra* note 316, at 159. Between 1988 and 1994, for-profit HMO membership expanded by 91.6% while not-for-profits expanded by only 24.8%. See Gabel, *supra* note 257, at 135.

322. See Himmelstein et al., *supra* note 316, at 159 (concluding that “[i]nvestor-owned HMOs deliver lower quality of care than not-for-profit plans”). The inferiority of investor-owned HMOs extended across all fourteen quality of care criteria used in the study. Similarly, an earlier study found that for-profit HMOs had a significantly lower rate of hospitalization than not-for-profit plans. See Alan L. Hillman et al., *How Do Financial Incentives Affect Physicians’ Clinical Decisions and the Financial Performance of Health Maintenance Organizations?*, 321 NEW ENG. J. MED. 86, 88 (1989).

323. Himmelstein et al., *supra* note 316 at 162. The authors concluded that many patients in for-profit HMOs “may die needlessly.” *Id.*

324. See *id.* at 162 (finding that spending on profit and overhead was 48% higher in investor-owned plans).

325. *Id.* (reviewing the literature).

326. See *id.* at 159 (noting the shift away from group- and staff-model plans).

327. *Id.* at 161-62 and tbl.3.

328. See Emanuel & Goldman, *supra* note 304, at 636-37 (stating that over 60% of managed care plans withhold a portion of payment to cover expenditures that exceed target projections for specialists or hospitals); Gabel, *supra* note 257, at 140 tbl.5 (noting that between 1989 and 1994, the percentage of HMO primary care physicians paid by capitation had increased from 35% to 50%); Himmelstein et al., *supra* note 316, at 159 (noting the shift away from group- and staff-model plans).

329. See Hillman et al., *supra* note 322, at 88 (finding that capitation was associated with a lower rate of hospitalization); Himmelstein et al., *supra* note 316, at 159 (noting the shift away from group- and staff-model plans and their impact on patient care). *But see* Douglas A. Conrad

Even nonprofit HMOs behave differently today than they did a decade ago. Today, they are more likely to reimburse their physicians in ways that encourage reduced utilization, to have abandoned community rating, and to have copied for-profit plans in other ways.<sup>330</sup> Finally, recent reports suggest that managed care has a spill-over effect. Doctors who frequently treat HMO patients tend to treat their non-HMO patients in the same cost-conscious way.<sup>331</sup> Because managed care norms are spilling over into fee-for-service practices, studies *comparing* managed care outcomes with nonmanaged care outcomes may miss the true impact of managed care on *absolute* health care quality. Because of the spill-over effect, managed care's concern with profitability could be producing outcomes throughout the health care industry that fall short of those which are reasonably attainable. As a consequence, it is impossible not to worry when reading reports that heart and asthma patients do better when seen by specialists than by primary care physicians,<sup>332</sup> that an increasing number of newborns are developing jaundice-related brain damage caused in part by premature hospital discharge after birth,<sup>333</sup> and that AIDS patients die earlier in managed care.<sup>334</sup>

Three conclusions emerge from this analysis. First, there is no evidence that overall health care quality has declined due to the growth of managed care. Second, the welfare of certain vulnerable subgroups has suffered from managed care. Finally, substantial uncertainty remains about the impact that recent changes in managed care systems have had on quality of care. These uncertainties justify continued judicial scrutiny. The jury-set reasonable physician standard provides this scrutiny.

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et al., *Primary Care Physician Compensation Method in Medical Groups: Does it Influence the Use and Cost of Health Services for Enrollees in Managed Care Organizations?*, 279 JAMA 853, 853 (1998) (abstract) (studying payment within medical groups, rather than by health plans, and finding no statistically significant relationship between compensation and utilization).

330. See Himmelstein et al., *supra* note 316, at 163 (reporting these behaviors).

331. See *Study: HMOs Influence Care of Doctors' Non-HMO Patients*, COLUM. DAILY TRIB., Feb. 4, 1999, at 8 (describing a study by Laurence Baker); Sherry Glied & Joshua Zivin, *How Do Doctors Behave When Some (But Not All) of Their Patients are in Managed Care?*, available at [http://papers.ssrn.com/paper.taf?abstract\\_id=242141](http://papers.ssrn.com/paper.taf?abstract_id=242141) (finding that treatment differences become attenuated when a physician's HMO practice share rises). Commentators attribute this carry-over to convenience or endorsement of HMO norms, but cognitive dissonance seems an equally plausible explanation. For doctors to treat their non-HMO patients more aggressively than their HMO patients would be to admit to themselves that they are giving their HMO patients inappropriate care.

332. See GEN. ACCOUNTING OFFICE, *SPECIALITY CARE: HEART ATTACK SURVIVORS TREATED BY CARDIOLOGISTS MORE LIKELY TO TAKE RECOMMENDED DRUGS 1* (1998).

333. See *Experts Blame Short Hospital Stays for Untreated Jaundice in Newborns*, ST. LOUIS POST-DISPATCH, May 3, 2001, at A7.

334. See *Aids Patients May Die Earlier in Managed Care*, INTERNAL MED. NEWS, Nov. 1, 1996, at 7.

G. ENCOURAGING FULL DISCLOSURE

The reasonable physician standard also gives the health care industry a much-needed incentive to engage the community in a dialogue about health care resources.<sup>335</sup> If the industry desires to lower the standard of care below the levels that juries demand, then the industry will need either to convince the public that frugality is socially responsible or else obtain the ex ante agreement of subscribers to a modification of the standard of care. In short, they will need to disclose their intention of providing more economical care and obtain either community or subscriber assent.

At present, however, neither physicians nor managed care plans currently disclose their cost-control philosophies or strategies.<sup>336</sup> In fact, they fight vigorously and effectively against legislation or judicial rulings that would mandate greater disclosure of their cost consciousness or of the financial incentives given to physicians to reduce utilization.<sup>337</sup> The result is a health plan utopia. Plans encourage cost-control at the bedside without disclosing this to patients. Furthermore, the bedside rationing that results is largely hidden from patients, unlike prospective utilization review.

Yet, it is disingenuous to hide important information from subscribers because they are likely to revolt against it and then to criticize jurors for having the same reaction that subscribers would have experienced. Critics often fear that the public wants a Cadillac for the price of a Chevy. However, health plans contribute to that mentality by promising equal quality at a

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335. In this respect, the reasonable physician standard constitutes an information-forcing default rule. To the extent that courts allow contractual modification of this standard of care, the rule is also information-forcing in a second respect. By obliging nonconforming plans and providers to rely on contract, the reasonable physician standard of care forces these providers to disclose their cost-containment philosophies and strategies to their patients and subscribers and to obtain bilateral agreement. See Ian Ayres & Robert Gertner, *Filling Gaps in Incomplete Contracts: An Economic Theory of Default Rules*, 99 YALE L.J. 87, 91 (1989) (suggesting that “penalty default” rules should sometimes be chosen to “give at least one party to the contract an incentive . . . to choose affirmatively the contract provision they prefer”); cf. James Lindgren, *Death by Default*, 56 LAW & CONTEMP. PROB. 185, 218-19 (1993) (applying the Ayres and Gertner proposal to the patient-physician relationship in the context of advance directives). Ayres and Gertner called these rules “penalty” defaults because the law intentionally selects a rule that the informed party would not prefer in order to induce that party to disclose and negotiate its preferred rule. In situations where repeat players are likely to have knowledge of both the default rule and the contingencies that might arise, the repeat players should be given an incentive to share this information with the other contracting parties. Ayres & Gertner, *supra*, at 98-99.

336. See, e.g., HALL, *supra* note 213, at 225 (noting that disclosure today is not adequate); Himmelstein, *supra* note 316, at 163 (noting that fewer HMOs are submitting data to the NCQA data bank used in the Himmelstein study); Spragins, *supra* note 270, at 74 (noting that declining numbers of health plans are disclosing quality data).

337. See *Ehlmann v. Kaiser Found. Health Plan of Tex.*, 198 F.3d 552, 556 (5th Cir. 2000) (holding that an ERISA health plan had no fiduciary duty to disclose physician compensation arrangements that included incentives to keep utilization to a minimum).

lower price.<sup>338</sup> Until plans and physicians are more honest and do their part to create a public consensus in favor of reasonable cost controls, they are poorly positioned to complain that juries are offended by cost-based treatment decisions.

The reasonable physician standard will give health plans an incentive to begin that conversation. The custom-based standard of care provides no similar incentive toward openness. Instead, the custom-based standard allows health care professionals to decide unilaterally what is good for the community. Under that regime, managed care organizations can pay physicians to lower the standard of care through hidden rationing decisions that, once customary, are immune from judicial scrutiny. Remarkably, this can be accomplished without ever disclosing that the standard of care is changing. This is a serious shortcoming of the custom-based standard of care.

#### H. SUMMARY OF POTENTIAL ADVANTAGES

Abandonment of the custom-based standard of care in favor of a reasonable physician standard offers several potential advantages. Most importantly, the reasonable physician standard assigns the task of legal standard-setting to representatives of the community, rather than to the regulated industry. Jury decision-making is more likely to incorporate community values. Moreover, the flexibility of the reasonable physician standard provides more protection for innovators and less shelter for those adhering to antiquated customs. Furthermore, the reasonable physician standard is a more honest way to accomplish these goals than bending the custom-based standard to cure its shortcomings. The reasonable physician standard of care also gives the health care industry an incentive to engage the community in a dialogue about health care resources. At the same time, it allows the courts to supervise the influence of the managed care industry on clinical practices.

#### V. CONCLUSION

The courts are gradually abandoning the custom-based standard of care. The policy implications of this ongoing shift are fundamental. The underlying issue is whether malpractice law will continue to be a unique

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338. Explains George Anders:

HMOs don't present themselves as the medical equivalent of a tawdry motel chain or a discount clothing store in a rundown part of town, blithely selling an inferior product in the name of having the cheapest possible price. Managed-care companies promise to uphold standards through their cost cutting, simply by targeting wasteful practices.

GEORGE ANDERS, *HEALTH AGAINST WEALTH: HMOs AND THE BREAKDOWN OF MEDICAL TRUST* 59 (1996), excerpted in CURRAN ET AL., *supra* note 41, at 392-93.

corner of tort law in which a respected industry sets its own standard of care or whether the standard will be set by members of the jury as it is in other tort actions. On the one hand, abandonment of a custom-based standard of care arguably demands more of lay jurors than we can reasonably expect of them. On the other hand, the delegation of standard-setting to the jury will give courts an improved ability to police the practices of physicians facing pressures to cut costs.

Tort law originally delegated the standard-setting power to physicians because of their expertise and their trustworthiness. During the ensuing century, both the health care delivery system and our understanding of it have changed enormously. We now know that many common practices have no scientific basis. Customs vary inexplicably from one town to another. Modern medicine is also rife with conflicts that influence clinical decision-making. Most importantly, physicians are losing their control over the health care industry to for-profit insurers, an industry that has not yet earned the right of self-regulation.

In theory, market forces might be expected to insure that medical customs accurately reflect consumer preferences. In practice, however, market imperfections in the health care sector are simply too pervasive to insure that health care practices reflect community wishes. Furthermore, there is often no governing custom at all, leaving the courts without guidance.

For all of these reasons, a custom-based standard of care has serious shortcomings. Are juries likely to perform any better? The empirical data on jury performance is largely reassuring. Judges and juries usually agree, even on complex cases. Moreover, jurors are even more skeptical of malpractice claims than are physician reviewers. However, the jury's capacity to understand statistical proof, its resistance to hindsight bias, and its willingness to take costs into account have yet to be confirmed.

The choice, therefore, is between two standards of care that are likely to be imperfect in operation. If the choice between the two standards had to be made exclusively on this basis, the choice would be difficult and highly speculative. However, there are important reasons for preferring the reasonable physician standard of care. First, the reasonable care standard is more honest. Second, it is more hospitable to innovation. Third, it empowers the jury, rather than the industry, to set the standard of care. This assignment of responsibility ensures that the increasingly commercialized health care delivery system is accountable to community values. As long as managed care entities are permitted to reward physicians for cutting back on referrals to specialists, hospitalizations, and diagnostic testing, community supervision of medical practices is warranted.

Fourth, and perhaps most importantly, the reasonable physician standard gives the health care industry an incentive to engage the community in a dialogue about health care resources. If the industry desires

to lower the standard of care below the levels juries demand, then the industry will need either to convince the public that frugality is socially responsible or to obtain the agreement of subscribers *ex ante* to a modification of the standard of care. The custom-based standard of care provides no similar incentive toward openness. Instead, the custom-based standard allows health care professionals to decide unilaterally what is good for the community. This is surely a serious shortcoming of the custom-based standard of care.

The crucial unanswered question, of course, is whether the law can delegate the standard of care to the jury without undermining socially responsible cost containment. Until better research is done, courts and scholars will have to speculate about the answer to this question. However, even the simplest tort action has social resource implications. Juries resolve these cases admirably. In addition, no crises have arisen in states rejecting the custom-based standard of care. Until more is known about jury reactions, it seems inappropriate to solve a problem that may not exist by continuing to confer on health care providers a privilege of self-regulation not afforded to other tort defendants.<sup>339</sup>

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339. States that wish to move more cautiously could also experiment with compromises. For example, courts could announce their use of the reasonable physician test only when no established custom applies. In practice, that is already how many customary care states appear to treat malpractice cases.

Different alternatives have been proposed by Keeton, King and Bloche. King recommended that physicians have a duty to comply with "accepted" standards. *See King, supra* note 62, at 1236-44. This appears to mean that plaintiffs should be able to challenge a defendant's compliance with customary practices if, but only if, the plaintiff can produce evidence of clinical trials showing that the custom is no longer good medicine. However, this approach would insulate customary practices that themselves have no scientific basis and it provides no role for cost-consciousness.

Keeton suggested immunizing physician conduct only when a physician complied with a formally adopted professional guideline. *See Keeton, supra* note 53, at 368. Juries probably will reach the same result under the reasonable physician standard whenever the adopting professional body is credible. In practice, however, the credibility of professional guidelines varies widely and their guidelines sometimes conflict.

More recently, a preliminary draft by Gregg Bloche has suggested that defendants who withhold marginally beneficial care be liable, at least when the care is potentially life-saving, unless they can offer proof of cost-ineffectiveness. *See Bloche, supra* note 249, at 69-70. In essence, this proposal rejects the custom-based standard of care and then puts the burden of proving reasonability on the defendant. As such, it is even more protective of patient access to care than the reasonable physician test.

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