ALTERING THE APPLICABLE STANDARD OF CARE

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I

INTRODUCTION

Identifying the essential characteristics that distinguish a profession from other service occupations is a common exercise. Perhaps a better way to judge the degree of professionalism, however, is with reference to the ease or difficulty of precisely specifying a provider's performance obligations in advance of the provision of services. For most medical services, the range of possible exigencies is so great that no imaginable contract or regulation could explicitly state the physician's duty under all of them. Efficiency in the delivery of such services therefore requires some departure from a pure contractual or regulatory model. Accordingly, society imposes special ethical and legal requirements on persons who are regularly employed by clients, not to bring about a specific, definable result, but to exercise specialized knowledge and skills on their behalf.[1]

Tort law recognizes the inefficiency that can arise because of the disadvantages under which consumers labor in dealing with professionals by making certain obligations to clients an incident of professional status.[2] The

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1. Thus, professionals are generally expected to act ethically in their individual dealings with clients and to work collectively to ensure that other practitioners adhere to high standards of performance and conduct. As antitrust actions involving professionals have shown, there are certain risks to society in letting an entire profession act in concert. *See, e.g.*, National Soc'y of Professional Eng'rs v. United States, 435 U.S. 679 (1978); American Medical Ass'n v. Federal Trade Comm'n, 638 F.2d 443 (2d Cir. 1980), *aff'd by an equally divided Court*, 455 U.S. 676 (1982); *see also* Havighurst, *The Doctors' Trust: Self-Regulation and the Law*, HEALTH AFF., Fall 1983, at 64. There are, however, strong theoretical justifications for looking beyond market and contractual mechanisms for the protection of uninformed consumers of medical services. *Compare* Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963) (a classic article finding benign explanations for nonmarket institutional arrangements), *with* P. STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 226-27 (1982) (faulting Arrow for too readily accepting profession-inspired trade restraints).

2. When tort doctrine is viewed in these terms—as assigning duties on the basis of professional status—it is essentially prescriptive and regulatory, an expression of community values and public policy. *See e.g.*, W. PROSSER & W. KEETON, THE LAW OF TORTS § 4 (5th ed. 1984) (defining a tort as a "breach of duties fixed and imposed upon the parties by the law itself, without regard to their intent to assume them, or their efforts to evade them"). It is possible, however, to take another view of the function of tort rules establishing the rights and duties of parties who are not strangers to one another but have a commercial relationship. In such circumstances, tort rules can be seen as terms of an implied contract by which the law allocates risk according to a combination of factors, including

thesis of several contributions to this symposium on medical malpractice, however, is that efficiency also requires that the legal system tolerate certain private agreements that seek to alter in some way the rights and responsibilities thus legally prescribed. This article, in pursuing this theme further, considers not so much *whether* but precisely *how*—that is, by what contractual formulation of service obligations—the substantive duties of health care providers[3] might be varied by private contract.[4] Consideration of the drafting problem naturally requires, however, some comment on the merits of the standard of care embodied in malpractice law and of particular attempts to alter that standard.

II

THE LEGAL PRESUMPTION IN FAVOR OF CUSTOMARY PRACTICE

The impossibility of precisely articulating in advance the performance required of a health care provider under all possible circumstances explains why professional custom has been widely used as a benchmark for evaluating a professional's work.[5] Indeed, if there is to be accountability at all, any specification of the obligation of true professionals to their clients must at some point have reference to what other professionals would do under the same circumstances. It is therefore not surprising that the law of medical malpractice makes all departures from prevailing professional standards at least suspect.

Although some courts attach greater significance than others to deviations from customary practice, there is always a presumption against providers who seem to be out of step.[6] The legal formulations vary, but the dominant

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the probable preferences and interests of the parties and the public's interest in spreading losses and deterring injuries. *See* 1 S. PEGALIS & H. WACHSMAN, AMERICAN LAW OF MEDICAL MALPRACTICE § 2:1 (1980). This contractarian view of tort law obviously leaves more room for the parties to provide explicitly for a different set of rights than the law presumes to create. *See* Epstein, *Medical Malpractice: The Case for Contract*, 1 AM. B. FOUND. RESEARCH J. 87, 94-95 (1976).

3. Although the problem of specifying enforceable duties is presented here in the context of individual professionals, it also arises with respect to institutional providers of health care, which supply the services of many individual professionals and are liable for their torts under the doctrine of respondeat superior. Legal standards governing hospitals as institutions are also frequently derived by observing industry custom and standards. *See, e.g.*, Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d 326, 338-39, 211 N.E.2d 253, 260-61 (1965).

4. This article should be read in conjunction with others in the symposium that explore other ways in which tort rights might be altered. *See, e.g.*, Ginsburg, Kahn, Thornhill & Gambardella, *Contractual Revisions to Medical Malpractice Liability*, LAW & CONTEMP. PROBS., Spring 1986, at 253; Henderson, *Agreements Changing the Forum for Resolving Malpractice Claims*, LAW & CONTEMP. PROBS., Spring 1986, at 243; O'Connell, *Neo-No-Fault Remedies for Medical Injuries: Coordinated Statutory and Contractual Alternatives*, LAW & CONTEMP. PROBS., Spring 1986, at 125; Tancredi, *Designing a No-Fault Alternative*, LAW & CONTEMP. PROBS., Spring 1986, at 277. Parties' doubts about their ability to formulate a meaningful and enforceable alternative standard of care might lead them to try to solve the malpractice problem in some other way. Obviously, the various approaches can be combined.

5. For another presentation of this explanation, see Epstein, *Medical Malpractice, Imperfect Information, and the Contractual Foundation for Medical Services*, LAW & CONTEMP. PROBS., Spring 1986, at 201.

6. For general discussions of the standard of care, indicating the strong de facto presumption in favor of those practitioners using mainstream methods, see J. KING, THE LAW OF MEDICAL MALPRACTICE IN A NUTSHELL 42-54 (1977); W. PROSSER & W. KEETON, *supra* note 2, § 32; King, *In*

principle is that adherence to prevalent professional standards creates an almost irrebuttable presumption of due care.[7] Even though the law may not treat a departure from custom as negligence per se or as raising an adverse presumption, its denial to deviating providers of the benefit of a favorable presumption increases the likelihood that liability will be found. Some courts allow physicians to offer in defense of a departure from customary practice the support of a "respectable minority" of professionals,[8] the existence of an "honest difference of opinion,"[9] or expert testimony that what was done was reasonable and prudent.[10] Nevertheless, the best defense is always that the physician did what most other physicians would have done and that the practice is approved and generally recognized in the profession as an appropriate procedure.[11] Thus, the law creates strong pressure to adhere to professional custom. Much care that physicians perceive as "defensive medicine" appears to be a response to the pressure to do more than individual professionals believe to be necessary and cost-justified.

Although the law's reliance on professional custom creates arguably excessive pressures to conform to conventional practice styles, it is hard to see how the law could otherwise define a professional's duty. Indeed, it is not only natural but efficient—given the absence of other ways of defining professional duties—for the law to have reference to professional custom. A private draftsman writing an explicit contract would also find it convenient to incorporate generally prevailing professional standards by reference. It is practically impossible to define the obligations of a true professional by any other means.

Interestingly, this explanation of why professional custom has been widely used as a legal benchmark also suggests why some contractual modifications

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Search of a Standard of Care for the Medical Profession: The "Accepted Practice" Formula, 28 VAND. L. REV. 1213, 1234-75 (1975); McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 605-09 (1959).

7. *See, e.g.*, Downer v. Veilleux, 322 A.2d 82, 88 (Me. 1974) (plaintiff must prove a departure from the "general custom and practice of those reasonably skilled in the profession"); Bailey v. Williams, 189 Neb. 484, 486, 203 N.W.2d 454, 456 (1973) (physician must exercise that level of care and skill that other physicians "would ordinarily exercise and devote to the benefit of their patients"); *see also* N.C. GEN. STAT. § 90-21.12 (1985). For the leading exception to the principle that adherence to custom shields a physician from liability, see Helling v. Carey, 83 Wash. 2d 514, 519 P.2d 981 (1974), in which the court found a physician negligent for not doing a diagnostic test that was not indicated by medical custom. On that case and on cases varying the locality rule to hold professionals to standards prevailing in other markets, see Havighurst, *Private Reform of Tort-Law Dogma: Market Opportunities and Legal Obstacles*, LAW & CONTEMP. PROBS., Spring 1986, at 143, 159 n.45.

8. *See, e.g.*, Baldor v. Rogers, 81 So. 2d 658, 660 (Fla. 1954).

9. *See, e.g.*, Bruce v. United States, 167 F. Supp. 579, 588-89 (S.D. Cal. 1958); Haase v. Garfinkel, 418 S.W.2d 108, 114 (Mo. 1967).

10. *See, e.g.*, Hood v. Phillips, 554 S.W.2d 160, 165-66 (Tex. 1977) (reviewing various legal definitions of the standard of care).

11. On the "accepted practice" formula, which shifts the focus from what is actually done to what is expected by the profession, see Blair v. Eblen, 461 S.W.2d 370, 373 (Ky. 1970); King, *supra* note 6, at 1240-41; *see also* WASH. REV. CODE § 7.70.040(1) (Supp. 1985). By appealing to the ideal of the profession, this standard prevents hiding behind bad practice, but, by leaving the definition of standards in professional hands, it fails to solve many of the problems that might prompt private efforts to seek a less demanding standard. *See* Havighurst, *supra* note 7, at 158-59.

of that basic standard should be acceptable. Custom has been incorporated into both implied and explicit contracts, not because customary practice is always optimal and right, but because it is a convenient and efficient way of specifying enforceable duties. Even though professional custom may be a good starting point for delineating professional obligations, its use as a standard may not yield the desired result in all cases. Although custom might be deemed useful as a general benchmark, particular occasions or circumstances can be imagined in which departures from custom should be authorized as a way of improving the quality or lowering the cost of care. Different consumers or consumer groups might perceive differently the appropriateness of particular exceptions to the general standard, or they might have different views concerning the trustworthiness of the particular providers with whom they deal. The extent to which customary practice should govern a particular professional relationship depends heavily upon whether custom is a good or a not-so-good general guide to appropriate professional performance.[12]

In health care at the moment, there are good reasons for doubting that the prevailing norms and standards of the medical profession are consistently reliable guides to appropriate practice and the efficient allocation of resources.[13] Those norms and standards became customary in an era in which health care was paid for in such a way that cost was virtually no object.[14]

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12. In addition to the deficiencies of the customary practice standard mentioned in the next paragraph, another shortcoming is the difficulty of reliably establishing professional custom. Not only is there less uniformity of practice than the law seems to assume, *see infra* note 17 and accompanying text, but the problem of discovering such consensus as does exist is compounded by adversary selection in malpractice cases of experts who purport to testify to professional standards. Thus, even if prevailing standards were deemed acceptable in principle as a benchmark for defining professional duties, the parties to a medical transaction might conclude that there is no good way to ascertain such standards and thus be driven to fashion another standard or make some other modification of the tort system.

13. A leading physician student of quality-of-care issues discusses professional norms as follows:

> The one best strategy is, of course, an idealized concept that is difficult, if not impossible, to specify in practice. One is handicapped, on the one hand, by the great variability in the manifestations of illness among various subjects. On the other hand, imperfections in knowledge force practitioners to fall back on personal experience and judgment to fill the gaps. There is, nevertheless, enough similarity among patients and enough medical knowledge to allow practitioners with recognized expertise to specify a strategy of care, or a set of alternative variants, that would serve to define either something close to the best care we can now provide or a sufficiently high level to be generally acceptable. Thus one codifies the norms of care, and uses these norms to judge the performance of individual practitioners. These practitioners do, of course, continue to have the opportunity, indeed the responsibility, to deviate from the norms without being censured, provided they can show that such deviations are justified because of the special circumstances of a particular case.
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> When expert practitioners specify the preferred strategies of care based on what they consider to be best for patients, and without regard to momentary [*sic*; read "monetary"] costs, we have what may be called an absolutist definition of quality.

Donabedian, *Quality, Cost, and Clinical Decisions*, 468 ANNALS 196, 200 (1983). Introducing the cost factor leads ultimately, says Donabedian, to "moral ambiguity," *id.* at 201, and serious tensions that the profession is poorly prepared to resolve. Because trials of malpractice cases invite the exercise of hindsight and the invocation of an "absolutist definition of quality," *see supra* note 12, the legal system seems likely to inspire inefficient practice.

14. *See* Havighurst, *supra* note 7, at 158-59.

It is therefore doubtful that they reflect an adequate awareness of the trade-offs between costs and benefits.[15] In addition, there is now recognition that many clinical methods embodied in professional standards have only a weak scientific basis. Numerous deficiencies can be observed in the supposedly scientific process by which the medical profession determines how specific medical conditions should be treated.[16] It appears that many factors that ought to be taken into account—cost being only one such factor—are systematically neglected in the profession's collective thinking. Finally, several students of the industry have recently called attention to the fact that clinical practices vary widely and inexplicably from place to place.[17] Given these reasons to doubt the appropriateness of professional standards, private parties might well find that customary practice, even though useful as a starting point in defining duties, ought not to be the definitive measure by which providers are judged.

The usual response to the discovery that an existing standard is unproven, inefficacious, or inefficient is to advocate further studies and the alteration of professional practice patterns to accommodate the new finding.[18] Such responses are clearly appropriate, but they do not solve the problem. Research often cannot definitively resolve differences of opinion, particularly in the short run. In the meantime, until customary practice is clearly shown to be unsatisfactory, the pressure to adhere to it remains intense. Moreover, when new findings do begin to appear, the law imposes special risks on those who first depart from the old custom, placing a greater burden of proof or persuasion on those who cannot show that they practiced according to established norms. Finally, the law, as currently formulated, takes no account of the possibility that some patients, particularly those who regard their providers as especially competent and trustworthy, might be willing to rely upon their providers' judgment and to assume some of the risk of foregoing unproven or marginally beneficial therapies in return for lower prices. Thus,

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15. On the importance of such trade-offs and the low likelihood that they can be taken account of in professional norms, see Havighurst & Blumstein, *Coping with Quality/Cost Trade-offs in Medical Care: The Case of PSROs*, 70 NW. U.L. REV. 6, 12-13, 25-33 (1975); *see also supra* note 13. Prevailing custom may be a more reliable guide to efficient behavior in nonmedical settings, where it reflects private decisions by buyers and sellers to incur or not to incur the cost of added increments of safety. *See* Posner, *A Theory of Negligence*, 1 J. LEGAL STUD. 29, 32-33 (1972); *see also* McCoid, *supra* note 6, at 605-06 (discussing the relevance of custom in nonmedical cases).

16. *See* Eddy, *Clinical Policies and the Quality of Medical Practice*, 307 NEW ENG. J. MED. 343-45 n.6 (1982) (specifically observing problems in the perspective and methods of medical researchers, in clinicians' uses of empiricism, and in incentive systems). Many of the accepted methods of clinical practice did not achieve their status through scientific demonstration of their superiority in all relevant respects over other methods.

17. *See Variations in Medical Practice*, HEALTH AFF., Summer 1984 (symposium). Of particular interest in this symposium is Wennberg, *Dealing with Medical Practice Variations: A Proposal for Action*, HEALTH AFF., Summer 1984, at 6.

18. *Cf.* Eddy, *supra* note 16, at 345. "The burden of proof is on anyone who wants to change an existing policy." *Id.* Initial recommendations, although often based on limited experience, become "time honored" and vulnerable to change only with great effort. As an example, "[i]t took more than half a century to evaluate and modify the surgical approach to breast cancer." *Id.* A great deal of promising reevaluation of medical practice has occurred in recent years, in large measure because of increased concern about the cost of care.

the argument that professional standards should not be conclusive is not an argument that professional standards should not be improved. Indeed, it can be argued that leaving the door open to agreed-upon departures from customary standards can actually speed both the discovery of better methods (by allowing natural experiments) and the implementation of new learning.

III

RESTATING THE PROVIDER'S DUTIES

Drafting a contract explicitly stating a health care provider's duty to patients is an interesting exercise. There is virtually no judicial guidance about how it might be done. Case law suggests, of course, that a court may view the agreement as a contract of adhesion and that its drafter must therefore be prepared to demonstrate that the terms are not basically unfair.[19] Proponents of these contracts must also be prepared to confront the charge that such an attempt to rewrite legal doctrine violates public policy and is therefore invalid. The cases invoking this principle, however, all appear to involve exculpatory clauses that go significantly further than anything proposed here.[20] Moreover, as already noted, there are some good public policy reasons for approving, not disapproving, at least some contractual modifications of the applicable standard.

The draftsman should begin by consulting local law. Judicial precedent may provide useful definitions of terms in addition to indicating that some approaches or formulations are more promising than others. Statutory law may present either some special opportunities or special problems that must be overcome. For example, an Illinois statute provides that releases entered into prior to treatment are against public policy, but it could be argued that this provision bars only exculpatory clauses and does not preclude an attempt merely to modify the prevailing legal standard.[21] A Florida statute that purports to state the applicable standard of care fully and explicitly[22] might be read to preclude contractual modifications; nevertheless, the statute does not explicitly preempt private agreements.

There are a variety of approaches that one can take in drafting a contractual modification of the applicable standard. The first may be called the "restatement" approach. This approach would not involve trying to change the applicable standard, but rather clarifying and shaping it in a desirable way. A reformer might, for example, review the cases in the jurisdiction and adopt the terminology that is most favorable and least ambiguous. A slightly less conservative approach might reach farther afield, perhaps taking doctrine or statutory language from another state; local courts might be less likely to declare "unconscionable" language that is the law of another jurisdiction. Alternatively, the draftsman might set out from scratch

19. *See* Havighurst, *supra* note 7, at 164-68.
20. *Id.* at 163-64.
21. Medical Practice Act § 41,ILL. ANN. STAT. ch. 111, ¶ 4478 (Smith-Hurd Supp. 1985).
22. FLA. STAT. ANN. § 768.45 (West Supp. 1985).

to write language that is intended as an improvement over local law, hoping to persuade a court later to see the merit in the effort.

An entirely different way of improving the legal climate might be to leave the substantive standard of care unchanged and to address instead the way in which breaches of the provider's legal duty can be proved. A patient might agree only to call expert witnesses having certain special qualifications, somewhat increasing the chance that the de facto test for negligence applied in the courtroom will be a realistic one. Other specifications of admissible evidence could be made. A particularly useful strategy might be to address the burden of proof, specifying that the plaintiff has not established a prima facie case just by showing a departure from customary practice.

A variety of approaches could be combined to produce a contract provision like the following:

> The Physician's Duty to You
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> The Physician warrants that he or she possesses at least the skill and knowledge of a reasonably competent medical practitioner in the Physician's specialty and undertakes to you that he or she will exercise that skill and knowledge in a reasonable and prudent manner in your case. In so doing, the Physician may sometimes depart from practices customary among other physicians. Such departures shall not be deemed to breach the foregoing undertaking, however, unless they are expressly found to have been unreasonable and imprudent; evidence to support such a finding shall consist solely of the testimony of experts knowledgeable about scientific studies bearing on the appropriateness of the actions taken and about what, in the light of all the circumstances including the cost of alternative measures, constitutes appropriate medical care. You agree that the undertaking in this paragraph fully defines the Physician's duty to you.

The advantages of this provision are that it leaves adherence to custom as a substantial (though not necessarily conclusive) defense, prevents departures from custom from being the basis for any automatic inference of negligence, and contemplates that scientific studies and cost factors will be considered before conduct is labeled negligent. The clause thus states a sound legal principle, one that is appropriate for legislative or judicial adoption. It is fair to ask how much difference such a clause would make in the outcome of cases. Although the answer probably is "not much," a jury instructed in accordance with the provision might appreciate that the issues are hard ones and not to be resolved on the basis of emotion alone.

A similar approach might be adopted by a group-practice or staff-model health maintenance organization (HMO)[23]:

> The Duty of the Plan's Physicians to You
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> The Plan warrants that each of its physicians possesses at least the skill and knowledge of a reasonably competent medical practitioner in his or her specialty and

23. These HMO varieties usually are more closely integrated, have different compensation arrangements, and exercise more control over their physicians than so-called individual practice associations (IPA's). *See generally* AM. MEDICAL ASS'N, HEALTH MAINTENANCE ORGANIZATIONS (1980). More loosely organized plans, including IPA's and so-called preferred provider organizations, might also contract for malpractice relief, but the suggested clause might not be deemed suitable.

A conceptualization helpful in understanding HMO's in the present context is provided by P. JOSKOW, CONTROLLING HOSPITAL COSTS: THE ROLE OF GOVERNMENT REGULATION (1981): "[W]e can certainly conceptualize an individual consumer's choosing an insurance contract with a negligible

> undertakes to you that its physicians will exercise that skill and knowledge in a reasonable and prudent manner in your case. In so doing, a Plan physician may sometimes depart from practices customary among other physicians. Such departures shall not be deemed to breach the foregoing undertaking, however, unless they are expressly found to have been unreasonable and imprudent; evidence to support such a finding shall include the testimony of experts knowledgeable about practices customary among physicians in other organized health plans in which physicians are not compensated on a fee-for-service basis. In instances where the Plan has consulted with the Members' Advisory Panel concerning a particular practice or method of diagnosis or treatment and obtained the Panel's approval of a particular clinical policy, adherence by the Plan's physicians to that policy shall not be deemed unreasonable and imprudent unless such approval was obtained by misrepresentation or unless changes in medical knowledge between the time such approval was obtained and the time you were treated indicate that continued adherence to such policy was unreasonable and imprudent. You agree that the undertaking in this paragraph fully defines the duties of the Plan and its physicians to you.

This provision requires that a plaintiff present evidence of practice standards in other prepaid plans whose physicians are not paid on a fee-for-service basis, thus letting the jury at least consider the custom that has evolved in more cost-conscious practice settings. An alternative approach would be to make such HMO standards the sole source of guidance to the jury, on the theory that adherence to standards supported by a "respectable minority" is a defense.[24] The HMO might prefer, however, not to appear reluctant to have its practices compared to those of the dominant system.

The other refinement suggested in the foregoing clause is the HMO's use of a "members' advisory panel" to screen decisions to economize or otherwise depart from medical custom. Such a panel, which should probably have the benefit of disinterested expert advice, could be viewed as a vehicle by which plan subscribers give their "informed consent" to deviations from accepted standards. Provision is made to ensure full disclosure and to protect against the possibility that new learning will render an approved clinical policy obsolete. The absence of explicit approval still leaves the issue of liability to be proved under the enlightened "reasonable and prudent physician" test.[25]

IV

REVISING THE LEGAL TEST FOR LIABILITY

The draftsman might take an entirely different approach to the problem of an unreasonably demanding standard of care. If the parties believe that the legal system is unreasonably biased toward finding liability in close cases, they might elect to raise the threshold of actionable negligence so that many

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coinsurance rate but with the restriction that care be provided only by physicians and hospitals who do so only if it satisfies some reasonable cost-benefit criterion." *Id.* at 37-38.

24. *See* Bovbjerg, *The Medical Malpractice Standard of Care: HMOs and Customary Practice*, 1975 DUKE L.J. 1375, 1408-14 (proposing "[a]n HMO custom rule . . . broader than the current 'reputable minority' doctrine, but narrower than a 'school of practice' rule accepting completely different philosophies of medical care"). If HMO standards were deemed too low, the higher standards of the fee-for-service community might be applied. *See supra* note 7.

25. *See, e.g.*, Shilkret v. Annapolis Emergency Hosp. Assoc., 276 Md. 187, 199-200, 349 A.2d 245, 252-53 (1975); Hood v. Phillips, 554 S.W.2d 160, 165-66 (Tex. 1977) (reviewing various legal definitions of the standard of care).

injuries currently actionable would not be compensable. The following is one possible formulation:

> Limitations on Your Legal Rights Against the Physician
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> In return for the Physician's acceptance of you as a patient on the terms provided for in this agreement, you agree that, in any legal action hereafter brought by you against the Physician for any injury suffered in the course of your treatment, you will be entitled to recover damages only if such injury was the result of the Physician's gross negligence. Gross negligence is distinguishable from ordinary negligence and is characterized by willful neglect of your personal well-being or reckless disregard for the consequences of some act or omission.

A similar clause might also be used by a hospital to protect itself and its personnel against suits for ordinary negligence. A contract seeking to limit the patient to suing only for gross negligence should include a clear definition of that term, one that not only informs the patient of his rights but could also be used in instructing the jury. To improve the odds on enforceability, this definition should certainly be no narrower than, and should perhaps be more liberal than, that found in local case law or statutes.[26] Such a clause would give a jury an opportunity to penalize any conduct by the provider that they found to be outrageous, but would result in a denial of compensation in some cases involving only arguable ordinary negligence.[27] If juries are as inclined to favor plaintiffs as they are reputed to be, there might not be a very large number of cases in which liability is denied even though objective observers would find clear fault.

This clause obviously does not purport to define the provider's contractual obligation to the patient, which would be spelled out elsewhere in the agreement. Instead, the clause directly forecloses the existing legal remedy for certain breaches of the provider's duty. Such a contract might be deemed to offend the Illinois rule that releases are against public policy[28] and would undoubtedly trouble many other courts. Nevertheless, a substantial case can be made for enforcing such an agreement.[29]

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26. Precedent for foreclosing actions for ordinary as opposed to gross negligence appears in automobile guest statutes. Formulations vary but would be useful in developing a contractual definition of gross negligence. *See generally* 60A C.J.S. *Motor Vehicles* §§ 399.3a, .5-.9 (1969). Other sources of definitions and relevant principles include the law of punitive damages. *See* Noe v. Kaiser Found. Hosps., 248 Or. 420, 435 P.2d 306 (1967); K. REDDEN, PUNITIVE DAMAGES § 4.2(A)(6) (1980 & Supp. 1983); Annot., 27 A.L.R.3D 1274 (1969). A plaintiff probably should not have to show intentional harm or malice, however, which some courts require as a prerequisite for punitive damages. *E.g.*, Ebaugh v. Rabkin, 22 Cal. App. 3d 891, 894, 99 Cal. Rptr. 706, 708 (1972) ("even gross negligence is not sufficient to justify an award of punitive damages").

27. Application of a gross negligence standard would require expert testimony, and a jury would not get the case unless a witness was willing to say that the standard had been breached.

28. *See supra* note 21 and accompanying text.

29. An agreement of this kind is almost certainly the most extreme limitation of a health care provider's liability that a court might be persuaded to enforce. As a general rule, "those who are not engaged in public service may properly bargain against liability for harm caused by their ordinary negligence in performance of contractual duty; but such an exemption is always invalid if it applies to harm wilfully inflicted or caused by gross or wanton negligence." 6A A. CORBIN, CORBIN ON CONTRACTS § 1472, at 596-97 (1962) (citations omitted). As argued in Havighurst, *supra* note 7, at 145-56, health care has become less a "public service" and more a consumer good in recent years, weakening the analogy to common carriers and other monopolistic enterprises to which the foregoing principle has historically been applied. Professors Robinson and Epstein, in arguing that

Today only a small percentage of the instances of actual provider negligence result in claims.[30] Explanations for the paucity of suits include the failure of patients to suspect, or discover, that negligence caused the injury; in other cases the potential recovery may be too small to prompt a plaintiff's attorney to invest the necessary effort. Some anecdotal evidence suggests, however, that many patients forego filing claims that carry some promise of a favorable result. This can occur because economic losses are covered by other mechanisms and the patient has no other reason to raise an issue.[31] Inaction could also be the result of loyalty to the provider, perhaps as a positive response to the provider's "bedside manner" or to other positive features in the provider/patient relationship. Other patients, perhaps reflecting cultural or subcultural values,[32] may have an affirmative distaste for litigation or may simply love doctors and hate lawyers.[33] It is arguable that

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even pure exculpatory clauses should be enforced, probably do not contemplate exoneration for intentional harms. *See* Robinson, *Rethinking the Allocation of Medical Malpractice Risks Between Patients and Providers*, LAW AND CONTEMP. PROBS., Spring 1986, at 173; Epstein, *supra* note 2.

30. *See* P. DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY 23-25 (1985) ("rough estimate that at most 1 in 10 negligent injuries results in a claim is probably an upper bound").

31. An acquaintance of the author claims to have once turned down a settlement offer of $25,000 without suing for the mishap, believing the hospital's clear error was a forgivable one. A study of accident victims who did not sue describes their thinking as follows:

> Fault and liability simply do not coincide [in their minds]. Sometimes payment of money is [viewed as] inappropriate because there was no financial loss. Or the other person may have already "paid" in some other way: he may have been very upset, prosecuted, or trying to help. Punishing the person or making sure it does not happen again may be seen as more appropriate than compensation. Sometimes the type of fault is not of the appropriate kind—e.g., "He couldn't really help it," "You couldn't blame him," "He didn't mean to do it," or even "It was just an accident." This apparent ambivalence over fault and blame need not mean that the respondents, or the principles they are applying, are confused, but rather that these principles are complex and flexible, depending on the context and anticipated consequences. These respondents may be acknowledging that fault can provide grounds for compensation, but not in their particular case.

Lloyd-Bostock, *Fault and Liability for Accidents: The Accident Victim's Perspective*, in COMPENSATION AND SUPPORT FOR ILLNESS AND INJURY 139, 156 (1984); *see also* Genn, *Who Claims Compensation: Factors Associated with Claiming and Obtaining Damages*, in COMPENSATION AND SUPPORT FOR ILLNESS AND INJURY 45, 70-76 (1984).

32. The sociological dimension of the malpractice phenomenon is revealed by Danzon's finding that urbanization is an important explanation of increased claims frequency. P. DANZON, *supra* note 30, at 70-75, 80-83.

33. Perhaps the most telling line of argument in support of contractual variations of tort principles is suggested by the divergence between the legal system's paradigmatic view of itself as a moral enterprise and consumers' views of its services. For an empirical demonstration of this divergence, see Lloyd-Bostock, *supra* note 31 (to which my attention was called by Patrick Atiyah). This insightful study and discussion—showing that, "contrary to what one might expect, the victim's attribution of fault for the accident does not predict whether he or she takes steps towards claiming damages under the tort system," *id.* at 139—cannot be fully summarized here, but the following excerpts strongly suggest that the fault system is somewhat dearer to its operators than to its supposed beneficiaries and that it may reflect values imposed upon rather than derived from the latter:

> [O]ne factor influencing what will be seen as fair in a particular context is the cost of applying strictly equitable norms. Such norms are frequently abandoned in everyday life in favour of norms simpler and less costly to apply, and such solutions are accepted as perfectly just. Abandoning the tort system on grounds of cost may have a greater claim to accord with "common sense morality" than does retaining it.

Id. at 142-43.

those persons who do not highly value their right to sue for minor deviations or minor mishaps should have room to express this disposition at a point in the transaction where they can obtain an appropriate concession from the provider. Only in this way can they avoid having to contribute to an insurance fund that they are much less likely to draw upon than are other, more litigious types.[34]

The legal system is perhaps too inclined to believe that it speaks and sets values for the community as a whole, that its processes are an unmitigated blessing on people, and that no one who is fully informed and in his right mind would ever renounce his chance to buy a ticket in the malpractice lottery. The contractual strategy recommended here, though not likely to be adopted soon, makes more sense than most lawyers and judges are apt to perceive. As argued elsewhere in this symposium,[35] consumers should not be deprived by law of their freedom to opt for fewer costly legal rights than the legal monopoly seeks to confer upon them.

If the possibilities of alternative legitimate attributions of fault, and alternative definitions of relationships, are taken into account, the model of social relationships underlying the tort system becomes much more complex than is usually allowed for by lawyers (or, for that matter, economists). Many factors other than the causes of the accident will govern not only the victim's actions in claiming or not claiming, but also his perceptions of, and feelings about the accident. Such factors may include the prospect of compensation, other aspects of the relationships involved, and the anticipated costs and benefits of various courses of action.

Id. at 147.

Attributing fault brings with it potential conflict which people may prefer to avoid altogether rather than resolve. Blaming, holding people liable, and pursuing a legal claim will obviously have different sorts of impact on relationships between friends, family members, employer and employee, fellow employees, and those who were strangers until the accident. Where the costs of blaming (including costs usually ignored by economists) are high and the prospects of benefit in the form of compensation remote, accidents tend to be seen as "just accidents."

Id. at 155.

Far from feeling that the law is backing him in what he sees as his moral rights, the accident victim involved in a legal claim seems frequently to feel confused, anxious, and buffeted by the system.

Id. at 160.

[T]he evidence that the present system is divisive, and creates more hostility than it dispels, does not seem to have been given serious enough consideration.

Id. at 161.

34. Controversy has recently arisen surrounding an information service that a physician can consult, for a fee, to determine whether a particular patient has ever been a plaintiff in a civil action, thus perhaps revealing a special propensity to sue. *See* Shwiff, *Service Promises to Help Physicians Identify Plaintiffs; Trial Lawyers Critical*, L.A. Daily J., Oct. 23, 1985, at 1, col. 2. The possibility that such patients might be denied care is troublesome, but private contracts offer a way to avoid this result and also to make those who are most likely to invoke their tort rights pay for them.

35. Havighurst, *supra* note 7.