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The Role of Custom in Medical Malpractice Cases

RICHARD N. PEARSON*

The well-nigh universal rule in this country is that a physician will not be liable for negligence in a medical malpractice case unless he fails "to possess and employ such reasonable skill and care as are commonly had and exercised by reputable, average physicians in the same general system or school of practice"¹ Under this rule, the medical profession is able to establish its own standard of care. Thus, it is medical custom, rather than standards of reasonableness determined by judges and juries, against which the conduct of a physician is measured. Although, as will be pointed out later, there are a few cases which indicate that the medical custom rule might have developed a few cracks, no court, until 1974, had directly rejected it. In that year, the Supreme Court of Washington, in its opinion in *Helling v. Carey*,² ruled that the defendant ophthalmologists were negligent as a matter of law for failing to administer a diagnostic test for glaucoma to the plaintiff. There was uncontroverted expert medical testimony that the custom was not to administer the test to persons under 40, the age group of the plaintiff, because of the rarity with which the disease appears in that group.

The extent of the departure of *Helling* from the traditional law is not entirely clear. The court cited an earlier Washington case, *Pederson v. Dumouchel*, in which it was stated that, "The degree of care which must be observed is, of course, that of an average, competent practitioner acting in the same or similar circumstances."³ The court then ignored

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¹ J. WALTZ & F. INBAU, *MEDICAL JURISPRUDENCE* 42 (1971). See McCoid, *The Care Required of Medical Practitioners*, 12 *VAND. L. REV.* 549, 558-59 (1959), for various judicial formulations of the standard.

² 83 Wash. 2d 514, 519 P.2d 981 (1974).

In the final stage of the preparation of this article, the author became aware of a recent Washington statute (*WASH. REV. CODE* § 4.24.290 (1975)), which provides that in a medical malpractice action, the plaintiff must establish "that the defendant or defendants failed to exercise that degree of skill, care and learning possessed by other persons in the same profession" I have not revised the article in light of this statute. Whether courts will resist the siren call of *Helling* will depend more on their appreciation of the issues involved than on whether the case has been legislatively overruled in Washington.

³ 72 Wash. 2d 73, 79, 431 P.2d 973, 978 (1967). The medical custom rule had been accepted without question in later Washington cases. See, e.g., *Vestig v. Mowrey*, 72 Wash. 2d 754, 435 P.2d 540 (1967); *Sanderson v. Moline*, 7 Wash. App. 439, 499 P.2d 1281 (1972).

Pederson, and relied instead on two nonmedical landmark cases⁴ expressing the general rule that custom is relevant to, but not conclusive of, the standard of care. However, the court characterized the facts of *Helling* as "unique"⁵ and, at three places in the opinion, stated that liability was imposed "under the facts of this case."⁶ In light of this judicial hedging, perhaps the court has left the door open to a later limitation of *Helling* to some subcategory of medical malpractice cases.⁷ But the description of that subcategory, if it does exist, does not appear in the opinion. Thus, it is reasonable to view *Helling* as standing for the proposition that professional custom no longer determines the standard of care.

Certainly, there has been pressure in recent years, brought by increasing numbers of persons complaining of harm caused by medical treatment, which might lead courts to reconsider the wisdom of the medical custom rule. Although no court, other than the Supreme Court of Washington, has made an open break with the traditional rule, there is language in earlier cases from Ohio, Louisiana, Illinois, and Pennsylvania which, on the surface, would seem to indicate at least limited support for the *Helling* approach. However, a close look at these cases reveals that the support is meager at best.

In *Morgan v. Sheppard*,⁸ an intermediate Ohio appellate court affirmed a judgment against the defendant physician, although the jury was not instructed that the defendant's liability was to be determined by the customary practices of the profession. In affirming, the court stated:

Evidence of conformity to such usual and customary methods, however, may, and should, be considered by the jury, along with all the other circumstances in the case, in determining whether or not the physician or surgeon exercised the care required of him by law.⁹

In making this statement, the court relied in part on *Ault v. Hall*,¹⁰ a case in which the plaintiff's claim was based on the failure of the defendant physician to remove a sponge following a gall bladder operation. The trial judge had instructed the jury that the defendant had a right

⁴ *Texas & Pacific Ry. v. Behymer*, 189 U.S. 468 (1903); *The T.J. Hooper*, 60 F.2d 737 (2d Cir. 1932).

⁵ 83 Wash. 2d at 517, 519 P.2d at 982.

⁶ *Id.* at 517, 519; 519 P.2d at 982, 983.

⁷ Some more or less restrictive interpretations of *Helling* are suggested and then rejected by the author of 28 VAND. L. REV. 441 (1975). A somewhat different list of possible interpretations is offered in 51 WASH. L. REV. 167 (1975).

⁸ 188 N.E.2d 808 (Ohio App. 1963).

⁹ *Id.* at 817.

¹⁰ 119 Ohio St. 442, 164 N.E. 518 (1928).

to rely upon the custom of surgeons to leave post-surgery sponge counts to nurses. Judgment for the defendant following a jury verdict in his favor was reversed by the supreme court, which stated that the removal of sponges is a part of the surgery contracted for by the patient, and that the responsibility for exercising care to remove sponges could not be delegated by the surgeon to a nurse. In the course of the opinion, the court stated:

The duty of a surgeon to exercise care cannot be delegated to another, without recourse. Custom will not justify a negligent act or exonerate from a charge of negligence. Long-conditioned careless performance of a duty by any trade, business or profession will not transform negligence into due care. Usage cannot avail to establish safe in law that which is dangerous in fact.¹¹

Since the case involved a sponge left in the plaintiff after surgery, it might have been limited in its application.¹² The court in *Morgan*, however, interpreted *Ault* as establishing the proposition that medical custom does not control in any medical malpractice case.

Whether the *Morgan* interpretation is correct is not entirely clear from later Ohio cases. In *Oberlin v. Friedman*,¹³ an intermediate appellate court ruled that a jury instruction embodying the medical custom rule was erroneous, and reversed a judgment on the jury verdict for the defendant. The Supreme Court of Ohio reinstated the judgment, ruling that on the facts of the case the instruction was not improper.¹⁴ In *Cooper v. Society of Sisters*,¹⁵ the court determined that on the evidence the jury could find that the defendant's conduct "did not satisfy the standard that a physician in the community should observe under like circumstances."¹⁶ While in this case the plaintiff's theory was that the defendant had been negligent because of his departure from custom,

¹¹ *Id.* at 438, 164 N.E. at 523.

¹² See note 104 *infra* & text accompanying.

¹³ 205 N.E.2d 663 (Ohio App. 1965).

¹⁴ *Oberlin v. Friedman*, 5 Ohio St. 2d 1, 213 N.E.2d 168 (1965). It is difficult to know what to make of the court's brief discussion of the contested instruction. The plaintiff's theory was that the defendant negligently injected the plaintiff with alcohol instead of spinal anesthetic. The intermediate appellate court's view of the evidence and instructions was that the jury in effect was required to return a verdict for the defendant because of the latter's testimony that he followed the customary procedure in administering the anesthesia. The supreme court, however, stated that the only evidence on the point was that the defendant did not follow the customary procedure, and that in effect the jury was instructed to return a verdict for the plaintiff if the defendant injected the plaintiff with alcohol. The fact that the jury returned its verdict for the defendant meant, to the court, that the jury found that the defendant did not inject the plaintiff with alcohol. Thus, the court probably did not feel compelled to directly confront the issue of the propriety of the contested instruction.

¹⁵ 27 Ohio St. 2d 242, 272 N.E.2d 97 (1971).

¹⁶ 27 Ohio St. 2d at 250, 272 N.E.2d at 102.

the court apparently would have sustained a judgment for the defendant had he conformed to custom. Relying on a different line of Ohio cases which require expert testimony to prove negligence in medical malpractice cases, a federal court sitting in Ohio concluded, in *Finley v. United States*,¹⁷ that Ohio adheres to the medical custom rule.¹⁸

In Louisiana, an intermediate appellate court opened the door to the abrogation of the medical custom rule in *Favalora v. Aetna Casualty & Surety Co.*,¹⁹ in which the court stated:

We believe that conformity with the standard of care observed by other medical authorities in good standing in the same community cannot be availed of as a defense in a malpractice action when the criterion relied on is shown to constitute negligence in that it fails to guard against injury to the patient from a reasonably foreseeable contingency.²⁰

The door has, however, been firmly closed by later Louisiana cases²¹ which have relied on *Meyer v. St. Paul-Mercury Indemnity Co.*,²² a case clearly adopting the medical custom rule. The court in *Favalora* may have intended only to abrogate the locality rule, but even that effect has been rejected by at least one later case²³ and by statute.²⁴

In *Darling v. Charleston Community Memorial Hospital*,²⁵ the Supreme Court of Illinois stated that medical custom is only one factor to be used in resolving the negligence issue. However, the opinion dealt with the liability of a hospital, the claim against a physician having been settled prior to trial. While the standard of care to which hospitals should be held is beyond the scope of this article, there are enough differences between hospitals and physicians to suggest that the same rules for determining the standard of care should not necessarily be the same for both.²⁶ Nevertheless, an intermediate appellate court in *Lundahl v.*

¹⁷ 314 F. Supp. 905 (E.D. Ohio 1970).

¹⁸ A recent case has interpreted *Morgan* and *Ault* as abrogating the locality rule. See *Faulkner v. Pezeshki*, 44 Ohio App. 2d 186, 337 N.E.2d 158 (1975) where the issue was whether a particular witness had sufficient expertise to testify, and the court did not discuss the medical custom rule. It did, however, quote from *Gillette v. Tucker*, 67 Ohio St. 106, 65 N.E. 865 (1902), a case which applied that rule.

¹⁹ 144 So. 2d 544 (La. App. 1962).

²⁰ *Id.* at 550.

²¹ See, e.g., *Green v. State*, 309 So. 2d 706 (La. App. 1975); *Slack v. Fleet*, 242 So. 2d 650 (La. App. 1970).

²² 225 La. 618, 73 So. 2d 781 (1953).

²³ See *Chapman v. Argonaut-Southwest Ins. Co.*, 290 So. 2d 779 (La. App. 1974).

²⁴ See the Louisiana statutes cited at note 59 *infra*.

²⁵ 33 Ill. 2d 326, 211 N.E.2d 253 (1965).

²⁶ For example, hospital decisionmakers are not necessarily physicians, and the decisions they make do not always involve matters beyond the ken of juries. In many respects, hospitals are more like hotels, with an aura of commercialism than like physicians. Hospitals, after all, do not subscribe to the Hippocratic Oath.

*Rockford Memorial Hospital Association*²⁷ stated that the liability of physicians as well as the liability of hospitals is to be determined by the *Darling* rule, and that conformity to custom is not conclusive of due care. However, later Illinois cases have not followed *Lundahl* in this respect. For example, in *Green v. Hussey*,²⁸ the court stated that the plaintiff had the burden of proving "by expert medical evidence that the reasonable medical practitioner of the same school, in the same or similar circumstances, would have [acted differently than the physician did in this case.]"²⁹ In *Ohligschlager v. Proctor Community Hospital*,³⁰ the Supreme Court of Illinois used different words to describe the standards applicable to physicians and hospitals. As to physicians, the court referred to "the standard of professional care" as the appropriate standard,³¹ and did not mention the *Darling* case at all. However, in discussing the standard applicable to the hospital, the court quoted from *Darling* that "the hospital was under a duty to 'conform to the legal standard of reasonable conduct in light of the apparent risk.'"³²

In Pennsylvania, the formulation of the standard of care applicable in medical malpractice cases is:

A physician . . . is required to *possess* and *employ* in the treatment of a patient the skill and knowledge usually possessed by physicians in the same or a similar locality, giving due regard to the advanced state of the profession at the time of the treatment; and in employing the required skill and knowledge he is also required to exercise the care and judgment of a reasonable man.³³

The Pennsylvania courts have not made much of the duty "to exercise the care and judgment of a reasonable man" as an independent basis of liability—that is, courts have not imposed liability on physicians in cases in which they have conformed to medical custom.³⁴ However, *Incollingo*

²⁷ 93 Ill. App. 2d 461, 235 N.E.2d 671 (1968).

²⁸ 127 Ill. App. 2d 174, 262 N.E.2d 156 (1970).

²⁹ *Id.* at 184, 262 N.E.2d at 161.

³⁰ 55 Ill. 2d 411, 303 N.E.2d 392 (1973).

³¹ *Id.* at 417, 303 N.E.2d at 396. While this phrase is rather vague, it is unlikely that the court intended it to mean anything other than the customary standard of the medical profession. The intermediate appellate court, in affirming a directed verdict for the defendant physician in this case, had cited *Green v. Hussey*, 127 Ill. App. 2d 174, 262 N.E.2d 156 (1970), as establishing the law controlling the standard of care. *Ohligschlager v. Proctor Community Hosp.*, 6 Ill. App. 3d 81, 283 N.E.2d 86 (1972). While the supreme court reversed and ordered a new trial, it did not do so on the ground that the intermediate appellate court had chosen the wrong standard, but rather that on the peculiar facts of the case the plaintiff need not introduce expert testimony as to what the standard was.

³² 55 Ill. 2d at 420, 303 N.E.2d at 397.

³³ *Donaldson v. Maffucci*, 397 Pa. 548, 553-54, 156 A.2d 835, 838 (1959) (emphasis in original).

³⁴ This is because of the requirement in almost all cases that the plaintiff present expert testimony that the defendant departed from established medical procedures. *See, e.g., Donald-*

*v. Ewing*³⁵ may have introduced an element of uncertainty into Pennsylvania law. In this case, the evidence was that the two defendant physicians prescribed chloromycetin for their joint patient, whose later death was attributed to the use of the drug. Instructions furnished with the drug warned of possible side effects which made it unsuitable for use in treating minor infections. There was evidence that notwithstanding these instructions, it was customary for physicians in the defendants' locality to prescribe chloromycetin relatively freely. In affirming judgments on jury verdicts against both defendants, the supreme court ruled that neither physician could rely on conformity to custom to establish due care. One of the two doctors had read the instructions and was aware of the risks involved. In view of this physician's actual knowledge, the court ruled that the jury could find that he did not use the "care and judgment of a reasonable man" in the circumstances. The other physician was not actually aware of chloromycetin's dangers, as he paid little attention to the warnings, and argued that the manufacturer's detail men "oversold" him on the use of the drug. Again, the court concluded that the jury could find the latter physician to have been negligent in not using "the care and judgment of a reasonable man."³⁶

On the peculiar facts of the case, *Incollingo* cannot be taken to stand for the general rejection of the medical custom rule. Other courts have reached similar results on similar facts without suggesting that the rule has been abrogated. For example, in *Toth v. Community Hospital*,³⁷ the Court of Appeals of New York ruled that a doctor may be negligent for failure to "use his own best judgment"³⁸ if he does not act on his peculiar knowledge that there are risks involved in the customary procedure which are not generally appreciated. Furthermore, doctors have never escaped liability by pleading ignorance of dangerous side effects of drugs as to which information is contained in manufacturers' warnings or in generally available medical literature.³⁹

son v. Maffucci, 397 Pa. 548, 156 A.2d 835 (1959); Ragan v. Steen, 225 Pa. Super. 515, 331 A.2d 724 (1974). See also Fala, *The Law of Medical Malpractice in Pennsylvania*, 36 U. PITT. L. REV. 203, 217-30 (1974). Pennsylvania, like other states, see text accompanying note 104 *infra*, has developed exceptions to the rule requiring expert testimony to establish the standard of care. *Id.*

³⁵ 444 Pa. 263, 282 A.2d 206 (1971).

³⁶ As to the latter the court also stated that there was no evidence that his conduct conformed to "the professional standard of conduct in the community," and that the jury, giving "due regard to the advanced state of the profession," could have found that he was negligent in failing to read the warnings and medical literature which discussed the dangers of chloromycetin.

³⁷ 22 N.Y.2d 255, 239 N.E.2d 368 (1968).

³⁸ This expression is often appended to the formulation of the standard of care. See J. WALTZ & F. INBAU, *supra* note 1, at 42.

³⁹ See A. HOLDER, *MEDICAL MALPRACTICE LAW* 162-63 (1975).

All in all, these cases furnish no substantial precedent for *Helling*. But the absence of precedent, in these days of judicial activism may not in itself be a sufficient basis of criticism. It is the thesis of this article, however, that the judicial abrogation of the medical custom rule is unwise as a matter of policy. In order to evaluate *Helling*, it is necessary to explore the reasons which underlie the medical custom rule and what might have led the court in *Helling* to abandon it. Courts have not been insensitive to the pressure for increased legal accountability of physicians, and have developed other approaches, which will be surveyed here, to accomplish that result. I will conclude with a discussion of why courts are unlikely to follow *Helling*, at least insofar as it is seen as a complete rejection of the traditional role of medical custom in malpractice cases.

A RATIONALE FOR THE MEDICAL CUSTOM RULE

Courts are not well suited institutionally to the making of evaluations of industry custom. Whenever a court brands a custom as unreasonably unsafe, it in effect decides that not enough resources have been devoted to safety, and that too much consideration has been devoted to competing values, such as functional utility, aesthetics, or overall cost.⁴⁰ In a perfectly functioning market, there would be no reason for courts to tackle the difficult problems of resource allocation necessarily involved in the evaluation of the reasonableness of custom. Competition in the market place would, by definition, result in the correct balance between safety and other values. But the market does not function perfectly, and courts have historically manifested a lack of faith in the market as a source of pressure to compel industry to give adequate consideration to safety in establishing custom.⁴¹ Thus courts, in the context of negligence

⁴⁰ Problems such as the allocation of resources in the market are described by Professor Fuller as "polycentric." See Fuller, *Adjudication and the Rule of Law*, PROC. AM. SOC. OF INT. LAW 1 (1960). Polycentric problems, according to Professor Fuller, are by their nature not suited to resolution by adjudication. For an application and expansion of the Fuller analysis to the liability of manufacturers for unreasonable product design, see Henderson, *Judicial Review of Manufacturers' Conscious Design Choices: The Limits of Adjudication*, 73 COLUM. L. REV. 1531 (1973). Professor Posner asserts that the "reluctance of courts to condemn customary practices reflects the difficulty of determining value forensically." The difficulty stems from the inadequacy of data available in judicial proceedings necessary to the making of rational value choices. R. POSNER, *ECONOMIC ANALYSIS OF LAW* § 23.1, at 323 (1972).

⁴¹ This is not to suggest that courts have consciously rejected custom as conclusive of the standard of care because they have concluded, on the basis of economic analysis, that the market functions imperfectly. However, as Professor Posner observed: "Few legal opinions, to be sure, contain explicit references to economic concepts But the true grounds of decision are often concealed rather than illuminated by the characteristic rhetoric of judicial opinions." R. POSNER, *ECONOMIC ANALYSIS OF LAW* § 1.2, at 6 (1972). See also, M. HANDLER, H. BLAKE, R. PITOFSKY & H. GOLDSCHMID, *TRADE REGULATION* (1975): "Even in strictly common law fields . . . courts have generally consciously or intuitively shaped

actions, function as a substitute for the market forces which might, but do not, operate to insure the optimal level of safety. While custom is relevant to the applicable standard of care, it does not conclusively establish it.⁴²

What, then, explains the rule that in medical malpractice cases custom establishes the standard of care? There are occasional suggestions that the rule is justified because juries lack the technical expertise to make independent judgments about the reasonableness of a particular course of medical care,⁴³ and yet juries are often required to consider difficult scientific matters which are beyond the knowledge of typical lay persons.⁴⁴ Expert testimony may be required to educate the jury, and experts are increasingly being permitted to express opinions as to the ultimate facts to be decided by the jury when such opinions are felt by judges to be helpful.⁴⁵ Thus, the esoteric quality of the practice of medicine does not in itself seem to be a sufficient justification for the medical custom rule.

A different explanation is that offered by Professor McCoid: The "preferred position" granted by the courts to the medical profession (and to other professions) may be in recognition of the peculiar nature of the "professional" activity. The qualified practitioner of medicine has undertaken long years of study to acquire knowledge of man, his body and its illnesses and the means of combatting such ailments, coupled with an intensive training of the senses and mind of the physician to respond to stimuli in a manner best described as "the healing art." A large measure of judgment enters into the practice of this art. That judgment should be free to operate in the best interests of the patient. If the "judge" is himself to be judged by some outsider who relies on after-acquired knowledge of unsatisfactory results or unfortunate consequences in reaching a decision as to liability, the medical judgment may be hampered and the doctor may become hesitant to rely upon his developed instinct in diagnosis and treatment. If, on the other hand, the doctor knows that his conduct is to be evaluated in terms of what other highly trained medical practitioners would have done or would accept as competent medical practice, he is more likely to pursue his own judgment when he is confident of the

rules of law responsive to the economic needs of the era as perceived by the dominant political forces." *Id.* at 143.

⁴² See 2 F. HARPER & F. JAMES, JR., *THE LAW OF TORTS* § 17.3, at 977-80 (1956); MORRIS, *Custom and Negligence*, 42 COLUM. L. REV. 1147 (1942).

⁴³ See, e.g., *Haase v. Garfinkel*, 418 S.W.2d 108, 113 (Mo. Sup. Ct. 1967): "Whether [the medical treatment in this case was proper] is a question beyond the knowledge and competence of lay jurors."

⁴⁴ See, e.g., *United States v. Stifel*, 433 F.2d 431 (6th Cir. 1970), *cert. denied*, 401 U.S. 994 (1971), in which the jury was called upon to determine the reliability of neutron activation analysis.

⁴⁵ See 3 J. WEINSTEIN & M. BERGER, *WEINSTEIN'S EVIDENCE* (704-1-10) (1975).

diagnosis and line of treatment, and is more likely to provide good medical service for his patient.⁴⁶

Essentially, this argument is that a malpractice litigation process not based upon the medical custom rule would be incapable of functioning properly, as it would deter physicians from practicing sound, as well as substandard, medicine. The argument, however, is incomplete. Even if courts were willing to accept the accuracy of the prediction, they would also have to be convinced that the medical custom rule would not permit an unacceptable amount of unsound medical care. The choice of the controlling standard of care would involve a trade-off, in which the societal costs of deterring sound medical practice, under the general standard of reasonableness, would have to be balanced against the societal costs of unsound medical care under the medical custom rule.

There is no data, nor is it likely that there ever could be, which would support a choice between the two standards. But even in the absence of such data, courts historically seem to have assumed⁴⁷ that the costs of unsound medical care which might result from the medical custom rule are minimal. This assumption is supported by the traditional view of the doctor-patient relationship. The relationship has not been seen as one of arm's length bargaining between the physician and the patient. Rather, the physician has been traditionally thought of as being on the patient's side, with a mission to heal that transcends all other considerations, a mission that lies at the core of the Hippocratic Oath.⁴⁸ This view is perhaps best summed up in Parsons's classic work, *The Social System*:

The "ideology" of the [medical] profession lays great emphasis on the obligation of the physician to put the "welfare of the patient" above his personal interests, and regards "commercialism" as the most serious and insidious evil with which it has to contend. The line, therefore, is drawn primarily vis-à-vis "business." The "profit motive" is supposed to be drastically excluded from the medical world. This attitude is, of course, shared with the other professions, but it is perhaps more pronounced in the medical case than in any single one except perhaps the clergy.⁴⁹

⁴⁶ McCoid, *supra* note 1, at 608.

⁴⁷ "For the most part . . . judges rely upon their own assumptions regarding general behavior patterns and the likely effects of their decisions upon those patterns. Thus, while it is fair to say that judge-made law is influenced by how people behave, it would be more accurate to say that it is influenced by the judges' 'seat of the pants' impressions of how people behave." J. HENDERSON, JR. & R. PEARSON, *THE TORTS PROCESS* 337 (1975).

⁴⁸ "I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients and abstain from whatever is deleterious and mischievous."

⁴⁹ T. PARSONS, *THE SOCIAL SYSTEM* 435 (1951). See also Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 *AM. ECON. REV.* 941, 949-50 (1963); and McCoid,

Thus, medical custom may be accepted as the standard of care in medical malpractice cases because physicians have been thought of as not exploiting the market for medical services for their own gain at the expense of the health of their patients. 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 profession make such extra-professional pressure unnecessary.

THE INCREASING LEGAL ACCOUNTABILITY OF THE MEDICAL PROFESSION

There is little doubt that this traditional view of physicians as having a single-minded concern with patient welfare has become seriously eroded. A variety of factors have contributed to this. The change in the nature of the relationship between doctors and their patients was noted in one important study of the malpractice problem:

Changes in medical technology also brought about changes in the patterns of medical practice. The general practitioner gave way to the specialist and subspecialist, and the locus of much practice moved from office and home to clinic and hospital. While most of these changes have been beneficial, they have resulted in a gradual shift from treatment of the patient by a single practitioner to treatment by groups or teams and institutions, and to more impersonal care. Few would deny the influence of psychological factors as contributing causes to litigation, and as changes in patterns of practice fostered a less personal physician-patient relationship, the stage was set for greater misunderstanding and disharmony.⁵⁰

The relative affluence of physicians⁵¹ suggests that they are not entirely unconcerned with the profit motive. Reports in the press of such things as Medicare fraud and unnecessary surgery appear frequently, and are bound to have an impact on the traditional view of the medical profession. One recent survey indicates that a substantial number of people

A Reappraisal of Liability for Unauthorized Medical Treatment, 41 MINN. L. REV. 381, 431-32 (1957), in which the author states that it is assumed "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."

⁵⁰ U.S. DEP'T OF H.E.W., REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE 3 (1973) [hereinafter referred to as REPORT].

⁵¹ The median income in 1973 for self-employed physicians was \$42,140. For general practitioners, the median was \$37,890, for surgeons \$47,290, and for obstetricians-gynecologists \$51,800. Incorporated physicians did substantially better; the median income for general practitioners was \$55,000, for surgeons \$67,500, and for obstetricians-gynecologists \$72,500. BUREAU OF THE CENSUS, U.S. DEP'T OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES, Tables 117, 118, at 77 (1975). The median income in 1973 for families with a male head was \$12,965. *Id.*, Table 635, at 391.

feel that physicians are more concerned with making money and are less dedicated than they were 20 years ago.⁵²

In an increasingly claims conscious society, it therefore seems inevitable that these factors would contribute to an increase in the number of claims against physicians for harm suffered in the course of medical treatment. In New York, for example, the number of medical malpractice claims rose from 564 in 1970 to 1,200 in 1974.⁵³ Courts have responded to this demand for increased legal accountability of physicians by the development of a number of techniques and doctrines, other than abrogation of the medical custom rule, which have increased the potential liability of physicians. These include the rejection of the locality rule, the requirement of informed consent to treatment, expansion of contract liability, and expansion of the use of *res ipsa loquitur*.⁵⁴ None of these developments involve direct confrontation with the medical custom rule, and thus have permitted courts to avoid the setting of standards of medical treatment. However, they all impinge on the exercise of medical judgment, and to that extent might be seen as precursors of specific abrogation of the medical custom rule.

Rejection of the Locality Rule

In the early formulations of the medical custom rule, the applicable standard of care was determined by the custom in the community in which the defendant practiced, although in some states the relevant geographic area was expanded to include other localities similar to that

⁵² Peterson, *Consumers' Knowledge of and Attitude Toward Medical Malpractice*, in REPORT, Appendix 658, 667-68.

⁵³ NEWSWEEK, June 9, 1975, at 59. See also REPORT at 6: "The number of malpractice claims has been [increasing] steadily, especially in certain parts of the country . . ." Statements such as these may be deceptive, for they do not purport to show an increase in the incidence of malpractice claims. The number of claims could be rising because the number of doctor-patient contacts which can generate claims is increasing, and not just because there are more claims per contact. There can be little doubt that the availability of Medicare, Medicaid, and health maintenance organizations have increased the number of doctor-patient contacts. Thus, an increase in the number of claims as such may tell us little about attitudes toward the medical profession. However, physicians seem to regard the malpractice situation as "worse than ever before," and assign reasons for this which would suggest that the increase in claims is not solely due to the increase in patient contacts. See Pabst, *A Medical Opinion Survey of Physicians' Attitudes on Medical Malpractice*, in REPORT, Appendix 83.

⁵⁴ There is little doubt that the "conspiracy of silence," whether real or imagined (*compare* Belli, *Ready for the Plaintiff!*, 30 TEMPLE L.Q. 408 (1957) with REPORT at 36-37), has played a part in the increased legal accountability of the medical profession. Courts on occasion express concern that plaintiffs are unable to secure the expert testimony necessary to support valid malpractice claims. The increased legal accountability of the medical profession has certainly decreased the necessity that plaintiffs rely on expert testimony.

community.⁵⁵ Waltz and Inbau have given the following explanation of the historical reasons underlying the locality rule:

The rule, in its early form, was demonstrably calculated to protect the rural and small-town practitioner, who was presumed to be less adequately informed and equipped than his big-city brother . . . The residents of our country towns and frontier outposts would have to be satisfied with second-rate health services. The rule that accomplished this result was a frankly expedient one; although their opinions are short of supporting data, courts one hundred years ago were probably justified in adopting a presumption that the large-city practitioner enjoyed a broader experience than his country cousin, and greater access to the latest medical knowledge and to the most advanced and elaborate facilities and equipment. If plaintiff's expert did not come from the defendant's town, he had no business testifying against him; they functioned in different worlds.⁵⁶

And, of course, the world in which the locality rule developed is a different world from today's. As a result of the wide availability of medical knowledge, many courts have rejected the locality rule and determine the standard of care without reference to any geographic limits. In some states, the rejection applies only to specialists, leaving the rule in effect in actions against general practitioners.⁵⁷ In other states, the rejection applies in actions against all physicians—general practitioners as well as specialists.⁵⁸ Although some recent decisions have continued to adhere to the locality rule,⁵⁹ it is likely that the rule will be abandoned

⁵⁵ The development of this rule is traced in J. WALTZ & F. INBAU, *supra* note 1, at 64-65 and McCoid, *supra* note 1, at 569-75.

⁵⁶ J. WALTZ & F. INBAU, *supra* note 1, at 64-65.

⁵⁷ See, e.g., *Naccarato v. Grob*, 384 Mich. 248, 180 N.W.2d 788 (1970). The Michigan Supreme Court specifically refused to consider whether the locality rule should continue to apply in cases involving general practitioners. An intermediate appellate court later applied the rule in such a case, stating that any change should come from the supreme court. *Siirila v. Barrios*, 58 Mich. App. 721, 228 N.W.2d 801 (1975).

⁵⁸ See, e.g., *Brune v. Belinkoff*, 354 Mass. 102, 235 N.E.2d 793 (1968); *Shier v. Freedman*, 58 Wis. 2d 269, 206 N.W.2d 166 (1973).

⁵⁹ See, e.g., *Dunham v. Elder*, 18 Md. App. 360, 306 A.2d 568 (1973); *Mecham v. McLeay*, 193 Neb. 457, 227 N.W.2d 829 (1975). It is not a safe prediction, however, that these states will continue with the existing law. In *Dunham*, the court bottomed its decision on its view of Maryland precedent. In *Raitt v. The Johns Hopkins Hosp.*, 274 Md. 489, 336 A.2d 90 (1975), the Maryland Supreme Court specifically left the question open, but stated that precedent did not support the holding in *Dunham*. In *Mecham*, the rule was stated without discussion, which suggests that the plaintiff, for some reason, did not attack the locality rule. In addition to judicial retention of the locality rule, at least one jurisdiction has adopted the locality rule legislatively. See LA. REV. STAT. ANN. § 40:1299.41A(7) (Supp. 1975). This statute is one of several passed by the Louisiana legislature on the same day dealing with medical malpractice. This statute makes no exception for actions against specialists, although LA. REV. STAT. ANN. § 9:2794A(1) (Supp. 1975), which deals with the standard of care applicable in malpractice actions, does. This latter statute provides no geographical limitation on the standard applicable to specialists.

in increasing numbers of states. The rule often has been criticized⁶⁰ and seldom defended.⁶¹

A rule by which the standard of care is determined without reference to geographic limits should go far toward assuaging the fears that apparently underlay the opinion in *Helling v. Carey*. In refusing to adhere to the medical custom rule, the court quoted from *The T.J. Hooper*⁶² that "a whole calling may have unduly lagged in the adoption of new and available devices."⁶³ By removing the geographic restrictions on the standard of care, courts may develop more confidence in the medical custom rule, for although the medical practice in a particular locality "may have unduly lagged," the wider medical community from which custom will be determined is much less likely to approve of a practice which could fairly be called unsound.⁶⁴ There is no doubt that the rejection of the locality rule offers a substantial opportunity for courts to increase the legal accountability of physicians without abrogating the medical custom rule. The standard of care will still be derived from the medical profession, but under circumstances which would make the concern of the court in *Helling* less justified.⁶⁵

The Requirement of Informed Consent

From a philosophical point of view, there is much to be said in favor of a rule of law which requires physicians to make full disclosure to their patients of matters relating to diagnosis and treatment. As Dr. Fletcher stated in his book on the intersection of medicine and morals:

[W]e may say that in general we can validly assert our right as patients to know the medical facts about ourselves. Several reasons have been given for it, but perhaps the four fundamental ones are: first, that as persons our human, moral quality is taken away from us if we are denied whatever knowledge is available; second, that the doctor is *entrusted* by us with what he learns, but the facts are ours, not his,

⁶⁰ See, e.g., Ellin, *The Law of Medical Malpractice in Maryland: A Plaintiff's Dilemma*, 3 U. BALT. L. REV. 207 (1974); Waltz, *The Rise and Gradual Fall of the Locality Rule in Medical Malpractice Litigation*, 18 DEPAUL L. REV. 408 (1969); Note, *An Evaluation of Changes in the Medical Standard of Care*, 23 VAND. L. REV. 729 (1970).

⁶¹ See King & Coe, *The Wisdom of the Strict Locality Rule*, 3 U. BALT. L. REV. 221 (1974).

⁶² 60 F.2d 737 (2d Cir. 1932).

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

⁶⁴ As to this point, the Supreme Court of Washington in *Helling* either did not consider it or was not impressed by it. The court had abrogated the locality rule seven years earlier in *Pederson v. Dumouchel*, 72 Wash. 2d 73, 431 P.2d 973 (1967).

⁶⁵ Expert testimony from other physicians will still be required; however, the "waning importance of the locality rule in malpractice actions, the increasing acceptance of national standards rather than local standards of care, as well as a more cooperative and conscientious response from individual physicians and medical societies, have all combined to make expert testimony more generally available." REPORT at 37.

and to deny them to us is to steal from us what is our own, not his; third, that the highest conception of the physician-patient relationship is a personalistic one, in the light of which we see that the fullest possibilities of medical treatment and cure in themselves depend upon mutual respect and confidence, as well as upon technical skill; and, fourth, that to deny a patient knowledge of the facts as to life and death is to assume responsibilities which cannot be carried out by anyone but the patient, with his own knowledge of his own affairs.⁶⁶

While Dr. Fletcher wrote largely of the problem of whether a physician could properly withhold a diagnosis of serious illness from a patient, he expressed a viewpoint which is gaining increasing acceptance by courts in cases in which liability is based on lack of informed consent to treatment.

The early cases, by and large, reflected this view. For example, in *Schloendorff v. Society of New York Hospital*, Justice Cardozo stated:

Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages.⁶⁷

In *Schloendorff* the defendant physician had performed an operation contrary to the expressed desire of the plaintiff and thus the claim fit within the conventional law of battery. Liability in battery has also been imposed when the physician has gone beyond the scope of the patient's consent and performed surgery on a part of the patient's body to which the patient had not consented.⁶⁸ Under battery law, there is little room for a physician to argue that good medical practice requires the unconsented treatment, except in very limited circumstances. A physician may escape liability in battery if, in the course of consented-to surgery, he discovers and corrects a condition which requires "immediate action for the preservation of the life or health of the patient under circumstances in which it is impossible . . . to obtain the patient's consent or the consent of anyone authorized to assume such responsibility."⁶⁹ Other courts have given greater leeway to physicians, and have refused to impose battery liability if the physician in the "exercise of his sound professional judgment, determines that correct surgical procedure dictates and requires such an extension of the operation originally contem-

⁶⁶ J. FLETCHER, *MORALS AND MEDICINE* 60-61 (1960).

⁶⁷ 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914).

⁶⁸ An exhaustive collection and analysis of such cases appear in McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 MINN. L. REV. 381 (1957).

⁶⁹ *Rogers v. Lumbermens Mut. Cas. Co.*, 119 So. 2d 649, 650 (La. App. 1960) (hysterectomy performed on patient who had only consented to appendectomy).

plated"⁷⁰ Thus, medical custom has little effect in cases in which there has been no consent to the particular treatment performed.

However, in cases in which there has been a failure to disclose and explain the risks involved in a course of treatment that has been consented to, the basis of the physician's liability generally is negligence rather than battery.⁷¹ Since in negligence cases generally the applicable standard of care is set by medically established custom, it is not surprising that courts adopted the medical custom rule in these cases. Thus, the law developed that a physician would not be liable for adverse consequences from risks not disclosed to the patient unless the patient could establish that it was the custom for physicians to disclose such risks.⁷² The reason given for the adoption of the medical custom rule in establishing the duty of a physician to disclose risks is that the physician is in a better position than the patient to determine what information should be revealed. In *Starnes v. Taylor*, the Supreme Court of North Carolina explained the rule as follows:

Where, as here, there is no contention of a fraud or misrepresentation by the surgeon in order to induce the patient to undergo an unnecessary or unwise surgical procedure, and the likelihood of an adverse result is relatively slight, much must be left to the discretion of the physician or surgeon in determining what he should tell the patient as to possible adverse consequences. While the patient, or the person acting for him, has the right to an informed election as to whether to undergo the proposed operation, treatment or to take a

⁷⁰ *Kennedy v. Parrott*, 243 N.C. 355, 356, 90 S.E.2d 754, 755 (1956) (ovarian cyst removed from patient who had only consented to appendectomy). *Kennedy* can perhaps be distinguished from *Rogers* on the basis of the difference in the magnitude of the unconsented-to operations. There is a qualitative difference between the removal of a cyst and the removal of the reproductive organs.

If the physician knows the full scope of the proposed operation ahead of time and fails to explain the extent of the surgery and secure consent to it, he also exposes himself to liability in battery. See *Bang v. Charles T. Miller Hosp.*, 251 Minn. 427, 88 N.W.2d 186 (1958).

⁷¹ See, e.g., *Trogon v. Fruchtmann*, 58 Wis. 2d 596, 207 N.W.2d 297 (1973). An occasional court will apply the law of battery to this class of case. See *Scott v. Wilson*, 396 S.W.2d 532 (Tex. Civ. App. 1965), *aff'd*, 412 S.W.2d 299 (Tex. 1967). A few other courts have spoken of battery as the underlying theory of liability, but the relevant issues appear to be substantially the same as they would be under the negligence theory. See, e.g., *Zeleznik v. Jewish Chronic Disease Hosp.*, 47 App. Div. 2d 199, 366 N.Y.S.2d 163 (1975); *Fogal v. Genesee Hosp.*, 41 App. Div. 2d 468, 344 N.Y.S.2d 552 (1973); *Congrove v. Holmes*, 308 N.E.2d 765 (Ohio App. 1973). See generally *Plante, An Analysis of "Informed Consent,"* 36 *FORDHAM L. REV.* 639 (1968).

⁷² The informed consent doctrine is the subject of extensive law review commentary. See, e.g., *Plante, supra* note 71; *Waltz & Scheuneman, Informed Consent to Therapy*, 64 *Nw. U. L. REV.* 628 (1970); Note, *Informed Consent—A Proposed Standard for Medical Disclosure*, 48 *N.Y.U.L. REV.* 548 (1973); Comment, *Informed Consent: Alternatives for Illinois*, 1973 *U. ILL. L. FORUM* 739; Note, *Failure to Inform as Medical Malpractice*, 23 *VAND. L. REV.* 754 (1970); Comment, *Informed Consent as a Theory of Medical Liability*, 1970 *WIS. L. REV.* 879.

prescribed drug, it must be borne in mind that the physician's or surgeon's primary concern at the time of the consultation is, and should be, the treatment of the patient's illness or disability, not preparation for the defense of a possible lawsuit. Obviously, an increase in the normal anxiety of one about to undergo a surgical procedure is not medically desirable. Advice, which is calculated to increase such anxiety by recounting unlikely possibilities of undesirable consequences, is not consistent with the above stated duty of the physician or surgeon to his patient.⁷³

The "doctor knows best" attitude of at least some in the medical profession was brought out in an Ohio case, in which the defendant explained the reason for his not telling the plaintiff of the risk of nerve damage in the course of surgery in the following terms:

I feel that were I to point out all the complications—or even half the complications—that I would take the responsibility for in trying to help people, that many people would refuse to have anything done, and therefore, would be much worse off.⁷⁴

Although it is safe to say that a majority of courts still adhere to the medical custom rule in disclosure cases,⁷⁵ the most recent cases show a decided trend toward a standard of disclosure measured by what patients need to know to make intelligent decisions rather than by what physicians think patients ought to know. The landmark case defining the standard in terms of the patient's need to know is *Canterbury v. Spence*.⁷⁶ In this case, the plaintiff alleged that he became paralyzed following an operation on his back performed by the defendant. The plaintiff was not told prior to the operation of the existence of a one percent risk of paralysis in operations of that sort. The trial judge directed a verdict for the defendant, which was reversed on appeal. In the course of a lengthy and scholarly opinion, the court stated:

Respect for the patient's right of self-determination on particular therapy demands a standard [of disclosure] set by law for physicians rather than one which physicians may or may not impose upon themselves.⁷⁷

As to what standard the law should set, the court ruled:

In our view, the patient's right of self-decision shapes the boundaries of the duty to reveal. That right can be effectively exercised only if the patient possesses enough information to enable an intelli-

⁷³ 272 N.C. 386, 393, 158 S.E.2d 339, 344 (1968).

⁷⁴ *Congrove v. Holmes*, 308 N.E.2d 765, 768 (Ohio App. 1973).

⁷⁵ See cases cited in Annot., 52 A.L.R.3d 1084 (1973).

⁷⁶ 464 F.2d 772 (D.C. Cir. 1972).

⁷⁷ *Id.* at 784. The court's unwillingness to rely on medical custom stemmed in part from doubt that there exists any "professional consensus on communication of option and risk information to patients . . ." *Id.* at 783.

gent choice. The scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is the information material to the decision. Thus the test for determining whether a particular peril must be divulged is its materiality to the patient's decision: all risks potentially affecting the decision must be unmasked

It is evident that many of the issues typically involved in non-disclosure cases do not reside peculiarly within the medical domain. . . . Experts are unnecessary to a showing of the materiality of a risk to a patient's decision on treatment, or to the reasonably, expectable effect of risk disclosure on the decision.⁷⁸

Since *Canterbury* was decided, a few courts have continued to adhere to the rule that the obligation of a physician to inform of the risks of treatment is to be determined by medical custom.⁷⁹ But most have rejected the medical custom rule and have held that the standard of disclosure is measured by what the patient needs to know to make a rational decision as to whether to undergo the proposed treatment.⁸⁰

Whether the abrogation of the medical custom rule in disclosure cases will have much of an impact on physician behavior is open to doubt, since, in most instances, good medical practice requires thorough disclosure.⁸¹ But there is no doubt that the patient's-need-to-know standard will enable plaintiffs to get to the jury more often, as expert testimony is not needed to establish the standard. Apart from this, the rejection of the medical custom rule is important because it withdraws one important aspect of the physician-patient relationship from professional control and subjects it to legal control. However, it should not be assumed from this fact that courts might, or should, be more willing to abandon the medical custom rule in cases involving diagnosis and treatment. Whether the benefits of a proposed course of treatment outweigh the risks may involve many factors personal to the patient. In *Canterbury*, the operation necessary to relieve the plaintiff of pain in-

⁷⁸ *Id.* at 786-87, 792. The court recognized two circumstances under which this obligation to disclose would not operate: (1) when the patient is unconscious, and (2) when the patient is so emotionally disturbed that he cannot make a rational decision, would be hindered in the treatment, or psychologically harmed by the disclosure.

⁷⁹ See, e.g., *Reidisser v. Nelson*, 111 Ariz. 542, 534 P.2d 1052 (1975); *Butler v. Berkeley*, 25 N.C. App. 325, 213 S.E.2d 571 (1975).

⁸⁰ See, e.g., *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); *Goodwin v. Aetna Cas. & Sur. Co.*, 294 So. 2d 618 (La. App. 1974); *Holland v. Sisters of St. Joseph*, 522 P.2d 208 (Ore. 1974); *Miller v. Kennedy*, 11 Wash. App. 272, 522 P.2d 852 (1974), *aff'd*, 85 Wash. 2d 151, 530 P.2d 334 (1975); *Scaria v. St. Paul Fire & Marine Ins. Co.*, 68 Wis. 2d 1, 227 N.W.2d 647 (1975). The law review commentary has been overwhelmingly in favor of rejection of the medical custom rule in disclosure cases, see generally the articles cited in note 72 *supra*.

⁸¹ See *Waltz & Scheuneman, supra* note 72, at 642; *Hagman, The Medical Patient's Right to Know: Report on a Medical-Legal-Ethical Empirical Study*, 17 U.C.L.A.L. REV. 758, 764-67 (1970).

volved a one percent chance of paralysis, and whether the hope of a less painful life is worth more than a chance of paralysis depends on such things as the plaintiff's tolerance of pain and the impact that paralysis would have on his life. The physician can help the decision process, and might advise that the operation be performed in spite of the risk, but the final decision ought to be that of the patient based upon his own weighing and balancing of subjective factors. However, that courts recognize the right of persons to choose for themselves based on disclosure of those risks necessary to rational choice does not mean that other matters relating to diagnosis and treatment should be subjected to nonprofessional evaluation in a medical malpractice case.

*Claims Based on Breach of Express Contracts
for Particular Results of Treatment*

The relationship between a physician and his patient usually arises out of contract, in which there is an implied term that the physician will use the customary care. In the early malpractice cases, plaintiffs' actions sounded in contract for breach of this implied obligation. Over the years, such actions became assimilated into tort law, and today it is generally recognized that liability for failure to conform to the required standard of care is governed by tort, rather than contract, law.⁸² However, the shift in legal theory did not involve a change in the applicable standard of care—medical custom determines the standard under both theories. Thus, even under an implied contract theory, courts delegated to the medical profession the function of establishing the standard of care.

In some instances, however, contract principles may enable courts to hold physicians liable for adverse results of treatment without reference to the medical custom rule. If a physician has undertaken by the contract with the patient to bring about a specific outcome, liability can be imposed without a judicial evaluation of whether the physician acted reasonably if that result is not achieved. Liability is imposed not by comparing what the physician did with what a reasonable physician would have done, but by comparing the results of the treatment with those promised.

The extent to which liability should be based upon breach of express promise of specific results is a matter of considerable disagreement. Because courts have had difficulty in distinguishing between opinions and assurances that "things will be all right," on the one hand, and on

⁸² The development of the shift from contract to tort law is traced in Miller, *The Contractual Liability of Physicians and Surgeons*, 1953 WASH. L.Q. 413, 413-16; Maynard, *Establishing the Contractual Liability of Physicians*, 7 U.C. DAVIS L. REV. 84, 87-89 (1974).

the other hand, promises that specific results will be attained, they have generally been reluctant to impose express contract liability on physicians. A few courts have held that there can be no action for breach of an express promise absent separate consideration to support that promise.⁸³ Although most courts have not required such consideration they have insisted upon clear proof that the physician intended to guarantee a specific result. The leading case is *Hawkins v. McGee*,⁸⁴ in which the court ruled that a statement to the plaintiff that within a few days after an operation he "will go back to work with a good hand" could not be taken as a promise of satisfactory results, but rather was only an "expression of opinion or prediction as to the probable duration of the treatment and the plaintiff's resulting disability."⁸⁵ However, the court ruled that the jury could find an express contract to cure based on evidence that the defendant stated that he guaranteed "to make the hand a hundred percent perfect hand or a hundred percent good hand," and that he actively solicited permission to perform the operation.⁸⁶

Since doctors do not typically go beyond expressions of opinion or assurance designed to ease patient tensions, it is not surprising that liability based on express guarantees of good results has been only infrequently imposed, although the incidence of plaintiff reliance on this theory appears to be increasing.⁸⁷ However, the success rate of plaintiffs may substantially increase if a recent Michigan case, *Guilmet v. Campbell*,⁸⁸ gains judicial acceptance. In this case, the plaintiff had undergone an operation to correct a bleeding ulcer. The plaintiff's post-operation condition was not all he thought it should have been, and he sued the surgeons for negligence and for breach of an express contract to cure. The jury returned a verdict for the defendants on the negligence count, and for the plaintiff on the contract count. On appeal, the

⁸³ See *Rogala v. Silva*, 16 Ill. App. 3d 63, 305 N.E.2d 571 (1973); *Karriman v. Orthopedic Clinic*, 516 P.2d 534 (Okla. 1973). See generally, Annot., 43 A.L.R.3d 1221 (1972).

⁸⁴ 84 N.H. 114, 146 A. 641 (1929).

⁸⁵ *Id.* at 115, 146 A. at 642-43. In *Marvin v. Talbott*, 216 Cal. App. 2d 383, 30 Cal. Rptr. 893 (1963), the court ruled that a statement by the defendant that "I will make a new man out of you," was not an express guarantee of good results, as it was too vague and impossible to fulfill. See also *Sullivan v. O'Connor*, — Mass. —, 296 N.E.2d 183 (1973).

⁸⁶ 84 N.H. at 118-19, 146 A. at 643.

⁸⁷ See Dietz, Baird & Berul, *The Medical Malpractice Legal System*, in REPORT, Appendix 87. Table III-57, *id.* at 129, shows that the frequency of breach of warranty as an issue in appeals of medical malpractice cases increased from 1.7 percent of the cases prior to 1950 to 4.6 percent of the cases in the period 1961-71. This increase occurred in spite of the fact that malpractice insurance has generally been held not to cover claims based on breach of express contract. See *McGee v. U.S. Fid. & Guar. Co.*, 53 F.2d 953 (1st Cir. 1931); *Safian v. Aetna Life Ins. Co.*, 260 App. Div. 765, 24 N.Y.S.2d 92 (1940). *Contra*, *Sutherland v. Fid. & Cas. Co. of N.Y.*, 103 Wash. 583, 175 P. 187 (1918).

⁸⁸ 385 Mich. 57, 188 N.W.2d 601 (1971).

Supreme Court of Michigan affirmed, holding that if the jury accepted the plaintiff's version of what the defendants told him, it could find an express contract to cure. The court collected various parts of the plaintiff's testimony relating to this issue, and put it together this way:

Once you have an operation it takes care of all your troubles. You can eat as you want to, you can drink as you want to, you can go as you please. Dr. Arena and I are specialists, there is nothing to it at all—it's a very simple operation. You'll be out of work three or four weeks at the most. There is no danger at all in this operation. After the operation you can throw away your pill box. In twenty years if you figure out what you spent for Maalox pills and doctor calls, you could buy an awful lot. Weigh it against an operation.⁸⁹

Although these statements were not all made at the same point in time, but were spread out over what appears to be a rather lengthy consultation, and although the defendants denied making some of the statements, the court ruled that a jury issue was raised as to the existence of an express contract of cure.

More important than the court's holding on the specific facts is its willingness to submit the existence of an express contract to the jury without the clear proof that has traditionally been required:

What was said, and the circumstances under which it was said always determines whether there was a contract at all and if so what it was. These matters are always for the determination of the fact finder.⁹⁰

The case has been roundly criticized by one commentator because it goes further than any previously reported American decision in allowing a contract of cure to be found on much slenderer evidence than has heretofore been thought necessary; . . . it leaves seemingly entirely in the jury's hands the power to find the existence and terms of a professional service contract; and it leaves so uncertain what a physician may safely say to his patients that it provides a substantial incentive to the former to reduce his contracts with the latter to writing.⁹¹

If the plaintiff can get to the jury on an express contract theory against a physician as easily as he could in any other contract action, the potential liability is increased greatly, and there may be little that physicians can do to protect themselves. The obvious method of avoiding contract liability under *Guilmet* would be for physicians to refrain from giving patients assurances or opinions indicating that a treatment will be successful. In reality, this will be difficult to do. A patient will naturally

⁸⁹ *Id.* at 68, 188 N.W.2d at 606.

⁹⁰ *Id.* at 69, 188 N.W.2d at 606-07.

⁹¹ Tierney, *Contractual Aspects of Malpractice*, 19 WAYNE L. REV. 1457, 1459 (1973).

want to know what the likely outcome of treatment is, and he ought to be entitled to the physician's evaluation. No matter how carefully circumscribed an opinion of success may be, the physician may not be able to prevent the patient, whose expectations of success may have been fed by reports in the media of miracle cures⁹²—whether factual or fictional—from converting an opinion into a promise. And under *Guilmet*, so long as the patient testifies that the physician promised success, a jury issue is created, no matter how vigorously the physician denies making such a promise.

Professor Tierney, in his critical analysis of *Guilmet*, suggests that doctors may respond by entering into written contracts with patients which spell out all of the undertakings by both parties.⁹³ Whether or not this would give physicians much protection as a matter of contract law,⁹⁴ reducing the agreement to writing might be counterproductive of patient therapy. A patient who has received an honest and accurate opinion that the risks of proposed treatment are minimal and that the chances of success are good is likely to be puzzled at a provision in a written agreement that the doctor has made no promise of success. Any attempt at explanation by the doctor that the contract does not mean that the opinion is not accurate, and that the provision has been inserted merely to prevent the patient from suing the doctor for breach of contract, is not likely to strengthen the doctor-patient relationship.

One proposed solution to the problem of where to draw the line is to require the plaintiff to "produce some evidence corroborating the existence of the contract, such as a writing, proof of additional consideration, or testimony of witnesses relating to the formation of the contract. Plaintiff's testimony alone would be insufficient."⁹⁵ Of the

⁹² REPORT at 19, concludes that public expectations of "miracle" cures are being unrealistically raised by the media, particularly television.

⁹³ Tierney, *supra* note 91, at 1479-80.

⁹⁴ A problem would arise if the patient testified that after the signing of a contract not containing a promise of particular results, the physician orally made such a promise. Written contracts can be orally modified, although any new promise by the physician might have to be supported by additional consideration from the patient. But the patient may argue that the original written contract was rescinded and a new one containing an oral promise of success created. See 1A A. CORBIN, CORBIN ON CONTRACTS § 186, at 158-63 (1963). *Guilmet* would suggest that such testimony would get the patient to the jury. The physician could not avoid this possibility by including a provision in the written contract prohibiting oral modifications, since such provisions are ineffectual. See 6 A. CORBIN, CORBIN ON CONTRACTS § 1295, at 206-08 (1962). Further, if the medical profession were to standardize the contractual relations with patients to exclude express promises of particular results, courts might develop a hostile attitude toward such standard contracts, as they have begun to do with consumer contracts generally. See generally D. RICE, CONSUMER TRANSACTIONS 425-80 (1975).

⁹⁵ Note, *Express Contracts to Cure: The Nature of Contractual Malpractice*, 50 IND. L.J. 361, 377 (1975).

three sorts of corroborative evidence, only the third would have an impact in cases like *Guilmet*. It is difficult to predict how over a range of cases the requirement of a witness other than the plaintiff would work. Typically, the doctor will discuss the patient's ailment only with the patient, or with members of his family. If the patient is the only one present when an express promise is made, for all practical purposes he will never get to the jury on a contract theory. Members of the patient's family arguably ought not to suffice as witnesses, for their testimony would not seem qualitatively superior to the patient's uncorroborated testimony, as they are likely to put the same contractual gloss on the physician's assurances as would the patient himself. Further, whether a third person is present when an express promise is made may be largely a matter of chance, and courts may not wish to allow the decision to send cases to the jury to hinge on such a fortuity. Finally, a physician may be able to avoid liability simply by making no assurances of any kind except when he is alone with the patient.

In any event, the proposals that the plaintiff must have independent, corroborative evidence suggest the hard choice that courts must make when confronted with an increasing number of claims based upon breach of express promise of specific results. Courts, absent legislation,⁹⁶ are likely to have to choose an approach under which plaintiffs with such claims will almost always get to the jury,⁹⁷ or under which they almost never will. Reliance on self-screening by patients is likely to be misplaced, not so much because of the danger that they will lie, but because they are, given the hope of a cure, likely to interpret an opinion as a promise. Cases in which the patient will admit that the opinion was carefully circumscribed are unlikely to be brought at all. Although courts in other states have shown no inclination to follow the Michigan lead,⁹⁸ it is still too early to predict with confidence how the law will develop. However, if courts see a continued erosion of confidence in the medical profession, liability based upon express promises of specific

⁹⁶ See IND. CODE § 16-9.5-1-4 (Burns Supp. 1975), and LA. SESSION LAWS, Act 817 § 1C (Regular Sess. 1975), which bar imposition of liability for breach of warranty of specific results unless the contract is in writing and signed by the physician.

⁹⁷ The case of getting to the jury under *Guilmet* is illustrated by *Marchlewicz v. Stanton*, 50 Mich. App. 344, 213 N.W.2d 317, 319 (1973):

Plaintiff testified that he was told by [defendant] that the arthroplasty would eliminate any pain from his hip and that he would be normal and back to work within six to eight months. [Defendant's] recollection of this conversation was substantially different. Under *Guilmet*, the determination of whether an express promise was made lies solely with the jury.

213 N.W.2d at 319.

⁹⁸ See *Herrera v. Roessing*, 533 P.2d 60 (Colo. App. 1975); *Rogala v. Silva*, 16 Ill. App. 3d 63, 305 N.E.2d 571 (1973); *Karriman v. Orthopedic Clinic*, 516 P.2d 534 (Okla. 1973); *Sullivan v. O'Connor*, — Mass. —, 296 N.E.2d 183 (1973).

results will be a tempting vehicle to achieve increased legal accountability of the profession without abrogating the medical custom rule.

Proof of Negligence Without Expert Testimony

Since the standard of care in a malpractice case is determined by medical custom, it follows that the plaintiff should be able to establish negligence only by producing expert medical testimony as to what the custom is. Without such proof, there would be no standard against which to measure the conduct of the defendant. However, it is generally accepted that in some circumstances the plaintiff can establish negligence without expert testimony. The primary doctrine courts have used to dispense with the requirement of expert testimony is *res ipsa loquitur*.⁹⁹ This doctrine developed as a means of permitting a plaintiff to establish negligence in the absence of evidence which describes with particularity the defendant's conduct upon which the determination of the negligence issue is ordinarily made. The requirements for the application of *res ipsa loquitur* are usually described as: (1) the event resulting in the plaintiff's injury must be one which ordinarily is caused by someone's negligence; (2) the defendant must have been in exclusive control of the instrumentality or conduct causing the injury; and (3) the conduct of the plaintiff must not have contributed to the injury.¹⁰⁰

In medical malpractice cases, it is the first of these requirements that permits a plaintiff to establish negligence without expert testimony as to the medically accepted standard of care.¹⁰¹ This requirement is satisfied if the judge determines that it is a matter of common knowledge that the injury would not have occurred absent negligence by the defendant.¹⁰² Since most aspects of medical practice are not within the knowledge of lay persons, reliance on *res ipsa loquitur* is not likely to be successful very often.¹⁰³ Plaintiffs are most likely to succeed in cases

⁹⁹ Whether *res ipsa loquitur* is a doctrine of substantive law, a rule of evidence, or a form of circumstantial evidence, is the subject of some disagreement. See 2 S. SPEISER, *THE NEGLIGENCE CASE—RES IPSA LOQUITUR* 12-15 (1972).

¹⁰⁰ W. PROSSER, *HANDBOOK OF THE LAW OF TORTS* 214 (4th ed. 1971). A fourth requirement—that the evidence which would explain the event is accessible to the defendant but not the plaintiff—is sometimes added. *Id.*

¹⁰¹ The second requirement—that of exclusive control—is also important in some medical malpractice cases, although it does not relate to the standard of care. *Res ipsa loquitur* has been applied against multiple defendants in the absence of evidence as to which defendant caused the plaintiff's harm. The leading case is *Ybarra v. Spangard*, 25 Cal. 2d 486, 154 P.2d 687 (1944). See also *Anderson v. Somberg*, 67 N.J. 291, 338 A.2d 1 (1975), *cert. denied*, 96 S.Ct. 279 (1975).

¹⁰² See J. WALTZ & F. INBAU, *supra* note 1, at 90.

¹⁰³ In the period 1950-1971, *res ipsa loquitur* was a significant issue to the outcomes of 8 percent of the medical malpractice cases appealed. Dietz, Baird & Berul, *supra* note 87, at 130. In a survey of 15 states, plaintiffs won 56.3 percent of the appeals in which *res ipsa loquitur* was the most significant issue during this period. *Id.* at 142.

involving a foreign object, such as a sponge, left in the patient's body after surgery, burns from equipment, infections from unsterilized equipment, misuse or slipping of instruments, and injuries outside the immediate area of surgery.¹⁰⁴

Whether knowledge that a particular injury would not occur without negligence on the defendant's part is common enough to warrant the application of *res ipsa loquitur* is a matter of judgment for the courts, and not for the medical profession. Thus, it is an issue that courts can manipulate to increase the legal accountability of physicians without expressly departing from the medical custom rule. Whether courts have engaged in such manipulation is difficult to determine. Certainly, many physicians think so, and lament the judicial expansion of the doctrine.¹⁰⁵ California seems to have carried the doctrine to its furthest point. In that state, a plaintiff is entitled to the benefit of *res ipsa loquitur* in cases in which there is a known risk of adverse consequences which rarely occur, and one of the consequences does occur.¹⁰⁶ Although Washington appears to have followed California in this regard,¹⁰⁷ most courts have held that the doctrine is not applicable in such cases, ruling that the occurrence of a rare adverse consequence is not in itself sufficient to justify an inference of negligence.¹⁰⁸

In theory, *res ipsa loquitur* does not permit the substitution of some jury created standard of care for that of the medical profession, but rather permits the jury, based on common knowledge, to find that the profession's own standard of care was not met. The reality is, however, that if courts expand the number of medical matters that are determined to be within the common knowledge of lay persons, juries will be able to impose liability without regard to the medical standard of care. Of course, *res ipsa loquitur* is not a theory of strict liability, and defendants have the opportunity to present evidence that the standard

¹⁰⁴ J. WALTZ & F. INBAU, *supra* note 1, at 107. For a somewhat different listing, see 1 D. LOUISELL & H. WILLIAMS, *MEDICAL MALPRACTICE* 439-41 (1973).

¹⁰⁵ See Dissenting Statement of Charles A. Hoffman, M.D., *REPORT* at 113, 122.

¹⁰⁶ See, e.g., Cline v. Lund, 31 Cal. App. 3d 755, 107 Cal. Rptr. 629 (1973) (death following hysterectomy). *Res ipsa loquitur*, California style, is analyzed in Adamson, *Medical Malpractice: Misuse of Res Ipsa Loquitur*, 46 MINN. L. REV. 1043 (1962); Comment, *Res Ipsa Loquitur: Its Place in Malpractice Litigation*, 8 U. SAN FRAN. L. REV. 343 (1973).

¹⁰⁷ See Douglas v. Bussabarger, 73 Wash. 2d 476, 438 P.2d 829 (1968) (paralysis of legs following spinal anesthesia); Younger v. Webster, 9 Wash. App. 87, 510 P.2d 1182 (1973) (loss of sensory perception in lower half of body following spinal anesthesia).

¹⁰⁸ See, e.g., Riedisser v. Nelson, 111 Ariz. 542, 534 P.2d 1052 (1975) (development of fistula following hysterectomy); Coleman v. Garrison, 327 A.2d 757 (Super. Ct. Del. 1974) (failure of sterilization operation to sterilize); Perin v. Hayne, — Iowa —, 210 N.W.2d 609 (1973) (vocal chord damage during cervical fusion surgery); Funke v. Fieldman, 212 Kan. 524, 512 P.2d 539 (1973) (nerve damage following spinal anesthesia); Louis v. Parchman, 493 S.W.2d 310 (Tex. Civ. App. 1973) (peroneal palsy after hysterectomy).

of care was complied with.¹⁰⁹ But even if the defendant does offer testimony, which is not otherwise controverted by the plaintiff, that he conformed to the medically approved procedure, the plaintiff may still get to the jury on the negligence issue.¹¹⁰ It is thus clear that an expansive use of *res ipsa loquitur* is a method by which courts can accomplish, by the back door, at least a partial abrogation of the medical custom rule. With a few exceptions, however, courts on balance seem to have confined *res ipsa loquitur* within its traditional boundaries in medical malpractice litigation. Nevertheless, the doctrine has a significant potential as a device to impose non-medical standards on the medical profession.

THE FUTURE OF *Helling v. Carey*

Given the development of the various doctrines and techniques discussed above by which courts have expanded the legal accountability of physicians for harm caused by medical treatment, it might be argued that the next logical step would be for courts to follow *Helling v. Carey* and abrogate the medical custom rule. However, any broad judicial rejection of the medical custom rule will almost certainly prove to be unfair and unworkable because the nature of the process of resolving torts disputes makes it an unsatisfactory one for setting standards of medical care.

Negligence cases come in an almost infinite variety of largely non-recurring fact patterns. Thus, the outcome of any case tells us little more than what a particular judge's or jury's opinion is as to what the defendant ought not to have done under the particular circumstances of that case. Thus, the outcomes are not likely to have much impact on how people behave. To the extent that fact patterns do tend to recur, the applicable standards of conduct are likely to come from criminal statutes,¹¹¹ which will have a much greater impact on behavior than will the torts process. Furthermore, the general public is not likely to hear very much about the outcomes of negligence actions in any event. For these reasons, negligence litigation is not a particularly effective vehicle by which to deter negligent conduct in a specific way.¹¹²

¹⁰⁹ See J. WALTZ & F. INBAU, *supra* note 1, at 106-07.

¹¹⁰ See, e.g., *Cline v. Lund*, 31 Cal. App. 3d 755, 107 Cal. Rptr. 629 (1973); *Fogal v. Genesee Hosp.*, 41 App. Div. 2d 468, 344 N.Y.S.2d 552 (1973). This is the usual rule in non-medical *res ipsa loquitur* cases. See W. PROSSER, *HANDBOOK OF THE LAW OF TORTS* § 40, at 233-35 (4th ed. 1971).

¹¹¹ In most states, the violation of an applicable criminal statute is negligence per se. See W. PROSSER, *HANDBOOK OF THE LAW OF TORTS* § 36, at 200 (4th ed. 1971).

¹¹² The deterrent capacity of the traditional negligence system of allocating accident losses has been questioned by many writers. See, e.g., R. KEETON & J. O'CONNELL, *BASIC PROTECTION FOR THE ACCIDENT VICTIM* 253 (1965); D. KLEIN & J. WALLER, *CAUSATION*,

Medical malpractice litigation, however, differs in several respects from the general run of negligence cases. Fact patterns do recur—otherwise there would be no customary methods of practice—and the medical profession is aware of and sensitive to the outcomes of malpractice cases. Thus, physicians are much more likely than the general public to take into account the outcomes of cases that evaluate their behavior and to attempt to comply with the law's edicts in an effort to avoid liability.¹¹³ But the process of adjudication of torts claims is an inherently irrational process to select as the means for imposing legal control on the methods of medical practice.

In the first place, the process is not calculated to indicate with clarity what reasonable care requires. In most negligence cases, a decision that the defendant was negligent tells him more about what he should not have done than what he should have done. There need be no consensus by the jury as to what reasonable care under the circumstances required so long as there is a consensus that the defendant did not meet any particular standard of reasonable conduct offered for consideration.¹¹⁴ Moreover, even if the evidence in a particular case suggests only one alternative to the defendant's conduct, a decision to send the case to the jury gives the jury the discretion to stamp the defendant's conduct as either reasonable or unreasonable. For these reasons, the same medical practice may be found to be negligent in some cases, but reasonable in others. To those not versed in the intricacies of the law, this will only seem whimsical, arbitrary, and unfair.

Even if the arbitrariness of outcomes could be ameliorated or eliminated by making the issue of the reasonableness of medical custom an

CULPABILITY AND DETERRENCE IN HIGHWAY CRASHES 137 (1970); James & Dickerson, *Accident Proneness and the Law*, 63 HARV. L. REV. 769 (1950). Those who argue that tort law does have a deterrent effect do so not so much because it has a specific impact on behavior but because it contributes to an overall sense of social responsibility. See Lawton, *No-Fault: An Invitation to More Accidents*, 55 MARQ. L. REV. 73 (1972); Mancuso, *The Utility of the Culpability Concept in Promoting Proper Driving Behavior*, 55 MARQ. L. REV. 85 (1972).

¹¹³ Liability insurance does not take the sting out of a judgment. Given the dramatic rise in malpractice insurance rates, see NEWSWEEK, June 9, 1975, at 58-60, doctors are more aware than most liability insureds of the impact of liability on premiums. Further, doctors feel they have a stake in malpractice claims for reasons that transcend economics. See Dissenting Statement of George Northrup, D.O., in REPORT 105, 106: "Community reputation is a socioeconomic asset for a physician. The malpractice problem he believes, tends to destroy this. His self-interest, if you want to call it that, and his reputation and credibility is a far greater personal concern to the physician than the availability of professional liability insurance and its cost." For this reason, doctors take a more active part in the processing of liability claims than do other liability insureds, and many policies prohibit settlement of a claim without the doctor's consent. See Brant, *Medical Malpractice Insurance: The Disease and How to Cure It*, 6 VALPO. U.L. REV. 152, 162-63 (1972).

¹¹⁴ See 2 F. HARPER & F. JAMES, THE LAW OF TORTS 963-66 (1956).

issue of law for judges in all cases,¹¹⁵ the judicial process is not institutionally suited to the evaluation of medical custom. *Helling* itself furnishes a good example. There the court indicated that the omitted test for glaucoma is harmless, reliable, and inexpensive.¹¹⁶ However, none of these assumptions may be accurate. The test is not always a reliable indicator of the presence of glaucoma, and it may cause injury to the eye.¹¹⁷ And it is inexpensive only when viewed in isolation. The test for glaucoma is only one of what is no doubt a large number of diagnostic tests which the medical profession does not administer unless special circumstances indicate that they should be.¹¹⁸ If physicians perceive *Helling* as requiring the administration of any test that by itself is inexpensive—and whether considered by itself any test is inexpensive is a value judgment—the cost of medical treatment could rise substantially.¹¹⁹ Whether a particular course of medical diagnosis or treatment should be followed is a problem that calls for the weighing of often conflicting values, such as cost, safety and effectiveness. Courts, acting in

¹¹⁵ The supreme court in *Helling* did rule that the failure to administer the glaucoma test was negligence as a matter of law, but did not suggest that in all cases the determination of the particular standard of care would be for judges and not juries. Such an approach would, of course, do violence to the traditional division of functions between judge and jury.

¹¹⁶ 83 Wash. 2d at 518, 519 P.2d at 983.

¹¹⁷ See Bradford, *A Unique Decision*, 2 J. LEGAL MED. 52 (Sept.-Oct. 1974). It is somewhat puzzling that the defendants in *Helling* did not introduce evidence contrary to the court's assumptions about the test. Perhaps they relied on the continued applicability of the medical custom rule, and felt that such evidence would be irrelevant.

¹¹⁸ The author of Comment, *The Role of Custom in Medical Malpractice Litigation*, 55 B.U.L. REV. 647 (1975), argues for the imposition of liability whenever an omitted diagnostic test is "simple, inexpensive, conclusive and harmless," *id.* at 662, but criticizes the court in *Helling* for not remanding the case for a hearing on these issues. The flaw in this approach is, of course, that it invites judicial evaluation of each test in isolation. Furthermore, the approach does not appear to recognize customary allocations of responsibility among fields of medical practice. Assuming that it is judicially determined that the test for glaucoma meets the requirements, would that test have to be administered by a general practitioner in the course of a routine physical examination? Or would an ophthalmologist, on pain of liability, have to take the blood pressure of each patient as part of an eye examination? If courts can be persuaded to reject custom and to approach each test in isolation, there would seem to be no reason in policy why all doctors ought not to administer all tests judicially determined to be cost, or largely cost, free.

¹¹⁹ Bradford, *supra* note 117, suggests that doctors ought not to be influenced by *Helling* and led to practice "defensive medicine"—the engaging in medical practices not because they are medically justified but to forestall malpractice claims—but to continue to practice as good medicine requires. The extent to which doctors practice medicine defensively is not clear. There is, however, substantial evidence that defensive medicine is practiced, and that it adds to the cost of medical treatment. See Bernzweig, *Defensive Medicine*, REPORT, Appendix 38; *Project—The Medical Malpractice Threat: A Study of Defensive Medicine*, 1971 DUKE L.J. 939.

Ophthalmologists in other states who are aware of *Helling* will not know how to practice defensively. If the test is administered and causes harm, the doctor runs the risk of liability for using a non-customary test. If the test is not administered, he runs the risk that the court will impose liability for not doing so.

an ad hoc, case by case fashion lack the institutional competence to decide for the medical profession that every patient complaining of a headache should be treated as a potential brain tumor case, or that every patient who needs glasses should be treated as a potential glaucoma case. Courts, in short, lack the institutional competence to establish standards of good medical practice.¹²⁰

However, the other methods by which courts have expanded the legal accountability of physicians have not, by and large, taken courts beyond their traditional institutional limitations. The abrogation of the locality rule still leaves the determination of standards of medical treatment to the profession. The emerging rules relating to informed consent to treatment place the burden of choice as to whether a patient should undergo a particular course of treatment on the patient, but do not subject the methods of treatment to non-professional evaluation. Liability based upon breach of express contract involves only the comparison of the promised with the actual results of treatment. A vigorous and expanded use of *res ipsa loquitur* would involve judicial setting of medical care standards, but, with some exceptions, *res ipsa* has not been so used.

Apart from any question about the institutional suitability of courts to act as overseers of standards of medical treatment, the increased interest of legislatures in the quality and cost of medical care in general, and in malpractice actions in particular, should give courts reason to pause before tinkering very much with the existing law. A considerable variety of legislation intended to come to grips with these problems has already been enacted. The 1972 amendments to the Social Security Act¹²¹ establishing Professional Standards Review Organizations reflect the concern at the Congressional level.¹²² Several states have enacted legislation dealing more directly with malpractice litigation,¹²³ and in at

¹²⁰ See note 8 *supra* & text accompanying.

¹²¹ 42 U.S.C. §§ 1320c-c19 (Supp. II, 1972).

¹²² It is too early to tell how effective PSROs will be. There has been extensive analysis of the legislation, however. See, e.g., Boikess & Winsten, *Can PSRO Procedures Be Both Fair and Workable?*, 24 CATH. U. OF AM. L. REV. 407 (1975); Havighurst & Blumstein, *Coping with Quality/Cost Trade-Offs in Medical Care: The Role of PSROs*, 70 NW. U.L. REV. 6 (1975); Comment, *PSRO: Malpractice Liability and the Impact of the Civil Immunity Clause*, 62 GEO. L.J. 1499 (1974); Note, *Federally Imposed Self-Regulation of Medical Practice: A Critique of the Professional Standards Review Organization*, 42 GEO. WASH. L. REV. 822 (1973-1974).

¹²³ See e.g., IND CODE § 16-9.5-1-1 et seq. (Supp. 1975); LA. SESSION LAWS 324, 371, 477, 527, 600, 674, 697, 798, 807, 817 (Regular Sess. 1975). Both of these legislative packages deal with a wide variety of matters relating to malpractice claims. For surveys of legislative activities in general, see *Legislators React to the Malpractice Problem*, 3 J. LEGAL MED. 30 (May 1975); *State Legislatures Address the Medical Malpractice Situation*, 3 J. LEGAL MED. 25 (Sept. 1975).

least two states the medical custom rule is now a matter of statutory command.¹²⁴ Even more fundamental than these changes are proposals to eliminate the traditional negligence system of compensation for medical injuries and to replace it with a system of no-fault insurance.¹²⁵ One such plan has already been introduced in Congress.¹²⁶ While it is too early to tell whether a no-fault scheme will be legislatively adopted,¹²⁷ or whether the recent legislation will prove to be adequate, the current legislative interest and action does suggest that there is at present no compelling need for courts to go beyond the traditional torts rules they have developed within the negligence system.

This is not to suggest that courts should always defer to legislatures in matters of tort law reform.¹²⁸ But in the end, the problem of medical care quality defies rational solution by courts. Courts, of course, have a role to play, within the confines of the traditional negligence system, in allocating losses resulting from harm suffered in the course of medical treatment. While the wisdom of some of the doctrines and techniques courts have developed to accomplish this result may be debatable, courts have generally functioned within their traditional limitations by refusing to become engaged in the establishment of standards of medical practice. If courts were to become so engaged, one likely result would be an increase in the cost of medical care with no assurance of a parallel increase in quality. Thus, any effort by courts to supervise the customary methods of medical practice is apt to be self-defeating.

¹²⁴ Louisiana, see statutes cited in note 59 *supra*; Washington, see statute cited in note 2 *supra*.

¹²⁵ See, e.g., Carlson, *A Conceptualization of a No-Fault Compensation System for Medical Injuries*, 7 LAW & SOC. REV. 329 (1973); Ehrenzweig, *Compulsory "Hospital Accident" Insurance: A Needed First Step Toward the Displacement of Liability for "Medical Malpractice,"* 31 U. CHI. L. REV. 279 (1964); Havighurst & Tancredi, *"Medical Adversity Insurance"—A No-Fault Approach to Medical Malpractice and Quality Assurance*, 1974 INS. L.J. 69; O'Connell, *Expanding No-Fault Beyond Auto Insurance: Some Proposals*, 59 VA. L. REV. 749 (1973).

¹²⁶ S. 215, 94th Cong., 1st Sess. (1975).

¹²⁷ There are enough differences between the automobile accident problem and the medical injury problem to make it likely that the proponents of medical no-fault will have to make out an independent case. See Keeton, *Compensation for Medical Accidents*, 121 U. PA. L. REV. 590 (1973). A concurring opinion in *Helling v. Carey* suggested that liability in that case should be based upon strict liability, rather than upon negligence, 83 Wash. 2d at 520-22, 519 P.2d at 984-85, although it is impossible to determine from the opinion when it would be appropriate to impose such liability. See also *Clark v. Gibbons*, 66 Cal. 2d 399, 414, 58 Cal. Rptr. 125, 135, 426 P.2d 525, 535 (1967) (Tobriner, J., concurring).

¹²⁸ As to the relative roles of courts and legislatures in the formulation of new tort rules, see R. KEETON, *VENTURING TO DO JUSTICE* 3-24 (1969); Peck, *The Role of the Courts and Legislatures in the Reform of Tort Law*, 48 MINN. L. REV. 265 (1963); *Comments on Maki v. Frelk—Comparative v. Contributory Negligence: Should the Court or Legislature Decide?*, 21 VAND. L. REV. 889 (1968).

If confidence in the medical profession has degenerated to the point that it cannot be trusted to establish adequate standards of patient safety, legislatures are more suited than courts to perform the function of bringing the standards up to an acceptable level.¹²⁹ No case has been made that courts should abandon their traditional limitations and take on this function. A healthy respect for the limits of adjudication as a means of coping with the problems of medical care quality suggests that they not do so. The future of *Helling v. Carey* ought to be a dim one.

¹²⁹ It is interesting to note that while the current legislative enactments and proposals alter the process by which malpractice claims are handled, or make some changes in the substantive rules by which liability is determined, or even change the basis of liability, no proposed legislation with which I am familiar has called for lay establishment of standards of medical care.