

THE MEDICAL MALPRACTICE STANDARD OF CARE: HMOs AND CUSTOMARY PRACTICE*

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INTRODUCTION

Medical care is a risky business. Health care providers risk their reputations and malpractice suits, but patients run the principal risks, namely that medical care may fail to achieve the expected improvement or may cause some new harm. Some risk is of course inescapable because it is inherent in the very nature of the medical enterprise—

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THE FOLLOWING CITATIONS WILL BE USED IN THIS ARTICLE:

- A. HOLDER, *MEDICAL MALPRACTICE LAW* (1975) [hereinafter cited as HOLDER];
- D. LOUISELL & H. WILLIAMS, *MEDICAL MALPRACTICE* (1973) [hereinafter cited as LOUISELL & WILLIAMS];
- W. PROSSER, *HANDBOOK OF THE LAW OF TORTS* (4th ed. 1971) [hereinafter cited as PROSSER];
- U.S. DEP'T OF HEALTH, EDUCATION AND WELFARE, *REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE* (1973) [hereinafter cited as *MEDICAL MALPRACTICE REPORT*];
- McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549 (1959) [hereinafter cited as McCoid].

that enterprise being the attempt to alter already present hazards of undesirable outcomes by sometimes drastic means whose effectiveness and safety are often uncertain. But health care providers, by providing additional services or by taking further precautions, can frequently avoid or reduce many, perhaps most, medical hazards—although at some cost in resources and in new risks created.

Not all avoidable risks should be avoided, however, since many are very unlikely either to occur or to cause significant harm, and the resources that would be consumed to avoid them always have valuable applications elsewhere. Individuals and society must somehow decide how much medical risk reduction is appropriate, given the alternatives, their costs, and the relative values of the expected outcomes. The law of medical malpractice exerts a large and apparently growing influence on the risk reduction actually undertaken by medical care providers.

One kind of provider, the Health Maintenance Organization, or HMO,¹ is especially well suited to weigh all relevant factors in deciding how, and how much, to reduce the medical risks faced by its enrollee-patients. HMOs' distinguishing characteristic is that they undertake to provide all the medical care their enrollees need in exchange for fixed, advance capitation payments. Precisely because they must provide comprehensive care from an inelastic pool of resources, HMOs are well motivated to scrutinize the effectiveness of every risk-reducing measure they might take. Moreover, because their responsibility for care is comprehensive and because their organization usually allows them to provide more integrated services than most other providers, HMOs are well situated to compare each possible risk reduction with other uses of the available resources and to choose the most productive course of action.

In these respects, HMOs stand in distinct contrast with the dominant mode of American medical practice, fee-for-service, wherein patients (or governmental or private financing mechanisms) pay for each service rendered by a variety of independent providers (doctors,

1. The term "HMO" was coined by Dr. Paul Ellwood, Jr., and his colleagues at the Institute for Interdisciplinary Studies (InterStudy) in Minneapolis and adopted by the Nixon Administration for several policy proposals. See, e.g., Ellwood, Anderson, Billings, *et al.*, *Health Maintenance Strategy*, 9 MED. CARE 291 (1971). InterStudy's definition ensures that HMOs will have the risk-evaluation incentives discussed here.

An HMO is an organization in which the HMO itself and/or participating physicians accept contractual responsibility to assure the delivery of a stated range of health services, including at least ambulatory and in-hospital care to a voluntarily enrolled population in exchange for an advance capitation payment (and assumes at least part of the financial risk and/or shares in the surplus for the delivery of ambulatory and hospital services). HEALTH SERVICES INFORMATION, Oct. 20, 1975, at 2.

hospitals, and so on). Unlike HMOs, fee-for-service providers have only weak financial incentives to weigh costs in evaluating possible risk-reducing measures, since neither they nor their patients are able to apply insurance money saved in one area to other, more productive uses. Nor does the fee-for-service providers' organization usually enable them to compare directly the value of a wide range of different health-promoting services and to implement their evaluations in practice.

How medical care providers approach risk-reduction decisions is very important in understanding the law of medical malpractice. Malpractice law does not purport independently to assess the reasonableness of risky behavior in order to determine the optimal levels of risk avoidance and risk acceptance, but instead enforces a standard of care derived almost entirely from the customary practice of providers themselves. In drawing its standard of care from the usages of the medical services market, the law may inadvertently perpetuate or exacerbate the deficiencies of that market in assessing the appropriate level of expenditures on risk reduction.

Although in a perfect world such customary practice might acceptably approximate the social optimum by aggregating the risk-assessing wisdom of informed individuals, in reality malfunctions of the marketplace for medical services may make this standard socially inappropriate as a guide to proper practice. Whereas the legal standard made sense when providers or their paying patients regularly had to assess risk-reducing measures in terms of their costs and the value of results achieved in establishing patterns of conduct, the customary practice standard of care has become increasingly inappropriate as third-party payment has subtly changed medical practice by gradually eroding the system's cost-consciousness. The apparent result has been a contemporary standard of care that exposes to substantial legal risks any provider who fails to imitate existing patterns of care, thus aggravating an already serious tendency of medical care providers to adopt even more procedures without careful consideration of the expense and results involved. Many providers, indeed, are said to practice "defensive" medicine in response to this perceived legal threat, performing extra tests and taking additional precautions prompted more by legal fears than by medical expectations.

This Article deals with the specific problem that legal enforcement of customary practice standards derived from fee-for-service norms may discourage innovative HMO practice based upon a different and possibly more accurate evaluation of the costs or risks involved or em-

ploying a different method of achieving similar risk reduction. Such a push to HMO conformity may in turn eliminate the healthy economic and philosophic competition between different medical approaches which might otherwise develop between HMO and fee-for-service providers. Related problems of the medical custom standard include undue judicial concentration on determining what medical methods are customary, to the exclusion of judging the risk reduction and results actually achieved; excessive penalties for nonconformity alone, without regard to comparative costs and results; and inappropriate consideration of medical risk reduction problems in isolation from one another. These shortcomings not only pose malpractice problems for HMOs but also show how difficult it is—especially within the confines of the current legal approach to medical injuries—to weigh all relevant considerations in attempting to determine the socially optimal level of medical risk reduction.

THE APPLICATION OF MALPRACTICE LAW TO HMO CARE

A. *HMOs' Structure, Incentives, and Contribution to Health Care Delivery*

Because HMOs must finance all needed care from the limited budget supplied by enrollee capitation payments,² they are highly motivated to count costs, as well as risks and results, in deciding what care to provide.³ The financial exigencies of prepayment engender strong

2. Though all HMOs meeting the InterStudy definition, see note 1 *supra*, provide very comprehensive care for the basic prepaid premium, HMOs do not provide literally one hundred percent of medical needs without further charge. There are often coverage limitations, though fewer than are common in conventional insurance policies; for example, many HMOs do not provide free drugs. *E.g.*, U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE, BUREAU OF COMMUNITY HEALTH SERVICES, INCLUSION OF PHARMACEUTICAL SERVICES IN HEALTH MAINTENANCE AND RELATED ORGANIZATIONS: A REVIEW OF SUPPLEMENTAL BENEFITS (DHEW Pub. No. (HSA)74-13017, 1974). Moreover, HMOs' subscribers may have to make nominal additional payments for some services. Note, *The Role of Prepaid Group Practice in Relieving the Medical Care Crisis*, 84 HARV. L. REV. 887, 902-03 & n.4 (1971).

3. There are many variations on the basic HMO theme, with considerable diversity in comprehensiveness of coverage, integration of services, and organization of affiliated provider groups. See, *e.g.*, Prussin, *HMOs: Organizational and Financial Models* (pts. 1-3), 55 HOSP. PROGRESS 33 (Apr. 1974); *id.* at 56 (May 1974); *id.* at 60 (June 1974). The character and strength of HMO economizing and risk-evaluating activities may vary accordingly.

Organizationally, HMOs may be either prepaid group practices (PGPs), of which the best known example is probably the Kaiser-Permanente plan, or foundations for medical care (FMCs), of which the archetype is the San Joaquin, California, FMC. See, *e.g.*, Egdahl, *Foundations for Medical Care*, 288 NEW ENG. J. MED. 491 (1973); Phelan, Erickson & Fleming, *Group Practice Prepayment: An Approach to Delivering*

incentives for HMOs continually to weigh the medical effectiveness and value of their expenditures and to curb, for example, superfluous x-rays and other tests.⁴ Their resource constraint and duty to serve an entire population also encourage HMOs both to maintain enrollees' health, through education and preventive medicine wherever cost-effective, and to find and treat health problems before they become acute and require still more expensive measures, for which HMOs cannot be reimbursed. The comprehensiveness and integration of their services give HMOs numerous occasions to evaluate alternatives in seeking to achieve maximum health benefits for given expenditures⁵—for ex-

Organized Health Services, 35 LAW & CONTEMP. PROB. 796 (1970).

The merits of PGPs versus FMCs in their various incarnations have been debated elsewhere, and the respective virtues of the two forms of medical organization are not relevant here. At issue here are the extent to which HMOs' efficiency incentives lead them to create patterns of resource use and styles of care different from those of the fee-for-service system and the implications of these differences for medical malpractice. Either PGP or FMC organization may raise these issues; the remainder of this Article does not generally distinguish between the two, except where the implications of the differences are major.

4. The degree of risk to which the HMO is subjected for financial losses from overutilization of health care services may vary among HMOs. The way in which HMOs translate their institutional economizing incentives into decision-making rules for the doctors actually providing and ordering the services also varies. PGP doctors are usually salaried; they have no incentive to provide extra services of only marginal risk-reducing value, because their income is not increased by doing so. Roemer, *On Paying the Doctor and the Implications of Different Methods*, 3 J. HEALTH & SOCIAL BEHAVIOR 4, 11 (Spring, 1962). Their positive incentive to economize comes from the identification of their future prosperity with that of the PGP, the ability to use savings from reduction in utilization for other services, and review of their care. FMC doctors are paid a fee for each service rendered and thus retain the usual fee-for-service incentive to increase their income by providing ever more services. However, FMC peer review must pass on the value of many services provided and, if charges exceed revenues, some FMCs' doctors' fees may be retroactively reduced. These factors motivate FMC physicians to weigh costs. Egdahl, *supra* note 3, at 492, 495. FMC doctors' cost-controlling incentives are probably weaker than those of PGP providers because they are imposed by outside review rather than by the nature of the financing and because FMC doctors typically retain a considerable outside practice, from which habits for serving insured fee-for-service patients probably carry over into their FMC practice. These different FMC and PGP arrangements may nevertheless have similar practical effects, and it is acceptable to speak generally of HMO cost-counting incentives regardless of their exact strength or their method of implementation.

5. Prepayment might instead motivate HMOs to maximize, for example, their own profits or their personnel's salaries rather than enrollees' health. See note 9 *infra*. Having to pay for all needed care, including that necessitated by their own neglect or ineffective treatment, provides some protection against tendencies toward underservice. Other protections include subscribers' ability to detect underservice, professional ethics, some government regulations, and, of course, malpractice liability. The point is to create malpractice incentives to deal with underservice without, in the process, inappropriately interfering with HMOs' desirable ability to count costs in evaluating what care to provide.

ample, by replacing physicians' services with nonphysician care when appropriate, or by substituting outpatient for expensive inpatient care.⁶ HMOs' scope and integration also enable them to maintain unified medical records, which can save time and resources as well as avoid needless exposure to the hazards of inaccuracy and of duplicative or incompatible diagnostic or therapeutic procedures. HMOs' multiprovider organization also facilitates quality control through consultation, referral, peer review, and other mechanisms,⁷ while the lack of charges for each service saves administrative costs, eases access to medical care, and encourages subscribers to make full and early use of their HMO's services.⁸

HMOs are not perfect, however. Their budget constraint and lack of fee-for-service inducement to provide care can lead to overeconomizing and neglect of valuable opportunities to reduce patients' risks.⁹ Moreover, HMOs may feature some disadvantages of large-scale organization, including reduced responsiveness to individual needs.¹⁰ Finally, HMOs do not appeal to all health care consumers; despite much attention from health policy analysts, many HMOs have had difficulty attracting enrollees and surviving in the medical services marketplace.¹¹

Nonetheless, there is substantial evidence that most prepayment plans in fact provide comprehensive care which is of low risk and high

6. This factor is stronger among the more tightly integrated HMOs. FMCs do not typically build their own outpatient clinics, for example, but depend instead on existing facilities. FMC providers may thus not be able to perform certain procedures outside rather than inside hospitals. Similarly, small PGPs may rely more heavily on inpatient services than those which are larger and more comprehensive. HMOs may still be said generally to offer wide opportunity for different allocations of medical resources, though the exact situation varies from HMO to HMO.

7. See, e.g., P. ELLWOOD, P. O'DONOGHUE, W. McCLURE, R. HOLLEY, *et al.*, ASSURING THE QUALITY OF HEALTH CARE 21-22 (1973); Greenlick, *The Impact of Prepaid Group Practice on American Medical Care: A Critical Evaluation*, 399 ANNALS 100 (1972); Institute of Medicine, Nat'l Academy of Science, HMOs: Toward a Fair Market Test 52 (policy statement, May, 1974).

8. The impact of these factors may be reduced by increased waiting time for medical attention in some HMOs. H. SCHWARTZ, THE CASE FOR AMERICAN MEDICINE 180-81 (1972).

9. The extreme example would be allowing a patient to die rather than to undertake an expensive and perhaps uncertain treatment. See, e.g., H. SCHWARTZ, *supra* note 8, at 177. The worst HMO abuses are likely to occur in plans serving the least-informed consumers, especially under conditions of government financing. See, e.g., Schneider & Stern, *Health Maintenance Organizations and the Poor: Problems and Prospects*, 70 NW. U.L. REV. 90 (1975). See note 5 *supra*.

10. E.g., Phelan, Erickson, & Fleming, *supra* note 3, at 797-98.

11. It is not clear to what extent HMOs' difficulties in this regard are due to dissatisfaction of potential enrollees. Legal and professional restraints against HMOs

quality—and at a lower cost than fee-for-service care—by deviating from many standard practices of fee-for-service providers.¹² HMOs have therefore been seen by many observers as an important and salutary development in organizing health care services.¹³ HMOs' promise of improved access to and quality of care is important when many have come to speak of a "right" to health care,¹⁴ and HMOs' economizing abilities are important virtues at a time when health care consumes about one twelfth of the country's gross national product.¹⁵ In fact, HMOs may help economize on two levels: first, HMOs are motivated to strive for an efficient internal allocation of health-care resources, to maximize the productivity of the resources they control; second, HMOs may facilitate consumer valuation of health care as a whole in a way that even insured fee-for-service care cannot. By offering a very comprehensive health care package, HMOs enable subscribers to budget for medical care, to express their evaluation of the total worth to them of all medical services—compared with their other expenditures. To the extent that they are informed, subscribers' choice of an HMO may also indicate what customary level of risk-reducing measures they desire.¹⁶

Some HMO proponents emphasize HMOs' potential to improve access and to provide high-quality care at reasonable costs,¹⁷ whereas

and their physicians are also responsible. *Compare* Institute of Medicine, *supra* note 7, at 19-49, with H. SCHWARTZ, *supra* note 8, at 154-58.

12. NATIONAL ADVISORY COMMISSION ON HEALTH MANPOWER, REPORT 197-229 (1967); Donabedian, *An Evaluation of Prepaid Group Practice*, 6 INQUIRY 3 (Sept. 1969); Roemer & Shonick, *HMO Performance: The Recent Evidence*, 51 MILBANK MEMORIAL FUND Q. 271 (1973).

13. See, e.g., *Health Maintenance Strategy*, *supra* note 1; MacLeod & Prussin, *The Continuing Evolution of Health Maintenance Organizations*, 288 NEW ENG. J. MED. 439 (1973); Seward & Greenlick, *Health Policy and the HMO*, 50 MILBANK MEM. FUND Q. 147 (1972); Note, *The Role of Prepaid Group Practice in Relieving the Medical Care Crisis*, 84 HARV. L. REV. 887 (1971). See also sources cited in notes 17-18 *infra*. HMOs have also achieved federal recognition as a desirable innovation. See Health Maintenance Organization Act of 1973, 42 U.S.C. §§ 300e *et seq.* (Supp. III, 1973); *The President's Message to the Congress Proposing a Comprehensive Health Policy for the Seventies, February 18, 1971*, 7 WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS 244 (1971).

14. For example, Leonard Woodcock, President of the International Union, United Automobile Workers, has maintained that "every American has a right to quality health care services . . ." *Hearings on National Health Insurance Before the Senate Comm. on Finance*, 93d Cong., 2d Sess., at 145 (1974).

15. Worthington, *National Health Expenditures, 1929-74*, 38 SOCIAL SECURITY BULL. 3, 6, Chart 1 (Feb. 1975).

16. See note 119 *infra*. While a person's joining an HMO does indicate that the level of care it offers is satisfactory at that time, insofar as the subscriber can judge it, membership does not preclude a subscriber's purchasing outside medical services should the actual onset of illness or other circumstances change the subscriber's evaluation of HMO coverage or services.

17. These are typified by the supporters of the HMO Act of 1973, which mandates

others attach more importance to HMOs' cost savings—achieved at little or no sacrifice in quality—which may lead other providers to balance cost and quality more effectively, thus reducing total health care expenditures.¹⁸ In any case, HMOs' ability and incentives to evaluate and choose appropriately among different medical procedures are essential to their social value, and undue interference with these HMO attributes by malpractice law or otherwise¹⁹ would be unfortunate.

B. *HMOs' Approach to Medical Risk Evaluation*

If HMOs were unfettered by outside requirements, they could be expected to expend resources on risk reduction only until their expenditures could be used to achieve greater benefits in alternative uses, such as reducing other risks, expanding coverage, lengthening clinic hours, lowering premiums, and extending medical services in other ways.²⁰ Neither HMOs nor other providers, of course, have special expertise in valuing the increments of illness and health, injury and cure, pain and relief, disability and recovery, or death and life that are at stake in the risks they assess. Such valuations can come only from patients themselves or from courts or other governmental authorities acting on patients' behalf. Nonetheless, because they provide an entire population with comprehensive care, HMOs are uniquely qualified to choose the proper mix of medical inputs and processes²¹ for each

very comprehensive services for federally recognized HMOs. See, e.g., W. ROY, THE PROPOSED HEALTH MAINTENANCE ORGANIZATION ACT OF 1972 (1972); American Public Health Ass'n, *Health Maintenance Organizations: A Policy Paper*, 61 AM. J. PUB. HEALTH 2528 (1971).

18. See, e.g., Havighurst, *Health Maintenance Organizations and the Market for Health Services*, 35 LAW & CONTEMP. PROB. 716 (1970); McNeil & Schlenker, *HMOs, Competition, and Government*, 53 MILBANK MEMORIAL FUND Q. 195 (1975); Institute of Medicine, *supra* note 7.

19. One article, Havighurst & Bovbjerg, *Professional Standards Review Organizations and Health Maintenance Organizations—Are They Compatible?*, 1975 UTAH L. REV. 381, considers the likely impact on HMOs of a nonmalpractice set of standards—those of the federally mandated PSROs under the Medicare and Medicaid programs.

20. This behavior would characterize a rational HMO dedicated to maintaining the health of enrollees. But see notes 5 & 9 *supra*.

21. "Inputs" refers to the providers and facilities used in health care. "Processes" are the methods or specific procedures used by health care providers. An important reason why HMOs are uniquely qualified to determine the value of inputs and processes is that, as providers of comprehensive care to entire populations, they have the ability to gather the requisite data to determine medical effectiveness of different care, as individual providers do not. See, e.g., Brook, *Critical Issues in the Assessment of Quality of Care and Their Relationship to HMOs*, 48 J. MED. EDUC. 114, 132-33 (Apr. 1973).

type of case; that is, HMOs can equalize, within the limits of the state of the art, the marginal risks that subscribers face from all hazards and maximize the health benefits to subscribers for the amount of money they are willing to devote to health care services.²²

It may be argued that the level of care embodied in malpractice standards is not susceptible to such analytic trading off of risks because the incidence and severity of bad outcomes associated with any given risk-reducing measure are unpredictable at best and unavoidable at worst. Malpractice law indeed often purports to deal with slippery and seemingly nonquantifiable matters of risk reduction, such as whether a provider's skill is sufficient for a particular procedure or whether an apparent slip of a scalpel in a particular case was culpable carelessness or an unavoidable side effect of a difficult procedure. Nonetheless, much of malpractice law involves quite discrete and manageable concerns, such as whether particular diagnostic procedures should be undertaken or whether particular safety precautions are appropriate. Such matters clearly may be analyzed for medical and cost effectiveness, which HMOs are well equipped to undertake.

In reality, moreover, even risks seeming to involve simple personal carelessness are often not entirely of a different and unmanageable type, but can instead profitably be treated as the far end of the same continuum. Numerous measures might be taken to reduce the risk of virtually any untoward result, if only marginally, and these are subject to rational scrutiny as to their risk-reducing effectiveness, their cost, and their other consequences. Except in emergency cases, for example, consultation or supervision could be required, stricter diagnostic or therapeutic protocols might be established, and so forth. In any case, an HMO could hire additional personnel, or fee-for-service providers could accept fewer patients, so as to allow more time to be devoted

22. This is not meant to imply that HMOs always make optimal decisions, judging only cost and value to patients; factors other than the incentives engendered by a fixed budget and the necessity to please enrollees are also involved. For example, the common training and continued association of HMO and fee-for-service physicians are likely to influence the HMO approach to medical decision-making in the direction of majority practice. An HMO management's close ties with labor unions or dependence on them for enrollees may lead to exclusive use of union-made products or services, almost regardless of cost and quality concerns. Legal restrictions may play a part, as where licensing laws prevent doctors from delegating certain tasks to trained and efficient assistants who are not state-certified. Malpractice fears may also deter an HMO from instituting cost-justified innovations. Finally, and perhaps most importantly, limited knowledge (or the expense of learning more) may impede the optimizing of risk reduction. The important point is that HMOs, unlike almost any other providers, are well motivated and constituted to seek efficiency. It is not argued that they always succeed.

to individual cases, thus reducing the probability of inadvertent error. Similarly, more highly trained (or more experienced or more careful) personnel would presumably lower risks. All such measures—obviously accompanied by some monetary or other cost—would somewhat lessen the incidence of bad results and negligence. Admittedly, because of lack of knowledge, human imperfection, patient idiosyncrasies, or pure chance, some risk is irreducible regardless of the effort and resources expended. Such truly unavoidable risk, however, may be more appropriately considered within the domain of the doctrine of informed consent²³ than as a matter of the proper level of risk avoidance under the malpractice standard of care considered here, since by hypothesis no amount of care can reduce the risk. In any event, despite the irreducibility of some risks, there remains wide scope for HMOs, freed of pressure to conform to fee-for-service practices, to consider the value of particular risk-reducing actions.

C. *Malpractice Standards and HMOs*

Malpractice law has traditionally judged the behavior of medical care providers almost exclusively by the customary practice of their peers,²⁴ rather than by the usual standard of socially appropriate care—the behavior of a hypothetical “reasonable and prudent” man under the same or similar circumstances. Thus, only in rare cases (predominantly those where risk evaluations can arguably be made by laymen) do courts independently evaluate medical conduct.²⁵

The paradigm of the standard of care required of any medical care provider is that required of physicians, classically formulated as a duty to

23. Where economic or practical reasons make serious risks of medical intervention irreducible, doctors must so apprise their patients and obtain their consent to proceed before undertaking the intervention. See Note, *Informed Consent in Medical Malpractice*, 55 CALIF. L. REV. 1396 (1967); Note, *Informed Consent as a Theory of Medical Liability*, 1970 WIS. L. REV. 879. Where medical intervention cannot completely eliminate the bad result expected from the underlying condition, providers are also protected from liability by the rule that due care does not guarantee a cure. See, e.g., *Carl v. Matzko*, 213 Pa. Super. 446, 249 A.2d 808 (1968).

24. See, e.g., HOLDER 40-43, 53-55; 1 LOUISELL & WILLIAMS ¶ 8.04; McCoid 558-60; Note, *An Evaluation of Changes in the Medical Standard of Care*, 23 VAND. L. REV. 729 (1970).

25. Such cases include leaving a sponge inside a patient after an operation, surgically removing the wrong organ or part of the body, very incompetently setting a fracture, burning a patient with hot water bottles, and failing to sterilize instruments. See generally PROSSER 227-28; McCoid 621-31. In such cases, expert testimony showing deviation from customary practice is not required. Note, *Medical Specialist May Be Found Negligent as a Matter of Law Despite Compliance with the Customary Practice of the Specialty*, 28 VAND. L. REV. 441 (1975).

possess the learning and skill and to use the care and diligence of the ordinary practitioner in similar circumstances and to apply their best judgment on behalf of patients.²⁶ The standard does vary for different providers, regions, and circumstances. Practitioners have traditionally been held only to that level of care customary in their own or similar localities.²⁷ Where doctors differ as to what procedure is appropriate, physicians may depart from the majority's customary practice to follow that of a "reputable" or "respectable" minority of practitioners.²⁸ Further, those holding themselves out as specialists are held to the customary level of skill and care of their fellow specialists, presumed to be a higher standard than that of a general practitioner.²⁹

Malpractice law's enforcement of customary practice standards of care has gone beyond simple requirements that doctors perform their chosen treatments carefully, so as to avoid iatrogenic injury,³⁰ and now appears to govern the most basic decisions in medicine. Thus, a provider may be liable for failing to follow customary practice in making a diagnosis or in choosing a treatment,³¹ although proof of causal con-

26. See, e.g., *Pike v. Honsinger*, 155 N.Y. 201, 210, 49 N.E. 760, 762 (1898); 1 LOUISELL & WILLIAMS ¶ 8.04; McCoid 558-60. Successful suits are almost always founded on breach of the duty of care; it is extremely difficult to show lack of skill or knowledge or failure to use best judgment. 1 LOUISELL & WILLIAMS ¶ 11.05 & nn. 19-20.

27. E.g., 1 LOUISELL & WILLIAMS ¶ 8.06; Comment, *Standard of Care for Medical Practitioners—Abandonment of the Locality Rule*, 60 KY. L.J. 209 (1971); Comment, *A Review of the Locality Rule*, 1969 U. ILL. L.F. 96. Specialists are frequently held to a national rather than a local standard. See, e.g., *Naccarato v. Grob*, 384 Mich. 248, 180 N.W.2d 788 (1970); Note, *Torts—Medical Malpractice—Michigan Abandons "Locality Rule" with Regard to Specialists*, 40 FORDHAM L. REV. 435 (1971).

28. *Bruce v. United States*, 167 F. Supp. 579 (S.D. Cal. 1958); HOLDER 44-45; 1 LOUISELL & WILLIAMS, ¶ 8.04; PROSSER 163; McCoid 565.

29. HOLDER 55-57; 1 LOUISELL & WILLIAMS ¶ 8.04; McCoid 566.

30. For example, when a patient with a broken arm comes to a doctor, the physician is enjoined to set the fracture carefully, and to avoid making the cast too tight. See 2 LOUISELL & WILLIAMS 614. Such safety standards govern the risks of medical intervention itself, and—while important in themselves—do not directly affect the central medical decisions on what care would best reduce the hazards of the underlying illness or condition. HMOs and other innovative providers are probably least affected by this aspect of malpractice law. (Standards of carefulness may have an indirect impact on basic medical decisions; if a particular procedure must be carried out with extreme care, the resulting increase in difficulty or cost may well cause the choice of an alternative method.)

31. The doctor confronted with a probable fracture, to continue the prosaic example of note 30 *supra*, is expected to conform to the standard practice of taking diagnostic x-rays before setting the arm. See 1 LOUISELL & WILLIAMS ¶ 2.10 n.40; 2 LOUISELL & WILLIAMS 719. Moreover, malpractice standards may dictate the form of treatment itself. For instance, a broken arm should be set in a cast rather than given some other therapy. E.g., *Walkenhorst v. Kesler*, 92 Utah 312, 67 P.2d 654 (1937) (chiropractor

nection with subsequent injury is more difficult where the complaint involves failure to alter satisfactorily the natural course of a disease or condition rather than introduction of new harm.³² Such malpractice regulation of providers' decision-making is a powerful and threatening influence, going as it does to very fundamental matters of medical judgment. Though cases alleging negligent diagnostic and treatment decisions have in the past been relatively infrequent,³³ their importance seems to be growing,³⁴ with the result that the standard of care is more and more seen as addressing not only the carefulness to be exercised but also the medical care to be rendered. Providers' perception that omission of available procedures can be an important determinant of liability may well prompt providers to adopt elaborate diagnostic and therapeutic regimes without clear consideration of their cost and value.³⁵ This aspect of malpractice law may be the most troublesome for innovative and cost-conscious providers.

The malpractice standard of care applied to HMO health care services is the same as that governing medical services generally. In practice, however, HMO exposure to liability may differ from that of other providers. For one thing, an HMO itself, as well as its constituent hospitals, physicians, nurses, and other personnel, may be liable for malpractice, under either contract³⁶ or negligence³⁷ theories of respon-

found negligent for treating fractured hip with manipulation); *Tell v. Taylor*, 191 Cal. App. 2d 266, 12 Cal. Rptr. 648 (1961) (osteopathic manipulation of fractured hip negligent).

32. See notes 84-86 *infra* and accompanying text.

33. Diagnostic errors (and the consequent failure to treat a condition) have not traditionally been an important basis for malpractice claims. Among malpractice insurance claims settled in 1970, only one in seven allegedly negligent incidents involved diagnostic failures. Rudov, Myers & Mirabella, *Medical Malpractice Insurance Claims Files Closed in 1970*, in MEDICAL MALPRACTICE REPORT Appendix 1, 9.

34. See, e.g., Curran & Moseley, *The Malpractice Experience of Health Maintenance Organizations*, 70 NW. U.L. REV. 69, 85 n.72 (1975); Note, *Negligence—Medical Malpractice—Should Lack of Diligence in Diagnosis Resulting in Loss of Chance to Live Be a Compensable Injury?*, 3 SETON HALL L. REV. 505 (1972).

35. The lack of consideration given to cost and value in setting customary practice is a major theme of this Article. See notes 46-76 *infra* and accompanying text. Diagnostic "accuracy" is used here to mean overall correctness of diagnosis. Such lay terminology glosses over the technical difference between a test's sensitivity and its specificity; more properly, one might hypothesize that a test increases true positive or true negative diagnoses and decreases false positives or false negatives. See McNeil, Keeler & Adelman, *Primer on Certain Elements of Medical Decision Making*, 293 NEW ENG. J. MED. 211 (1975).

36. See generally Curran & Moseley, *supra* note 34, at 70-77. HMOs' contractual liability for enrollee injuries is somewhat problematic. HMO contracts are thoroughgoing, typically promising to provide all needed medical services within certain rather comprehensive limits. See generally sources cited in note 3 *supra*. A sample subscriber-HMO contract is printed in J. KRESS & J. SINGER, *HMO HANDBOOK* 54-62 (1975). A

sibility, thus allowing plaintiffs an additional potential defendant, though not altering the standard of care applied.³⁸ Other differences

disgruntled subscriber-patient might sue in contract if an HMO simply failed to offer particular services or facilities it had promised to provide. A more radical complaint might be that the HMO contract entitled a subscriber to particular procedures that were inappropriately withheld. This is essentially a claim of negligent failure to treat, which courts might or might not choose to hear in contract. In any such inquiry, the exact wording of the HMO contract and the definition of medical "need" would be crucial; this inquiry would greatly resemble one for negligence, and what services are "needed" under an HMO's contract would probably have to be determined by reference to medical custom generally. Ironically, while this Article contends that customary practice may often be a poor malpractice standard for HMOs, some customary standards would be essential to limit HMOs' contractual obligations.

Alternatively, a warranty of due care might be legally implied from an HMO's undertaking to treat patients, as one often was in early malpractice cases. See, e.g., *Adkins v. Ropp*, 105 Ind. App. 331, 334, 14 N.E.2d 727, 728 (1938), quoting *Adolay v. Miller*, 60 Ind. App. 656, 659-60, 111 N.E. 313, 314 (1916) ("a physician . . . is held in law to have impliedly contracted [to] exercise at least reasonable skill, diligence and care"). See generally HOLDER 1-7. However, few jurisdictions today still allow malpractice complaints to be framed in contract, rather than in tort; most hold that malpractice actually sounds in tort. E.g., *Gauteri v. New Rochelle Hosp.*, 4 App. Div. 2d 874, 166 N.Y.S.2d 934 (1957), *aff'd*, 5 N.Y.2d 952, 157 N.E.2d 172, 183 N.Y.S.2d 803 (1959). See generally 1 LOUISELL & WILLIAMS ¶ 8.03; McCoid 550-53; Miller, *The Contractual Liability of Physicians and Surgeons*, 1953 WASH. U.L.Q. 413; Note, *Contractual Liability in Medical Malpractice*, 24 DEPAUL L. REV. 212 (1974).

37. Like all employers, HMOs are responsible for the negligence of their employees or agents under the doctrine of *respondet superior*. *Bernardi v. Community Hosp. Ass'n*, 166 Colo. 280, 443 P.2d 708 (1968); PROSSER § 70; RESTATEMENT (SECOND) OF AGENCY § 219 (1957); Southwick, *The Hospital's New Responsibility*, 17 CLEV.-MAR. L. REV. 146 (1968).

HMOs may also be responsible for the provision of care by non-employees under what seems to be an emerging doctrine of institutional negligence: where patients justifiably look to a health care institution to select, supervise, or vouch for the actual provider of care, the institution must take appropriate steps to protect patients from unwarranted risks. This principle seems to be the common thread of several developments in hospital liability. Thus, hospitals may be held liable for the negligence of non-employee doctors under a theory of apparent agency, especially where a doctor's principal practice is in the hospital. See *Beeck v. Tucson Gen. Hosp.*, 18 Ariz. App. 165, 500 P.2d 1153 (1972) (radiologist); *Principles of Hospital Liability*, 2a HOSP. L. MANUAL ¶ 2-1 nn.46 & 51 (1972). Hospitals may also be liable for insufficiently weighing the potential risk of harm to patients from non-employee doctors with hospital "staff privileges." See *Purcell v. Zimelman*, 18 Ariz. App. 75, 500 P.2d 335 (1972); *Mitchell County Hosp. Authority v. Joiner*, 229 Ga. 140, 189 S.E.2d 412 (1972); *Principles of Hospital Liability, supra*, ¶ 1-4 n.35 (1972). Another source of hospital liability may be emerging—a duty to supervise ongoing institutional care and, where appropriate, to require consultation in the interest of preventing unduly risky care. See *Darling v. Charleston Community Memorial Hosp.*, 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966); Southwick, *The Hospital as an Institution—Expanding Responsibilities Change Its Relationship With the Staff Physician*, 9 CALIF. W.L. REV. 429, 443-53 (1973).

Such precedents from hospital law could easily be applied to HMOs, since HMOs' promises to provide their enrollees with health care services are much more direct than are those of hospitals. Moreover, HMOs' control over services may also be greater,

in HMO and fee-for-service malpractice experience, such as patients' increased willingness to sue engendered by impersonal HMO care, are sometimes cited,³⁹ but these are largely behavioral rather than legal and are unrelated to this Article's main concern, the impact on HMOs of the customary practice standard itself. This impact is strong not only because of the fundamental influence of the standards themselves but also because of the generally increasing frequency and cost of malpractice claims and all medical care providers' concern about them.⁴⁰ Malpractice standards are thus coming to constitute an ever more considerable incentive toward customary practice.⁴¹

since HMOs periodically negotiate, on behalf of their subscribers, specific terms of service with their associated doctor groups which actually provide the services. See, e.g., Curran & Moseley, *supra* note 34, at 74-75. A sample medical service agreement and hospital contract are presented in J. KRESS & J. SINGER, *supra* note 36, at 63-80.

38. HMO liability founded on *Darling v. Charleston Community Memorial Hosp.*, 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966), might conceivably result in a somewhat different standard of care than would HMO liability grounded in *respondeat superior*. Whereas the latter vicarious liability would typically result from HMO providers' deviance from standard practice, *Darling* found negligence in part in the defendant institution's deviance from its own internal rules and regulations—not necessarily the same as those of other providers. *Id.* at 331, 211 N.E.2d at 257.

39. E.g., Curran & Moseley, *supra* note 34, at 81. See also *The Malpractice Crisis: How It Affects HMOs* (pt. 2), HEALTH SERVICES INFORMATION, Sept. 22, 1975, at 5.

40. Until the 1960s, the probability of a provider's being sued for malpractice in connection with any single service was extremely low. A 1957 American Medical Association survey found that only one doctor in seven (*i.e.* about fourteen percent) was a malpractice defendant at any time during his entire career. *Opinion Survey on Medical Professional Liability*, 164 J.A.M.A. 1583 (1957). An extreme, non-representative contrast is the 1972 experience in northern California, where twenty-one claims were filed for every 100 physicians. CAL. ASSEMBLY SELECT COMM. ON MEDICAL MALPRACTICE, PRELIMINARY REPORT 15 (June 1974).

The much-discussed current malpractice "crisis," however, is less a problem of physicians actually being sued than it is one of liability insurance—its decreasing availability and increasing cost. See, e.g., *Malpractice in Focus* (Aug. 1975) (an AMA Source Document prepared by the editors of *Prism*). How much legal standards have contributed to these problems (as opposed to patients' litigiousness, larger jury awards, and other factors) is quite uncertain, but it is clear that great publicity has made doctors more aware than ever of the importance of malpractice standards and legal doctrines for their practice. See, e.g., Welch, *Medical Malpractice*, 292 NEW ENG. J. MED. 1372 (1975).

41. Six years ago, a leading authority commented, "[T]he most effective mechanism for coercing compliance with customary standards of care is the threat of malpractice litigation . . ." Bernzweig, *HEW Response to the Subcommittee*, in SUBCOMM. ON EXECUTIVE REORGANIZATION, SENATE COMM. ON GOVERNMENTAL OPERATIONS, 91ST CONG., 1ST SESS., MEDICAL MALPRACTICE: THE PATIENT VERSUS THE PHYSICIAN 18 (Comm. Print 1969). Since then, the latest "crisis" has further exacerbated malpractice fears—probably even beyond the actual increased impact of malpractice suits and awards.

PROBLEMS WITH THE CURRENT MALPRACTICE
APPROACH TO HMO CARE

HMO practice, like all medical care, should be subject to judicial scrutiny. But the best means of implementing such legal oversight are debatable. The current use of customary medical practice as the malpractice standard of care poses a number of troubling problems, particularly for innovative providers like HMOs. The following discussion of four such problems is predicated on the realistic postulate that much is uncertain about the provision and value of health care services, so that there is a considerable legitimate leeway for HMOs to diverge from majority custom, on either medical or economic grounds.

Medical practitioners generally—regardless of the form of their payment—often disagree about the medical effectiveness of particular procedures.⁴² Such divergent medical views may involve not only the obvious difficulty of choosing between types of medical intervention (is one drug, operation, or treatment as good as another—in result and risk?), but also less obvious cases of selecting the proper provider (are paramedics as competent as doctors in certain fields?) or style of care (is outpatient treatment preferable to inpatient care in some instances?). A cost-conscious HMO, for example, might choose to treat heart attack victims in their homes rather than in hospital coronary care units. There is substantial medical research evidence, largely from Britain, that at-home treatment achieves the same results as hospital care,⁴³ but American custom is decidedly contrary, and thus outpatient

42. See generally A. COCHRANE, *EFFECTIVENESS AND EFFICIENCY: RANDOM REFLECTIONS ON HEALTH SERVICES* (1972). Because of their immediate resource constraints, however, HMOs might be expected to question more readily a procedure's medical effectiveness than might fee-for-service practitioners. But see note 89 *infra*.

43. Mather, Pearson, Read, *et al.*, *Acute Myocardial Infarction: Home and Hospital Treatment*, 3 *BRIT. MED. J.* 334, 336-37 (1971). See also A. COCHRANE, *supra* note 42, at 50-54; Hofvendahl, *Influence of Treatment in a Coronary Care Unit on Prognosis in Acute Myocardial Infarction*, *ACTA MED. SCANDINAVIA* 519 (Supp. 1971); Hutter, Sidel, Shine, *et al.*, *Early Hospital Discharge After Myocardial Infarction*, 288 *NEW ENG. J. MED.* 1141, 1143-44 (1973) (heart patients receive no additional benefit from three weeks' hospitalization over two weeks' stay).

There is growing recognition that in much of modern medicine, as in coronary care, the benefits of customary practices are either not well established or not worth their costs in resources and new risks. For excellent short summaries of this line of thought, see A. COCHRANE, *supra*; Neuhauser, *The Future of Proprietaries in American Health Services*, in *REGULATING HEALTH FACILITIES CONSTRUCTION* 233, 233-37 (C. Havighurst ed., 1974); and U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE, *PUBLIC HEALTH SERVICE, FORWARD PLAN FOR HEALTH, FY 1977-81*, at 144-61 (DHEW Pub. No. (OS)76-50024, 1975).

treatment might create considerable malpractice problems where patients suffer reverses or die.⁴⁴

An HMO's practice might also diverge from fee-for-service custom because of a different valuation of the benefits undeniably achieved by customary action or nonactions. Thus, there might be universal agreement that a certain test improves the accuracy of a diagnosis from ninety to ninety-five percent in some moderately serious and generally treatable condition; a fee-for-service doctor would almost certainly perform such a test if it were readily available and covered by insurance, since no obvious benefit for his patient or himself could be achieved by foregoing the potential insurance payment.⁴⁵ On the other hand, an HMO might decide that its subscribers' resources were better spent, for example, on upgrading the staff of its emergency room than on the test. Such valuation problems are at the heart of tort law's establishing appropriate levels of risk and, in various forms, cause the most intractable difficulties in the application to HMOs of standards derived from customary insured fee-for-service practice.

A. *Inadequate Valuation of the Costs and Results of Reducing Risks*

Whereas the law of negligence generally evaluates risky behavior through an independent judicial assessment of its reasonableness, medical malpractice cases judge health care providers almost exclusively by their compliance with customary medical practice.⁴⁶ Whether this substitution of medical custom for judicial evaluation is desirable depends upon how well customary practice standards achieve the goals of negligence law.

A major goal of tort standards is to achieve the socially optimal level of risk in the various activities society undertakes, including providing medical care.⁴⁷ Negligence rules accomplish this by holding non-optimal behavior substandard and by requiring compensation of

44. For example, *Armstrong v. Svoboda*, 240 Cal. App. 2d 502, 49 Cal. Rptr. 701 (1966), held that a doctor was negligent in not immediately hospitalizing a patient whose electrocardiogram indicated possibly serious cardiac abnormalities. Hospitalization for known heart attack would seem to be *a fortiori* required.

45. See Brook, Brutoco, & Williams, *The Relationship Between Medical Malpractice and Quality of Care*, 1975 DUKE L.J. 1197.

46. See notes 24-29 *supra* and accompanying text.

47. Deterrence and compensation are often cited as twin goals of tort law. *E.g.*, W. SEAVEY, P. KEETON, & R. KEETON, *CASES AND MATERIALS ON THE LAW OF TORTS* 1 (1964). Deciding what behavior should be deterred and which injuries should be compensated, however, requires deciding upon the optimal level of risk for each activity. See Mechanic, *Some Social Aspects of the Medical Malpractice Dilemma*, 1975 DUKE L.J. 1179, 1190-91. See also sources cited in note 49 *infra*.

victims injured by failure to take appropriate safety measures.⁴⁸ The relevant considerations here are the degree of risk of the activity, the risk-reducing capacity of various precautionary steps, and the costs and benefits of running and reducing the risks; the law should encourage taking all risk-reducing steps the cost of which is smaller than the cost of running the unreduced risk.⁴⁹

The customary practice of parties engaged in a given enterprise is quite relevant to judicial evaluation of whether particular safety measures are appropriate, and evidence of customary practice is generally admissible for the factfinder to weigh in deciding whether the standard of due care was met.⁵⁰ The probative value of such evidence is somewhat limited, though many virtues are sometimes ascribed to

48. This simplified formulation ignores negligence law's concern that a duty to act be established before the cost of risk-running versus risk-reduction calculus is applied. In the case of medical malpractice, the duty to avoid negligence to a patient is clear, and deciding when the provider-patient relationship is established is seldom difficult.

49. Requiring measures to reduce risk where the marginal cost of each reduction of risk is less than its value (the cost of running the risks and allowing injuries to occur) will achieve the optimum amount of risk reduction, that is, the minimum injury and injury prevention costs. R. POSNER, *ECONOMIC ANALYSIS OF LAW* 69-70 (1973); Brown, *Toward an Economic Theory of Liability*, 2 J. LEGAL STUDIES 323 (1973); Calabresi & Hirschhoff, *Toward a Test for Strict Liability*, 81 YALE L.J. 1055, 1057 (1972).

Judge Learned Hand's famous formulation of the negligence standard of care sets forth just such a test:

The degree of care demanded of a person by an occasion is the resultant of three factors: the likelihood that his conduct will injure others, taken with the seriousness of the injury if it happens, and balanced against the interest which he must sacrifice to avoid the risk. *Conway v. O'Brien*, 111 F.2d 611, 612 (2d Cir. 1940), *rev'd on other grounds*, 312 U.S. 492 (1941).

See Brown, *supra*; Posner, *A Theory of Negligence*, 1 J. LEGAL STUDIES 29 (1972); Note, *Comparative Approaches to Liability for Medical Maloccurrences*, 84 YALE L.J. 1141 (1975).

Theoretically, other legal rules which incorporated the correct social valuations of costs, risks, and results could achieve the same optimal result. A strict liability test, for example, could induce exactly the same level of risk-reducing precautions; a major difference would be that the cost of injuries not worth avoiding would fall on medical care providers rather than on injured patients as under the fault system. See Calabresi, *Optimal Deterrence and Accidents*, 84 YALE L.J. 656, 666-70 (1975). (This might also mean that different amounts of medical care would be undertaken.) At the theoretical extreme, under idealized circumstances of perfect information and no transaction costs, market economic theory holds that any (or no) liability rule would achieve optimal risk reduction, since the parties involved would bargain with each other (by hypothesis, at no cost) until optimality was attained. Coase, *The Problem of Social Cost*, 3 J. LAW & ECON. 1 (1960); Calabresi, *Transaction Costs, Resource Allocation and Liability Rules—A Comment*, 11 J. LAW & ECON. 67 (1968). See also notes 55-57 *infra* and accompanying text. Malpractice rules, however, are negligence rules, and only the negligence approach is considered here.

50. PROSSER 162, 227; Morris, *Custom and Negligence*, 42 COLUM. L. REV. 1147, 1153-54 (1942).

it.⁵¹ At a minimum, however, evidence of custom shows the practical and economic feasibility of undertaking certain safety precautions (and customary omission, in contrast, may hint the inappropriateness of undertaking them) and establishes that a defendant had the opportunity to learn what untaken precautions were feasible.⁵² Evidence of medical custom, of course, plays a much larger role.

There seem to be two principal justifications for judicial reliance on medical custom to set malpractice standards. The first is intensely practical: most medical decision-making is beyond the ken of laymen—patients, judges, and juries alike—so that decisions and evaluations of them are thought better left to experts, with the judicial role largely limited to weighing credibility.⁵³ This rationale is apparent in the major exception to the requirement for expert testimony of medical negligence, namely, that laymen may testify to, and lay factfinders may independently evaluate, alleged negligence involving circumstances clearly comprehensible to non-experts, such as failure to x-ray a suspected fracture. The rationale is partly persuasive: clearly, only medical experts can be expected to assess medical probabilities—the normal and usual hazards of certain conditions, the likely success of particular risk-reducing interventions, and so on.⁵⁴ In this, medicine, like other

51. Among these rather nebulous virtues are the stability that custom brings to society; the desirability of limited autonomy for certain groups, *e.g.*, professionals; custom's internal moral quality of rightness; and the harshness of requiring more than customary safeguards. See Linde, *Custom in Negligence Law*, 11 CAN. B.J. 151, 152-54 (1968).

52. Morris, *supra* note 50, at 1147-53.

53. This judicial deference to medical expertise parallels the typical patient's deference to his doctor's opinion. See notes 63-66 *infra* and accompanying text. Clarence Morris clearly states this rationale: "[N]o other standard [than medical custom] is practical. Our judges and juries are usually not competent to judge whether or not a doctor has acted reasonably. The conformity test is probably the only workable test available." *Id.* at 1164.

54. The pervasive impact of uncertainty in medical care may well be the decisive factor here, as in many aspects of the health care enterprise. See Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963). Despite a physician's possession of acceptable skill and use of accepted procedures, one can never be sure that the desired outcomes will be achieved. At its most basic level, this is the familiar problem of causality. Doctors accept a diagnosis or therapeutic procedure as effective based upon statistical evidence of its efficacy in a certain proportion of cases; absolute certainty that a method will be followed by a certain result is elusive and rare. Moreover, clear and undisputed proof of effectiveness by the accepted methods of statistically standardized or randomized controlled trials is surprisingly uncommon. The clinical judgment of each doctor thus has a very large role to play. Under these circumstances, it is easy to understand the law's reluctance to set its own independent standards, which would require judging whether particular procedures actually cause the risk reduction (achieve the results) they are meant to. The question of causal connection of medical procedure and particular result, of course, arises not only in deciding on

technical areas, is not susceptible to unaided judicial inquiry. However, doctors and other medical providers are not experts in *valuing* in social terms the expected results or costs inherent in particular standards; in fact, they may quite inappropriately weigh the social costs of taking a risk-reducing precaution, even where they very accurately assess its medical effectiveness. Nonetheless, by accepting medical custom as the legal standard of care, malpractice law has implicitly left both the assessment of risk and the valuation of cost and results to the judgment of medical practitioners. It should be recognized that the standards thus established can only be as good as the circumstances and incentives which give rise to medical custom.

The second rationale for customary practice standards in fact recognizes this, but asserts that custom—representing the aggregate of individual judgments as to what medical care is appropriate—can best set the social norm. This reasoning starts with an ideal type of customary standards of care and safety—those established in the course of perfectly free market transactions between parties who are fully informed, equal in bargaining position, and capable of extensive and inexpensive bargaining. Custom developed under such circumstances should indeed indicate the socially optimum level of risk avoidance—at least as between the bargaining parties, since they should know better than any court how much they want to reduce their own risks. Parties to hazardous activities can bargain with each other to reduce risks as much as they feel worthwhile, and to have irreducible risk fall on the party better able to bear bad results. Medical risks seem particularly well covered by this reasoning, since they are almost exclusively limited to the individual patients involved,⁵⁵ who theoretically participate in valuing them and agree to undergo them.⁵⁶ Since third

the appropriate standard of care, but also in assessing whether failure to meet the established standard actually caused a given injury. Here, though expert testimony is again needed, it is not determinative; the final decision is the legal factfinder's. 1 LOUISELL & WILLIAMS ¶ 11.20; B. SHARTEL & M. PLANT, *THE LAW OF MEDICAL PRACTICE* 147-52 (1959). See also notes 84-88 *infra* and accompanying text.

55. There are some exceptions to this—for example, a surgeon may operate on the wrong person. Interestingly, in this case of harm to an outsider, malpractice liability follows almost automatically upon proof of the facts, and the law does not look to medical practice as a guide. *E.g.*, *O'Grady v. Wickman*, 213 So. 2d 321 (Fla. Dist. Ct. App. 1968). (Such cases may be treated as batteries rather than as negligence.) In the main, however, a decision on one patient's standard of care directly affects only that patient.

56. In theory, if fully informed patients knowingly chose the level of care they actually received, no legal intervention would be necessary. See note 49 *supra*. In reality, of course, patients largely put themselves in their doctors' hands; what they seek from medical providers is their medical expertise, including knowledge of what risk-

parties not privy to provider-patient agreements on care are not at risk, their exclusion from standard-setting is immaterial. Provider-patient agreements as to what risk reduction is appropriate may thus be taken to establish the socially optimal standard of care for all.⁵⁷ The medical custom rule has been cogently defended on this market-theory ground.⁵⁸

These theoretical underpinnings of medical custom standards are unfortunately not very persuasive in practice, at least not to the extent that the standards draw upon the customs of insured fee-for-service practitioners, who dominate the medical care market.⁵⁹ Most attacks on the rule emphasize that it may perniciously allow an entire industry—or subset thereof—to legitimize its own corner-cutting as the standard of due care, validating through its own practice what independent assessment would label negligence.⁶⁰ Neither the theory nor the law of customary practice standards gives much attention to the possibility that an entire industry may set standards too high, or perhaps too high in some areas and too low in others. In the usual market case, of course, a rational decision-maker will not behave uneconomically with respect to safety precautions (and thus systematically lose money) by undertaking procedures which add less value to a marketable product or service than they cost⁶¹ or by foregoing procedures which would reduce risk more than they cost.⁶² The peculiar organization and economics of contemporary insured fee-for-service medical care, however, do not fit these classic optimizing economic assumptions. In particular, fee-for-service practice is apt systematically to give insufficient weight to the cost of providing services, as opposed to the reduction of risk they achieve. Since malpractice law adopts medical custom as

reducing steps are appropriate. See, e.g., Arrow, *supra* note 54, at 964-66. See also notes 63-66 *infra* and accompanying text.

57. Because individuals cannot appropriately judge their own standards of care, see note 56 *supra*, malpractice law undertakes to protect them from aberrant physicians' judgments through the custom rule.

58. R. POSNER, *supra* note 49, at 72.

59. About 6.5 million people are now enrolled in HMOs, according to InterStudy, HEALTH SERVICES INFORMATION, Aug. 11, 1975, at 1, so that some 200 million others are served—if at all—by fee-for-service providers.

60. See, e.g., The T.J. Hooper, 60 F.2d 737 (2d Cir. 1932); Favalora v. Aetna Cas. & Sur. Co., 144 So. 2d 544 (La. App. 1962).

61. Morris, for example, succinctly dismisses this consideration: "Super-cautious industrial usages are conceivable, but the self-interest of businessmen checks milquetoastish fears." Morris, *supra* note 50, at 1161.

62. Of course, the relevant risks here are those to the parties in the transaction or to others whom the liability rule internalizes into the transaction. Risks to outsiders will be ignored, except as a matter of charity or public relations.

its standard, its requirements of due care are also often apt to be too high.

The theoretical assumption that customary medical practice reflects provider-patient agreements on risk reduction is also highly suspect. Providers and patients do not usually negotiate over the provision of health care services.⁶³ Providers have a near-monopoly on medical expertise; once patients make the initial decisions to seek care, they generally delegate most decision-making to medical professionals. Of necessity, patients rely on their doctors and others to evaluate the medical risks they face, both from disease and from medical intervention. Indeed, a doctor's principal products are his knowledge, skill, and expertise. Physicians make almost all medical decisions, including what standard of care is appropriate, and most patients—especially very sick ones—simply accept the services their doctors decide are needed.⁶⁴ This physician dominance underlies the common observation that doctors can “create demand” for their own and other medical services.⁶⁵ Given this delegation of decision-making, patients’ “purchase” of medical services is hardly an arm’s-length transaction between well-informed equals agreeing on the provision of a certain standard of care for a certain price according to their interests and evaluations. Rather, doctors are relatively free to consider many other factors besides the benefit and cost to the patient and the probable reduction of risk in deciding whether to provide or order a given service.⁶⁶

Nonetheless, the dominance of physicians in decision-making would not by itself necessarily result in standards of uneconomical risk reduction; most doctors doubtless take quite seriously their fiduciary

63. In contrast, an HMO's subscribers, at least as a group, may well be able to bargain over the general style of their medical care, including, for example, what facilities are to be provided and whether physician assistants are acceptable. But sick HMO patients are no more apt to bargain over the actual provision of their care than are fee-for-service patients—perhaps less so, since they do not pay extra for the services received.

64. See, e.g., Lave & Lave, *Medical Care and Its Delivery: An Economic Appraisal*, 35 LAW & CONTEMP. PROB. 252, 258-59 (1970).

65. This is supported by the finding that spending on physicians' services is best predicted by technology and the number of physicians and not by patient demand factors. V. FUCHS & M. KRAMER, DETERMINANTS OF EXPENDITURES FOR PHYSICIANS' SERVICES IN THE U.S., 1948-1968, at 2 (1973).

66. Such factors could include the effect on provider income, professional or institutional prestige, humanitarianism, desire to experiment, desire to maintain high technical expertise, and even the desire to avoid any chance of a malpractice suit, however unmeritorious. None of these has any bearing on what standard of risk reduction is appropriate, yet they clearly may influence medical custom.

duty to patients and would not bankrupt them in an uncertain quest for small reductions in risk. Doctors owe no fiduciary duty, however, to the insurers and government agencies that pay for the lion's share of medical care, including almost all hospital care, where most malpractice claims arise.⁶⁷ In the insured fee-for-service sector, sick patients perceive nearly "free" care, providers see open-ended financing, and third-party payors (largely governmental and private insurers) are removed from the provision of services and have only weak capabilities for injecting cost considerations into the balance.⁶⁸ Providers of insured medical services can be expected to consider not whether their patients or society can afford a particular risk-reducing measure, but rather only whether their patients will receive any medical benefit. Freed of cost concerns, physicians often feel an ethical obligation to do everything possible for their patients.⁶⁹ As a moral principle under the circumstances this may be unimpeachable, but it is clearly a poor decision rule for the social valuations of malpractice law.⁷⁰

67. Between eighty and ninety percent of Americans are estimated to have some form of health insurance, with half of them carrying quite comprehensive coverage. Mueller, *Private Health Insurance in 1973: A Review of Coverage, Enrollment, and Financial Experience*, 38 SOCIAL SECURITY BULL. 21 (Feb. 1975). Private insurers and governmental programs now pay about sixty-three percent of personal health care expenditures, while individuals pay only about thirty-five percent themselves, Worthington, *supra* note 15, at 16, Table 6, but just how much malpractice occurs in the course of uninsured and insured care is not clear. One would expect most malpractice to arise from serious cases, the expense of which is likely to be covered by insurance. For example, almost ninety percent of personal health care expenditures for hospital care is now paid for by third parties, *id.* at 15, Chart 2, and about seventy-five percent of malpractice claims filed concern hospital occurrences, Rudov, Myers, & Mirabella, *supra* note 33, at 10.

68. This analysis of the workings of insured fee-for-service medical care is not original. An extremely clear and complete presentation is given in Address by W. McClure, *The Medical Care System Under National Health Insurance: Four Models that Might Work and Their Prospects* 11-20, American Political Science Convention, Sept., 1975.

69. Thus, a doctor notes, "as a physician, I have been taught throughout my professional career that I had an absolute obligation to my patients to provide them with the highest quality medical care within my reach, almost without regard to cost." Caper, *The Meaning of Quality in Medical Care*, 291 NEW ENG. J. MED. 1136 (1974). See also V. FUCHS, *WHO SHALL LIVE?* 60 (1974) (physicians guided in part by "technological imperative" to do everything they can, "regardless of the benefit-cost ratio").

70. This analysis is not meant to condemn insurance, which is a salutary means for policyholders to reduce the uncertainties of their otherwise unpredictable financial outlays for illness. Further, people doubtless also buy insurance because it enables them to buy more risk reduction collectively than they could individually; not all insurance-financed safety measures are worth less to policyholders than their cost. Nonetheless, because of the structural separation of the roles of policyholder, insurer, doctor, and patient, medical decisions on insured care are made with little regard for cost. Unlike HMOs, third-party insurers have not developed effective claims-reviewing capabilities.

That many insured fee-for-service providers do in fact often provide too much care and take too many precautions⁷¹ is most obviously illustrated by the prevalence of “unnecessary” surgical or other procedures,⁷² including “defensive” medicine.⁷³ The existence of these phenomena—which are of no use to patients—is widely conceded, though their extent is much debated.⁷⁴ (Some commentators claim to detect a more subtle phenomenon: a pervasive tendency in customary practice to seek to eliminate all risks to patients, regardless of cost.⁷⁵) Significantly, many such assessments that the fee-for-service sector over-treats its patients are made by comparing usual practice with that of HMOs.⁷⁶

The main deficiency of the medical custom rule is that it derives the malpractice standard of care from medical practice dominated by insured fee-for-service care, the providers of which can make decisions with little regard for actual social cost. Applying such standards to HMO practice pressures HMOs to conform to this non-optimizing behavior and reduces the likelihood that HMOs will evolve different styles of practice offering valuable insights to other providers and to legal standard-setters alike.

Testimony of C. Havighurst, *Hearings on Competition in the Health Services Market Before the Subcomm. on Antitrust and Monopoly of the Senate Comm. on the Judiciary*, 93d Cong., 2d Sess., pt. 2, at 1076-77 (1974).

71. However, just as availability of insurance may cause over-reduction of risks in some areas, lack of insurance coverage may somewhat inhibit taking justifiable precautions in others.

72. See, e.g., Blackstone, *Misallocation of Medical Resources: The Problem of Excessive Surgery*, 22 *PUB. POLICY* 329 (1974); McCarthy & Widmer, *Effects of Screening by Consultants on Recommended Elective Surgical Procedures*, 291 *NEW ENG. J. MED.* 1331 (1974).

73. “Defensive medicine” is the pejorative term used to describe complete dominance of legal over medical considerations, either undertaking a medical procedure to protect a provider against lawsuit rather than to benefit a patient or not undertaking a procedure out of fear of suit.

74. For example, compare Welch, *supra* note 40, at 1375 (defensive medicine costs at least \$3 billion annually), with Project, *The Medical Malpractice Threat: A Study of Defensive Medicine*, 1971 *DUKE L.J.* 939, 957 (phenomenon exists, but is overrated).

75. Havighurst & Blumstein, *Coping with Quality/Cost Trade-Offs in Medical Care: The Role of PSROs*, 70 *Nw. U.L. REV.* 6 (1975). The authors call the phenomenon “the quality imperative.” *Id.* at 20-30.

76. Blackstone, *supra* note 72, at 343-44. Some other studies of unnecessary procedures compare rates in the United States with those of Great Britain, where the health of the population is comparable to that of the United States and where the National Health Service, which provides comprehensive care from limited resources, closely resembles a nationwide HMO. Bunker, *Surgical Manpower: A Comparison of Operations and Surgeons in the United States and England and Wales*, 282 *NEW ENG. J. MED.* 135 (1970).

B. *Overemphasis on Methods of Care*

Not only is the theoretical and practical desirability of deriving malpractice standards from practice in the contemporary medical services market quite uncertain, but also there is a danger that the nature of the customary standards themselves may tend to inhibit medical practice from best evaluating medical risks. Medical custom standards, like other negligence standards, necessarily address the manner in which people ought to act and the precautions they ought to take, not the level of risk or pattern of results they ought to achieve.⁷⁷ But, lacking an independent assessment of reasonableness, this concentration on methods of care—potentially including nearly everything health care providers do—makes malpractice standards a very thoroughgoing regulation⁷⁸ and may well inappropriately increase costs and inhibit

77. Since the relation between a particular medical procedure and the final result is seldom totally clear, the perfect system for judging optimal risk reduction would look almost exclusively at the pattern of outcomes achieved, the actual effects on patients' health. Improved results, after all, are the goal of the presumably risk-reducing inputs and processes used, and the use of statistical results would obviate the need for case-by-case analysis of causation. See generally ASSURING THE QUALITY OF HEALTH CARE, *supra* note 7, at 25-49. James W. Bush, M.D., has suggested using a "coefficient of causality" he has developed to supersede the traditional notion of proximate cause. MEDICAL MALPRACTICE: A DISCUSSION OF ALTERNATIVE COMPENSATION AND QUALITY CONTROL SYSTEMS 22-24 (D. McDonald ed., Center for the Study of Dem. Inst., 1971). Although malpractice law commendably intervenes only after a demonstrably bad result, in practice the law must concern itself with methods used rather than with results achieved. Particularized standards of conduct help achieve compliance with legal requirements of the optimum level of risk reduction; it would be difficult for providers to obey an injunction to achieve a certain level of risk and no more. One book, 1 LOISELL & WILLIAMS ¶¶8.04-.05, for example, praises the legal adoption of particularized standards of practice as "objective," unlike the "subjective" reasonable man test. Moreover, since every malpractice case involves only one outcome, a bad one, some standards must be adopted to distinguish acceptable from unacceptable bad outcomes. The formulation of legal standards guiding the use of inputs and processes serves this function. The essential determination to be made is whether the adopted standards actually achieve the desired outcome. This determination is left to medical custom.

78. Malpractice considerations may constrain medical decision making at almost every point. See notes 30-31 *supra* and accompanying text. The application of negligence principles to nonmedical activity usually involves less thoroughgoing specification of behavior. Car manufacturers, for example, may be enjoined to produce safe vehicles, but need not mimic their competitors' construction of bumpers or brakes. Moreover, product liability does not typically spell out all the attributes a car should have, whereas almost every aspect of a medical provider's business—his knowledge, skill, judgment, and choice of particular procedures—may be heavily influenced by malpractice considerations.

Malpractice law seems to have undertaken to govern what would in other contexts be contractual concerns of purchasers, perhaps because patients, as very poorly informed consumers, must rely on their doctors and therefore need more legal protection. It is also true that decisions on the appropriate level of risk to personal safety are less central to

beneficial development of alternative methods to achieve similar results.

In the case of medical malpractice, the standards are those for selecting the medical inputs and processes to be used (whose contribution to risk reduction is not always clear), and their appropriateness, unlike that of other negligence standards, is not usually subject to independent judicial scrutiny. Many medical practices, of course, are of established efficacy, achieving undoubtedly valuable reductions in risk at reasonable cost.⁷⁹ In fact, the effectiveness and value of some customary methods may be so obvious as to take them out of the customary practice rule altogether and place them in the province of normal negligence judgment by a factfinder unaided by expert testimony. Most often, however, causation and the valuation of risk and results are unclear; these are major reasons for adopting legal standards from medical custom in the first place.

There is thus a real danger that customary methods and procedures may assume a validity independent of their actual worth and may be followed (or enforced) for their own sake. At its worst, such a situation is what all doctors despise as "cookbook" medicine,⁸⁰ but its effects are probably most pernicious for prepaid providers, who may have to forego a more valuable procedure for every less valuable one they feel obligated by malpractice law to provide. Concentration on what procedures should be given is, of course, an important part of medicine; and "cookbook" medicine differs only in emphasis and degree from what might be called "textbook" medicine. The medical custom malpractice regime, however, by focusing attention almost

the principal transaction in nonmedical cases than in the medical sphere. Thus, for example, automobiles' capacity, style, comfort, and the like are the principal concerns of car buyers, and the passengers' safety and appropriate level of risk are only two among many concerns. In the provision of health care services, however, the central goal and overriding concern is the patients' personal health and safety, so that standards of care are of the essence.

79. This is true both of measures to reduce the basic risk of bad outcome from an existing illness or condition and of measures to reduce the risks of the medical intervention itself. For example, few would question the law's wisdom in calling for doctors to treat a major infectious disease with a widely known, cheap, and effective drug having only minor side effects. Similarly, the law may confidently require a meticulous sponge count at the close of all surgical operations (with an exception for emergency cases where speed is more important than avoiding post-operative complications from a neglected sponge).

80. "Cookbook" medicine, following required procedures by rote, without exercising independent clinical judgment, has of late been most vehemently denounced in connection with PSRO standards, see note 88 *infra*, rather than malpractice standards, but the two phenomena are similar.

exclusively on what practices are customary, instead of on what practices are desirable, contributes to the basic problem: all concerned may lose sight of the standards' actual impacts on end results (except perhaps the bad one in the particular lawsuit under consideration), and innovative providers, including HMOs, may be inhibited from developing less expensive methods to achieve similar results.

Moreover, malpractice enforcement of customary practices may act as a kind of crude ratcheting mechanism, allowing more and more elaborate procedures to become standard, but not—or only slowly—allowing an established procedure to fall into disuse. Without independent judicial assessment of the effectiveness and value of the criteria, malpractice standards can change only as customary practice changes—and providers' customs will follow standard practice because of malpractice fears. It is possible, in fact, that the legal imprimatur given particular methods through malpractice litigation may encourage providers to play “catch-up” or “keep up with the Joneses” by routinely offering ever more ways of reducing ever smaller risks.⁸¹ Whether such behavior should be condemned for putting providers on a treadmill of inflationary and unneeded procedures or praised for inducing a beneficial upward spiral of quality depends upon whether or not the methods adopted reduce risk commensurately with the costs and other risks they engender—and neither the medical services market nor the judicial malpractice approach is now structured to answer that question.

The situation is not entirely bleak. Medical practice is not monolithic, and the adoption by malpractice law of customary practice standards does not always lock HMOs and other providers into a “one right way” approach to care. There are often several standard styles of diagnosis or treatment, and the “reputable minority” exception to the medical custom rule may legitimize them,⁸² allowing HMOs and others to choose a method on their own medical and cost-effectiveness grounds. Moreover, malpractice law does not actually compel the provision of standard services, but merely penalizes the failure to provide them when injury is the proximate result. If a particular customary

81. Many observers think that hospitals, in particular, show a marked tendency to acquire ever-increasing capabilities to perform medical procedures, presumably for enhancing institutional prestige and attracting staff physicians. Feldstein, *Hospital Cost Inflation: A Study of Nonprofit Price Dynamics*, 61 AM. ECON. REV. 853 (1971); Newhouse, *Toward a Theory of Nonprofit Institutions: An Economic Model of a Hospital*, 60 AM. ECON. REV. 64 (1970). Such tendencies could only be powerfully reinforced by potential malpractice liability for failure to perform customary procedures.

82. It is not clear, however, that the law will recognize a reputable minority's rejecting customary practice when the rejection depends upon doubts of economic efficiency rather than of medical efficacy.

practice is truly ineffective,⁸³ not following it will cause no harm,⁸⁴ and an HMO might safely dispense with it.

The requirement of causal connection between nonconformity and injury is thus theoretically a major protection against the forced adoption of relatively ineffective medical procedures by HMOs and others. In practice, however, though adoption of customary practices as the legal norm may not directly require their use, their mere existence, which enables plaintiffs to characterize nonconformity as negligence, probably has a considerable *in terrorem* cautionary effect, for several reasons. First, as a legal matter, some decisions seem to reflect a weakening of the causation requirement, at least in serious cases.⁸⁵ Second, as a practical matter, the very existence of a customary standard of practice carries a strong implication that the approved method works. It is probably very difficult to convince a factfinder confronted with an injury that standard treatment would not have been any more

83. Where an HMO can easily demonstrate that standard practices are useless, it may be sure of avoiding liability for omitting them. This situation is probably rare. More often, customary practice will have some utility, but not enough, in the HMO's estimation, to warrant its costs. Here, an HMO might nonetheless decide not to conform, if the price of potential liability is less than that of conformity. Such liability may constitute an excessive penalty for nonconformity. See notes 91-98 *infra* and accompanying text.

84. However, harm may nonetheless ensue from the underlying illness and be difficult to distinguish from that allegedly due to substandard care. See generally 1 LOUISELL & WILLIAMS ¶ 8.07. Even where customary practice is completely or nearly ineffective in reducing risks, medical providers may still comply out of fear that legal factfinders will not be able to distinguish the bad results due to the underlying illness from those due to omission of the customary practice. The availability of evidence of failure to conform as a "sword" for the plaintiff may thus have a considerable impact on providers even where causation is not clear.

85. These cases involve a failure to provide the particular procedure required by malpractice standards or providing it too late, allegedly "causing" the injury by failing to prevent it. For example, the court in *Hicks v. United States*, 368 F.2d 626 (4th Cir. 1966), stated:

When a defendant's negligent action or inaction has effectively terminated a person's chance of survival, it does not lie in the defendant's mouth to raise conjectures as to the measure of the chances that he has put beyond the possibility of realization. If there was any substantial possibility of survival and the defendant has destroyed it, he is answerable *Id.* at 632.

See also Note, *Medical Malpractice—Rejection of "But For" Test*, 45 N.C.L. REV. 799 (1967); Note, *Negligence—Malpractice*, *supra* note 34. Thus, where failure to give standard treatment was followed by death, plaintiff need not show that decedent would probably have lived if given the treatment, but merely that he would have had a substantial chance of living. If extended to less serious cases, such an approach to causation would surely motivate health care providers to do everything possible for patients out of fear of malpractice liability. See also *Clark v. United States*, 402 F.2d 950 (4th Cir. 1968) (failure to perform diagnostic test to distinguish between kidney infection and blocked ureter in a timely manner).

effective than the noncustomary treatment,⁸⁶ especially because in medical cases causation is often not clear-cut. By definition, moreover, customary practice will have numerous adherents, some doubtless ready to testify to its utility, even if it is only marginal: otherwise, they would not use it. Third, so long as following customary practice is an almost certain defense to malpractice suits,⁸⁷ providers' strong desire to avoid any brush with litigation will lead them to conform, regardless of their own evaluations of the practice's merits.⁸⁸ Certainly, where fee-for-

86. As Curran notes, "It is axiomatic that a bad result is not in itself proof of negligence, yet it comes close to it at times." Curran, *Professional Negligence—Some General Comments*, 12 VAND. L. REV. 535, 541 (1959). Further, if a plaintiff can succeed in categorizing departure from customary practice as "experimentation," recovery will be almost automatic because of the old rule that "a doctor experiments at his peril" (unless informed consent is obtained). See, e.g., *Slater v. Baker*, 95 Eng. Rep. 860 (K.B. 1767); *Carpenter v. Blake*, 60 Barb. 488, 514 (N.Y. Sup. Ct. 1871), *rev'd on other grounds*, 50 N.Y. 696 (1872). Of course, a defendant will simultaneously seek to show that the noncustomary practice was a proven technique of a reputable minority.

87. See notes 24-26 *supra*. In a few cases, courts have looked beyond customary practice, making an independent negligence determination. See, e.g., *Helling v. Carey*, 83 Wash. 2d 514, 519 P.2d 981 (1974). This may or may not evidence a trend. See Note, *Comparative Approaches*, *supra* note 49, at 1149 n.44.

88. The availability of the customary practice defense as a shield may be a more important incentive for conformity than the threat of the standard as a sword. This incentive is particularly strong because avoiding litigation, with its attendant bad publicity, personal trauma, and great inconvenience, may be even more important to physicians than the successful defense of a lawsuit once begun, since almost all damages are typically paid by malpractice insurance. The strength of the "shield" effect is apparent from the controversy surrounding the "civil immunity" clause of the PSRO legislation, 42 U.S.C. § 1320c-16(c) (Supp. II, 1972), which purports to protect doctors acting in conformity with PSRO norms from malpractice liability. Comment, *PSRO: Malpractice Liability and the Impact of the Civil Immunity Clause*, 62 GEO. L.J. 1499, 1505-07 (1974); Note, *Professional Standards Review and the Limitation of Health Services: An Interpretation of the Effect of Statutory Immunity on Medical Malpractice Liability*, 54 BOSTON U.L. REV. 931 (1974); Note, *Federally Imposed Self-Regulation of Medical Practice: A Critique of the Professional Standards Review Organization*, 42 GEO. WASH. L. REV. 822, 837-42 (1974).

The AMA opposes the civil immunity provision because it "could have the unintended and undesirable effect of pressuring practitioners to adhere to the [PSRO] norms." AMA Council on Legislation, PSRO Amendments 2 (May 1, 1974). The controversy heated up in January, 1975, when Caspar Weinberger, then Secretary of Health, Education and Welfare, whose department is the home of the PSRO program, called for compliance with PSRO norms to be accepted "as a real defense to a malpractice suit . . ." *Malpractice Insurance Denials Spark Weinberger's Concern*, PSRO LETTER, Jan. 15, 1975, at 3-4. AMA President Malcolm Todd, M.D., vehemently opposed even such use of PSRO norms, ostensibly because it would "reduce medicine and medical practice to a 'cookbook' approach . . ." *Am. Med. News*, Jan. 13, 1975, at 1, col. 2. See also *id.* at 4, col. 3. (The AMA supports amendments to eliminate the offending provision. See, e.g., Statement of the AMA, *Hearings on H.R. 5515 & 5528 Before the Subcomm. on Health, House Comm. on Ways and Means*, 94th Cong., 1st Sess. (Sept. 19, 1975).) The "cookbook" problem, however, is inherent in the PSRO concept, regard-

service insurance will pay for services or precautions of questionable risk-reducing utility, they are likely to be provided in order to comply with customary practice standards, becoming in the process more thoroughly established than ever and creating even larger pressures for conformity. HMOs, having no such outside insurer to pay for customary services, might be expected to resist more strongly the malpractice pressure to provide them,⁸⁹ but enforcement of customary practice as the legal standard nonetheless probably exerts a profound influence on every phase of the health care enterprise of HMOs⁹⁰ (and other innovative providers).

C. *Potentially Excessive Penalties for Noncustomary Care*

Malpractice law, after adopting standards to reflect the optimal level of risk, must correctly motivate potential tortfeasors to meet those standards by penalizing those whose conduct would otherwise unacceptably increase risk. Tort law seeks to achieve this by requiring those whose conduct is deemed unduly risky to pay for all injuries caused that could reasonably have been avoided, requiring no compensation for injuries resulting from acceptably risky behavior. In the malpractice sphere the strong emphasis on compliance with customary practice and the difficulty of the causation issues may easily combine to create an excessive penalty for noncustomary behavior, like that of HMOs. The danger is that nonstandard practice may be assessed for damages that would not have been averted by adherence to custom.

less of PSRO norms' impact on malpractice. Since the AMA grudgingly accepts the PSRO program itself, *see, e.g.*, AMA, A Summary of AMA's Policy on PSRO, in PSRO Information Kit (Oct. 1974), the real objection seems to be that clearly making PSRO norms a malpractice shield would more effectively motivate conformity than the PSROs' own sanctions could. Malpractice law would also apply the norms more broadly than would PSROs' own supervision of medicare and medicaid care.

89. One study's HMO interviews, however, found that HMOs are just as likely as other providers to practice "defensive" medicine. Curran & Moseley, *supra* note 34, at 85. This finding tends to support the proposition that customary practice malpractice standards considerably disrupt HMO incentives to devote their limited resources to the medically most effective uses, but it may also reflect, to some extent, other professional influences. These influences are difficult to distinguish from the impact of malpractice law, since the legal standard itself is largely derived from medical custom.

90. It would seem, however, that FMC HMOs—almost by definition—could not be shown to deviate from customary practice, since FMCs typically utilize most or all physicians in a county medical society. (PGP HMOs, in contrast, use small physician panels.) See note 3 *supra*. Nonetheless, FMCs may prescribe methods somewhat different from the same doctors' customary fee-for-service practice. The first malpractice case to consider the application of the medical custom rule to such circumstances should make interesting reading.

The all-or-nothing rule of compensation works well where legal factfinders are capable of assessing an activity's level of risk and can easily judge whether unreasonable behavior caused the particular injury at issue. In most cases, we feel comfortably able to distinguish harm caused by failure to take justified safety measures from harm which would have occurred despite all reasonable precautions. Questions of medical causation, however, may often be a matter of probabilities and not clear-cut, making it difficult to distinguish injury caused by noncustomary practice from that which would have occurred anyway.⁹¹

If a noncustomary practice at issue in a malpractice suit can be shown by expert testimony to reduce risk below customary levels, ensuing injuries should not be compensated; this result could be achieved either by finding a lack of proximate cause or by holding the noncustomary practice non-negligent as a "reputable minority" practice.⁹² The classic dilemma of noncustomary behavior, however, is posed by an increased risk of bad results knowingly undertaken in exchange for other benefits—for example, further improving the results in successful cases, increasing comfort, or saving money to spend on reducing other risks or to return to patients. This is exactly the sort of behavior likely to be engendered by HMOs' efficiency incentives.⁹³

Unfortunately, malpractice law does not now and probably cannot structure appropriate financial incentives to deal solely with *increased* risk accompanying noncustomary behavior. For example, even the most highly trained, board-certified anesthesiologist can expect a certain mortality rate in connection with a particular operation—perhaps

91. See, e.g., 1 LOUISELL & WILLIAMS ¶ 8.07. Clearly, cases involving alleged failure to provide certain care—the cases with which this Article is primarily concerned—are more difficult in this respect than are cases involving alleged injury from the medical care provided.

92. A showing that a noncustomary procedure is just as effective in reducing risks to patients as is customary procedure would satisfy the essence of the requirement that a minority practice be "reputable" to be accepted. Such objective evidence is certainly preferable to subjective consideration of whether practitioners using non-standard procedure have good reputations, but may be difficult and expensive to develop.

93. How characteristic of HMOs this behavior actually is depends upon how resistant HMO subscribers are to price increases and upon how much other factors, including malpractice concerns, counterbalance HMOs' natural cost-counting incentives. See note 89 *supra*. HMOs would wish to alter the pattern of care established by malpractice standards only if their valuations of the costs, risks, and results were different from those implicit in the standards. By hypothesis, negligence standards that accurately reflect social valuations could not be improved upon, though this Article has argued that customary practice does not in fact make such correct valuations. See notes 67-76 *supra* and accompanying text. Whether an HMO and its subscribers nonetheless ought to be able knowingly to choose a different level of care from the hypothetical social optimum is discussed at note 119 *infra* and accompanying text.

one tenth of one percent. If such personnel are generally available and surgeons utilize their services for most of those operations in the relevant locality, their level of training may well set the standard of care, and those deaths will be uncompensated. Personnel with less training might well experience a higher rate, perhaps two tenths of one percent. Using the less-trained personnel might constitute negligence,⁹⁴ but not all those thereby injured should be compensated. Noncustomary practice in this case by hypothesis causes one extra death per thousand procedures, but may cause two lawsuits. The problem cannot be approached as one of the negligence standard itself, since by definition breach of custom is malpractice. It must be seen as a problem of causation and damages, which is unfortunate because of the all-or-nothing rule of damages and the lack of an acceptable means of determining which of the two potential plaintiffs was injured by deviation from accepted practice. No middle ground is now available to reflect such uncertainty as to causation, since compromise verdicts are unlawful.

As a practical matter, it is quite likely that the hypothetical nonstandard practice would be condemned by a jury in both cases, if there were undisputed breach of the customary practice, testimony as to the general efficacy of the customary practice, and clear injury.⁹⁵ As a matter of law, the problem of the uncertain plaintiff injured by increased risk might seem to be covered by the rule denying recovery where it could be predicated only on the factfinder's speculation as to which of two causes was responsible for an injury.⁹⁶ Neither result is satisfactory; what is needed is a financial incentive related to incremental risk, which cannot be provided through the case-by-case approach of malpractice law under normal tort procedures.

One analogy does suggest itself, though it is doubtful that it could be applied, namely, tailoring compensation to degree of culpability, as in apportionment of damages among defendants according to degree of fault⁹⁷ or in reduction of damages according to the comparative negligence of the plaintiff.⁹⁸ Legislation along these lines would provide

94. In *Pederson v. Dumouchel*, 72 Wash. 2d 73, 431 P.2d 973 (1967), for example, the Supreme Court of Washington found a hospital liable for allowing an unsupervised dentist, rather than a doctor, to administer general anesthesia.

95. See note 86 *supra* and accompanying text.

96. See, e.g., *Schulz v. Feigal*, 273 Minn. 470, 142 N.W.2d 84, 89 (1966).

97. UNIFORM CONTRIBUTION AMONG TORTFEASORS ACT § 1; PROSSER § 50; Note, *Adjusting Losses Among Joint Tortfeasors in Vehicular Collision Cases*, 68 YALE L.J. 964, 981-84 (1959).

98. See WIS. STAT. ANN. § 895.045 (Supp. 1975); Abraham & Riddle, *Comparative Negligence—A New Horizon*, 25 BAYLOR L. REV. 411 (1973).

a theoretically valid solution, but the same problems of accurate judicial assessment of risk which underlie the medical custom rule would probably make such an approach impractical.

D. *Unduly Narrow Focus on the Risks of Individual Procedures*

A major virtue of the HMO concept is the great control each HMO has over the allocation of all health care resources for a given population.⁹⁹ That control theoretically enables an HMO to undertake the optimum amount of risk reduction in each and every medical area, thus maximizing the aggregate health of the HMO population by equalizing the marginal value of risk averted in each area.¹⁰⁰ In particular, an HMO can theoretically fund the proper amounts of preventive and acute care, pre-operative and post-operative treatment, diagnostic and therapeutic procedures, care for one type of condition or illness and care for another, and so on, throughout the entire medical spectrum. Perhaps the most fundamental objection to application of the current malpractice approach to HMO care is that its case-by-case setting of standards—largely reflecting fee-for-service practice—interferes with this great potential of HMOs to adjust the standards of care in one area to accommodate those in another. Malpractice law's enforcement of customary practice does not recognize the relevance of risks in any area other than the one being litigated.

In the course of one treatment a single patient may undergo diagnosis, surgery, post-operative hospital care, and follow-up treatment. In the fee-for-service sector each phase of this care may well be undertaken by a separate provider (or combination of providers), and each phase will be governed by a standard of care set independently of the others. The practices of anesthesiologists set the anesthesia standard, those of surgeons the surgery standard, and those of other specialists the standards in their respective fields—but there is no incentive to determine whether some of the resources devoted to

99. Highly integrated and comprehensive PGPs obviously have more control over resource allocation than do FMCs, whose providers use independently owned and operated facilities. See also note 3 *supra*.

100. Theoretically, HMO subscribers would be best served if the last dollar spent on each action achieved the same value of health; otherwise, adjusting expenditures from less to more productive areas could improve subscriber health at no additional cost. Some health-promoting expenditures are directly or indirectly governed by malpractice standards; others are not. Within the medical areas affected by malpractice law, there is also room for adjusting expenditures according to which are most cost-effective in reducing risks. It is this type of adjustment which HMOs may be impeded from making by malpractice norms set in the fee-for-service sector, where such re-allocations of resources are usually far more difficult, if not impossible, to make.

careful surgery might be better spent, for instance, on more nurses. Malpractice law will set and enforce each of these standards separately.¹⁰¹ This means that very different levels of care can and do prevail in different areas.¹⁰² An HMO, responsible for all care, has the capability to gather adequate data, evaluate the findings, and take appropriate precautions at each stage of care, according to the costs, values, and risks throughout diagnosis and treatment, and also has the incentive and ability to shift resources from one area to another if similar overall risks can be achieved at less cost. This ideal resource-allocation process may be extraordinarily difficult to achieve in practice because of limited knowledge and high costs of data-gathering, implementation, and the like. But the potential is there, and HMOs' unique capabilities and incentives in this regard could be nullified by requiring them to follow the patterns of risk-reducing measures established by very different fee-for-service practice.

An even more basic task than harmonizing the standards for different phases of one type of care is balancing the risk-reducing worth of care for different illnesses and of preventive versus acute care. Which is more important: very highly qualified surgeons or more residents in the emergency room; screening for birth defects or treating middle-aged hypertension? Fee-for-service medicine cannot effectively address such questions, since these issues are not encompassed within the jurisdiction of any decision-maker who controls, provides, or finances care. Nor can malpractice litigation, concentrating on a particular kind of bad result in an individual case, offer much guidance in this important social area; the judicial process is inadequate for consideration of such broad resource-allocation issues. It may not be too much to ask of malpractice law, however, that it refrain from enforcing standards which effectively deter HMOs from achieving whatever progress in this area is feasible within the state of the medical art.

101. This is not meant to imply that the law of malpractice will actually govern all medical actions. Malpractice standards can best deal with the most straightforward medical cases; where particular services are not clearly and directly related to individual bad results, malpractice is a poor enforcement tool. Many risk-reducing measures may be seen statistically to improve results without their omission's being demonstrably related to particular bad results. For example, clean hospital corridors might be very important for quick recovery of patients, but the problems of proving that filthy ones caused harm would normally be insuperable.

102. In fact, some authorities think that simple measures to coordinate the fragmented approach to health care within large hospitals may be the most valuable contribution to overall risk reduction that can now be easily made—at very little cost compared with using much more highly qualified practitioners or expensive diagnostic or treatment procedures to reduce risks. ASSURING QUALITY OF HEALTH CARE, *supra* note 7, at 63.

A PROVISIONAL SOLUTION WITHIN THE CUSTOMARY APPROACH: HMO CUSTOM AS THE STANDARD OF CARE

Both fairness and socially appropriate risk reduction would be served by independent assessments of fee-for-service and HMO care by the same standards of reasonableness, with full judicial cognizance of the importance of costs.¹⁰³ Instead, the law must rely upon medical custom to set standards: despite numerous theoretical and practical objections, no workable replacement for this approach seems likely to emerge in the foreseeable future. Under these circumstances, it seems desirable to insulate HMOs from having to follow the custom of a very differently organized system of medical care. There is one way to recognize the legitimacy of HMO practices in the absence of independent judicial assessment of each noncustomary practice. The law could

103. Judicial evenhandedness and full social consideration of costs in standard-setting could be achieved by well-informed judicial evaluation of negligence, and there is some indication that courts may be turning away from a strict customary practice approach to malpractice. Note, *Evaluation of Change*, *supra* note 24, at 745-47; Note, *Comparative Approaches*, *supra* note 49, at 1149 n.44. In *Helling v. Carey*, 83 Wash. 2d 514, 519 P.2d 981 (1974), for example, the Supreme Court of Washington held the failure to administer a particular diagnostic test negligent as a matter of law, in spite of undisputed evidence of customary practice to the contrary. The court seemed to reason that a pressure test for glaucoma should be routinely given to all ophthalmological patients because of the seriousness of glaucoma-induced loss of sight and the small expense and low risk of the test itself. *Id.* at 519, 519 P.2d at 983.

In this case, however, custom may well have correctly assessed the costs and risks in not administering the test to people under forty because of the rarity of glaucoma before that age. See Note, *Comparative Approaches*, *supra* note 49, at 1149 n.38. The *Helling* court, however, took no account of the magnitude of the risk sought to be reduced, which, for the plaintiff in her late twenties, was less than one in 25,000. The plaintiff had a history of repeated vision problems, however, 83 Wash. 2d at 515-16, 519 P.2d at 981, and the court might have limited its holding by placing her in a higher-risk category to which different customary standards might have applied, *id.* at 517-18, 519 P.2d at 982. Instead, the holding effectively requires ophthalmologists to omit the test at their peril, and 25,000 patients will have to pay for the diagnosis of a single illness. The concurring opinion, *id.* at 520, 519 P.2d at 984, correctly noted that this result in fact closely resembles a strict or absolute liability approach—but following the new customary practice set out by the court will immunize providers and prevent compensation to the injured (in the likely event that the test is not 100 percent foolproof), so that neither optimal deterrence nor full compensation is achieved. If *Helling* is typical of independent judicial assessment of negligence, HMOs and other providers would be better off without it.

A more rigorous negligence assessment should be possible, and the growing literature of medical cost-benefit analysis, especially of diagnostic tests, may facilitate this in the future. See, e.g., Mass. Dep't of Public Health, *Cost-Benefit Analysis of Newborn Screening for Metabolic Disorders*, 291 NEW ENG. J. MED. 1414 (1974) (finds screening cost-justified; but note failure to discount future savings to present value); Neuhauser & Lewicki, *What Do We Gain from the Sixth Stool Guaiac?*, 293 NEW ENG. J. MED. 226 (1975).

accept HMO custom as determinative of due care, to the same extent that insured fee-for-service custom is now accepted, in effect allowing this subgroup of medical practitioners to set its own malpractice standards. Whether or not a particular HMO practice was negligent would thus be judged by the practice of other HMO providers under comparable circumstances.¹⁰⁴

Such a solution may at first blush seem radical, since it would in some cases accept as appropriate two different standards of care—HMO and fee-for-service—for a single treatment or diagnosis. In many cases, however, the standards would probably be nearly identical because of widespread agreement on the worth of particular practices. Moreover, the differences in standards would not necessarily reflect different levels of risk reduction, but often only variations in the style of achieving a similar risk of bad outcomes.¹⁰⁵

Actually, it is not so surprising that different medical standards should be accepted as appropriate, given the uncertainties inherent in much medical care and the inability of malpractice law to evaluate most medical risks and the risk-reducing or -enhancing effects of different standards. After all, it is these factors which have led to reliance on market-oriented standards in place of judicial judgment. Malpractice law formerly accepted the coexistence of a great variety of health care practices in the medical marketplace—each “school of practice” had its own practitioners, standards, and prices—and judged each case by the custom of the school of treatment of the health care provider elected by the patient.¹⁰⁶ Malpractice law today, while it holds all providers to certain minimum requirements,¹⁰⁷ accepts multiple standards where noncustomary practice is supported by a “reputable minority” of practi-

104. Courts should, nevertheless, continue to examine HMO customary practice for reasonableness whenever judicial assessment is feasible, see note 103 *supra*, to the same extent that fee-for-service custom is also scrutinized.

105. HMOs offer good quality care, comparing favorably with that of providers in general. See note 12 *supra*.

106. *E.g.*, *Klimkiewicz v. Karnick*, 150 Colo. 267, 372 P.2d 736 (1962) (chiropractor); *Force v. Gregory*, 63 Conn. 167, 27 A. 1116 (1893) (homeopath). The “school of practice” doctrine has faded somewhat as modern allopathic medicine has come to be accepted as the only scientifically valid school, and both licensure and malpractice law reflect this. Other “schools” have adopted medical tenets, like osteopathy, or accepted limited scopes of practice, like chiropractic. A nonmedical doctor or health care practitioner will be judged by the standards of medical doctors if the care given constitutes medical practice. *E.g.*, *HOLDER* 44. The “school” approach has merged into the similar “reputable minority” approach, but now usually covers minority opinion among medical doctors. Spiritualists, magnetic healers, and the like do not constitute reputable minorities. *PROSSER* 163.

107. *PROSSER* 163.

tioners on the ground that it is just as effective medically as majority practice.¹⁰⁸ Furthermore, there is precedent for dual standards of care, on economic as well as medical grounds, in the different standards applied to specialists and general practitioners¹⁰⁹ and in the rationale underlying the locality rule.¹¹⁰

An HMO custom rule would be broader than the current "repu-

108. See authorities cited at note 28 *supra*. This doctrine is not well suited for examining the legitimacy of all noncustomary HMO practice, however. It is normally applied where there is a medical disagreement on the risk-reducing effectiveness of different procedures, as where one group of surgeons favors one medical ground on operation and another a different operation. The difficult HMO case, in contrast, arises from a noncustomary HMO valuation of agreed-upon medical facts. The doctrine is also applied on a procedure-by-procedure basis, which would complicate consideration of the likely HMO rationale—that a given procedure is not provided because another is more valuable.

109. Medical specialists and general practitioners coexist, providing services which frequently overlap, but under markedly different malpractice standards of care. The performance of specialists is measured by the standards of fellow specialists. Those standards are higher than those of doctors generally, and may be national rather than local. See note 27 *supra*. Malpractice law thus accepts at least two different standards, with different economic antecedents and consequences, for identical procedures. The patient's choice of provider will determine the standard of care he receives. The ostensible rationale for a higher specialist standard is that specialists hold themselves out as more than ordinarily qualified. *Belk v. Schweizer*, 268 N.C. 50, 56, 149 S.E.2d 565, 569 (1966); 1 LOUISELL & WILLIAMS ¶ 8.04 n.60. Lurking in the background, though not seen as crucial, is the fact that specialists typically are paid considerably higher fees, a factor which surely has some bearing on their ability to maintain a higher standard. That patients may choose a GP's lower standard of care, perhaps for reasons of lower cost, lends some support to the notion that separate HMO standards, resulting largely from cost considerations, are appropriate.

110. The locality rule, as traditionally applied, reflects a very real concern for the costs of achieving particular standards of care, though the rule is not usually discussed in those terms. Normally, the application of different standards in different localities is explained by the great variation among regions in the availability of facilities, personnel, and continuing education. Isolated practitioners, for example, have been thought unable to keep abreast of developments in medicine elsewhere. *HOLDER* 53-54; *McCoid* 569-70. Such differences are not due to an absolute impossibility of meeting higher standards, but rather in large measure can be explained as a matter of cost. The most backward area could, after all, allow its doctors six months of the year to train at some advanced medical center, or achieve a very high standard of care, except perhaps in cases of the utmost emergency, by simply providing helicopter service to the Mayo Clinic. Nonetheless, the locality rule retains, and it is important that it does, an implied recognition that different costs may dictate different medical malpractice standards.

So analyzed, the locality rule supports the legitimacy of weighing costs in setting standards for HMOs, but a separate HMO standard is not strictly analogous to separate rural standards. HMOs, like rural areas, are apt to balk at the cost of meeting some customary malpractice standards, but, unlike rural areas, not because of the practical impossibility of raising the cash. The reason, instead, is a different valuation of the worth of the standard. Moreover, people are more apt to have considered what standard of care they will receive when joining an HMO than when moving to a rural area.

table minority" doctrine,¹¹¹ but narrower than a "school of practice" rule accepting completely different philosophies of medical care.¹¹² Allowing HMO custom to set negligence standards would be a recognition that, theoretically, HMO risk-reducing incentives are just as appropriate as those of fee-for-service providers for judging the social value of particular care, and that, empirically, the quality record of HMOs is excellent.¹¹³ In taking market-derived standards as its own, malpractice law would recognize the existence of two equally valid marketing approaches in the provision of health care. It is true that the economizing incentives of HMOs could lead some of them to "under-reduce" some medical risks. There is nothing to indicate, however, that such incentives would be greater than the incentives which cause over-spending in the fee-for-service context in attempts to eliminate risks.¹¹⁴

Moreover, to create separate and potentially different HMO standards is not to allow HMOs to exist in a vacuum. Insured fee-for-service is the dominant mode of practice, and dissatisfied HMO enrollees can change to other providers and conventional insurance coverage.¹¹⁵ HMOs thus feel constant competitive pressure to perform as well as fee-for-service providers.¹¹⁶ The reverse is seldom the case, since HMO care is not a competitive force in most areas. Furthermore, HMO physicians are educated at the same medical schools as other doctors, read the same journals, join the same professional organizations, and are presumably equally humane and desirous of helping their patients—factors which constitute extremely important protection against HMO corner-cutting in evaluating and acting to reduce medical risks. Further, HMO patients (and their relatives) are probably just as demanding of high-quality, low-risk care for a given illness as are others and may be more capable of detecting underservice than others

111. The HMO custom rule would apply across the board to all HMOs, not merely procedure by procedure like the reputable minority doctrine. It would also encompass noncustomary practice based upon evaluative disagreements with majority practice, not merely upon differences of opinion over medical effectiveness.

112. HMO divergences from majority custom would be acceptable because of different evaluations and style differences in applying similar methods, but not because of fundamentally conflicting philosophies of healing methods.

113. See generally authorities cited in note 12 *supra*.

114. Overeconomizing, moreover, would not be universal among HMOs, and the general level of care would set the standard.

115. Many HMOs follow a "dual choice" policy. See, e.g., Phelan, Erickson & Fleming, *supra* note 3, at 799-800. Dual choice is also embodied as federal policy in the HMO Act of 1973. 42 U.S.C. § 300e-9 (Supp. III 1973).

116. Lack of subscriber-patient knowledge and understanding may, however, limit competition's effects.

are of resisting overservice.¹¹⁷ Finally, the integration of services and the centralization of many important medical decisions inherent in the HMO concept enable subscribers to wield substantial influence through grievance procedures, consumer participation on policy boards, and the like.¹¹⁸ Such efforts are far more difficult in the more fragmented fee-for-service sector, where each hospital, clinic, or medical partnership is independent. Such consumer inputs are imperfect substitutes for well-informed individual patient or subscriber choice, but they are superior to the alternative of nearly total physician discretion in medical decision-making, which creates the customary practice now enforced by malpractice law.

An HMO custom rule would increase emphasis on subscriber choices—and willingness to pay—as determinants of the socially acceptable level of risk in HMO care.¹¹⁹ It would also shift the perspective of decision-making somewhat away from individual illnesses or crises, the management of which sets the current standard, and toward the more dispassionate focus of a health subscriber's evaluation of hazards from all health-threatening conditions. To the extent that the rationale for a market-oriented negligence standard rests on the assumption that medical custom represents both physician and "customer" views, this is an appropriate shift. To the extent that the medical custom standard simply accepts aggregate physician judgment in lieu of a social judgment on risks, the HMO custom rule would substitute physician judgment constrained by cost considerations for largely unconstrained physician judgment. Finally, a separate HMO custom standard would permit use of different standards as a kind of social

117. HMO or insured patients face little cost for extra service and are apt to demand more services rather than less—at least to the extent that they know about possible risk-reducing measures their doctors might provide.

118. See Starr, *The Undelivered Health System*, 42 PUB. INTEREST 66, 81-84 (1976).

119. The extent to which agreements on risk reduction between provider and patient or enrollee ought to influence or supersede malpractice standards is an important, difficult, and seldom considered question. Particular medical measures, even if more than normally risky, are acceptable where a patient knowledgeably assumes the risk or gives informed consent. More difficult is the case of an HMO which might offer a higher level of risk in medical care in exchange for lower premiums. Here, subscribers, though they could not know in advance exactly what risks are at stake, could rationally choose the general level of care they wish, from Volkswagen to Mercedes, and general regulation could keep quality of care above acceptable minimums. Havighurst & Bovbjerg, *supra* note 19, at 415-16. Thoroughgoing malpractice specification of what care is appropriate obviously would inhibit the making of such choices. Our society generally allows free consumer choice between Volkswagens and Mercedes, without expecting the former to be as safe as the latter, even though consumers are only very poorly able to weigh the exact differences in safety. The law, however, intervenes much more readily in the provision of medical care than in the sale of cars.

experiment, perhaps ultimately generating enough information about both fee-for-service and HMO standards for an independent judicial assessment to be made of both of them.

The objections to an HMO custom standard mirror those against customary practice standards generally.¹²⁰ Unfettered HMO discretion in the setting of standards might be abused, given the imperfections of patient influence on medical decision-making generally. Moreover, established HMO practice might, through malpractice law, unduly inhibit others—for example, very innovative new HMOs or an entirely new type of medical organization—from legitimate experimentation with noncustomary methods.

In implementing the proposed HMO custom standard, courts must set forth clearly their rationale; exactly why HMOs are a special case must be understood or the old battle over what schools of practice are legitimate could be reopened: if HMOs set their own standards, why not snake-oil salesmen? Similarly, exactly what constitutes an “HMO” eligible for different standards must be clear; the proposed rule should not serve to legitimate the practice of any group choosing to accept prepayment.¹²¹ Judicial experience with deciding whether a given minority’s practice is “reputable” might offer helpful precedent, but the underlying theory of that doctrine is poorly articulated, and the question of the legitimacy of HMO practice generally goes far beyond that of whether a particular noncustomary practice is acceptable in one set of circumstances. The questions here may be difficult and costly to handle under established judicial procedure, as they potentially involve the entire scope of operation of complex institutions. The locality rule in some jurisdictions would also need modification, since there are so few HMOs in most of the country. The law should compare the custom of similarly situated HMOs, so as to avoid grouping together the practices of very disparate organizations, ranging from large urban conglomerates to small rural group clinics, which operate under very different

120. This Article has argued that HMOs are less likely than fee-for-service providers to miscalculate risk reduction and costs, to concentrate inappropriately on process standards, or to be subject to other problems stemming from custom-derived standards. See notes 42-102 *supra* and accompanying text.

121. To borrow Prosser’s comment on the “school of practice” doctrine, not any “quack, charlatan or crackpot” should be allowed to “set himself up as” an HMO. PROSSER 163. This problem would not be so serious in the HMO case because so many HMOs are clearly reputable and these providers would set the new HMO group’s standards of care. Nonetheless, especially where HMOs accept higher risks in one area for the sake of lowering others, see notes 100-02 *supra* and accompanying text, malpractice suits might have to examine practice in both areas, a task for which the case-by-case judicial process is not well suited.

resource constraints. Finally, some HMOs might resist a separate HMO custom standard, fearing that separateness would suggest non-equality to potential enrollees.

Nonetheless, despite theoretical and practical problems with an "HMO custom" malpractice standard, the proposed test makes sense. Allowing HMOs to develop different malpractice standards should help to hold down risk-reducing costs and to maintain a healthy diversity of approaches to medical care—a very desirable goal in an uncertain field.

CONCLUSION

It should not be expected that unleashing HMOs from the majority medical custom rule will solve all malpractice problems or greatly ease the intractable difficulties of deciding how much medical care is enough and how safe it should be. It is, however, a modest step in the right direction. The capacity of modern medicine to intervene on behalf of human health is immense and growing rapidly, as is the capacity to gather information in deciding whether and how to intervene. But the ability to finance medical procedures is limited, and choices must be made. Medical custom and the law of medical malpractice are important influences on these choices—though perhaps less so than are the organization and financing of health care itself. In any case, finding workable approaches to these problems requires additional attention from the medical and legal communities.

It seems likely that only decision-makers motivated to face up to the harsh fact of limited medical resources can be expected to incorporate cost considerations effectively into their risk-reduction calculations. In theory, patients, third-party insurers, or courts might perform this function, but HMOs offer a unique opportunity to combine the viewpoints of patient, insurer, and provider in determining the proper standard of care. Policed by a malpractice rule of customary HMO practice, and by independent judicial evaluation of standards when feasible, such relative autonomy for HMOs might well be the best solution achievable within the customary practice approach to malpractice law.