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## The Continued Existence and Benefit of Medicine's Autonomous Law in Today's Health Care System

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### Cover Page Footnote

Special thanks to the Pathology Department at Oregon Health Sciences University and the Northwestern School of Law for their general support.

# ARTICLES

## THE CONTINUED EXISTENCE AND BENEFIT OF MEDICINE'S AUTONOMOUS LAW IN TODAY'S HEALTH CARE SYSTEM

*Ken Marcus Gatter*

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# THE CONTINUED EXISTENCE AND BENEFIT OF MEDICINE'S AUTONOMOUS LAW IN TODAY'S HEALTH CARE SYSTEM

Ken Marcus Gatter\*

## I. INTRODUCTION

Many doctors rant and rave against the specter of men and women with MBAs and business suits invading the hallways of hospitals and the sanctity and sterility of the operating rooms.<sup>1</sup> Some legal scholars describe the change as revolutionary.<sup>2</sup> One commentator succinctly writes, "[t]oday in health care policy, there is only one subject: managed care."<sup>3</sup> Implemented primarily to control seemingly endless escalating costs, managed care (or managed competition) seeks to use market forces to control costs,<sup>4</sup> and recognizes the efficacy of economic incentives.<sup>5</sup>

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<sup>1</sup> See, e.g., Karen Donelan et al., *The New Medical Marketplace: Physician's Views*, 16 HEALTH AFF., Sept./Oct. 1997, at 139. A 1995 survey of physicians showed that physicians in states with high penetration of health maintenance organizations were significantly more likely to be unhappy with both the health care system and their own medical practices. *Id.* at 144.

<sup>2</sup> See, e.g., Mark Hall, *Institutional Control of Physician's Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 433 (1988) (indicating that "[a] revolutionary transformation is occurring in American medicine"); John Blum, *The Evolution of Physician Credentialing into Managed Care Selective Contracting*, 20 AM. J.L. & MED. 173 (1996). Blum explains:

[I]n a field littered with analogies, health care in the mid-nineties is best characterized as an enterprise caught in the violent cross winds of a tropical storm known as managed care. Like a series of hurricanes, managed care has reshaped the landscape of health care delivery in drastic and unpredictable ways.

*Id.* at 173.

<sup>3</sup> Troyen A. Brennan, *Moral Imperatives Versus Market Solutions: Is Health Care a Right?*, 65 U. CHI. L. REV. 345, 346 (1998) (reviewing RICHARD A. EPSTEIN, MORAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE? (1997)).

<sup>4</sup> Alain Enthoven and Clark Havighurst, among others, postulated that changing the direction of economic incentives would motivate physicians to decrease costs—reducing the overall cost of health care. See, e.g., Paul Ellwood & Alain Enthoven, "Responsible Choices": *The Jackson Hole Group Plan for Health Reform*, 14 HEALTH AFF., Summer 1995, at 24; Alain Enthoven, *The Rand Experiment and Economic Health Care*, 310 NEW ENG. J. MED. 1528 (1984).

<sup>5</sup> Empirical evidence has long existed demonstrating that doctors were more likely to order additional tests on patients if they had a financial stake in the outcome. See, e.g., Bruce J. Hillman et al., *Frequency and Costs of Diagnostic Imaging in Office Practice: A Comparison of Self-Referring and Radiologist-Referring Physicians*, 323 NEW ENG. J. MED. 1604 (1990) (concluding that doctors

To some, managed care represents "nothing more than the application of the economic incentives of the market place to the doctor-patient relationship."<sup>6</sup> Others, particularly physicians, argue that it is more. They complain that capitation,<sup>7</sup> one of the common methods utilized to change the direction of economic incentives, places doctors in an unfair position. They argue that capitation forces doctors to choose between their patients' best interests and their own financial security.<sup>8</sup> Many doctors complain that obtaining prior approval from a faraway nurse reviewer for everything from surgeries to an additional day in the hospital insults their medical judgment and wastes time pursuing bureaucratic tasks instead of patient care.<sup>9</sup> Non-medical administrators review medical charts to determine the cost-effectiveness of patient care, and computers track the number, type, and pattern of laboratory testing and drugs ordered by an individual physician.<sup>10</sup> If such surveillance reveals something unusual or excessive, administrators contact the doctor and request a justification for the orders.<sup>11</sup>

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who practice in-house radiology—from which they gain a financial benefit—refer more often than doctors practicing outside radiology); Richard H. Egdahl & Cynthia H. Taft, *Financial Incentives to Physicians*, 315 NEW ENG. J. MED. 59 (1986); Alan Hillman et al., *How Do Financial Incentives Affect Physicians' Clinical Decisions and the Financial Performance of Health Maintenance Organizations?*, 321 NEW ENG. J. MED. 86 (1989). Their analysis of survey results shows that in some cases, financial incentives and the type of HMO influence physician behavior. *Id.* Capitation was associated with lower hospitalization rates. *Id.*

<sup>6</sup> Brennan, *supra* note 3, at 346.

<sup>7</sup> Under a capitated health care plan, a physician or group agrees to provide all of the necessary medical services required by a patient in exchange for a predetermined set price. Many forms of capitation exist, but the common thread is that they shift the risks inherent in any system of medical insurance—the risks of when a person will get injured, become sick, and how costly that injury or sickness will be. Capitation shifts the risk from third party insurers to the providers. Some forms of capitation are more onerous to a physician's financial security than others. On the surface these forms of capitation vary only in the degree in which they infuse the patient-physician relationship with economic incentives. Many physicians believe that capitation damages the patient-physician relationship. See generally Frances H. Miller, *Foreword: The Promise and Problems of Capitation*, 22 AM. J.L. & MED. 167 (1996) (noting that the attraction of capitation for physicians is the ability to maintain the clinical autonomy that was eroded through managed care).

<sup>8</sup> See Steven D. Pearson et al., *Ethical Guidelines for Physician Compensation Based on Capitation*, 339 NEW ENG. J. MED. 693 (1998) (indicating that capitation creates conflicts of interest and that more research is needed to clarify how capitation effects physician-patient relationship, decision making and clinical outcomes); Jon Gabel, *Ten Ways HMOs Have Changed During the 1990s*, 16 HEALTH AFF., May/June 1997, at 134; Robert W. Broyles et al., *A Practical Method of Adjusting for Risk in the Prospective Costs of Capitated Systems*, 23 HEALTH CARE MANAGEMENT REV. 63 (1998); Marsha R. Gold et al., *A National Survey of the Arrangements Managed Care Plans Make With Physicians*, 333 NEW ENG. J. MED. 1678 (1995).

<sup>9</sup> See, e.g., Evan J. Ellman, *Monitor Mania: Physician Regulation Runs Amok!*, 20 LOY. U. CHI. L.J. 721 (1989) (describing how physicians resent "overregulation"). See also *Wickline v. State*, 239 Cal. Rptr. 810 (Cal. Ct. App. 1986) (stressing the importance of the treating physician's obligation to protest when disagreeing with the reviewing physicians pretreatment denial of reimbursement).

<sup>10</sup> Ellman, *supra* note 9, at 764-65.

<sup>11</sup> *Id.* at 765-66.

A hospital or managed care organization ("MCO") may terminate a physician's contract if the physician repeatedly breaches guidelines put in place to increase efficiency and maintain or improve quality.<sup>12</sup>

Some of these practices result in better medicine while others do not.<sup>13</sup> Regardless, many physicians feel that their independence has suffered and that managed care interferes with their relationships with patients.<sup>14</sup> Similarly, many patients have less trust in their doctors because of managed care.<sup>15</sup> Patients often attribute the doctors' objections to MCOs' concern about lost income.<sup>16</sup>

Current scholarship has not completely identified the reasons for the hostility of many physicians toward managed competition or managed care. The medical world's intensely negative reaction to the growth of managed care is not simply due to personal economic stakes, the particular annoyances of gaining prior approval for patient treatments, or the possibilities of reduced quality of medical care.<sup>17</sup> Rather, doctors rant and

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<sup>12</sup> See Robert Field, *Quality in the Physician-Patient Relationship: Legal Trends as Facilitators of Business Trends*, 1 WIDENER L. SYMP. J. 365 (1996) (explaining the trend toward hospitals gaining employment arrangements with doctors, and the reduced due process rights of physicians as employees in contrast to independent physicians with staff privileges); Peter B. Jurgeleit, Note, *Physician Employment Under Managed Care: Toward a Retaliatory Discharge Cause of Action for HMO-Affiliated Physicians*, 73 IND. L.J. 255 (1997).

<sup>13</sup> See Robert H. Miller & Harold S. Luft, *Does Managed Care Lead to Better or Worse Quality of Care?*, 16 HEALTH AFF., Sept./Oct. 1997, at 7 (noting that a survey of recent studies showed mixed results on managed care plan performances and that rapid change and increased complexity of plans were factors that contributed to the difficulty in analyzing results).

<sup>14</sup> See, e.g., Steffie Woolhandler & David U. Himmelstein, *Extreme Risk—The New Corporate Proposition for Physicians*, 333 NEW ENG. J. MED. 1706 (1995) (articulating concern that "traditional" medical ethics' central principle of duty to the patient's best interest may be threatened by the new corporate structure increasingly prevalent in medicine). See Bradford H. Grey, *Trust and Trustworthy Care in the Managed Care Era*, 16 HEALTH AFF., Jan./Feb. 1997, at 34. Trust in the physician's fiduciary ethic is essential to the doctor-patient relationship but has become less plausible within the context of managed care. *Id.* at 35. This article concludes that despite measures available to MCOs to ensure trustworthiness, the strong fiduciary ethic held by physicians remains essential to trustworthy care. *Id.*

<sup>15</sup> David Mechanic & Mark Schlesinger, *The Impact of Managed Care on Patient's Trust in Medical Care and Their Physicians*, 275 JAMA 1693 (1996).

<sup>16</sup> See William L. Stewart, *The Public Perception of Physicians*, 21 J. FAM. PRAC. 335 (1985). A 1985 survey showed that seventy percent of the population believed that U.S. physicians made too much money. *Id.*; see HOWARD BRODY, *THE HEALER'S POWER* (1992); Robert Blendon et al., *What Americans Know About Entitlements?*, 16 HEALTH AFF., Sept./Oct. 1997, at 111 (citing a 1997 survey which showed that eighty percent of respondents thought excessive charges by doctors and hospitals were a reason for Medicare financing problems).

<sup>17</sup> A 1997 editorial in the *Archives of Internal Medicine* reveals the confusion and frustration felt by many physicians:

Our civilization holds that some aspects of life should be off limits to the market. Government, the police and fire departments, and the military should not be for sale; nor should profits be made selling sexual intimacy or children for adoption. Our constitution

rave because recent changes threaten to fundamentally undermine medicine's authority, independence, and status by eroding its ability to create and administer its own rules.<sup>18</sup> For years, doctors have created their own rules.<sup>19</sup> The self-regulated character of the medical profession, though more readily evident in the past,<sup>20</sup> continues today despite increasing regulation by government and the marketplace. Many of medicine's laws function independently of the formal law.<sup>21</sup>

This Article argues that medicine is in its own world. Medicine's autonomy helps it to create and administer its own laws. A recognition and examination of medicine's autonomous laws reveals particular benefits threatened by current social, business, legislative and judicial innovations.<sup>22</sup> Policy makers should, therefore, recognize and examine the character and benefit of medicine's autonomous laws before implementing changes that

recognizes a compelling public interest in religious free speech and in unfettered discourse on public policy. Here, commercial interests have no standing. They should have none in medicine.

David U. Himmelstein & Steffie Woolhandler, *Bound to Gag*, 157 ARCHIVES OF INTERNAL MED. 2033, 2033 (1997). The passage quoted above illustrates a lack of familiarity with First Amendment jurisprudence since commercial interests are often recognized in First Amendment cases. *See id.* *See e.g.*, 44 Liquormart, Inc. v. Rhode Island, 517 U.S. 484 (1996); Rubin v. Coors Brewing Co., 514 U.S. 476 (1995). The passage also reflects the sentiment of many doctors that civilization and the Constitution ought to protect medicine from commercial intrusions, because medicine inherently differs from ordinary business. *See Himmelstein & Woolhandler, supra*, at 2033. Many doctors unconsciously view medicine as similar to the lawmaking institutions of the family and government. *Id.*

<sup>18</sup> *Id.*

<sup>19</sup> *See* SAMUEL HABER, THE QUEST FOR AUTHORITY AND HONOR IN THE AMERICAN PROFESSIONS, 1750-1900 (1991); PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (1982). The idea of the professions, or other groups, creating their own rules and trying to advance them in the larger society is not new. *See, e.g.*, Reva Siegal, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 266 (1992) (noting the medical profession's creation of a "physiological paradigm" for abortion and its influence on the successful nineteenth century campaign to criminalize abortion).

<sup>20</sup> *See* HABER, *supra* note 19, at 3; STARR, *supra* note 19, at ix-xiv.

<sup>21</sup> *See* Hall, *supra* note 2, at 448. Professor Hall identifies the importance of recognizing physicians' strong autonomy when implementing cost containment measures. *Id.* The law has "codified the ethic of professional dominance, effectively shielding physicians from the institutional influence contemplated by revolutionary changes in health care policy." *Id.* Professor Hall argues that because doctors control the bulk of medical costs, any cost containment plan will fail if it cannot control medicine's autonomy. *Id.* Furthermore, control of medicine's autonomy is unlikely because of "the remarkable extent to which the law reinforces the medical profession's interests, power, and autonomy." *Id.* at 533.

Although Professor Hall acknowledges the power of an autonomous medical profession, he does not identify the operation of an autonomous law. *Id.* Hall discusses the legal underpinnings of medicine's authority, autonomy and power. *Id.* Hall's argument is consistent with my argument to the extent Hall views the relationship between law and medicine as "an organic one," and that law "is naturally contoured to fit the shape of traditional medical relationships." *Id.* at 536.

<sup>22</sup> *Id.*



erode the beneficial aspects of these internal laws. In other words, medicine's autonomous laws benefit the larger community, and some attributes of managed competition threaten this benefit.

Part II describes the existence and workings of autonomous law, beginning with definitions of autonomous law provided by theorists such as Walter Weyrauch, Maureen Bell,<sup>23</sup> and Lynn LoPucki.<sup>24</sup> Weyrauch and Bell's description of Gypsy lawmaking, and LoPucki's description of the "unwritten law in lawyers' heads," both apply to medicine.<sup>25</sup> Medicine's autonomous lawmaking creates the standard of practice through consensus building and administers the standard of practice through various means.

Part III discusses medical malpractice as an example of how medicine works to maintain its autonomy in the face of state law.<sup>26</sup> Medicine utilizes empirical evidence to reveal the formal law's shortcomings in administering medicine's law against medical malpractice.<sup>27</sup> Studies disseminated in prominent medical journals indict the medical malpractice system for its inability to compensate injured patients, punish negligent doctors, and deter future injuries.<sup>28</sup> Moreover, organized medicine attacks the ability of legal fact-finders to make competent decisions about scientific evidence.<sup>29</sup> The judicial system's acceptance of some of these efforts to preserve autonomy supports the autonomy of medicine's laws.<sup>30</sup> Part III concludes with an examination of medicine's powerful internal prohibition against medical malpractice.<sup>31</sup> The foundation of this prohibition lies in medicine's internal rule against medical malpractice—not in the formal law's rules of negligence. Policy decisions made in the new landscape of managed care should recognize and encourage the autonomous medical source of the prohibition against medical malpractice.<sup>32</sup>

Part IV demonstrates that the formal legal system's recognition of medicine's internal law can help it to better administer health care in

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<sup>23</sup> Walter O. Weyrauch & Maureen A. Bell, *Autonomous Lawmaking: The Case of the "Gypsies,"* 103 YALE L.J. 323 (1993); see *infra* notes 36-67 and accompanying text.

<sup>24</sup> Lynn M. LoPucki, *Legal Culture, Legal Strategy, and The Law in Lawyers' Heads*, 90 NW. U. L. REV. 1498 (1996); see *infra* notes 68-88 and accompanying text.

<sup>25</sup> Weyrauch & Bell, *supra* note 23, at 332-33; LoPucki, *supra* note 24, at 1510-16.

<sup>26</sup> See *infra* notes 150-275 and accompanying text.

<sup>27</sup> See *infra* notes 163-206 and accompanying text.

<sup>28</sup> See *infra* notes 163-206 and accompanying text.

<sup>29</sup> See *infra* notes 207-38 and accompanying text.

<sup>30</sup> See *infra* notes 207-38 and accompanying text.

<sup>31</sup> See *infra* notes 239-75 and accompanying text.

<sup>32</sup> See *infra* notes 266-75 and accompanying text.

today's changing landscape.<sup>33</sup> Part IV reviews the doctrine against the corporate practice of medicine and argues for its renewed application in cases evaluating the liability of MCOs for the medical malpractice of their physicians.<sup>34</sup> Judicial recognition that MCOs practice medicine dilutes and irrevocably damages medicine's prohibitive law against medical malpractice. Part IV concludes with Professor Schlesinger's theory of countervailing agency and its implicit recognition of the continuing benefits of medicine's autonomous law in today's profoundly changing health care system.<sup>35</sup>

## II. AUTONOMOUS LAW AND MEDICINE

### A. *The Idea of Autonomous Law*

"A doctor, (unlike a politician or an actor) is judged only by his patients and immediate colleagues, that is, behind closed doors, man to man."<sup>36</sup>

"The law's ability to regulate developments in biology and medicine is severely limited."<sup>37</sup>

*The Unbearable Lightness of Being*, though published by a Czechoslovakian author in 1984, remains relevant today in the United States. Kundera compares the doctor in his novel with politicians and actors, who intrinsically depend on public opinion for validation.<sup>38</sup> The quote focuses on the individual doctor, and illustrates the personal and private character of a doctor's life. Patients and peers judge a doctor in a private setting, rather than the public judgment faced by official judges, well-clad businesspersons, or the masses. The quote captures the essence of doctoring that persists today even in the face of managed care, and it is managed care's threat to medicine's relative independence that doctors find

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<sup>33</sup> See *infra* notes 276-343 and accompanying text.

<sup>34</sup> See *infra* notes 276-312 and accompanying text.

<sup>35</sup> See *infra* notes 313-43 and accompanying text.

<sup>36</sup> MILAN KUNDERA, *THE UNBEARABLE LIGHTNESS OF BEING* 183 (Michael H. Heim trans., Harper & Row 1985) (1984).

<sup>37</sup> RONALD B. DWORKIN, *LIMITS: THE ROLE OF THE LAW IN BIOETHICAL DECISIONMAKING* 164 (1996).

<sup>38</sup> See KUNDERA, *supra* note 36.

disturbing.<sup>39</sup> Kundera captures the context within which many doctors would like to continue to operate.

While Kundera focuses on the individual doctor, Dworkin focuses on the large and abstract entity of "biology and medicine." Dworkin asks whether the law can effectively regulate biology and medicine. Dworkin suggests that formal law is ill-suited for the regulation of biology and medicine, and that biology and medicine should regulate themselves.<sup>40</sup>

## 1. The Autonomous Law

The term "autonomous lawmaking" has been recently described and defined by Weyrauch and Bell in their article about the autonomous lawmaking of the Gypsies.<sup>41</sup> Autonomous lawmaking, closely related to the notion of private lawmaking, is not a new idea.<sup>42</sup> Private law is evident

<sup>39</sup> Kundera's quote is also instructive for what it does not mention. He does not discuss what law is used when the doctor's patients and immediate colleagues judge, nor how they apply the law. The source of the law is also left out. One may conclude that Kundera does not discuss these issues because he does not have in mind the law as it is commonly understood. Rather, Kundera's patients and colleagues unconsciously judge medical competency or moral and ethical standards. No formal written law applies when judging doctors. The judging of doctors is personal ("man to man") and private ("behind closed doors"). See Timothy S. Jost, *Oversight of the Quality of Medical Care: Regulation, Management, or the Market?*, 37 ARIZ. L. REV. 825 (1995). Jost discusses the history of legal oversight of the medical profession. *Id.* He describes the doctor's life in the period before 1960: "In ordinary day to day life, however, the physician answered to no one but himself. His practice was largely invisible to his peers, incomprehensible to his patients, and unconstrained by external institutions." *Id.* at 831. Although physicians enjoy less independence today than they did forty years ago, doctors' relative degree of independence remains significant enough that its threatened loss disturbs doctors. *Id.*

<sup>40</sup> See DWORKIN, *supra* note 37, at 1. Dworkin also writes of the limits of the law when dealing on the more personal level of patient, family and doctor:

Similarly, it is hard to see that two decades of legal involvement in the area of death and dying have significantly improved the situation for patients, their loved ones, or their physicians. What used to be a simple and dignified encounter among patient, family, and doctor, has now been formalized to require legal documents and often judicial hearings and other procedural steps.

*Id.* at 169.

<sup>41</sup> Weyrauch & Bell, *supra* note 23, at 324-400; see W. Michael Reisman, *Autonomy, Interdependence, and Responsibility*, 103 YALE L.J. 401 (1993). Reisman's commentary on the article by Weyrauch and Bell categorizes them as historicists. *Id.* He notes:

Historicism, however, systematically rejects power considerations. Historicists believe that power is not relevant to studying the development and application of the law in a particular society, because law is predetermined rather than the product of interaction among society's members. Weyrauch and Bell do not address power, at least not explicitly.

*Id.* at 407.

<sup>42</sup> Weyrauch & Bell, *supra* note 23, at 327 (citing EUGEN EHRlich, *FUNDAMENTAL PRINCIPLES OF THE SOCIOLOGY OF LAW* (Walter L. Moll trans., 1936)). Weyrauch and Bell state: "Eugen Erlich Published by eCommons, 1998

when we wait in line,<sup>43</sup> or when we hear lawyers stress public policy and communal values during arguments.<sup>44</sup> Reminding juries not to forget about common sense is really, after all, a subtle appeal to allow for private law. Weyrauch and Bell note that effective legislation and substantive outcomes often depend on how closely the formal laws of the state match the private laws.<sup>45</sup> In most circumstances, private law and the traditional state law imperceptibly interact. For example, Weyrauch and Bell discuss appellate courts unconsciously considering private law when reversing lower courts for an abuse of discretion, or when making rulings contrary to established legal rules.<sup>46</sup> In other circumstances, Weyrauch and Bell argue that private law and state law clash, and private lawmaking often prevails.

Weyrauch and Bell explain the crucial differences between private and autonomous laws.<sup>47</sup> Both private and autonomous laws serve to protect a group from external and internal threats and help organize the group.<sup>48</sup> Autonomous laws differ from private laws, however, in the degree of isolation and independence of the lawmaking group.<sup>49</sup> For example, private law is at work in a large law firm, governing the complex

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suggested that in the Middle Ages, prior to the rise of monarchies—when state authority as we understand it arose, most lawmaking took place in a variety of autonomous institutions and groups, such as cities and guilds . . .” *Id.*

<sup>43</sup> See W. Michael Reisman, *Lining Up: The Microlegal System of Queues*, 54 U. CIN. L. REV. 417, 432-36 (1985).

<sup>44</sup> Weyrauch & Bell, *supra* note 23, at 331. An effective lawyer will “stress social context, communal values, and public policies, which are often veiled references to private forms of lawmaking.” *Id.*

<sup>45</sup> *Id.* at 310; see Paul Robinson & John Darley, *The Utility of Desert*, 91 NW. U. L. REV. 453 (1997). Robinson and Darley argue that criminal laws are more likely to be effective if they accurately reflect the moral and social norms of the community. *Id.* at 457. They state:

The real power to gain compliance with society’s rules of prescribed conduct lies not in the threat or reality of official criminal sanction, but in the power of the intertwined forces of social and individual moral control. The networks of interpersonal relationships in which people find themselves, the social norms and prohibitions shared among those relationships and transmitted through those social networks, and the internalized representations of those norms and moral precepts cause people to obey the law.

*Id.*

<sup>46</sup> Weyrauch & Bell, *supra* note 23, at 330. These authors explain:

For instance, a court’s formalistic application of law may be reversed on appeal as an abuse of discretion or a violation of established canons or interpretation. Yet, in their written opinions appellate courts rarely articulate that the basis for their decision rests at least as much on the amorphous body of private law as on public laws.

*Id.*

<sup>47</sup> *Id.* at 395.

<sup>48</sup> *Id.* at 394.

<sup>49</sup> *Id.* at 395.

interactions between the members and employees.<sup>50</sup> Every person working within the firm is also a member of many other groups, each with its own, often incompatible, laws.<sup>51</sup> Individuals make internal adjustments, and the result is that “the dichotomy between private lawmaking and the law of the state disappears, and law, even in its traditional form, can be viewed as a network of small group interactions.”<sup>52</sup>

True autonomous law, of the kind engaged in by the Gypsies, is different.<sup>53</sup> It aims to stay outside of the “network of small group interactions” present in the larger community.<sup>54</sup> Autonomous law emanates from fervently autonomous groups that understand how contact with the “host” society compromises their beliefs.<sup>55</sup> Thus, much of Gypsy law maintains autonomy, and, in turn, the foundation of Gypsy law depends upon the lawmaking group’s autonomy.

The existence of autonomous lawmaking by the Gypsies is evident by an examination of how Gypsy law “serves as a code that organizes Gypsy society” and how it protects the group from external and internal threats.<sup>56</sup> For example, to help organize Gypsy society, Gypsies’ autonomous law establishes a set of everyday rules.<sup>57</sup> Relying on the important distinction between pure (*vujo*) and polluted (*marime*), everyday rules regulate sexual taboos, hygiene, social roles, and more.<sup>58</sup> Rules regarding *marime* also maintain the separation between what is Gypsy and what is non-Gypsy.<sup>59</sup> These rules involve everyday activities—such as mandating that dishes and eating utensils not be shared with non-Gypsies—to less mundane activities, such as forbidding the marriage between a Gypsy woman and a non-Gypsy man.<sup>60</sup> Violation of the *marime* rules may result in the severe sanction of

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<sup>50</sup> *Id.*

<sup>51</sup> *Id.*

<sup>52</sup> *Id.*

<sup>53</sup> *Id.*

<sup>54</sup> *Id.*

<sup>55</sup> *Id.*

<sup>56</sup> *Id.* at 340. Weyrauch and Bell explain:

An important goal of this Article is to demonstrate that the Gypsy legal system not only protects the Gypsies from external and internal threats, but also serves as a code that organizes Gypsy society. In particular, Gypsy law has evolved to insulate Gypsies from the host society, and thus to maintain its own insularity from the host legal system.

*Id.*

<sup>57</sup> *Id.* at 342.

<sup>58</sup> *Id.* at 342–44.

<sup>59</sup> *Id.* at 342.

<sup>60</sup> *Id.* at 348–49.

banishment, generally considered the harshest punishment available in Gypsy society.<sup>61</sup>

When autonomous Gypsy law conflicts with the host nation's formal law, the Gypsies "may tolerate it or violate it, all the while maintaining that their own law is the only true law."<sup>62</sup> One example of this clash is welfare fraud, which is acceptable within the Gypsy group because fraud is only a crime under Gypsy law when perpetrated against another Gypsy.<sup>63</sup> Another example concerns a Gypsy man jailed by the host country for the murder of another Gypsy.<sup>64</sup> He dies after eating poisoned food brought to him by Gypsies.<sup>65</sup> It is not clear whether this was suicide or the rare imposition of the death sentence by the Gypsies, but it does reveal an effort to maintain the autonomy of Gypsy law.<sup>66</sup>

Weyrauch and Bell describe Gypsy law to support the validity of their concept of autonomous lawmaking.<sup>67</sup> Considering prior popular conceptions about the isolation and autonomy of Gypsies, the authors' choice of subject matter is an effective one. Intuitively, the proposition that Gypsies engage in autonomous lawmaking rings true. For some, the idea that *doctors* also engage in autonomous lawmaking may ring more softly. Perhaps, after the background noise is removed, the notion will ring more loudly.

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<sup>61</sup> *Id.* at 359.

<sup>62</sup> *Id.* at 360.

<sup>63</sup> *Id.* at 363.

<sup>64</sup> *Id.* at 364.

<sup>65</sup> *Id.*

<sup>66</sup> *Id.*

<sup>67</sup> See Reisman, *supra* note 41, at 412-13. Reisman points out that Weyrauch and Bell are historicists and are highly critical of Positivism. *Id.* First, Positivism fails to account for private or autonomous law in its jurisprudence. *Id.* at 412. Second, a positivist viewpoint will render a lawyer a less effective advocate because of the failure to recognize, understand and use autonomous law. *Id.* Reisman acknowledges this critique, and adds that, "[r]edefining law in secular and entirely ahistorical terms, as authoritative policy clarification and implementation by the state apparatus, certainly has intellectual limits. Nevertheless, it permits the law to take on a constructive mediating role between the different groups that constitute the community." *Id.* at 412-13. Perhaps, then, in Reisman's view the law's view of the patient-physician relationship "permits the law to take on a constructive mediating role." *Id.* at 413.

## 2. "The Law in Lawyers' Heads"<sup>68</sup>

LoPucki's description of "the law in lawyers' heads" may surprise readers more than the description of autonomous law by Weyrauch and Bell. Eight years of experience as a bankruptcy lawyer in a small legal community<sup>69</sup> helped LoPucki formulate her theory that lawyers in their daily activities employ a "shared mental model of law."<sup>70</sup> LoPucki explains, "[i]t is mental representations—referred to in the cognitive psychology literature as 'mental models'—not written law, by which lawyers and judges process cases."<sup>71</sup> This mental model of the law is distinct from and simpler than the written law, and it is largely resistant to change by the written law.

There are several advantages to using a shared mental model of the law, and most of the advantages accrue to practicing lawyers and judges. One advantage is that mental law is much more efficient than the written law.<sup>72</sup> It takes far less time, after all, to rely on a simplified mental view of the law than it does to research the inherently complex written law. Another advantage is that shared mental models result in consistent outcomes.<sup>73</sup> The shared mental model of the law explains the law most practicing lawyers and judges believe in—a law that is determinate.<sup>74</sup>

LoPucki argues that a shared mental model of the law also explains the "persistent, systematic differences in legal outcomes between communities governed by the same written law."<sup>75</sup> She cites empirical evidence that reveals striking local differences in how the federal Bankruptcy Code is applied.<sup>76</sup> The written law and the facts are essentially

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<sup>68</sup> See LoPucki, *supra* note 24, at 1498.

<sup>69</sup> *Id.* at 1501.

<sup>70</sup> *Id.* "Much of what passes for theory in legal scholarship is in fact what I have called 'paradigm dominance.' Such pseudo-theory argues for a particular way of thinking about some subject and may provide a catchy label, but ultimately makes no empirically testable assertions." *Id.* at 1503. In contrast, LoPucki states that her assertions can be empirically tested. *Id.*

<sup>71</sup> *Id.* at 1500. For discussions about differences in the law as written and the law as applied see Roscoe Pound, *Law in Books and Law in Action*, 44 AM. L. REV. 12 (1910); Richard L. Abel, *Law Books and Books About Law*, 26 STAN. L. REV. 175 (1974); Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899 (1994). In particular, Schuck discusses the gap between the "law in books," the "law in action," and the "law in the mind" for the law of informed consent. Schuck, *supra* at 903. The law "in the mind" that Schuck has in mind is the doctrine of informed consent "as imagined, feared and often caricatured by some physicians." *Id.* at 903.

<sup>72</sup> LoPucki, *supra* note 24, at 1513-14, 1519-21.

<sup>73</sup> *Id.* at 1521.

<sup>74</sup> *Id.*

<sup>75</sup> *Id.* at 1502.

<sup>76</sup> *Id.* at 1504-08.

the same in the cases LoPucki examines, but the outcomes vary from one geographic locale to the other.<sup>77</sup> For example, the legal outcome in Cleveland, Ohio will consistently differ from the legal outcome in Gainesville, Florida.<sup>78</sup> Importantly, the outcomes are the same *within* each locale, so that a Cleveland attorney may consistently predict the legal outcome. The variation *between* regions, LoPucki maintains, results from the shared mental model of the law that exists *within* a specific locale.

LoPucki concludes that "[l]aw exists principally in the minds of members of the legal community."<sup>79</sup> Differences in the oral legal tradition and "the law in lawyers' heads"<sup>80</sup> explain the regional variations in legal outcomes even when the written law remains constant. The law may not appear consistent when viewed across the broad spectrum, but it appears determinate when looking *within* a coherent legal community. This result "is not well-suited to the governance of a society as large and well-integrated as the United States."<sup>81</sup>

LoPucki argues that differences in local legal communities explain why most lawyers and judges share a determinate view of the law, whereas some of the best trial lawyers—and many law professors—believe that outcomes depend on inconsistent factors that often lead to unpredictable and varying results.<sup>82</sup> Ethical systems, practical considerations or the legitimacy of science may mandate consistent outcomes. The appeal to science as a justification for consistent outcomes is of particular interest because of science's relationship to medicine.<sup>83</sup> Science, after all, invokes more than simply knowledge.<sup>84</sup> Rather, science invokes a rigorous form of truth.<sup>85</sup> Reproducible and consistent outcomes, essential features of science, are problematic for both law and medicine.<sup>86</sup>

<sup>77</sup> *Id.*

<sup>78</sup> *Id.*

<sup>79</sup> *Id.* at 1555.

<sup>80</sup> *Id.* at 1498.

<sup>81</sup> *Id.* at 1556.

<sup>82</sup> See *id.* at 1516-21. The law professors and elite trial lawyers described by LoPucki either think that determinate outcomes do not now exist or are impossible regardless of improvements in understanding of the law and its administration. *Id.* I think, however, that both groups value determinate, consistent or reproducible outcomes for a variety of reasons. The reference is to consistency between similarly situated cases. The problem is that even similarly situated cases are not identical cases. The issue can be brought into relief when one looks at the problem of internally inconsistent verdicts in criminal cases. See Eric L. Muller, *The Hobgoblin of Little Minds? Our Foolish Law of Inconsistent Verdicts*, 111 HARV. L. REV. 771 (1998) (criticizing the Supreme Court's do-nothing approach in reviewing logically irreconcilable criminal jury verdicts).

<sup>83</sup> HABER, *supra* note 19, at 202-12.

<sup>84</sup> *Id.*

<sup>85</sup> *Id.* at 202. In his chapter on the history of lawyers from 1880 to 1900, Haber quotes Article 1 of the ABA constitution which states: "Its object shall be to advance the science of jurisprudence,



The description of an autonomous law existing within formal state law is a striking feature of LoPucki's article. Indeed, LoPucki often cites to Weyrauch and Bell.<sup>87</sup> Although LoPucki's conclusions may be disturbing and disruptive to some, she intends to promote debate and reform.<sup>88</sup> Her description of lawyers engaged in a version of autonomous lawmaking that impacts and forms formal state law is a model that doctors should recognize. After all, it is similar to what they do.

## *B. Medicine's Autonomous Law*

### 1. Of Paradigms and Powerful Norms

The study of paradigms . . . is what mainly prepares the student for membership in the particular scientific community with which he will later practice. Because he there joins men who learned the bases of their field from the same concrete models, his subsequent practice will seldom evoke overt disagreement over fundamentals. Men whose research is based on shared paradigms are committed to the same rules and standards for scientific practice. That commitment and the apparent consensus it produces are prerequisites for normal science, *i.e.* for the genesis and continuation of a particular research tradition.<sup>89</sup>

Doctors have sought to align themselves with the scientific tradition for a long time.<sup>90</sup> The description of the scientific community by Thomas Kuhn applies to medicine and to the process of becoming a doctor.

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promote the administration of justice and the uniformity of legislation throughout the Union . . . ." *Id.* at 213. Throughout the book, Haber emphasizes the appeal to science by both law and medicine, but he identifies the latter part of the nineteenth century as marking a new pre-eminence of medicine among the professions. *Id.* This was in large part due to a shift in American cultural life toward the context of human needs. Haber reasons:

Surely the sense of sin and the demand for rights were powerful moving forces in the late nineteenth century; yet now they were mitigated by the insistence of the rapidly advancing biological sciences that man must also be seen as a complex organism and that much of his conduct could best be understood in those terms.

*Id.* at 203.

<sup>86</sup> *Id.*

<sup>87</sup> See, e.g., LoPucki, *supra* note 24, at 1502. LoPucki cites Walter Weyrauch fourteen times throughout the article. *Id.* Of these cites, eight are specifically from the article written by Weyrauch and Bell on Gypsy lawmaking. *Id.*

<sup>88</sup> *Id.*

<sup>89</sup> THOMAS S. KUHN, *THE STRUCTURE OF SCIENTIFIC REVOLUTIONS* 10-11 (2d ed. 1970).

<sup>90</sup> See HABER, *supra* note 19, at 327-28; STARR, *supra* note 19, at 338-47.

Doctors in the United States generally share a mechanistic view of the workings of the human body that seeks to rely upon scientific evidence.<sup>91</sup> For example, doctors believe that a large, prospective, double-blinded study is more scientific—and thus more valuable—than a small, retrospective, non-blinded study.<sup>92</sup> History teaches, however, that physicians are not the only professionals to use science to support assertions of validity and authority. For example, in the late nineteenth century, the legal profession sought to advance a scientific view of the law as shown in Article I of the constitution of the then newly-formed American Bar Association: “Its object shall be to advance the science of jurisprudence . . . .”<sup>93</sup> The pull of science continues today as legal scholars emphasize the need for more empirical research.<sup>94</sup>

This Part argues that despite the pull of science, “scientific rules” do not constitute medicine’s autonomous laws. Instead, medicine’s autonomous laws are more akin to those of the Gypsies described by Bell and Weyrauch, in that medicine’s autonomous laws are rules that operate to organize and protect medicine. The medical community makes and applies laws through its use of hierarchy and language. Commitment to scientific rules is part of medicine’s autonomous law, but the importance lies not in the science. Instead, the importance lies in the rules’ ability to organize, isolate and protect a largely autonomous group. The medical community inculcates these rules to members of the profession during medical school, internship, residency, and throughout a doctor’s professional life.<sup>95</sup>

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<sup>91</sup> STARR, *supra* note 19, at 144.

<sup>92</sup> *But cf.* Scott Brewer, *Scientific Expert Testimony and Intellectual Due Process*, 107 YALE L.J. 1535 (1998) (overviewing and explaining some of the differing points of view about scientific reasoning).

<sup>93</sup> *Constitution of the American Bar Association*, 1 ABA REP. 16 (1878); *see* HABER, *supra* note 19, at 213-18. Haber also discusses C. C. Langdell, the dean of the Harvard Law School in the late nineteenth century and his emphasis on the law’s scientific foundation. *Id.*

<sup>94</sup> *See, e.g.,* LoPucki, *supra* note 24, at 1503. “Professors Warren and Westbrook have proposed, as the antidote to such armchair theorizing, that scholars routinely propose empirical research, in part to begin the process of testing their theories, but in part merely to assure that their theories have anything at all to say about reality.” *Id.* (citing Elizabeth Warren & Jay Westbrook, *Search for Reorganization Realities*, 72 WASH. U. L.Q. 1257, 1259-62 (1994)). *See also* Michael J. Saks, *Do We Really Know Anything About the Behavior of the Tort Litigation System—And Why Not?*, 140 U. PA. L. REV. 1147 (1992).

<sup>95</sup> *Cf.* Joan M. Gibson & Robert L. Schwartz, *Physicians and Lawyers: Science, Art, and Conflict*, 6 AM. J. L. & MED. 173 (1980). The authors attribute reasoning differences as the cause of lack of understanding and conflict between the legal and medical professions. *Id.* at 176. They argue that since prospective lawyers and doctors come from similar backgrounds, social class, suburbs, and schools, that “the explanation must lie in the nature of the professions themselves, or in the nature of the education that socializes law and medical students into their respective professions.” *Id.* Doctors and lawyers reason differently largely because of differences in their views of “truth.” *Id.* The authors

While Kuhn effectively describes the scientific community's study of paradigms, he fails to explain *how* and *why* the medical students learn and adopt the paradigm. Is it simply because medical students study the same "concrete models" as their elders? Admittedly, apprentices study their masters to learn what works; they rely on the implicit promise that if the skill and manners are learned, the rewards will come to the student as they have come to the teacher. But Kuhn describes a harmonious group where there is "seldom . . . disagreement over fundamentals."<sup>96</sup> He describes a group where all members are committed to the same rules.<sup>97</sup> This describes the end result, and the view is likely an accurate one. There may be arguments and controversies within a group that belies the description of harmony. Nevertheless, the group agrees on the fundamentals. The process not fully described by Kuhn is *how* the student becomes a member of the group.

Forty years ago, William Goode observed that "[t]hree professions—the clergy, the military, and medicine—almost isolate their recruits from important lay contacts for several years, furnish new egos, ideals, and reference groups, impress upon the recruit his absolute social dependence upon the profession for his further advancement, and punish him for inappropriate attitudes or behavior."<sup>98</sup> Goode's words describe a less subtle process than Kuhn's. Goode uses the language of power.

reflect the more traditional perspective when they write: "While medicine seeks objective, absolute truths, the law, employing the adversary system, seeks relative truths." *Id.* In addition, the authors assert that "[t]o have any meaning, scientific laws must accurately predict an event, a relationship, or a consequence, and to the extent that physicians see themselves as scientists, their reality is described and controlled by laws that must be empirically verifiable and universally generalizable." *Id.* (emphasis added).

In contrast, the authors explain:

A law announced by a common law court is "truth" because the community, authoritatively represented in this instance by a majority of the court's members, believes it works well in individual cases that have arisen. It is not, however, universally generalizable; it may, in fact, be inconsistent with laws adopted by different societies.

*Id.* (emphasis added).

The view presented by Gibson and Schwartz is insightful and valid, but it does not present the entire view. Doctors and lawyers do view things differently. Although the medical world does operate, to a large extent, separately, it functions under many of the same kinds of rules as the law. Scientific rules have less impact in the daily interactions among physicians than portrayed by Gibson and Schwartz. It is true, for example, that the legal and medical professions have differing views and rules about causation. The medical and legal professions, however, similarly formulate, administer and apply rules and views about causation. The conflict between doctors and lawyers is in part due to differences in reasoning and, as is herein argued, in greater part due to a clash of laws.

<sup>96</sup> KUHN, *supra* note 89, at 11.

<sup>97</sup> *Id.*

<sup>98</sup> See William Goode, *Community Within a Community: The Professions*, 22 AM. SOC. REV. 194, 196 (1957).

"Recruits" are almost completely isolated for many years, and the profession "impresses" "absolute social dependence" upon them.<sup>99</sup> "Inappropriate attitudes" are "punished."<sup>100</sup> The recruits must not only learn the rules and standards of the profession, but they must internalize the lessons.<sup>101</sup>

This section will show that both Kuhn and Goode contribute to an accurate portrait of medicine and the process of becoming a doctor. The medical community exercises subtle and not-so-subtle means to create a shared commitment to rules and standards. The process of becoming and remaining a doctor involves the development and internalization of strict and powerful norms.<sup>102</sup> In a manner reminiscent of Gypsy lawmaking, medicine's norms function as autonomous laws. These norms are "taken for granted" by members of the medical profession and by many other members of society.<sup>103</sup> These autonomous norms substitute for—and occasionally challenge—the formal state law.

<sup>99</sup> *Id.*

<sup>100</sup> *Id.*

<sup>101</sup> *Id.*

<sup>102</sup> There are many articles in legal literature examining the workings and significance of various norms and their relation to the law. In a manner, Weyrauch and Bell's *Autonomous Lawmaking: The Case of the "Gypsies"* is one of these. See Weyrauch & Bell, *supra* note 23. Their article, however, argues that the Gypsies have done more than merely establish norms, albeit powerful norms. *Id.* at 393-97. The Gypsies have developed an autonomous law that competes with state law and often prevails over state law. *Id.* For a discussion, largely from a law and economic perspective, of the possible origin of norms as they function in our everyday world, see Richard H. McAdams, *The Origin, Development, and Regulation of Norms*, 96 MICH. L. REV. 338, 340 (1997). This article defines norms as informal social regularities that individuals feel obligated to follow because of an internalized sense of duty, because of a fear of external non-legal sanctions or both. *Id.* The origins of norms are to be found in the individual's need for the esteem of others. *Id.* at 355.

Norms matter in legal analysis because they sometimes govern individual behavior to the exclusion of the law. Sometimes norms and law together influence behavior and sometimes they influence each other. *Id.* at 347. See generally Robinson & Darley, *supra* note 45, at 468 (developing the view that the law works best when it nurtures existing norms, and the law is incapable of creating new norms on its own).

<sup>103</sup> See Lawrence Lessig, *The Regulation of Social Meaning*, 62 U. CHI. L. REV. 943 (1995). Lessig states:

As a first cut, we can describe context as the collection of understandings or expectations shared by some group at a particular time and place. But to function in the sense that I mean here, these understandings or expectations must be shared in a particular way. They must be *taken for granted* by those within the group at issue, or put another way, they must be relatively uncontested in that context. It is not enough that individuals understand that a particular idea along with a given action may yield a given meaning. For it to function as a "social meaning," the individuals in this context must also accept it. For an action to convey a social meaning in the sense I want to use the term here, it must do so without appearing contingent or contested; it must do so in a way that feels natural.

*Id.* at 958-59 (footnotes omitted).

## 2. On Becoming a Doctor

The medical hierarchy engages in constant surveillance of its members beginning on the first day of medical school.<sup>104</sup> Although more apparent during the training years of medical school and residency, the constant surveillance continues throughout most physicians' professional lives. The following discussion focuses on how various disciplinary tools, particularly observation and the promotion of a sense of community within medicine, instill the rules of medicine and promote a sense of isolation and uniqueness among doctors. In a manner reminiscent of the Gypsies described by Bell and Weyrauch, an inculcated sense of isolation, uniqueness and allegiance creates the foundation upon which autonomous laws are built. These autonomous laws, in turn, promote and protect the isolation of the group.<sup>105</sup>

The first two years of medical school consist mostly of class work. Frequent written and oral examinations, as well as long mandatory classes, occupy almost all of a student's time. In addition, the character of the time-demands contributes to medicine's disciplinary power over students. Students spend time at the medical school with their classmates and at the hospital, among residents, nurses, patients and staff physicians. The opportunity for observation by members of the medical hierarchy is strong in these surroundings. Moreover, since medical students occupy the lower rungs of the hierarchy, they seek to assimilate the manners of those on the rungs of the ladder above.

The system of medical education counters the oppressiveness of the constant evaluations by making the medical students a valuable part of the medical team. Medical school is a communal experience. During the first two years, the entire class takes the same classes at the same time in the same room,<sup>106</sup> for five or six hours a day, five days a week.<sup>107</sup> Significant

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<sup>104</sup> See, e.g., Hugh Baxter, *Bringing Foucault into Law and Law into Foucault*, 48 STAN. L. REV. 449, 451-56 (1996). Foucault describes of surveillance, organization and training as part of a disciplinary power. *Id.* For Foucault, power can be productive. *Id.* at 453.

<sup>105</sup> Weyrauch & Bell, *supra* note 23, at 371.

<sup>106</sup> A few medical schools, such as the University of Vermont, cover the 'basic sciences' or classwork portion in a year and a half. In addition, most medical schools today include an introduction to clinical medicine within the first year. This usually means that several afternoons are spent talking to patients during the first year.

<sup>107</sup> My medical school had a note service that enjoyed faculty support. Students rotated taking "official" notes for a class and then copies were distributed to everyone. Some lecturers took their exam questions from the note service. Some students supplemented the notes and a few opted out, but most relied predominantly on the note service. This was possible because everyone was in the same class, and the emphasis was to get through a set knowledge base. This is anecdotal and may not be the case everywhere.

life occurrences, such as marriages, divorces and births, and relatively insignificant occurrences are common knowledge among the class. Gossip is rampant. The atmosphere is that of an extended, albeit cantankerous, family. The communal experience continues during the third and fourth years.<sup>108</sup> This sense of community is also promoted by the constant monitoring of what is considered the acceptable level of competition. Certainly, medical students are ambitious and competitive, but the atmosphere tempers, or directs, the competition. Students and attending physicians penalize and discourage medical students who exhibit raw ambition at the expense of team play.<sup>109</sup>

The medical community's emphasis on community as a benefit of isolation and enforced devotion reveals similarities with the Gypsy community. From the perspective of an outsider, it appears that members of both the Gypsy and medical communities receive some benefits and suffer some detriments because of their membership within the group. However, the process of constant surveillance and correction makes it likely that individual members have difficulty delineating the benefits and detriments, and members of these cohesive communities are unlikely to fundamentally question the demands asked of them.

The functioning of disciplinary observation is also evident during "rounds," which are the keystone of the third and fourth years.<sup>110</sup> Rounds involve the medical student making *daily* oral presentations of a patient's medical history and progress to the attending physician, interns, residents and classmates. How well a student performs presenting patients during these daily rounds forms the basis of the student's evaluation by attending physicians and largely determines the respect of classmates and residents. Articulate and confident students generally fare better than do shy and less

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<sup>108</sup> The community expands to include interns, residents, nurses and attending physicians. Moreover, the emotional demands of working with and among sick and dying patients are greater than during the first two years. The need to share experiences with an understanding person can often be met only by someone in medicine. Therefore, along with the increased sense of community there is an increased isolation. Patient confidentiality is stressed and medical students commonly discover that it is not socially acceptable to talk about operating room experiences with non-medical friends even if the confidentiality is preserved.

<sup>109</sup> At my medical school, successful ambition was tamed, and students sought to work hard within the acceptable norms. The result was a sense of commonality, togetherness and community.

<sup>110</sup> Typically, the first two years of medical school cover the "basic sciences," such as anatomy, physiology, pathology, biochemistry and others. The third year covers the basic clinical disciplines, such as, internal medicine, pediatrics, obstetrics and gynecology, psychiatry, family practice and general surgery. The fourth year is for elective clinical rotations such as emergency medicine, neurosurgery or other surgical specialties, hematology, radiology, anesthesiology and others. Of course there are variations.

confident students.<sup>111</sup> Thus, the medical community subtly molds even personality traits through the constant surveillance and correction that is part of becoming a doctor.

Both written and subjective examinations increase the group's disciplinary power over medical students. Subjective evaluations provide an effective opportunity for attending physicians and residents to constantly, and perhaps subtly, correct and provide small rewards to students on a daily basis. Written exams provide a concrete record of evaluation and promote a feeling of unity of knowledge and experience for both students and teachers. The disciplinary function provided by the constant evaluations passes largely unnoticed. Educators and students both view the evaluations as necessary parts of learning medicine and ensuring a minimum level of competency. Moreover, the quantity and quality of the time demands result in students being forced to reduce the amount of interactions they may experience with groups *outside* of medicine. Thus, much like the Gypsies, the medical community works to stay outside of the "network of small group interactions" that dilutes the force of the autonomous group's laws.

The language of medicine is an important component in the normalizing process of students. Much of medical school, after all, consists of learning the many medical terms, phrases and abbreviations. Educators estimate that students learn 10,000 new words during medical school.<sup>112</sup> Simple statements become incomprehensible when couched in medical vernacular. This not only serves as another opportunity for correction and examination, but also strengthens the isolation of medicine from the non-medical community. The apparently incomprehensible medical terminology functions similarly to the Gypsy language with its special words that serve to maintain a separation between what is Gypsy and what is non-Gypsy.<sup>113</sup> A doctor's use of medical terminology serves as a source of authority when speaking to patients, but it also functions to identify and isolate the doctor as a member of the medical community.

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<sup>111</sup> The preference of confident and articulate persons may be almost universal in our society. It is likely that all professions reward such behavior and punish the opposite behavior. In some circumstances this may lead to double-blinds. See, e.g., *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989). Ann Hopkins, the plaintiff, sued her employer, the accounting firm of Price Waterhouse for gender discrimination. *Id.* at 232. The partners who evaluated her were exclusively male and disagreed on whether she should be made a partner. *Id.* at 233. Some of the evaluations praised her for her confidence, articulateness, and professionalism, whereas others criticized her for her lack of femininity and abrasive communication skills. *Id.* at 234-35.

<sup>112</sup> Interview with Dr. Christopher Corless, Drs. Anne & Benjamin Rader, at Oregon Health Sciences University (July 1998); Interview with Dr. David O'Dell, at Univ. of Neb. Med. Ctr. at Omaha (Spring 1995).

<sup>113</sup> See *supra* notes 56-61 and accompanying text.

Melvin Konner, an established anthropologist at the time he entered medical school, wrote a personal account of the third year of medical school, and describes the process of socialization that occurs when becoming a doctor.<sup>114</sup> He concludes that the goal of medical school, unlike graduate school, is to produce students as similar to one another as possible—with no room for originality.<sup>115</sup> Moreover, the uniformity of medical education is not limited to medical facts, but extends to the teaching of proper emotions in response to clinical situations.<sup>116</sup> Again, medicine is similar to the isolated and autonomous community exemplified by the Gypsy community described by Bell and Weyrauch. Medicine's structure and law control knowledge—and even emotion—through its use of language and constant observation and correction.

Samuel Shem's book, *The House of God*, describes the first year of an internal medicine residency in a humorous, sarcastic, and, at times, impertinent tone that captures the flavor of internship and many other aspects of the medical community.<sup>117</sup> Shem describes a powerful initiation process.<sup>118</sup> His main characters include a group of patients known as "gomers."<sup>119</sup> These patients are generally elderly and very sick.<sup>120</sup> All they really want to do is die, but medicine does not let them.<sup>121</sup> Despite their lack of informed consent, the "gomers" provide a function.<sup>122</sup> They are a source for the interns to practice procedures such as placing central lines.<sup>123</sup> Later, interns will be able to use such procedures to help patients who want to live.<sup>124</sup> Arguably, this particular emphasis on ends over means is contrary to the non-medical viewpoint. Not only does the cynical and sarcastic portrayal of internship in *The House of God* show how powerfully the medical community indoctrinates the neophyte, but it reveals how medicine's autonomous laws begin to become established within its members. Part of the difficulty of the internship, Shem implies, is the intern's forced switch from non-medical norms—vestiges of which

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<sup>114</sup> MELVIN KONNER, *BECOMING A DOCTOR: A JOURNEY OF INITIATION IN MEDICAL SCHOOL* (1987).

<sup>115</sup> *Id.* at 362. "The medical student must on the contrary end by being similar as possible to every other medical student, must master as much as possible of the body of knowledge that is taught, according to a process that leaves no room for originality." *Id.*

<sup>116</sup> *Id.* at 363.

<sup>117</sup> SAMUEL SHEM, *THE HOUSE OF GOD* (1978).

<sup>118</sup> *Id.*

<sup>119</sup> *Id.*

<sup>120</sup> *Id.* at 38.

<sup>121</sup> *Id.*

<sup>122</sup> *Id.* at 89.

<sup>123</sup> *Id.*

<sup>124</sup> *Id.*



remained in medical school—to medicine's norms.<sup>125</sup> The two sometimes conflict; however, similar to Gypsy law, medical law maintains that it is the only true law.

The continuous observation and surveillance of medical students persists throughout residency and beyond.<sup>126</sup> After residency, a doctor is eligible to take a board examination to become "boarded" in that specialty. Subspecialty boards require additional board examinations.<sup>127</sup> Many subspecialty boards now require a renewal of board certification every several years.<sup>128</sup> Once boarded, most doctors will gain staff privileges in one or more hospitals. Most hospitals have several weekly interdisciplinary conferences intended to maintain quality, continue physician education and provide input for the management of difficult cases.<sup>129</sup>

The many examinations, evaluations and almost constant observation within the communal atmosphere described above have a tremendous normalizing effect on doctors.<sup>130</sup> Similar to the Gypsy community described above, the medical community normalizes the behaviors, attitudes, and language of its members. This "normalizing" within the

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<sup>125</sup> See *id.*

<sup>126</sup> For example, a third year surgery resident finds it difficult to remember that she ever had pangs of nausea as a person's abdomen was cut open. It is likely that she would deny ever feeling nauseated. She has physically adjusted, more or less, to being on call every third night. A second year pathology resident can't remember the hesitation as he began his first autopsy or the disgust as pints of blood are literally hosed off the table. A first year medicine resident feels nothing after the death of her patient. The patient's death means that she has to talk to the family. The blood and guts, and the emotion of life and death, become part of the routine, something to get done. See KONNER, *supra* note 114, at 366; SHEM, *supra* note 117, at 257.

<sup>127</sup> Many doctors complain that much of the content of board examinations has little to do with the everyday practice of medicine. Whether this is true is not known and board administrators would likely deny the allegation. The significance lies in the implication that physicians sense that the examinations function for another purpose. Physicians likely sense the dual purpose of board exams to ensure quality, and maintain control and dedication of its members.

<sup>128</sup> See CLARK HAVIGHURST ET AL., HEALTH CARE LAW AND POLICY 469 (1998). Critics note that renewal is perfunctory since the boards seldom require new demonstrations of competence. *Id.* Nevertheless, renewal provides a reminder to physicians that they must remain aware of recent developments and it reminds specialists of the surveillance authority possessed by the board. *Id.*

<sup>129</sup> Examples include bone marrow transplant conferences, breast conferences, and morbidity and mortality conferences. I recently counted twenty-two conferences in one week at University Hospitals of Cleveland. This is probably a typical number for a large teaching hospital. The interdisciplinary conferences are weekly opportunities to informally evaluate the clinical judgment and knowledge of one's peers, as well as have one's own knowledge and judgment evaluated.

<sup>130</sup> No effort is made herein to argue that medicine's efforts at creating an autonomous group are greater or more effective than another profession's efforts. Certainly, the years lawyers spend as associates or the years spent as an untenured professor may be analogous to the time spent in residency. Nevertheless, this Article aims not to distinguish between medicine and other professions, but to describe the process by which medicine creates and administers its own law.

community organizes, protects, and isolates the medical community. As with the Gypsies, it also allows the autonomous group to make and administer its own laws.

### 3. On the Differences in Hysterectomy Rates or an Explanation of the Variations in the Medicine in Doctors' Heads

#### a. The Importance of Reproducibility or Consistency in Science

Scientists evaluate research more on the science than on the result. An innovative process is more valuable than a stunning result arrived at by a questionable or often used process. The practical essence of science is that isolated results mean little, and results must be reproducible to be scientifically valid. This faith in reproducibility presumes a natural world that operates according to unchanging principles. After all, if two experiments are conducted and everything is accounted for, the results should be the same. Nevertheless, scientists recognize that it is impossible to account for every variable, particularly in biological systems. Therefore, inconsistent results are not necessarily garbage if the methodology or the science, is valid.

What does this have to do with doctors and the creation of autonomous law? Medicine seeks its foundation and public legitimacy in science. Science is reproducible and has consistent outcomes. Therefore, if medicine is a science, how does the medical community explain the well-documented variations in the rates of certain procedures? Faced with the variability of procedure rates and the inability to scientifically validate many of the clinical indications, the focus in medicine has been to determine the *appropriateness* of a procedure.

The studies that determine appropriateness may look like science, but they are not. Appropriateness, in contrast to effectiveness, represents an attempt to establish a consensus about what constitutes a valid indication for a procedure. The consensus is both a consensus among experts and a consensus between experts and non-expert practicing physicians. Establishing effectiveness is primarily a scientific process because it relies on reproducible and inevitably narrow studies. In contrast, appropriateness is more akin to an aspect of *lawmaking* because it relies on establishing and documenting a consensus among the members of the autonomous group. The substantive content of the consensus is then used by the autonomous group in their daily activities. This helps define and protect the group. Importantly, the consensus of appropriateness exists not only among the

academic elite, but seeks to include all physicians. This adds legitimacy and promotes solidarity. The determination of appropriateness operates similarly to a political poll that gives legitimacy to the policies advocated by a political representative—a kind of representative plebiscite with a scientific gloss.

#### b. Variation or Inconsistency in Hysterectomy Rates and Variation Generally

Studies have shown a six-fold variation in hysterectomy rates among countries in Western Europe and North America, with the highest rates in the United States and the lowest rates in England, Norway and Sweden.<sup>131</sup> A three- to five-fold variation exists in the United States within large as well as small regions.<sup>132</sup> Male gynecologists are more likely than female gynecologists to perform a hysterectomy, and blacks are more likely than whites to undergo a hysterectomy.<sup>133</sup> While these factors explain some variation, they do not correlate to the regional differences. Thus, the profile of the variability resembles the one found by LoPucki—intra-regional variability, but not *inter*-regional variability.<sup>134</sup> Factors such as the availability of medical resources and patient characteristics other than race do not consistently explain these variations in hysterectomy rates.<sup>135</sup> Significant variability has also been shown in diagnostic testing such as mammographies,<sup>136</sup> Pap smears,<sup>137</sup> coronary angiographies,<sup>138</sup> and others,<sup>139</sup> as well as in the use of medicine and surgery generally.<sup>140</sup>

<sup>131</sup> Klim McPherson et al., *Small-area Variations in the Use of Common Surgical Procedures: An International Comparison of New England, England, and Norway*, 307 NEW ENG. J. MED. 1310 (1982); Karen J. Carlson et al., *Indications for Hysterectomy*, 328 NEW ENG. J. MED. 856 (1993).

<sup>132</sup> Carlson et al., *supra* note 131, at 856.

<sup>133</sup> *Id.* (citing Gianfranco Dominighetti et al., *Hysterectomy and Sex of the Gynecologist*, 313 NEW ENG. J. MED. 1482 (1985); Richard C. Dicker et al., *Hysterectomy Among Women of Reproductive Age*, 248 JAMA 323 (1982)).

<sup>134</sup> LoPucki, *supra* note 24, at 1504-08.

<sup>135</sup> See Mark Chassin et al., *Does Inappropriate Use Explain Geographic Variations in the Use of Health Care Services? A Study of Three Procedures*, 258 JAMA 2533, 2537 (1987).

<sup>136</sup> Joann G. Elmore et al., *Variability in Radiologists' Interpretations of Mammograms*, 331 NEW ENG. J. MED. 1493 (1994).

<sup>137</sup> K. Kato et al., *Inter-observer Variation In Cytological and Histological Diagnosis of Cervical Neoplasia and Its Epidemiologic Implication*, 48 J. CLINICAL EPIDEMIOLOGY 1167 (1995); Sezgin M. Ismail et al., *Observer Variation in Histopathological Diagnosis and Grading of Cervical Intraepithelial Neoplasia*, 298 BRIT. J. MED. 707 (1989).

<sup>138</sup> Timothy A. DeRouen & John A. Murray, *Variability in the Analysis of Coronary Arteriograms*, 55 CIRCULATION 324 (1977).

<sup>139</sup> See, e.g., Zobair M. Younossi et al., *Nonalcoholic Fatty Liver Disease: Assessment of Variability in Pathologic Interpretations*, 11 MOD. PATHOLOGY 560 (1998); John E. Wennberg et al., Published by eCommons, 1998

One review article postulates: "[t]he available evidence indicates that professional uncertainty . . . is the primary cause of the variation in rates."<sup>141</sup> Another investigator concludes that "practice factors" play a decisive role in variability of procedure rates.<sup>142</sup> Reminiscent of LoPucki's description of the law in lawyers' heads, the variation in procedure rates undermines claims of legitimacy made by medicine's autonomous group—whether they are based on scientific reproducibility or on the determinability of legal outcomes.

### c. The Meaning of This Variation

The relatively large number of studies investigating this variation in rates reflects medicine's sensitivity to this issue. The underlying sentiment is that such variation should not exist if medicine were a pure science. Which doctor one chooses, after all, ought not to determine whether or not one will undergo a hysterectomy.

That medicine is not a pure science surprises few people.<sup>143</sup> But variations do more than remind us that clinical medicine is not a basic science. The variations imply that procedures such as hysterectomies are either being performed too often or not often enough. In other words, the existence of variations raises the question of *appropriateness*. In turn, questions of appropriateness raise questions of quality, cost and risk management. Are patients unnecessarily exposed to the risks of surgery? Are patients foregoing hysterectomies when the procedure may result in

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*An Assessment of Prostatectomy for Benign Urinary Tract Obstruction: Geographic Variation and the Evaluation of Medical Care Outcomes*, 259 JAMA 3027 (1988); Mary K. Sidawy et al., *Interobserver Variability in the Classification of Proliferative Breast Lesions by Fine-Needle Aspiration: Results of the Papanicolaou Society of Cytopathology Study*, 18 DIAGNOSTIC CYTOPATHOLOGY 150 (1998) (concluding that low rate of agreement, Kappa = 0.35, among cytopathologist reviewers for proliferative breast lesions warranted simplification of diagnostic categories).

<sup>140</sup> See Mark Chassin et al., *Variations in the Use of Medical and Surgical Services by the Medicare Population*, 314 NEW ENG. J. MED. 285 (1986). The authors linked the large variations they found "directly to the degree of medical consensus concerning the indications for its use." *Id.* at 288 (footnotes omitted).

<sup>141</sup> Carlson et al., *supra* note 131, at 856.

<sup>142</sup> See John Wennberg, *Dealing With Medical Practice Variation: A Proposal for Action*, HEALTH AFF., Summer 1984, at 6-7.

<sup>143</sup> See, e.g., Hall, *supra* note 2, at 477. One author states:

Physicians trumpet the scientific basis of medicine when it suits their purpose. At the turn of the century, the medical profession relied on the scientific foundation of allopathic theory to establish exclusive authority over the domain of medical practice through licensing legislation. In modern times, belief in a uniform standard of care provides the protection of professional custom as a defense to malpractice liability.

*Id.* at 477-78 (footnotes omitted).

improved long-term health? Is a hysterectomy that is performed today going to save money or cost money in the long-term?

The question of what locale's hysterectomy rate reflects the best medicine remains unanswered. But can it really be answered? Any cost-benefit or cost-effectiveness analysis is extremely difficult because of the incredible number of unknown variables that may impact the analysis. For example, medicine has much to learn about the hormonal function of the uterus and the effects of its removal.<sup>144</sup>

#### d. How the Determination of Appropriateness Is Lawmaking

Faced with the variability of procedure rates and the inability to scientifically validate many of the clinical indications, the focus in medicine has been to determine the *appropriateness* of a procedure. As previously discussed appropriateness, in contrast to effectiveness, attempts to establish a consensus about what constitutes a valid indication for a procedure such as hysterectomy. Most determinations of appropriateness rely on collecting existing scientific data and having acknowledged experts analyze the data. The experts, mostly professors at teaching hospitals with a record of publications in their areas of expertise, discuss the data and reach a consensus about the acceptable indications even where no scientific data precisely addresses a particular indication. The experts' consensus should reflect the actual behavior of non-expert practicing physicians. Doctors may then use the resulting criteria as a basis for practice guidelines or for a review of existing cases.

Recent studies aim to establish a model that could show statistically significant agreement about what constitutes appropriate care, thus establishing a consensus as the source of legitimacy.<sup>145</sup> Such a model is

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<sup>144</sup> Little rigorous scientific data exists to establish the effectiveness for the vast majority of medical procedures. Several studies estimate that such hard scientific data supports the effectiveness of only 15% to 20% of medical practices. See M. Dubinsky & J.H. Ferguson, *Analysis of the National Institute of Health Medicare Coverage Assessment*, 6 INTERNATIONAL J. OF TECH. ASSESSMENT IN HEALTH CARE 480 (1990); Arlene Fink et al., *Sufficiency of Clinical Literature on the Appropriate Uses of Six Medical and Surgical Procedures*, 147 W. J. OF MED. 609 (1987). The low percentage is not necessarily due to lack of effort and may also be misleading because the efficacy of many medical practices cannot be subjected to vigorous scientific testing without violating ethical norms. For example, ethical considerations constrain implementing a prospective double-blinded study when the available evidence already indicates the therapeutic advantages of one arm of the study. Moreover, blinded studies do not work when evaluating the efficacy of a surgical treatment compared to a non-surgical treatment because the patients will know what treatment they received. The result is that many medical treatments lack vigorous scientific support.

<sup>145</sup> A recent study evaluated the most commonly used method for looking at appropriateness, the RAND-University of California at Los Angeles ("RAND-U.C.L.A.") appropriateness method. Paul G. Published by eCommons, 1998

significant because it uses a scientific method (statistics) to validate what is essentially a lawmaking process. The model relies upon establishing consensus to validate appropriateness instead of the opinions of a small, select group of medical experts. The rules that result from the consensus guide physician behavior and reduce variations that are troubling to the autonomous group.

The recent appropriateness studies do more than establish a consensus among experts. For example, one recent study focused on whether primary care physicians and private practice cardiologists agreed with each other (and whether they agreed with experts) about the appropriate indications for coronary angiography.<sup>146</sup> On one level, the study represents an effort to correlate theory with practice. On another level, it reveals the importance of consensus and the continual establishment of norms within the medical community. What is implicit in any such study is the belief that a lack of agreement between the experts and the "practicing physicians" would undermine the validity of the guidelines and the tools used to determine

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Shekelle et al., *The Reproducibility of a Method To Identify The Overuse and Underuse of Medical Procedures*, 338 NEW ENG. J. MED. 1888 (1998) (examining rates of coronary revascularization and non-emergency, non-oncologic hysterectomies). The authors evaluated overuse in terms of appropriateness and evaluated underuse in terms of necessity. *Id.* at 1888. Emergency and oncologic indications necessitated exclusion of an examination of hysterectomy rates for underuse. *Id.* The study examined the reliability or the reproducibility of the RAND-U.C.L.A. method. *Id.* The RAND-U.C.L.A. method "combines a systematic review of the scientific literature with expert opinion." *Id.* A group of experts review the applicable scientific evidence, and then determine criteria for appropriateness. *Id.* The criteria are then used to evaluate specific clinical situations. *Id.* For example, should a forty-one year old pre-menopausal woman with a significantly enlarged uterus from uterine fibroids, pain unresponsive to medicine, and excessive vaginal bleeding, undergo a hysterectomy? The authors of the study performed a parallel, three-way replication of the RAND-U.C.L.A. method and compared the results of the three groups of experts. *Id.* at 1889. The kappa statistic, or the coefficient of concordance measured how well the three groups agreed. *See generally id.* The kappa statistic is a measurement of agreement between groups that takes into account agreement due to chance. *See id.* The experts' level of agreement was only moderate. *See id.* The authors also had the three expert groups review 636 actual cases of hysterectomy from seven MCOs. These results showed a 100% variation in what the groups of experts considered inappropriate cases, with one group finding 331 inappropriate cases out of the 636 hysterectomies and another group finding 153 inappropriate cases. *Id.* The authors concluded that the RAND-U.C.L.A. appropriateness method "is far from perfect." *Id.* Although it should not be used to direct care for individual patients, the authors agree that it may be a useful tool for comparing levels of appropriate procedures among populations. *Id.* The continuing goal is to formulate a better tool that can determine what constitutes appropriate care.

<sup>146</sup> John Z. Ayanian et al., *Rating the Appropriateness of Coronary Angiography—Do Practicing Physicians Agree with an Expert Panel and with Each Other?*, 338 NEW ENG. J. MED. 1896 (1998). The study surveyed physicians from five states (New York, Pennsylvania, Texas, California and Florida) about twenty indications for coronary angiography. *Id.* at 1897. The response rate was approximately fifty percent, similar to other published surveys of physicians. *Id.* at 1898. The survey was directed to internists, family practitioners and cardiologists because they care for almost all the patients with acute myocardial infarctions. *Id.* at 1897. The authors acknowledge their topic's notoriety, the existence of a large body of published literature about the topic, and the existence of published guidelines by respected professional organizations. *Id.* at 1902.

appropriateness. The medical practice may lack consistent outcomes, but the medical community tests and thereby encourages an internal consistency in the medical ranks from expert to practicing physician. The result is a more solid and united front, one that looks more "scientific."

John Ayanian's appropriateness study concludes that "[v]ariations in beliefs among practicing physicians suggest that evaluations of medical practice should incorporate the views of a range of relevant types of physicians."<sup>147</sup> The variations result from local factors or local medical culture, such as whether one is a primary care doctor, or a cardiologist performing invasive procedures, or whether cardiac procedures (angioplasty or coronary artery bypass grafts) are even available at the hospital. Again, this is reminiscent of LoPucki's description of the law in lawyers' heads.<sup>148</sup> Local custom and conditions determine the views towards angiography, just as they determine the views that local lawyers share regarding the meaning of particular sections of the Bankruptcy Code.

The prevalence of variability in the use of procedures and diagnostic testing, and the medical community's reliance on appropriateness, illustrate that the existence of variation may reflect the influence of local custom and conditions on treatment decisions. Medicine uses these variations to support medicine's autonomy, arguing that the inherent diversity in clinical circumstances and the uniqueness of every patient's medical condition supports individualized, and thus, variable, treatment. Medicine also uses the existence of variability as the reason for appropriateness studies. The process of determining appropriateness, as well as testing the validity of appropriateness, establishes the importance of norms by consensus within the health care community. Importantly, both medicine and MCOs embrace the examination of appropriateness. Physicians, however, establish the consensus—a consensus between experts and a consensus between experts and non-expert practicing physicians.<sup>149</sup>

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<sup>147</sup> *Id.* at 1896. The results showed that although there was agreement between experts and community physicians, there was also some variation by the practicing physicians. *Id.* at 1900. These variations were based on the applicable region (New York doctors were less likely to recommend angiography in certain clinical circumstances), the availability of coronary procedures (physicians were more likely to recommend angiography if the hospital had angioplasty or cardiac surgeons qualified to place coronary artery bypass grafts), and the type of practice (whether it was a primary care physician or cardiologist who performed invasive procedures). *Id.* at 1900-03. The study asked physicians what was medically indicated and made no requirement that the responding doctor perform the procedure. *Id.* at 1897. Similar variations have been found among experts. See, e.g., James P. Kahan et al., *Variations by Speciality in Physician Ratings of the Appropriateness and Necessity of Indications for Procedures*, 34 MED. CARE 512 (1996).

<sup>148</sup> See *supra* notes 68-88 and accompanying text.

<sup>149</sup> One might argue that any deference to non-expert physicians undermines my earlier assertions about the importance and prevalence of hierarchy within the medical community. The precise hierarchy is, however, not always clear and one should not assume that private practitioners or primary

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Thus, appropriateness studies help medicine maintain a measure of autonomy against encroaching MCOs. The medical community's promulgation of appropriateness by consensus building represents more than simply a commitment to a shared paradigm. It allows medicine to maintain an aspect of self-governance by determining not only what medical procedures to recommend, but also how the determination is made. The building and documentation of a consensus has characteristics of lawmaking. Appropriateness studies determine *rules* that govern medical practice by relying on the opinions of the individuals that will be governed by these rules rather than looking to science to dictate the substantive content of the rules. On the one hand, appropriateness studies allow the medical profession to present a unified front to managed care administrators. On the other hand, the medical community continues to emphasize the importance of maintaining the authority to make individualized decisions regarding patient care. The consensus building that results from determinations of appropriateness allows the medical community to maintain autonomy and promotes the internal organization of medicine.

### III. HOW MEDICINE MAINTAINS AUTONOMY IN THE FACE OF STATE LAW

#### A. *The Formal Law's View of the "Standard of Care"*

The formal law recognizes the broad spectrum of the standard of care through such legal doctrines as "two schools of thought"<sup>150</sup> or the "respectable minority."<sup>151</sup> Some courts continue to acknowledge the variability of the standard of care by their acceptance of the locality rule,

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care physicians occupy a lower rung. Professor Haber points out, in his book on the history of the professions in the United States, that in the late nineteenth century, the AMA embraced private practice physicians, as medicine's prestige and authority were on the rise and the leadership moved toward the more scientific and academic centers. See HABER, *supra* note 19, at 337-42. Professor Haber notes that this was a strategically beneficial move. *Id.*

<sup>150</sup> See, e.g., *Levine v. Rosen*, 616 A.2d 623, 627 (Pa. 1992); *Downer v. Veilleux*, 322 A.2d 82, 87 (Me. 1974).

<sup>151</sup> See *Hood v. Phillips*, 554 S.W.2d 160, 165 (Tex. 1977). The court rejected a jury instruction that the standard of practice is to be determined by polling of the medical profession. *Id.* Instead, jury should ask "whether, a reasonable and prudent member of the medical profession would undertake [the procedure] under the same or similar circumstances." *Id.*



which determines the applicable standard of care based on local norms and practice patterns.<sup>152</sup>

Medicine, like the formal law, also supports a broad standard of care. However, unlike the formal law, medicine does so through its support of what it considers legitimate variability in procedure rates and physicians' attitudes.<sup>153</sup> Medicine maintains a solid rationale for the broad swath occupied by the standard of care. It is grounded in nature. For example, an empirical study of disabling injuries caused by medical treatment explains why not all errors in medicine constitute negligence.<sup>154</sup> The authors of the study explain that "vagaries of biology and human behavior make perfection unattainable, in either execution or outcome, for any form of treatment."<sup>155</sup> Thus, "[p]erfection can never be the standard of practice . . . . Accordingly, standards of practice must always include an acceptance of some degree of error."<sup>156</sup>

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<sup>152</sup> However, this doctrine is being eroded. See, e.g., *McDaniel v. Hendrix*, 401 S.E.2d 260 (Ga. 1991); *Bates v. Meyer*, 565 So. 2d 134 (Ala. 1990). It is still applied in some areas. See, e.g., *Medley v. Davis*, 529 N.W.2d 58, 62 (Neb. 1995) (evaluating expert testimony regarding "standard of care for psychiatrists in Omaha and similar communities"); *Leiker v. Gafford*, 778 P.2d 823 (Kan. 1989) (requiring doctors to exercise degree of learning and skill possessed by physicians in same or similar community). Academicians attribute the erosion of the locality rule to courts trying to prevent reliance on the limits of medical resources. See Mark Hall, *The Malpractice Standard Under Health Care Cost Containment*, 17 LAW MED. & HEALTH CARE 347 (1989). Another possible reason is the difficulty in plaintiff's obtaining medical expert witnesses. See Maxwell J. Mehlman, *The Patient-Physician Relationship in an Era of Scarce Resources: Is There a Duty to Treat?*, 25 U. CONN. L. REV. 349 (1993). Improvements in access to continuing medical education and computer accessed medical journal libraries contribute to a more uniform standard of practice. In the future, improvements in telemedicine may also contribute.

<sup>153</sup> The AMA's proposal for a fault-based administrative alternative for medical malpractice argues for the law to recognize an even broader standard of practice.

The primary motivation behind the change in the standard of care is to ensure that the broad range of acceptable medical care is recognized in law as nonnegligent. The proposed formulation, which is based on the standards of a "prudent and competent practitioner," specifically will direct the decision maker to consider the full spectrum of factors that legitimately affect a health care provider's medical judgments. These factors include the availability of medical facilities and the health of the patient.

The traditional standard of care, which is based on "customary practices," often has led physicians to be judged by unrealistically high standards of care.

Kirk Johnson et al., *A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims*, 42 VAND. L. REV. 1365, 1394 (1989). The AMA/Specialty Society Medical Liability Project designed the administrative proposal. *Id.* (footnote omitted).

See Mark Hall, *The Malpractice Standard Under Health Care Cost Containment*, 17 LAW MED. & HEALTH CARE 347 (1989). "What is almost never recognized is the tremendous variation in behavior that current medical custom encompasses." *Id.* at 352.

<sup>154</sup> See Lucian L. Leape et al., *The Nature of Adverse Events in Hospitalized Patients*, 324 NEW ENG. J. MED. 377, 381 (1991).

<sup>155</sup> *Id.*

<sup>156</sup> *Id.*

The formal law's approach to negligence supports the notion of intrinsic variability of human behavior and underlying factual circumstances through its reliance on the "reasonable person standard," which determines whether an injury or error is the result of negligence. Not every error or injury, after all, is the result of negligence. Since the variability of biology and human behavior sometimes results in unavoidable error (*i.e.*, a wrong but reasonable decision), the reasonable person standard helps determine which errors ought to be labeled "negligent" and which should be considered non-negligent accidents. Mere injury is not enough; the injury must be to some extent reasonably foreseeable.<sup>157</sup> However, though everyone can presumably understand the vagaries of life, an understanding of the vagaries of biology and the medical system requires an expert. The legal system, therefore, relies on expert medical testimony to determine what is reasonable and prudent in the circumstances.

For these reasons, only medical experts may establish the medical standard of care. A successful medical malpractice action almost always requires proof of a breach of the standard of care.<sup>158</sup> Medical experts also establish causation<sup>159</sup> and the adequacy of informed consent.<sup>160</sup> The legal system's significant reliance on doctors to provide essential testimony in almost every aspect of a medical malpractice case supports the existence of medicine's autonomy.

Medical autonomy in malpractice, much like the "law in lawyers' heads," also supports a comparison to the autonomous law of the Gypsies. Weyrauch and Bell, after all, emphasize that Gypsy law is noteworthy for

<sup>157</sup> But see Benjamin C. Zipursky, *Rights, Wrongs, and Recourse in the Law of Torts*, 51 VAND. L. REV. 1 (1998). Zipursky argues that his formulation of "substantive standing" explains Justice Cardozo's opinion in *Palsgraf v. Long Island R.R. Co.*, 162 N.E. 99 (N.Y. 1928), and all of tort law, better than the more accepted idea of foreseeability. *Id.* at 12. He focuses on "relational legal duties" in Cardozo's opinion and uses the idea to formulate a view of torts generally. *Id.* Such an approach can be used for cases involving MCOs sued under theories of vicarious liability for the medical malpractice of employee physicians. See *supra* Part II.

<sup>158</sup> See W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 32, at 185-93 (5th ed. 1984). Courts rarely disregard the standard of care as unreasonable. See, e.g., *Helling v. Carey*, 519 P.2d 981 (Wash. 1974). A physician's screening practices for glaucoma that was based on age was within the standard of care, but was also determined to be unreasonable in light of the low cost for the screening test and the severe consequences of the easily treated disease of glaucoma. *Id.* at 983.

<sup>159</sup> The doctrine of *res ipsa loquitur* may necessitate expert testimony to establish causation. See, e.g., *Tappe v. Iowa Methodist Med. Ctr.*, 477 N.W.2d 396 (Iowa 1991). Conversely, *res ipsa loquitur* may be used to allow the jury to find causation after experts establish a breach of the standard of care. See, e.g., *Connors v. University Assoc. in Obstetrics & Gynecology, Inc.*, 4 F.3d 123 (2d Cir. 1993); Karyn K. Ablin, Note, *Res Ipsa Loquitur and Expert Opinion Evidence in Medical Malpractice Cases: Strange Bedfellows*, 82 VA. L. REV. 325 (1996).

<sup>160</sup> See, e.g., *Cox v. Jones*, 470 N.W.2d 23 (Iowa 1990). The claim of lack of informed consent is an issue beyond the common knowledge of laypersons and requires expert evidence. *Id.* at 26.

its ability to occasionally prevail or strongly influence state law.<sup>161</sup> Gypsies make and administer their own law, but their autonomous law also has the ability to influence the content of the host nation's law.<sup>162</sup> This ability is critical to establishing the perpetual existence of autonomous law. Otherwise, an autonomous group might be able to engage in lawmaking, but the resultant laws would no longer be effectively autonomous were they unable to withstand a conflict with the formal law.

The medical malpractice system represents the meeting of medicine's autonomous law with the formal law. The resultant conflict provides a good example of how medicine's law maintains its autonomy. As seen above, medicine accomplishes the first step of creating autonomous rules through the use of appropriateness studies. The medical community's second step involves protecting the ability of these autonomous rules to withstand influence from the formal law in trials for medical malpractice. Medicine's success is apparent from the formal law's deference to medicine in the legal determination of the standard of care. Medicine further ensures the formal law's deference by its ambivalent—at times hostile—treatment of the formal law's medical malpractice system. The medical community views the state's medical malpractice law as undue interference by the legal community. Moreover, medicine seeks to instill within its members an internal prohibition against medical malpractice—a prohibition that does not emanate from the formal law.

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<sup>161</sup> See Reisman, *supra* note 41, at 411. Reisman questions the assertion that the autonomous law described by Weyrauch and Bell virtually always prevails over the law of the state. He writes:

This proposition seems too broad. Surely we need to know more about the relationship between autonomous law and the law of the state before we can say if and when one trumps the other. For example, we would need to assess the intensity of demand for each of the competing norms from these different sources, the consequences of their application in particular cases, and the relative power positions of different groups.

*Id.*

<sup>162</sup> See Weyrauch & Bell, *supra* note 23, at 362. The authors cite *Spiritual Psychic Science Church of Truth v. Azusa*, 703 P.2d 1119 (Cal. 1985), as an example of host law explicitly accommodating Gypsy law. *Id.* "[S]ome persons believe they possess the power to predict what has not yet come to pass. When such persons impart their beliefs to others, they are not acting fraudulently." Weyrauch & Bell, *supra* note 23, at 362 n.170.

## B. The Medical View of Medical Malpractice

### 1. Medicine's Apparent Strength: The Compilation of Empirical Evidence About the Medical Malpractice System

In 1992, one legal scholar asked, "Do we really know anything about the behavior of the tort litigation system . . . ?"<sup>163</sup> Medical researchers have asked the same question. Many physicians continue to believe that the medical malpractice system is haphazard.<sup>164</sup> They assert that plaintiffs often bring lawsuits with little regard to the medical care received, while actual negligence goes unnoticed.<sup>165</sup> The empirical evidence appears contradictory.<sup>166</sup> Regardless, many of the articles in the medical journals support the view that the legal system's determination of medical malpractice is haphazard when compared with the gold standard—a determination made by medical experts.

The Harvard Medical Practice Study ("Harvard Study"), a series of such articles, supports the views held by many physicians.<sup>167</sup> The first two articles of the series categorized the rate and character of disabling injuries

<sup>163</sup> Saks, *supra* note 94, at 1147; see Gary T. Schwartz, *Reality in the Economic Analysis of Tort Law: Does Tort Law Really Deter?*, 42 U. CAL. L. REV. 377 (1994) (discussing the difficulty of assessing the effectiveness of negligence law to deter).

<sup>164</sup> See Ann G. Lawthers et al., *Physicians' Perceptions of the Risk of Being Sued*, 17 J. HEALTH POL. POL'Y & LAW 463 (1992); James S. Todd, *Reform of the Health Care System and Professional Liability*, 329 NEW ENG. J. MED. 1733 (1993) (describing the problem with the malpractice mess).

<sup>165</sup> See, e.g., Sara C. Charles et al., *Sued and Non-Sued Physicians' Self-Reported Reactions to Malpractice Litigation*, 142 AM. J. PSYCHIATRY 437 (1985).

<sup>166</sup> See R. Bovbjerg, *Medical Malpractice: Problems and Reforms*, 1995 URBAN INST. (proposing that the filing of lawsuits may not be correlated to the quality of care but that generally compensation is overall made only for meritorious cases); Henry S. Farber & Michelle J. White, *Medical Malpractice: An Empirical Investigation of the Litigation Process*, 22 RAND J. ECON. 199, 199 (1991) (concluding that quality of care is "an extremely important determinant of defendants' medical malpractice liability"); Mark I. Taragin et al., *The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims*, 117 ANNALS INTERNAL MED. 780 (1992) (asserting that defensibility of the case and not severity of the injury is predictive of outcome in medical malpractice cases); FRANK SLOAN ET AL., *SUING FOR MEDICAL MALPRACTICE* (1993) (proposing that severity of the injury predictive of payment in injuries during emergency and neonatal care); Troyen A. Brennan et al., *Relationship Between Negligent Adverse Events and the Outcomes of Medical-Malpractice Litigation*, 335 NEW ENG. J. MED. 1963 (1996) (arguing that severity of patient's disability was the only predictor of payment to plaintiff and that occurrence of adverse event or of adverse event due to negligence was not predictive of payment).

<sup>167</sup> The data and analysis first presented in the series of articles was later published in a book. I reference the articles because the medical community learned of the results through the articles. All of the articles draw upon data collected from a review of 31,429 randomly selected records from patients discharged from 51 hospitals in New York State in 1989.

caused by medical treatment.<sup>168</sup> These studies concluded that 3.7% of patients received injuries from either errors of omission or commission.<sup>169</sup> Not all injuries, of course, were due to negligence. Utilizing a process of physician review, the studies found that negligent care caused 28% of the injuries.<sup>170</sup> The authors concluded that “a substantial amount of injury [occurs] to patients from medical management, and many injuries are the result of substandard care.”<sup>171</sup> This high rate appeared to indict the medical system.

The next article of the series, however, dispelled any notion that the legal system effectively addressed medical malpractice. It examined the relationship between injuries due to negligence and medical malpractice claims resulting therefrom. The study revealed that only 1.53% of patients injured by medical negligence filed malpractice claims.<sup>172</sup> The authors concluded that “the civil-justice system only infrequently compensates injured patients and rarely identifies and holds health care providers accountable for substandard medical care.”<sup>173</sup> The medical-malpractice system fulfilled its social objectives “crudely” at best.<sup>174</sup>

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<sup>168</sup> Troyen A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients—Results of the Harvard Medical Practice Study I*, 324 NEW ENG. J. MED. 370 (1991); Leape et al., *supra* note 154, at 377.

<sup>169</sup> Brennan et al., *supra* note 168, at 370; Leape et al., *supra* note 154, at 377.

<sup>170</sup> Brennan et al., *supra* note 168, at 370; Leape et al., *supra* note 154, at 377.

<sup>171</sup> Brennan et al., *supra* note 168, at 370. The authors' concluding remarks are noteworthy for several reasons. First, the authors display optimism and faith in progress. They write:

Indeed, the safety and effectiveness of many current medical treatments result from the earlier reduction or elimination of complications similar or identical to those we have identified as adverse events here . . . . These were the adverse events of an earlier day, and they were greatly reduced in frequency after research led to an understanding of their causes.

*Id.* at 383.

Second, the authors call for continued research into the causes of adverse events and for an increased emphasis on education. *Id.* Third, the authors' description of the complexity of the delivery of medical care makes one wonder whether prevention is ever possible. They conclude:

Adverse events result from the interaction of the patient, the patient's disease, and a complicated, highly technical system of medical care provided not only by a diverse group of doctors, other care givers, and support personnel, but also by a medical-industrial system that supplies drugs and equipment.

*Id.* at 383-84.

<sup>172</sup> Russell Localio et al., *Relation Between Malpractice Claims and Adverse Events Due To Negligence: Results of the Harvard Medical Practice Study III*, 325 NEW ENG. J. MED. 245, 245 (1991).

<sup>173</sup> *Id.* at 250.

<sup>174</sup> *Id.*

The Harvard Study also examined the relationship between negligent events and outcomes of medical malpractice litigation. The study followed fifty-one malpractice claims from the original 31,429 records for ten years.<sup>175</sup> Interestingly, the study identified twenty-nine cases with *no injury*; yet, in ten of these twenty-nine cases, the plaintiff gained an average settlement amount of \$28,760.<sup>176</sup> Thirteen cases involved an "adverse event" but no negligence and six of these thirteen settled for an average of \$98,192.<sup>177</sup> The nine cases rated as "negligent" by the physician review panel resulted in five settlements for an average of \$66,944—approximately \$30,000 less than the settlement amount for the non-negligent but adverse outcome cases.<sup>178</sup>

The results of this portion of the Harvard Study described a dismal malpractice system where only one-sixth of the claims filed involved any evidence of negligence in the medical record. Lack of negligence, however, did not preclude payment.<sup>179</sup> The average settlement amount for cases involving a medical injury, but no negligence, was about \$30,000 more than cases involving negligence.<sup>180</sup> Using multivariate analysis, the authors of the study concluded that only severity of the patient's disability was predictive of payment.<sup>181</sup> Negligence was not a statistically significant predictor of payment.<sup>182</sup>

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<sup>175</sup> Forty-six of the fifty-one had been closed. Brennan et al., *supra* note 166, at 1964.

<sup>176</sup> *Id.*; see also SLOAN ET AL., *supra* note 166, at 50-122 (explaining that there are a substantial proportion of medical malpractice claims brought even though there is no negligence or, in some instances, no medical injury).

<sup>177</sup> Brennan et al., *supra* note 166, at 1964.

<sup>178</sup> *Id.*

<sup>179</sup> See PAUL C. WEILER ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION AND PATIENT COMPENSATION (1993) (noting that the results of the Harvard Medical Malpractice Project are not surprising when one understands the probabilities and that proper analysis focuses on the prevalence of the event in the population examined). The authors further explain:

[W]hile the absolute number of unfounded claims is considerably larger than the absolute number of valid claims, the pattern . . . shows that the chances that any one doctor will be sued are far greater if negligent treatment has occurred than if it has not. To return to our traffic analogy, even though more drivers may be ticketed by police after going through green than red lights, the reason is that far more drivers go through green lights in the first place. With that difference controlled for, the odds that a careless driver will get a ticket, or that a careless doctor will be sued, are far greater than the odds faced by their careful counterparts.

*Id.* at 75. This is, however, a rather sophisticated analysis of the result showing that a large number of cases were filed in which there was no negligence. It is likely that most doctors would not reach the same conclusion, even though they are familiar with the concepts of prevalence of disease affecting positive and negative predictive values when evaluating laboratory tests.

<sup>180</sup> *Id.* at 76.

<sup>181</sup> *Id.*

<sup>182</sup> *Id.*

The authors also commented on the litigation system. Access to defense litigation files allowed them to “[uncover] examples of the ‘art’ of litigation” as applied in the medical malpractice context.<sup>183</sup> The examples included settling a case only because the defendant physician would have made an unsympathetic witness, and providing a vigorous defense even though the insurer privately acknowledged negligence by the physician.<sup>184</sup> These examples, the authors maintain, “raise questions about whether tort law is the most effective system of compensating injured patients and creating rational mechanisms of preventing injuries.”<sup>185</sup>

Having demonstrated the inaccuracy of determinations of negligence made by the medical malpractice system, Troyen Brennan and his co-authors questioned why such a determination is necessary when considering compensation. According to the authors, the formal law of negligence should only be used in the medical context if it has a deterring effect—a quality not easily ascertained through traditional research methods. The available empirical evidence does not reveal that the law of negligence has meaningful deterring effect. Medical malpractice, therefore, neither accurately compensates patients who have been injured by negligence, nor does it effectively deter future injuries.<sup>186</sup>

The Harvard Study group interviewed a large number of physicians to learn what factors they believed most affected the standard of care.<sup>187</sup> The most effective factors cited were continuing medical education programs and medical journals.<sup>188</sup> Standard operating procedures devised by hospitals or in-house specialty departments and clinical care guidelines had a moderate effect.<sup>189</sup> Personal interviews with doctors, external peer review and state disciplinary boards each indicated that physicians believe that the

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<sup>183</sup> See Brennan et al., *supra* note 166, at 1967.

<sup>184</sup> *Id.*

<sup>185</sup> *Id.*

<sup>186</sup> The study's results are subject to differing interpretations. See *id.* (discussing the statistical interpretation of the result that 39 claims were filed when there was no evidence of negligence); see also Michael Saks, *Medical Malpractice: Facing Real Problems and Finding Real Solutions*, 35 WM. & MARY L. REV. 693 (1994) (reviewing PAUL C. WEILER ET AL., *A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION* (1993)). Professor Saks notes that the design of the Harvard Study does not allow valid conclusions about deterrence because the data is a snapshot and does not allow any comparison over time. Saks, *supra*, at 718. Also, the determination of the number of negligent injuries is used for both measuring the sanction (number of claims per negligent injuries) and the incidence of malpractice (number of negligent injury per patient charts reviewed). *Id.* Professor Saks explains, “[t]hat means that any error in measurement—and there is always error in all measurement—would tend to produce a spurious correlation. The greater the measurement error, the more it would appear that a deterrent effect existed.” *Id.* at 718-19.

<sup>187</sup> WEILER ET AL., *supra* note 179, at 112.

<sup>188</sup> *Id.* at 128-29.

<sup>189</sup> *Id.* at 131.

law's medical malpractice system has even less of an effect.<sup>190</sup> This was despite the fact that many physicians overestimated the risks of being sued for malpractice.<sup>191</sup> Many doctors spoke of their distress at the prospect of lawsuits and having their professional competence attacked.<sup>192</sup> They reported engaging in defensive medicine, despite study results that questioned the extent to which physicians practiced defensive medicine.<sup>193</sup>

The results of the study are inconsistent but not surprising. On the one hand, doctors complain about defensive medicine and the great likelihood of lawsuits; on the other hand, they do not acknowledge that the medical malpractice system affects their standard of practice.<sup>194</sup> This sentiment is understandable for reasons that recall the concept of autonomous law. The sentiment reflects the implicit view, held by physicians, that institutions outside of the medical community, such as the formal law, ought to have less of an effect on the standard of care than entities such as medical journals and continuing education programs that are administered from within.<sup>195</sup>

Several other points from the Harvard Study are noteworthy. First, the study examined fifty-one filed medical malpractice cases and not fifty-one trials.<sup>196</sup> Only one case went to trial. One may apply the dismal results to the medical malpractice liability system, but the results do not support any direct conclusions about the ability of juries or judges to accurately determine negligence by a physician.<sup>197</sup> The study more appropriately indicts the pragmatic approach taken by liability insurers and attorneys in resolving conflicts.<sup>198</sup> Notwithstanding the lack of evidence about trial results, the Harvard Study does reflect the frequency of trials within the medical malpractice system because most estimates are that ninety percent of filed cases do not go to trial.<sup>199</sup>

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<sup>190</sup> *Id.* at 124.

<sup>191</sup> *Id.* at 125.

<sup>192</sup> *Id.* at 126.

<sup>193</sup> *Id.* at 127.

<sup>194</sup> *Id.* at 126.

<sup>195</sup> *Id.*

<sup>196</sup> *Id.* at 112.

<sup>197</sup> *Id.*

<sup>198</sup> *Id.*

<sup>199</sup> See NEIL VIDMAR, MEDICAL MALPRACTICE AND THE AMERICAN JURY: CONFRONTING MYTHS ABOUT JURY INCOMPETENCE, DEEP POCKETS, AND OUTRAGEOUS DAMAGE AWARDS 49-59 (1995). Professor Vidmar examined the approximately ten percent of cases that went to trial in North Carolina during 1984 to 1987 and suggested that cases that do go to trial, on average, are not strong cases for the plaintiffs. *Id.* at 49-50. Trial cases also had a higher incidence of requests for punitive damages, suggesting cases beginning on a contentious note were less likely to settle. *Id.* at 56; see also Farber & White, *supra* note 166, at 203 (discussing study of one hospital's 252 malpractice suits that showed



A second noteworthy point lies in the study's complete reliance on the assessment of negligence by *physicians*.<sup>200</sup> For example, the failure in the case that settled only because the defendant physician made a poor witness was attributed to the questionable "art" of litigation. An individual witness, however, may be a poor witness because of other reasons, such as inconsistent testimony or problems of character or veracity. This would affect the facts of the case and perhaps alter the outcome. It may also cast doubt on the reliability of the medical chart entries, upon which the reviewing physicians relied in making their determinations of negligence. Regardless of the reasons that made this physician a poor witness, the study evaluated the issue of negligence in wholly *medical* terms. This approach centers on a medical view of negligence and implicitly indicates the formal legal determination of negligence as haphazard.

Reliance on medical fact-finders as the sole determiners of malpractice resembles the approach taken by the American Medical Association ("AMA"). The AMA proposes the replacement of the jury system with an administrative panel of physicians recommended by the state medical board, or some similar organization.<sup>201</sup> Contrary to the general indictment of the medical malpractice system presented by the Harvard Study of the fifty-one filed New York cases, the AMA proposal focuses on more specific problems—namely, juries and judges. For the AMA, the problem lies in the inherent incompetence of juries to decide complex medical matters, and the inability of judges to ferret out scientifically incredible medical opinions.<sup>202</sup>

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only thirteen suits, or five percent, went to trial); Mark Taragin et al., *The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims*, 117 ANNALS OF INTERNAL MED. 780, 783 (1992) (stating that twelve percent of 8,231 New Jersey cases between 1977 and 1992 went to trial).

<sup>200</sup> See Brennan et al., *supra* note 166, at 1666. The authors note only three cases in which the initial physician review panel's judgment regarding negligence disagreed with the decision about negligence in the litigation file. *Id.* They maintain, however, that this did not change their findings. *Id.*

<sup>201</sup> See, e.g., Kirk B. Johnson et al., *A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims*, 42 VAND. L. REV. 1365, 1366-67 (1989) (citing revised version of the AMA SPECIALTY SOCIETY MEDICAL LIABILITY PROJECT, A PROPOSED ALTERNATIVE TO THE CIVIL JUSTICE SYSTEM FOR RESOLVING MEDICAL LIABILITY DISPUTES: A FAULT-BASED ADMINISTRATIVE SYSTEM (1988)).

<sup>202</sup> *Id.* at 1370. Johnson explains:

[T]he fact finder must decide whether the patient was treated appropriately whenever experts cannot agree on that question. Lay juries . . . are ill-equipped to resolve the arcane issues involved. Furthermore, juries cannot evaluate independently the expert testimony almost always introduced in malpractice cases to explain the two major elements of liability: failure to meet the appropriate standard of care and causation.

The nature of medical knowledge compounds the difficulties presented as a result of the jury's lack of expertise . . . . Because of the complexity of the issues, judges allow juries to hear medical views that may not be scientifically credible.

Taken together, the AMA proposal and the Harvard Study imply that doctors would do a better job deciding questions of negligence instead of merely describing the standard of care and the probabilities of causation. Implicit in the minds of many physicians is the belief that they should apply as well as create the law of medical malpractice.

The authors of the Harvard Study make the noteworthy point that the results warrant an exploration of no-fault compensation for medical injuries. An oft-cited physician criticism of the medical malpractice system is the high financial and personal cost of a lawsuit.<sup>203</sup> Litigation damages professional reputations and relationships with patients. In a no-fault system, the legal system would not judge a physician's medical technique or judgment. Causation would still require expert medical opinion, but neither jury, judge, lawyer, nor other physician would assess the quality of the defendant doctor's medical knowledge, skill or judgment.<sup>204</sup> The defendant would thus be insulated from criticism from outside the medical profession, while the victim would still be compensated. Under a no-fault system doctors would, as one commentator writes, "gain what in their heart of hearts they long for most, namely, escape from the lawyers."<sup>205</sup> In addition, the instances of public criticism

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*Id.*

<sup>203</sup> See Paul Weiler et al., *Proposal for Medical Liability Reform*, 267 JAMA 2355, 2356 (1992). The authors state:

Malpractice law litigation functions, then, somewhat like income tax audits. First, only a small proportion of potential cases are singled out for scrutiny. Second, although the targets are too often innocent parties, the risk is much greater for error prone parties. Finally, the costs imposed by the process seem so high as to motivate significant changes in behavior to avoid running afoul of the law.

*Id.*

<sup>204</sup> *Id.* "[A no-fault program] would not, however, avoid tough decisions concerning causation of some current disabilities. For example, was a child's cerebral palsy the result of a difficult delivery?"

*Id.*

<sup>205</sup> Saks, *supra* note 186, at 702. A no-fault system for medical injuries may not be without problems to the medical profession. It may increase the law's ability to interfere with the medical profession. For example, although Professors Weiler and Abraham believe the present medical malpractice system deters future injuries, they endorse a broader system of strict liability that would extend to hospitals and other health care organizations. Kenneth Abraham & Paul Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381, 383 (1994).

Such a system would more effectively compensate injured patients, and it would help prevent future injuries. The authors write, "[a]t least as important, such an expansion of legal liability could materially improve the law's leverage on the health care system to develop more effective preventive measures against future patient injuries, both negligent and non-negligent." Weiler et al., *supra* note 203, at 2357. The authors explain that medical organizations today have access to large amounts of information that is used to promote cost-effectiveness. *Id.* Under a no-fault system one can assume that more patients would seek compensation for their injuries since plaintiffs would no longer have to prove negligence. In turn, the cost of compensating medical injuries would increase. The hospitals

from fellow physicians would decrease since licensed colleagues would no longer testify in medical malpractice cases where a physician breached the standard of care. Quality control and assessment would, presumably, be left either to hospitals, MCOs, medical groups' internal reviewers, or indirectly to the marketplace.<sup>206</sup> The fundamental point remains: Through advocacy of a no-fault system, medicine seeks to minimize the interference of the law and to assert its independence.

## 2. Medicine's Regulation of Expert Witnesses

The medical community also maintains its independence by regulating the testimony of medical expert witnesses regarding the standard of care. Doctors who practice in the same locale as the defendant physician are often reluctant to testify against another doctor.<sup>207</sup> Their reluctance may stem from a fear of economic or social repercussions,<sup>208</sup> or it may result from many doctors' willingness to acknowledge mistakes but

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and MCOs would then increasingly monitor physicians in order to minimize costs in compensating medical injuries. Of course, the involvement by business, insurance and hospital administrators is a reality. This discussion concerns only the degree of involvement. See, e.g., William Peters & Mark Rogers, *Variations in Approval by Insurance Companies of Coverage for Autologous Bone Marrow Transplantation for Breast Cancer*, 330 NEW ENG. J. MED. 473, 473 (1994) (concluding that the predetermination process as applied to patients in clinical research trials for cancer therapy was "arbitrary and capricious").

Ironically, a shift from negligence to strict liability may only exchange one of a physician's demons (interference by the legal institution) for another (interference by business, insurance, and hospital administrators). See Abraham & Weiler, *supra*, at 383. "And many physicians, especially those represented by the AMA, were wary of a proposal that, while promising to get lawyers off their backs, might simply put insurance company bureaucrats or hospital administrators in the lawyers' place." *Id.*

<sup>206</sup> There are many different types of proposed reform, including a proposal for a "neo-no-fault" approach where a health care provider may preempt a tort action by offering to pay all economic damages arising from a medical injury. Under such an approach, the provider would not have to pay for non-economic damages and the injured patient, in turn, gets a relatively quick and guaranteed payment. See Jeffrey O'Connell, *Neo-No-Fault Remedies for Medical Injuries: Coordinated Statutory and Contractual Alternatives*, 49 LAW & CONTEMP. PROB., Spring 1986, at 129-31; W. Henson Moore & John S. Hoff, *H.R. 3084: A More Rational Compensation System for Medical Malpractice*, 49 LAW & CONTEMP. PROB., Spring 1986, at 117 (discussing the failed Moore-Gephardt bill proposing such a system).

<sup>207</sup> See SLOAN ET AL., *supra* note 166, at 93 (arguing that the "conspiracy of silence" still exists, but that it is diminishing).

<sup>208</sup> See, e.g., Bill Richards, *Doctors Seek Crackdown on Colleagues Paid for Testimony in Malpractice Suits*, WALL ST. J., Nov. 7, 1988, at A7. See also Robinson & Darley, *supra* note 45, at 469 (identifying reasons why people obey the law as social sanctions and internal social sanctions, both of which apply to doctors within the medical community).

not negligence.<sup>209</sup> For these reasons, plaintiffs' lawyers, in contrast to defense attorneys, often have difficulty in obtaining expert physician witnesses to testify against another physician. The number of physician-experts testifying for the defense often exceeds the number testifying for the plaintiff.<sup>210</sup>

Medicine also tries to regulate the law of medical malpractice at a more formal level. A variety of medical organizations provide oversight of expert medical witnesses.<sup>211</sup> For example, the American Association of Neurological Surgeons keeps a file of depositions and testimony given nationwide by neurosurgeons.<sup>212</sup> The American Academy for Orthopedic Surgeons has a committee to address expert testimony, and the American College of Surgeons asks its members to send information about "improper testimony" to the Defense Research Institute in Chicago.<sup>213</sup> These files and committees represent attempts by the autonomous group to influence the impact of the formal law upon their members.

### 3. Medicine's Criticism of the Law's Process for Determining Scientific Facts

In yet another example of autonomous behavior, the medical community is often critical of juries' and judges' findings of fact in medical malpractice cases. The AMA, in a 1988 task force on medical liability, wrote:

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<sup>209</sup> See VIDMAR, *supra* note 199, at 74 (discussing results of Harvard Study survey of 47 doctors who almost unanimously conceded that doctors make mistakes but were reluctant to label the mistakes as negligent).

<sup>210</sup> *Id.* at 75-76. Professor Vidmar notes that in his review of North Carolina court records, defense attorneys often made arguments to the court about the failure of the plaintiffs to obtain an expert witness or the inadequacies of the witness retained. *Id.* at 76. Arguments by plaintiffs, on the other hand, tended to complain that defense tactics unfairly burdened the plaintiff with the costs of deposing the large number of medical experts ready to testify for the defense. *Id.* at 76-77. He estimates that defense expert medical witnesses outnumbered plaintiffs' medical experts about four to one. *Id.* at 77.

<sup>211</sup> See Gary N. McAbee, *Improper Expert Medical Testimony: Existing and Proposed Mechanisms of Oversight*, 19 J. LEGAL MED. 257 (1998). Dr. McAbee cites one study that concluded that during a ten year period in Massachusetts thirty-seven percent of lawsuits with questions requiring a neurologist's testimony involved an error of fact or interpretation by an expert medical witness. *Id.* at 260. All the errors were by plaintiff's expert witnesses. *Id.* He acknowledges that the study had a number of problems and biases. *Id.* at 259. The estimate of 37% is therefore probably high. Dr. McAbee also acknowledges the inherent subjectivity in determining what constitutes improper testimony. *Id.* Fraudulent testimony, by contrast, is more straightforward. *Id.* at 258.

<sup>212</sup> *Id.*

<sup>213</sup> *Id.* at 259 (citing Paul F. Nora & Lucy Hynds Karnell, *Liability Pilot Survey Examines Claims, Expert Witnesses*, 75 BULL. OF THE AM. COLLEGE OF SURGEONS, 16 (1990)).

In the medical liability context, a source of at least some of the problem for physicians and other health care providers . . . appears to many to be the jury . . . . [Problems with the jury] include decisions that are not based on a thorough understanding of the medical facts and awards that increase at an alarming rate and in a fashion that seems uniquely to disadvantage physicians as compared with other individuals who have acted negligently.<sup>214</sup>

One medical society portrayed juries as vindictive and non-scientific, while physicians are the victims of the jury's ill will. The North Carolina Plastic Surgery Society stated: "The jury system seems to show a desire for punitive [action] and retribution above and beyond the degree of injury—'let's get the rich doctor.'"<sup>215</sup> Organized medicine also criticizes judges. The AMA task force mentioned above declared that "[b]ecause of the complexity of the issues, judges allow juries to hear medical views that may not be scientifically credible."<sup>216</sup>

The quotes above illustrate the negative view of the jury in medical malpractice cases shared by many physicians. These critics decry either the jury's bias against doctors, or the jury's inability to accurately assess scientific evidence. Recently, Professor Scott Brewer elaborated on this question of institutional competence with a model of "the reasoning process by which nonexpert legal reasoners defer to scientific experts in the course of applying a law to individual litigants."<sup>217</sup> For Brewer, the factfinder in the present legal system cannot make good decisions when faced with complex scientific questions. Most judges have inherent difficulties applying these rules because they lack the necessary scientific training. Central to Brewer's discussion is the Supreme Court's 1993 decision, *Daubert v. Merrell Dow Pharmaceuticals, Inc.*<sup>218</sup> *Daubert* interprets key provisions of the Federal Rules of Evidence and places the trial judge in the role of the "gatekeeper." *Daubert* sets forth several guidelines to assist trial judges in deciding reliability, and thus the admissibility, of scientific evidence.<sup>219</sup> For Brewer, however, *Daubert* raises the following question:

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<sup>214</sup> VIDMAR, *supra* note 199, at 4-5 (quoting AMA Specialty Society Medical Liability Project, *A Proposed Alternative to the Civil Justice System for Resolving Medical Liability Disputes: A Fault-based Administrative System* 7-8 (1988)).

<sup>215</sup> *Id.* at 4 (quoting UNITED STATES GENERAL ACCOUNTING OFFICE (U.S. GAO), REPORT TO CONGRESSIONAL REQUESTERS, MEDICAL MALPRACTICE: CASE STUDY IN NORTH CAROLINA (Dec. 1986)).

<sup>216</sup> Johnson et al., *supra* note 201, at 1370.

<sup>217</sup> Brewer, *supra* note 92, at 1539.

<sup>218</sup> 509 U.S. 579 (1993).

<sup>219</sup> *See id.* at 591-94. The Court provides four guidelines to help the trial judge decide what scientific knowledge should be admitted. *Id.* These are whether the scientific evidence is testable and feasible, whether it has been subjected to peer review and publication, whether the error rate of a test is

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How could a scientifically untrained judge be sufficiently epistemically *competent* to perform the gatekeeping task imposed upon it [sic] by Daubert's reading of the Federal Rules of Evidence? Moreover, assuming the judge admits the evidence, how could a scientifically untrained trier of fact, whether judge or jury, be sufficiently epistemically competent to assess competing putatively scientific claims by *competing* expert witnesses when . . . that factfinder does not have the requisite expertise to judge the evidence itself?<sup>220</sup>

The decision-makers who lack scientific training and understanding inevitably make "epistemically arbitrary" judgments about the validity of scientific evidence. The non-expert legal decision-maker nearly always evaluates the testimony of scientific expert witnesses based on factors other than the scientific quality of the proffered evidence.<sup>221</sup> Non-expert decision-makers, for example, assess the demeanor of the expert to evaluate the expert's credentials, which may be helpful when evaluating the veracity of a witness.<sup>222</sup> Witness demeanor, however, does not help the decision-maker evaluate the *quality* of the science.<sup>223</sup> In fact, a decision-maker might be misled by relying on a witness's demeanor and conclude that the older, more distinguished and articulate scientist is correct when, in fact, the opposing expert's theory has a greater degree of scientific validity.<sup>224</sup> Cross-examination also loses much of its effectiveness when the lawyers trying the case may also have difficulty understanding the science.<sup>225</sup> A good point made on cross-examination may be lost on the

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high or potentially high and whether it is generally accepted within the scientific community. *Id.* at 592-94. This last prong is the previous standard, the *Frye* rule, which made general acceptance the only consideration and did not require trial judges to evaluate the science as would a scientist. *Id.* at 589.

<sup>220</sup> See Brewer, *supra* note 92, at 1551-52. Brewer quotes Judge Kozinski, who wrote the opinion after it was remanded from the Supreme Court. Judge Kozinski voiced similar concerns:

The first prong of *Daubert* puts federal judges in an uncomfortable position. The question of admissibility only arises if it is first established that the individuals whose testimony is being proffered are experts in a particular scientific field . . . [t]herefore, though we are largely untrained in science and certainly no match for any of the witnesses whose testimony we are reviewing, it is our responsibility to determine whether those experts' proposed testimony amounts to "scientific knowledge," constitutes "good science," and was "derived by the scientific method."

*Id.* at 1551 (citing *Daubert v Merrell Dow Pharm., Inc.*, 43 F.3d 1311, 1315-16 (9th Cir. 1995)).

<sup>221</sup> Brewer, *supra* note 92, at 1621.

<sup>222</sup> *Id.*

<sup>223</sup> *Id.* at 1622.

<sup>224</sup> *Id.* at 1622-24. Professor Brewer cites a 1967 Los Angeles area survey that found that lawyers preferred an impressive "courtroom manner" to medical expertise when choosing medical experts. *Id.* at 1623 (citing Note, *The Doctor in Court: Impartial Medical Testimony*, 40 S. CAL. L. REV. 728, 728-29 (1967)).

<sup>225</sup> Brewer, *supra* note 92, at 1622.

trier of fact if the science is not understood. Professor Brewer argues that the present method of evaluating science violates the dictates of intellectual due process<sup>226</sup> and results in erroneous conclusions. Unfortunately, the problem Brewer describes will only worsen with society's increasingly widespread use of scientific theories, and the inevitable evolution of science into more complex and specialized applications.

Brewer does not propose to have judges solicit more scientific information "by using court appointed experts, appointing special masters or specially trained law clerks, or using pretrial conferences to narrow the scientific issues."<sup>227</sup> These solutions fail because "the judge is not capable of making an epistemically legitimate decision about *which special master, law clerk, or court-appointed expert* to consult."<sup>228</sup> Professor Brewer suggests avoiding the problem by having the "same legal decision[-]maker wear two hats, the hat of epistemic competence and the hat of practical legitimacy."<sup>229</sup> Notably, Brewer does not discuss whether one science may be different from another science. He does not discuss whether a biologist could better assess a physicist's testimony than could a judge or jury. Rather, he emphasizes the scientific method, and notes the existence of differing philosophies of science. A better proposal may be that the second hat of Professor Brewer's two-hatted decision-maker should be that of the particular science in front of him or her. For example, the decision-maker in a medical malpractice case would have medical as well as legal training, and not training in engineering. The advantages of such a decision-maker would be twofold. First, a decision-maker wearing the specific hat of the scientific discipline at issue would allow for greater epistemological competence of the type Brewer advocates. Secondly, it would allow for the unconscious recognition of the autonomous laws of the institution that grants the second hat. Perhaps intellectual due process would be better satisfied by the decision-maker having a familiarity with the operation of the autonomous laws, as well as an understanding of the science.

The criticisms of the accuracy of juries and judges discussed by the AMA and Brewer are dampened by empirical evidence suggesting that juries' decisions about medical malpractice are similar to the decisions reached by neutral physicians. One study compared the opinions given by reviewing physicians—who determine medical negligence as part of a

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<sup>226</sup> Professor Brewer describes intellectual due process as a "norm that requires, among other things, that the decision-making process not be arbitrary from an epistemic point of view. In other words, nonexpert judges and juries often fail to satisfy the demands of intellectual due process when they solicit and rely upon scientific expert testimony." *Id.*

<sup>227</sup> Brewer, *supra* note 92, at 1681.

<sup>228</sup> *Id.*

<sup>229</sup> *Id.*

liability insurer's internal review process—with jury verdicts in 988 cases.<sup>230</sup> The results revealed that the jury verdicts on the question of liability correlated with the determinations of negligence made by the presumably independent doctors.<sup>231</sup> Furthermore, the severity of the plaintiffs' injuries did not correlate with the outcome of liability determined by the jury.<sup>232</sup>

Other studies support this result, but the question of a jury's ability to decide complex scientific questions remains.<sup>233</sup> Neil Vidmar has tried to help answer the question with his book, *Medical Malpractice and the American Jury*.<sup>234</sup> As the title suggests, Professor Vidmar maintains that juries do a credible job and that attacks on jury competence are misguided. In the concluding chapter of his book, Professor Vidmar examines why the myth about juries is incongruent with the empirical evidence.<sup>235</sup> Among several plausible explanations, Vidmar quotes Professor Patrick Hubbard's argument, formulated during the medical malpractice crisis of the late 1980s:

"[T]ort reform" functions as a symbol used by physicians to register their protest against a broad range of changes in the American health care system. Physicians are seeking social support for a symbolic reaffirmation of their role and importance in society. Consequently, from their point of view, opposition to the fairness or efficacy of the reform proposals is tantamount to opposition to the medical profession.<sup>236</sup>

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<sup>230</sup> Mark Taragin et al., *The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims*, 117 ANNALS OF INTERNAL MED. 780 (1992). The authors looked at a total of 8,231 closed claims in New Jersey. *Id.* at 782. The conclusion that severity of injury was not the predominant influence on whether payment was made applied to all cases, not just those going to trial. *Id.* at 783-84.

<sup>231</sup> *Id.* at 782. The authors note that a physician-based reviewing process may be biased towards assessing performance in favor of other physicians and that insurance companies may initially favor classifying cases as defensible to save money. *Id.*

<sup>232</sup> *Id.* at 782-83.

<sup>233</sup> See, e.g., SLOAN ET AL., *supra* note 166, at 22. The authors reviewed 187 closed cases of emergency room and birth-related injuries. *Id.* at 6-7, 11. Thirty-seven went to trial. *Id.* at 85. Although not statistically significant, authors concluded that, "[d]efendants thought by the evaluators to have been not liable lost at verdict in less than a fifth of the cases." *Id.* at 168.

<sup>234</sup> VIDMAR, *supra* note 199.

<sup>235</sup> *Id.*

<sup>236</sup> VIDMAR, *supra* note 199, at 268 (quoting F. Patrick Hubbard, *The Physician's Point of View Concerning Medical Malpractice: A Sociological Perspective on the Symbolic Importance of "Tort Reform"*, 23 GA. L. REV. 295, 296-97 (1989)). Professor Hubbard's view may explain the inconsistent data on "defensive medicine." The notion that fear of the tort system will result in increases in overall health care cost as argued by physicians is well-suited for the political climate. Tort reform can save money.



Professor Hubbard's words ring true. "Tort reform" has evolved to mean legislative changes such as caps on the amount of damages for pain and suffering and other measures to protect physicians. This trend continues despite empirical evidence suggesting that "the focus of legislative concern should be that the malpractice system is too inaccessible, rather than too accessible, to the victims of negligent medical treatment."<sup>237</sup>

Why do physicians continue to oppose the medical malpractice system so vehemently even when the evidence shows that a doctor's chances of being sued successfully are relatively slim? Why choose the reform of the medical malpractice system as the symbol for gaining social support? The answer lies in a paradox.<sup>238</sup> The world of medicine resents, yet also benefits from, the medical malpractice system with its focus on the standard of practice and its emphasis on fault. The degree of antagonism and the choice of the medical malpractice system as the target reflect an effort by the medical community to gain the ability to further the independent administration of its autonomous laws. Doctors support, however, maintaining an emphasis on rules about the standard of care. They support the legitimacy and authority that the law's medical malpractice system and the standard of care endow to the medical community. The medical community's status and authority benefit from the public's perception that a certain level of quality will be maintained.

### *C. The Prohibitory Character of Medicine's Rule Against Medical Malpractice*

#### **1. Medicine's View of the Legal Rules About the Standard of Care: Formal Guidance Rules with Medicine's Sanctions**

The medical community enforces a prohibitory rule against medical malpractice. The source of this prohibition lies more *within* medicine than within the formal law's definition and application of the rule. The prohibition against malpractice is evident in the distinction made by

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<sup>237</sup> WEILER ET AL., *supra* note 179, at 76.

<sup>238</sup> Importantly, medicine's autonomous laws function largely on an unconscious level. The fact that doctors and other medical personnel are not conscious of the existence of their autonomous law makes the paradox more understandable. Medical personnel may categorize their differences with the legal system as one of differences in legal versus scientific views of the world, e.g., the incapacity of judges or juries to understand complex scientific information, or misunderstandings about what it is really like practicing medicine, e.g., the inherent difficulties and uncertainties of patient care.

physicians between mistakes and malpractice in their daily work and in the language doctors use to describe medical malpractice. The prohibition is ingrained into medical students beginning on the first day of medical school and is intricately interwoven throughout the medical community. This Part argues that the foundation of this prohibition within the medical community is the source of the rule's effectiveness.

When doctors speak of medical malpractice, they often speak in the language of criminal law. They tell stories about other doctors who were found "guilty" of malpractice or "committed malpractice."<sup>239</sup> Moreover, doctors rely on an internally defined distinction between mistakes and malpractice. Studies have shown that physicians will acknowledge a fellow physician making a mistake, but that most physicians are reluctant to categorize the mistake as malpractice.<sup>240</sup> Mistakes may be understandable errors in medical judgment, whereas malpractice means error that indicates carelessness or otherwise violates professional responsibility.<sup>241</sup> An adverse outcome results from a "mistake" if the physician responsible made a sincere effort within the limits of the physician's knowledge and skill. Mistakes must often be publicly acknowledged to the peer group. Although mistakes are embarrassing, peers recognize them as inevitable and ultimately excusable. In contrast, malpractice is neither inevitable nor ultimately excusable. Malpractice occurs when a doctor acts inappropriately and it is clear to all that he or she should have had the knowledge or skill to act otherwise.

Many doctors believe that if a doctor "commits malpractice," as defined by the medical community then the doctor is incompetent.<sup>242</sup> This determination of incompetence, in turn, can only be fairly made by examining the doctor's entire pattern of practice. In other words, one mistake, no matter how obvious, is not enough for malpractice. Richard DeMay, Professor of Pathology, explains:

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<sup>239</sup> See, e.g., Richard DeMay, *To Err Is Human—To Sue, American*, 15 DIAGNOSTIC CYTOPATHOLOGY iii (1996). Professor DeMay is an expert and author of a leading book on cytology. In this editorial commenting on the increasing number of lawsuits involving Pap smears, DeMay writes, "[i]n other words, you are guilty until proven innocent." *Id.*

<sup>240</sup> Neil Vidmar, *Are Juries Competent to Decide Liability in Tort Cases Involving Scientific/Medical Issues?*, 43 EMORY L.J. 885, 901 (1994). "Physicians tended to equate a finding of negligence with a judgment of incompetence. Thus, although willing to admit that all doctors make mistakes, physicians were often unwilling to label substandard care as negligent and were opposed to compensation for iatrogenic injury." *Id.*

<sup>241</sup> See Jost, *supra* note 39, at 845. Jost distinguishes between errors in judgment and techniques with normative failures that indicate unwillingness to learn and increase the likelihood of repeated failures. *Id.*

<sup>242</sup> See WEILER ET AL., *supra* note 179, at 125.

It is unrealistic to think that in the course of a lifetime of diagnosis that even the best of us won't make a few 'obvious' errors. So, if there is no practical way to identify an acceptable error, then no individual error, no matter how obvious it seems in retrospect, proves negligence. It is the track record, not the individual case, that is important.<sup>243</sup>

The view articulated by Professor DeMay illustrates the confusion expressed by many doctors about the law of negligence.<sup>244</sup> His comments also suggest that the approach taken by state medical boards for incompetence is more in keeping with many doctors' understanding of medical malpractice. Medical boards exercise their authority to revoke or suspend medical licenses conservatively.<sup>245</sup> For these sanctions, they generally require repeated acts of negligence such that the physician's continued practice poses some threat to patients or the public.<sup>246</sup> Their determinations of incompetence fit Professor DeMay's description of negligence.<sup>247</sup> This difference in views regarding malpractice explains some of the dread that many physicians experience at the prospect of being found "guilty" of medical malpractice. It also has some profound advantages for the formal law's administration of its rules against medical malpractice, considering the possible deterring effect of the prohibitive character of the rule against medical malpractice. The formal law benefits from medicine's establishment of a normative principle that demands strict adherence to vague standards of practice.

What explains physicians' views toward medical malpractice? As shown previously, only two percent of patients harmed by medical malpractice bring lawsuits against their doctors<sup>248</sup> and, although studies vary, the majority of claims are closed without any payment.<sup>249</sup> Those claims that settle often settle for modest amounts.<sup>250</sup> Evidence also

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<sup>243</sup> DeMay, *supra* note 239, at iv.

<sup>244</sup> *Id.*

<sup>245</sup> See James Morrison & Peter Wickersham, *Physicians Disciplined by a State Medical Board*, 279 JAMA 1889 (1998). A small proportion (0.24% in one year in California) of physicians are disciplined every year. *Id.* The most common cause was negligence or incompetence, thirty-four percent. *Id.* at 1891.

<sup>246</sup> See *Azima v. Department of Prof'l Regulation*, 473 So. 2d 761, 762 (Fla. Dist. Ct. App. 1985) (affirming suspension of medical license and noting that testimony against defendant represented "a broad cross-section of the local medical community"), *cert. denied*, 476 U.S. 1183 (1986); *Pritchard v. Catterson*, 401 S.E.2d 475, 477 (W. Va. 1990) (affirming suspension and noting that the Board made decision to suspend based on recommendation that resulted from a review of twenty of the physician's substandard medical cases by sixteen different physicians).

<sup>247</sup> DeMay, *supra* note 239, at iv.

<sup>248</sup> Localio et al., *supra* note 172, at 246-48.

<sup>249</sup> VIDMAR, *supra* note 199, at 40-43 (reviewing various studies that examined settlement rates).

<sup>250</sup> *Id.*

indicates that physicians win more than half of the time when a medical malpractice action goes to trial.<sup>251</sup> Insurance covers the loss most of the time.<sup>252</sup> Considering that the odds appear to favor physicians, one wonders whether the formal legal system really has a deterring effect, and whether the constant trepidation and attention doctors pay to medical malpractice arises from the legal system.

From medical school onward, the rule against malpractice is stated in the powerful prohibitive language, "one shall not commit medical malpractice." This is not the language typically associated with tort liability, which instructs persons to act reasonably and exercise due care under the circumstances.<sup>253</sup> Professor John Coffee, writing about the distinction between torts and crime, postulates that an advantage of the clear prohibiting statements of the criminal law is that such rules are "more easily learned, internalized, and made habitual."<sup>254</sup> These are the kinds of rules that are within the conscience of law-abiding citizens, who never consider disobeying "thou shall not" laws even when an occasion arises where breaking the rule may be profitable. Prohibitive rules, such as the rule against murder, are generally clear commands and easy to follow.<sup>255</sup> In contrast, the more "soft-edged" language of negligence authorizes pricing decisions.<sup>256</sup> The language for negligence is less clear and its meaning is not universally accepted.<sup>257</sup> It is couched in relatively imprecise terms like

<sup>251</sup> *Id.*

<sup>252</sup> *Id.* at 80-82.

<sup>253</sup> The language of malpractice in the medical community is not, for example, the language of Judge Learned Hand's rule for tort liability where the individual engages in determining whether the marginal costs of precautions exceed the marginal cost to society resulting from no additional precautions. See *United States v. Carroll Towing Co.*, 159 F.2d 169 (2d Cir. 1947); see also Richard Posner, *A Theory of Negligence*, 1 J. LEGAL STUD. 29, 32-33 (1972). I do not mean to suggest that all of negligence law is captured by Judge Learned Hand's formulation, but rather that the language and meaning of negligence law is broader, more vague, and less "instinctive" than criminal law. See Leonard Nelson, *Medical Malpractice and the Transformation in Health Care Delivery*, 17 CUMB. L. REV. 313, 338-40 (1987) (suggesting that courts place a greater emphasis on compensation and less on fault because of the ubiquity of medical malpractice insurance, and the influence of law and economics jurisprudence in tort law).

<sup>254</sup> John Coffee, Jr., *Does "Unlawful" Mean "Criminal"? Reflections on the Disappearing Tort/Crime Distinction in American Law*, 71 B.U. L. REV. 193, 225 (1991).

<sup>255</sup> *Id.*

<sup>256</sup> *Id.*

<sup>257</sup> *Id.* at 226. Professor Coffee, relying on Dean Colin Diver's formulation of determining a legal rule's precision writes:

As Dean Colin Diver has recognized, precision is not a neutral concept. The optimal degree of precision with which a legal rule is stated depends on trade-offs among several factors. He suggests that the more "transparent" a rule is (that is, the clearer and more universally accepted are the meanings of the terms it uses), the more likely the rule is to be either underinclusive or overinclusive. On such a continuum, criminal law and tort law are at opposite ends: the former's rules approach "transparency," but historically were often

"reasonableness" and the "standard of care." In sum, "tort law prices, while criminal law prohibits."<sup>258</sup>

The problematic character of medical malpractice stems in part from its dual nature. The medical community fosters an internal prohibition against medical malpractice. This conflicts, however, with the frequent lack of clarity in the details of the formal law's administration, such as the

underinclusive . . . . Tort law, in contrast, is seldom underinclusive, but its rules are typically far from "transparent." Often they require a retrospective and prolonged evaluation of the facts, which means that they also rank low in terms of "accessibility." As a result such rules are incapable of performing a socializing function.

*Id.* at 225-26 (citing Colin Diver, *The Optimal Precision of Administrative Rules*, 93 YALE L.J. 65, 66-71 (1983)).

<sup>258</sup> Coffee, *supra* note 254, at 194. Professor Coffee also writes about the distinction between prices and sanctions identified by Professor Cooter. *Id.* at 197 (citing Robert Cooter, *Prices and Sanctions*, 84 COLUM. L. REV. 1523 (1984)). Although Coffee cites Cooter, he uses the terms differently. Cooter defines sanctions as "a detriment imposed for doing what is *forbidden*, such as failing to perform an obligation" whereas a price is the "payment of money which is required in order to do what is *permitted*." Cooter, *supra*, at 1524-25. Cooter explicitly includes the payment of compensatory damages in a negligence lawsuit as a sanction. *Id.* at 1524. Pricing is used by Coffee to mean an effort "to force the defendant to internalize the costs" imposed on others. Coffee, *supra* note 254, at 228. In this sense, tort law is characterized by pricing by contrast to criminal law. See Dale Nance, *Guidance Rules and Enforcement Rules: A Better Rule of the Cathedral*, 83 VA. L. REV. 829 (1997) (using the terms "price" and "sanctions" in a manner similar to Cooter). As Nance uses the terms, negligence laws operate as sanctions, and not prices. Nance explains:

[T]he paradigmatic sanction will involve a substantial discontinuity in the private cost function of the affected citizen, whereas the paradigmatic price will involve a continuous tradeoff between the payment of the price and the cost of conduct necessary to avoid payment.

For example, a rule prescribing liability for negligently inflicted injuries will create a discontinuity at the point where the level of precaution drops below the legal standard; at lower levels, a substantial liability will be added to the costs of precaution, whereas at higher levels of precaution, the private cost will be only the significantly lower cost of precaution. In contrast, a rule that simply prescribes that one should pay for the costs of accidents that one causes, or some subset of such accidents not defined with reference to a standard of conduct, produces a relatively continuous private cost curve that is the sum of the costs of precaution and the costs of the damages done.

*Id.* at 881-82 (footnotes omitted). For Nance, sanction rules are preferable when the social norms are readily known. *Id.*

The disagreement between Nance and Coffee stems from their differing topics. Coffee's article primarily compares tort law with criminal law. Nance distinguishes between negligence (sanctions) and forms of strict liability (pricing). Although Nance discusses criminal law, the criminal law is not central to his focus on the deficiencies of the economic analysis of the law. Both recognize the importance of norms in their theories.

For the purpose of this Article, no clear distinction between price and sanction is made. In Nance's and Cooter's terms, medicine's law imposes sanctions on doctors when the rule against medical malpractice is disobeyed because of the strong social norms at work. The sanctions manifest as damaged professional reputation, personal anxiety about competence, etc. In contrast, the formal law operates by pricing if the entire medical malpractice system is considered (caps on compensation, high rates of settlement and low rate of cases filed versus potential cases).

vagaries of determining the standard of practice and the lack of correlation between legal outcomes and occurrences of medical malpractice.

Professor Coffee's distinction between the law's treatment of crimes and torts illuminates the dual character of medical malpractice. The criminal law would apply a prohibitive rule to a physician who callously weighed his financial benefit (e.g., gained from withholding proper care from a sick patient without the patient's consent under a capitated health care plan) against the arguably small risk of being named in a malpractice suit.<sup>259</sup> However, the typical malpractice case does not involve a legal prohibitive rule. Instead, the legal rules apply to the difficult questions of what constitutes the standard of practice and whether the doctor followed that standard.<sup>260</sup> Legal rules often limit compensation through the use of statutory caps.<sup>261</sup> Instructions to juries favor the reasonable doctor in similar circumstances with similar specialty training. Thus, the formal law of negligence recognizes that the difficulties in accurately describing and applying the standard of care justify a relatively modest compensatory response.<sup>262</sup> These rules resemble the guidance rules discussed by Professor Dale Nance—"rules designed for law-abiding citizens."<sup>263</sup> The law presumes that doctors wish to follow the law's guidance rules against medical malpractice. The problematic character of medical malpractice, from the formal law's standpoint, is how to effectively administer the standard of practice established by medicine. It is not how to establish the prohibitive essence of the rule, because the medical community has already internalized the prohibitive force.

The rule against medical malpractice is beyond the level of a doctor's conscious decision-making. Instead, it operates largely unconsciously in the physician's daily work. Unlike a fast driver who is willing to pay a higher insurance rate for the speeding tickets and fender-benders, a doctor is not engaged in any conscious decision-making when it comes to

<sup>259</sup> See Localio et al., *supra* note 172, at 246-48 (indicating an approximate two percent rate).

<sup>260</sup> One can argue that the difficulties in determining the standard of practice and whether it has been breached leads to uncertainty of results. Again, utilizing Dean Diver's analysis for determining a rule's precision, medical malpractice law lacks transparency and accessibility. See Diver, *supra* note 257, at 66.

<sup>261</sup> See Nance, *supra* note 258, at 927.

<sup>262</sup> *Id.* "And in situations where the legal standard that separates prohibited from permissible conduct is unavoidably vague, as in the case of negligence law, concern for the difficulties in accurately knowing and applying the standard to particular acts argues in favor of the modesty of compensatory responses." *Id.*

<sup>263</sup> *Id.* at 861. "Thus, one can distinguish between *guidance rules*, rules designed for law-abiding citizens, and *enforcement rules*, rules designed to deal with recalcitrants." *Id.* The legal rules are fundamentally different from Nance's guidance rules since I argue that doctors follow the rules primarily because they are law-abiding citizens of the autonomous law of medicine.

malpractice. This is because the internal cost is great, and it is great for the same reasons that disobeying the criminal law has significant costs for the law-abiding citizen.<sup>264</sup> The law-abiding citizen obeys the law because he or she wants to do the right thing and because he or she fears disapproval of his or her peer group if he or she violates the law.<sup>265</sup> Likewise, a doctor wants to do the right thing and fears disapproval of other members of the medical community. The difference is that the relevant peer group for doctors is other doctors, and the source of law is the largely autonomous medical community. The broader societal norm against medical malpractice comparatively lacks the effectiveness of the tightly knit medical community upon which doctors rely for economic security and identity. In other words, medical malpractice is a prohibitory rule for doctors because of medicine's autonomous law—not the formal law.

The power for gaining compliance to a rule does not lie in the threat or reality of official sanction.<sup>266</sup> Rather, the power to gain compliance lies in "the power of the intertwined forces of social and individual moral control."<sup>267</sup> An effective prohibitive law must reflect the community's perceptions of moral blameworthiness. It must have moral credibility to do its job, and its job is to "facilitate and communicate societal consensus."<sup>268</sup>

Although an established norm against medical malpractice exists in the non-medical community, several factors make the medical community the fundamental source of the prohibition. First, the language of the formal legal standard against medical malpractice (the language of negligence) is not as strong as the prohibitive rule against medical malpractice that exists within medicine's autonomous group. Second, most non-medical persons have difficulty recognizing the occurrence of medical malpractice. Even experienced lawyers often need extensive discovery to grasp whether a bad outcome resulted from malpractice or bad luck.<sup>269</sup> Although the non-medical community condemns medical malpractice, it cannot practically apply the prohibition in daily life because it cannot easily determine the occurrence of malpractice. Third, the historical autonomy of physicians continues to reduce the effectiveness of norms emanating from the non-medical community. Courts continue to defer to the standard of practice established by medicine and to decisions regarding competency made by

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<sup>264</sup> See Robinson & Darley, *supra* note 45, at 475.

<sup>265</sup> See *id.* at 468.

<sup>266</sup> *Id.* at 457.

<sup>267</sup> *Id.*

<sup>268</sup> *Id.*

<sup>269</sup> See generally VIDMAR, *supra* note 199, at 59, 69-82 (providing an overview of the litigation process).

state medical boards.<sup>270</sup> Fourth, much effort is expended by the medical community in defining and upholding the standard of practice through studies published in medical journals,<sup>271</sup> peer review conferences, the promulgation of care guidelines, and other means. Medical school and residency can be viewed as places for learning and applying the standard of practice for one's specialty. Fifth, the medical community believes that the legal system does a poor job of compensating patients injured by medical malpractice, effectively deterring substandard care and identifying doctors who provide substandard care. Thus, medicine has created the standard of care, and it has instilled within its members an effective internal prohibition against "committing" medical malpractice. The effectiveness of this prohibition stems from the medical community rather than the legal community or society. The ineffectiveness of the medical malpractice system documented by the Harvard Study supports the idea that the prohibition does not emanate from the legal system.<sup>272</sup> Moreover, the basis for the prohibition in medicine means that current empirical efforts to evaluate deterrence are misplaced.<sup>273</sup> One should carefully consider medicine's autonomously created and administered laws when evaluating the medical malpractice system's ability to deter future injuries.

## 2. Problems in Applying the Standard of Practice

The substantive content of the prohibition against malpractice is problematic from both the legal and the medical perspectives. The legal directive to follow the standard of care means little when applied to the facts of a particular case without expert medical testimony to attempt to give content to the standard of care. The medical testimony, however, often fails to give a clear picture of what comprises the standard of care. Experts, after all, often disagree. The law looks to medicine to provide

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<sup>270</sup> See, e.g., *Kansas State Bd. of Healing Arts v. Foote*, 436 P.2d 828, 837 (Kan. 1968) ("Much of it is difficult to assess and weigh, illustrating why this kind of evaluation is best placed, in the first instance, in those particularly skilled by training and experience to interpret such matters, leaving the judicial role to that of determining substantiality of evidence." *Id.*

<sup>271</sup> See, e.g., Samuel Goldhaber, *Pulmonary Embolism*, 339 NEW ENG. J. MED. 93 (1998). Goldhaber's review article demonstrates the promulgation of the standard of care. *Id.* The article reviews the epidemiology, pathophysiology, diagnosis, therapy and prevention of pulmonary embolism. *Id.* The standard of care is also formulated through various studies to determine effective therapies or diagnostics. *Id.* Case reports also contribute by reminding physicians of the unusual cases and reviewing the differential diagnosis of a particular case. *Id.*

<sup>272</sup> See generally *supra* notes 163-206 and accompanying text.

<sup>273</sup> Citing the low proportion of claims filed for actual medical malpractice, for example, does not mean that medical malpractice is not being deterred.



guidelines about the content of the standard of practice<sup>274</sup> and the medical profession looks to the law. The words of a well-known pathologist, Louis Dehner, illustrate the frustration felt by some members of the medical community:

Because most physicians are legal laypersons, standard of practice as a concept or definition in common law has less than well-circumscribed margins that most surgical pathologists can readily understand. Is the standard of practice what the majority of pathologists would agree on as the necessary elements in the examination of a biopsy or surgical specimen and the final conclusion or diagnosis after these deliberations? Does the standard of practice require us to get the "right" diagnosis in 100% of cases?<sup>275</sup>

The frustration results from having a prohibitive rule defined in the vague language of negligence law. The result is a kind of turbulence, especially strong for the doctors who view medical malpractice akin to a crime but find little guidance as to what exactly constitutes the standard of care. Recall the distinction made by the medical community between mistakes and malpractice. Doctors' frustrations with medical malpractice law are due in part to the incongruity between what the medical community views as an excusable mistake and what the formal law sees as negligence. The formal law applies "guidance" rules of negligence to the criminal law-like prohibition formulated by the medical community.

The standard of practice remains an essential feature of medicine because of medicine's ability to define and administer the standard of care as its own law. The law's formulation of medical malpractice owes its ability to gain compliance to the more powerful prohibition created and

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<sup>274</sup> See, e.g., BARRY FURROW ET AL., *THE LAW OF HEALTH CARE ORGANIZATION AND FINANCE* (3d ed. 1997). The authors describe the origins of the standard of practice as follows:

The standard of care applied in a tort suit or a hospital peer review process does not normally derive from an external authority such as a government standard. In the medical profession, as in other professions, standards develop in a complicated way involving the interaction of leaders of the profession, professional journals and meetings, and networks of colleagues. Neither the Food and Drug Administration, the National Institutes of Health, the Department of Health and Human Services, nor state licensing boards have had much to do with shaping medical practice. Most clinical policies derive from a flow of reports in the literature, at meetings, and in peer discussions.

*Id.* at 35.

<sup>275</sup> Louis Dehner, *On Trial: A Malignant Small Cell Tumor in a Child—Four Wrongs Do Not Make a Right*, 109 AM. J. CLINICAL PATHOLOGY 662 (1998). Dr. Dehner is a pediatric pathologist with a significant part of his practice involving his consultation with pathologists from around the country who send him cases they cannot diagnose with certainty. He has also written countless articles and a textbook. As such, he has been described as one of the leaders of the profession. See FURROW ET AL., *supra* note 274. Interestingly, Dr. Dehner begins his article as follows: "If one were to issue a cautionary advisory about the practice of medicine today, it would certainly contain two predictable admonishments—medical malpractice and managed care." Dehner, *supra*, at 662.

applied internally by the medical profession. An analysis of the legal system's treatment of medical malpractice cannot, therefore, determine the deterrent effect of the rules against medical malpractice. Instead, one must examine the operation of *medicine's* law regarding malpractice. Moreover, the arguably inconsistent enforcement of the rules against medical malpractice by the formal legal system may mean little about the continued prohibitive effectiveness of the rule. In the future, business, legislative, judicial and societal changes may erode medicine's ability to create and administer its own rules. These broad changes would undermine the prohibitive character of the rules established and administered by medicine's autonomous laws and may lessen the deterrence of the rules against medical malpractice. In other words, medicine's autonomous laws benefit the larger community, and the rise of managed competition threatens this benefit.

#### IV. SUGGESTIONS FOR THE LAW'S RECOGNITION OF MEDICINE'S AUTONOMOUS LAW IN TODAY'S CHANGING HEALTH CARE SYSTEM

##### *A. The Corporate Practice Against Medicine*

In the late nineteenth century, the United States Supreme Court decided the fate of M. H. Dent, a medical practitioner and graduate of the American Medical College of Cincinnati, Ohio.<sup>276</sup> The West Virginia State Board of Health refused to grant Dent a license because he had neither practiced long enough nor graduated from a reputable school.<sup>277</sup> After being convicted for the unlicensed practice of medicine, Dent argued to the Court that his six-year-old medical practice was a constitutionally protected property interest.<sup>278</sup> The Supreme Court unanimously rejected Dent's claim. Justice Field wrote:

Every one may have occasion to consult [the physician], but comparatively few can judge of the qualifications of learning and skill which he possesses. Reliance must be placed upon the assurance given by his license, issued by an authority competent to judge in that respect, that he possesses the requisite qualifications.<sup>279</sup>

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<sup>276</sup> *Dent v. West Virginia*, 129 U.S. 114, 115 (1889).

<sup>277</sup> *Id.* at 117-18.

<sup>278</sup> *Id.* at 119-20.

<sup>279</sup> *Id.* at 122-23.

The licensing laws seek to assure competence by asking members of the profession to establish particular qualifications.<sup>280</sup> Today, courts continue to defer to the opinions made by state medical boards regarding the suspension or revocation of medical license.<sup>281</sup> However, state medical boards rarely sanction licensed physicians.<sup>282</sup> Increasingly, physicians, business managers and others oversee quality,<sup>283</sup> but the role of medical licensure remains.<sup>284</sup>

The doctrine against the unlicensed practice of medicine protects physician autonomy, in part, by forbidding the corporate practice of medicine. A quote from a 1938 case, *Ezell v. Ritholz*, shows how times—and views on the corporate practice of medicine—have changed:

If such a course were sanctioned the logical result would be that corporations and business partnerships might practice law, medicine, dentistry or any other profession by the simple expedient of employing licensed agents. *And if this were permitted professional standards would be practically destroyed, and professions requiring special training would be commercialized, to the public detriment.* The ethics of any profession is based upon personal or individual responsibility. One who practices a profession is responsible directly to his patient or his client. Hence he cannot properly act in the practice of his vocation as an agent of a corporation or business partnership whose interests in the very nature of the case are commercial in character.<sup>285</sup>

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<sup>280</sup> See Jost, *supra* note 39, at 827-41 (discussing the history of legal oversight, which includes *Dent v. West Virginia*, 129 U.S. 114 (1889), and the changing character of licensure laws). Physician licensing laws first appeared in the seventeenth century and by about 1850 gradually disappeared. *Id.* at 829. Licensing laws then began to appear again in the 1870s. *Id.* Jost notes that, traditionally, licensing laws have been concerned only with competence and have a limited role in improving quality. *Id.* at 828. For a more detailed account of licensing laws and the medical profession, see HABER *supra* note 19.

<sup>281</sup> See, e.g., *Kansas State Bd. of Healing Arts v. Foote*, 436 P.2d 828, 837 (Kan. 1968).

<sup>282</sup> See Christine E. Dehlendorf & Sidney M. Wolfe, *Physicians Disciplined for Sex-Related Offenses*, 279 JAMA 1883 (1998) (stating that few physicians are disciplined for sex-related offenses, but the incidence is increasing); James Morrison & Peter Wickersham, *Physicians Disciplined by a State Medical Board*, 279 JAMA 1889 (1998) (observing that a small proportion, 0.24% in one year in California, of physicians are disciplined every year, with the most common cause was negligence or incompetence); Richard Kusserow et al., *An Overview of State Medical Discipline*, 257 JAMA 820 (1987).

<sup>283</sup> See generally 17:4 HEALTH AFF. 1998 (devoting issue to performance measurement); Field, *supra*, note 12, at 365.

<sup>284</sup> See Jost, *supra* note 39, at 859. Professional licensure and discipline is not obsolete, even though the ability of management and the market to address quality issues has grown. *Id.* The task of professional regulation needs to be refocused on assuring initial and ongoing competency and the professionalism that supports it. *Id.* at 861.

<sup>285</sup> 198 S.E. 419, 424 (1938) (emphasis added), quoted in Arnold Rosoff, *The Business of Medicine: Problems with the Corporate Practice Doctrine*, 17 CUMB. L. REV. 485, 491 (1987).

The authors of the opinion express deep concerns that commercial incentives should not infiltrate the patient-physician relationship.<sup>286</sup> Today, however, proponents of fast-growing MCOs feel that the public benefits from the "managed" commercialization of the health care industry because society must control costs.<sup>287</sup>

Not surprisingly, the rise in managed care has eroded the doctrine against the corporate practice of medicine.<sup>288</sup> Many states permit hospitals to employ doctors, and exempt MCOs from the corporate prohibition.<sup>289</sup> Federal law permits the employment of physicians by health maintenance organizations provided the health maintenance organization meets federal standards.<sup>290</sup> Concomitant with the rise of MCOs, courts have developed theories that impose liability on managed MCOs for medical malpractice.<sup>291</sup> Various theories exist, including vicarious liability under theories of respondeat superior and ostensible agency, direct corporate liability for negligent selection or utilization management, breach of warranty, breach of contract, misrepresentation and bad faith.<sup>292</sup> In evaluating such theories, courts should be cognizant of medicine's autonomous law and decide cases in such a way as to foster medicine's internal prohibitive rule against medical malpractice.

In this section, I will argue that the formal law should not hold MCOs liable for medical malpractice since MCOs create neither the standard of practice nor the prohibitive force of the rules. Likewise, courts should strike down—as a violation of the corporate practice of medicine—any attempts by a corporate structure to directly regulate the standard of

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<sup>286</sup> *Ezell*, 198 S.E. at 424.

<sup>287</sup> Some members of the citizenry continue to support the idea that the profit motive should be regulated in medical care. In the spring of 1998, several bills on the legislative docket from both Republicans and Democrats addressed perceived excesses of managed care. See WASHINGTON INSIDER'S FOCUS: A SUPPLEMENT TO NATIONAL INTELLIGENCE REPORT (Jan. 28, 1998). Subsequent political developments abolished the bipartisan sentiment, most notably the Monica Lewinsky scandal which polarized the parties. *Id.* The Democrats, however, continued to support various controls of managed care. *Id.* Popular reaction to managed care practices such as "drive-through" mastectomies and other curbs on physician and patient choice suggests support for increased regulation of managed competition. *Id.*

<sup>288</sup> See Field, *supra* note 12, at 368.

<sup>289</sup> See *id.*

<sup>290</sup> 42 U.S.C. § 300e-10(1)(A) (1988).

<sup>291</sup> See Diana Joseph Bearden & Bryan J. Maedgen, *Emerging Theories of Liability in the Managed Health Care Industry*, 47 BAYLOR L. REV. 285 (1996).

<sup>292</sup> *Id.* at 288 (providing detailed review of all the listed theories and concluding that courts will approach the question of liability for an MCO much in the same way as courts determine liability for a hospital); Michael Kanute, Comment, *Evolving Theories of Malpractice Liability for HMOs*, 20 LOY. U. CHI. L.J. 841 (1989); William E. Milks, Annotation, *Liability of Health Maintenance Organizations (HMOs) for Negligence of Member Physicians*, 51 A.L.R. 5th 271 (1997).

practice in individual cases, for example, through the use of utilization review. The test for whether an entity is capable of practicing medicine should be whether it can create and administer rules regarding the standard of practice and whether it can maintain the prohibitive force of the rule against medical malpractice. Allowing MCOs to "practice medicine" will abolish the prohibitive force of the rule against medical malpractice that has been developed by medicine, and will ultimately have an adverse effect on the standard of care.

## 1. Vicarious Liability

### a. Respondeat Superior

Are MCOs liable, under a theory of respondeat superior, for the medical malpractice of their physicians? In part, the determination depends on whether the court views the establishment of an employer-employee relationship sufficient to impose liability on the employer-MCO. Such was the case in *Sloan v. Metropolitan Health Council*, where an Indiana appellate court held that "where the usual requisites of agency or an employer-employee relationship exist, a corporation may be held vicariously liable for malpractice for the acts of its employee-physician."<sup>293</sup> The court relied on a previous case which held that since a city cannot escape liability for the negligent driving of one of its employees, then a hospital or MCO cannot escape liability for the negligent practice of medicine by one of its employee-physicians.<sup>294</sup> The analysis of the acts placed great weight on the *employee status* of the physician.<sup>295</sup> The analogy, that driving is similar to doctoring, reveals the shortcomings of the court's reasoning. The practice of medicine differs from driving in its degree of complexity and years of training. Moreover, the law has traditionally treated physicians as independent contractors. Finally, and fundamentally, the court's analogy fails because physicians, unlike drivers, are members of an autonomous group that has made and administered its own standard of practice.

Unlike the *Sloan* court, an appeals court in Massachusetts, in *Chase v. Independent Practice Association* ("IPA"), did not stop at the establishment of an employer-employee relationship when considering

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<sup>293</sup> 516 N.E.2d 1104, 1109 (Ind. Ct. App. 1987).

<sup>294</sup> *Id.* at 1108 (citing *Estate of Mathes v. Ireland*, 419 N.E.2d 782, 785-86 (Ind. Ct. App. 1981)).

<sup>295</sup> *Id.* at 1107-09.

whether to hold MCOs liable for the medical malpractice of one of its doctors.<sup>296</sup> Instead, the court looked to several variable factors within the employment context, such as the character of the work.<sup>297</sup> The court reasoned, "[b]ecause of the high level of skill involved in the practice of medicine, physicians have traditionally been viewed as independent contractors, allowing hospitals and other medical centers to remain exempt from liability for negligent acts of a physician."<sup>298</sup> Nevertheless, the court held that Massachusetts courts would impose liability on MCOs provided that the employer has sufficient control over the employee-physician. Such was not the case in *Chase*, where the court found that "IPA did not control the actual medical decisions made by [its doctors]."<sup>299</sup> Therefore, the MCO was not vicariously liable.<sup>300</sup>

Both *Sloan* and *Chase* contemplate the practice of medicine by managed care corporations. Both decisions, therefore, suggest warning signs for medicine's autonomy. The better approach, taken by the Ohio appellate court in *Propst v. Health Maintenance Plan, Inc.*, implicitly acknowledges the existence of medicine's autonomy.<sup>301</sup> The *Propst* court reviewed the trial court's finding that the defendants constituted a health maintenance organization and could not, therefore, practice medicine pursuant to an Ohio statute.<sup>302</sup> The court of appeals agreed, and reasoned that, "[s]ince the corporate defendants do not practice medicine, they may not be held liable under a complaint which sounds in medical malpractice."<sup>303</sup> The Ohio court drew a line between the employee-physician's practice of medicine and the employer-MCO, because the Ohio statute recognized the practice of medicine to be inherently different from the ordinary course of business.<sup>304</sup> I do not argue that the law ought to completely insulate MCOs from liability for acts of medical malpractice by

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<sup>296</sup> *Chase v. Independent Practice Ass'n*, 583 N.E.2d 251, 253 (Mass. App. Ct. 1991).

<sup>297</sup> *Id.* The court stated:

In the employment context, a master-servant relationship is determined by a number of factors, including the right of the employer to control the details of the work done by the employee, the method of payment, *the skill required in the particular occupation*, whether the employer supplies the tools, instrumentalities and place of work, as well as the parties' own belief as to whether they are creating a master-servant relationship.

*Id.* (emphasis added).

<sup>298</sup> *Id.* at 254.

<sup>299</sup> *Id.*

<sup>300</sup> *Id.*

<sup>301</sup> *Propst v. Health Maintenance Plan, Inc.*, 582 N.E.2d 1142 (Ohio Ct. App. 1990).

<sup>302</sup> *Id.* at 1143.

<sup>303</sup> *Id.* at 1125.

<sup>304</sup> *Id.*

its physicians.<sup>305</sup> Other legal theories previously used to establish liability for hospitals might exist for liability to attach to MCOs.<sup>306</sup>

#### b. Apparent Agency

Should the doctrine against the corporate practice of medicine shield MCOs from liability based on an ostensible or apparent agency theory? One argument against liability based on ostensible agency is that if MCOs cannot be liable under respondeat superior, because of the doctrine against the corporate practice of medicine, it makes little sense to hold MCOs liable under a theory of ostensible agency. In other words, if the degree of control MCOs have over their employee-doctors is insufficient to establish liability based on respondeat superior, then a claim that liability should be based on apparent agency makes little sense.

Nevertheless, courts in jurisdictions recognizing the doctrine against the corporate practice of medicine have indicated that the doctrine is no defense to liability based on ostensible agency.<sup>307</sup> Similarly, courts have held that a doctor's status as a hospital's independent contractor does not shield the hospital from liability based on apparent agency.<sup>308</sup> The focus of the two theories of vicarious liability differs. The focus of respondeat superior is on the relationship between the MCO and the doctor, whereas

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<sup>305</sup> As it is now, many medical malpractice claims against MCOs arising in the context of an employee benefit plan are preempted by the preemption clause in ERISA, 29 U.S.C. Section 1001 et seq., particularly Section 514.

<sup>306</sup> See, e.g., *Darling v. Charleston Comm. Mem'l Hosp.*, 211 N.E.2d 253 (recognizing cause of action for hospital's direct corporate negligence), *cert. denied*, 383 U.S. 946 (1966); *Kearney v. U.S. Healthcare, Inc.*, 859 F. Supp. 182, 187 (E.D. Pa. 1994) (recognizing that MCO might be liable for failing to use due care in selecting providers of health care, but such a claim would be preempted under ERISA); *Elam v. College Park Hosp.*, 132 Cal. App. 3d 332, 337 (1982) (holding that hospital has a general duty to insure the competence of its medical staff and evaluate the quality of treatment). See also James Bartimus & Christopher Wright, *HMO Liability: From Corporate Negligence Claims for Negligent Credentialing and Utilization Review to Bad Faith*, 66 UMKC L. REV. 763 (1998) (providing a brief overview of various legal theories for holding an HMO liable for the negligent acts of its agents or employees).

<sup>307</sup> See *Baptist Mem'l Hosp. Sys. v. Smith*, 822 S.W.2d 67, 76-77 (Tex. App.—San Antonio 1991).

<sup>308</sup> See *McDonald v. Hampton Training Sch.*, 486 S.E.2d 299, 300 (Va. 1997). In this case, the pathologist's contract stated that the pathologist was an independent contractor. *Id.* at 304. Nevertheless, the court concluded that the question of whether the pathologist was an independent contractor or an employee was a question of fact. *Id.* The hospital, therefore, might be liable in spite of the physician's status as an independent contractor. *Id.*; see *Sword v. N.K.C. Hosp., Inc.*, 661 N.E.2d 10, 15 (Ind. Ct. App. 1996) (noting that hospitals increasingly hold themselves out to the public as rendering health services and benefit from such representations and concluding, "[w]e therefore find that hospitals may be held liable for the negligence of their apparent agents, notwithstanding the fact that the agents are independent contractors").

the focus of ostensible agency is on the relationship between the MCO and the patient.<sup>309</sup> A plaintiff seeking to establish ostensible agency must show that the MCO represented to the patient that its doctors are employees under its control, and that the patient reasonably believed and relied on the MCO's representations.<sup>310</sup> MCOs, therefore, could be liable under a theory of ostensible agency even though the plaintiff was unable to establish the elements required for liability under respondeat superior. Although liability based on a theory of ostensible agency is better than one based on respondeat superior, the recognition that the patient reasonably believed that the MCO practiced medicine dilutes the patient-doctor relationship. The MCO ought to carry the burden of ensuring that it has not represented to patients that it engages in the practice of medicine. Therefore, a claim for fraudulent misrepresentation is better suited than a medical malpractice claim based on ostensible agency in these circumstances.

The better approach is for the law to recognize neither respondeat superior nor ostensible agency as viable theories in cases of managed care liability for employee-physician malpractice. Several reasons exist. First, the potential plaintiff may address the improper "holding out" by an MCO through claims based on breach of contract or direct corporate negligence.<sup>311</sup> Second, the law should acknowledge and protect the existence of medicine's autonomous laws, especially in the areas of medical malpractice and determinations of appropriateness. Allowing vicarious liability for medical malpractice presumes that MCOs affect the standard of practice in more than subtle ways, because the MCOs' control or apparent control of the doctor is essential. Judicial recognition of vicarious liability in such cases would alter the bargaining relationship between physicians and MCOs. This shift in responsibilities for fulfilling the duty to the patient would likely push the content of the standard of practice too far toward cost-effectiveness. Maintaining that the corporations that finance and manage health care also engage in the practice of medicine will weaken the prohibitive character of the rule against medical malpractice that the medical community has formulated

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<sup>309</sup> See Zipursky, *supra* note 157 (discussing "relational legal duties" as focus for finding liability rather than reasonable foreseeability).

<sup>310</sup> See Bearden & Maedgen, *supra* note 291, at 310. The authors summarize ostensible agency as follows:

In order to establish ostensible agency, a plaintiff must plead and prove the following three elements: (1) The third party must have a reasonable belief in the agent's authority; (2) the belief must be generated by some holding out by act or neglect of the principal, i.e., the HMO; and (3) the third party must justifiably rely on the representation of authority.

*Id.*

<sup>311</sup> See Bartimus & Wright, *supra* note 306, at 764-67.



and administered over many years. Finally, public opinion supports the view that MCOs should not directly interfere with their doctors' practice of medicine.<sup>312</sup> Patients may accept more subtle means of controlling costs, but they want assurances that their doctor—not their managed care corporation—practices medicine.

### c. Countervailing Agency

Mark Schlesinger recognizes the divergence of views and sympathies between managed care and traditional, established medicine.<sup>313</sup> Each institution has its strength. Doctors are "well equipped to deal with the idiosyncratic needs of individual patients" whereas health plans are in a better position to calculate the complexities of external cost to family, employers and others.<sup>314</sup> Schlesinger believes the problem with managed competition is though it may save society money, it will inevitably do so at the expense of individual patients.<sup>315</sup> Managed care fails to recognize that the interests of individual patients differ from those of society as a whole. For example, a new treatment for cancer may cost \$80,000 but only increase five-year survival from ten to twenty percent. From the patient's perspective, the \$80,000 paid by insurance is worthwhile for the increase in survival odds from one in ten to one in five. Society, on the other hand, may determine that the \$80,000 should be spent elsewhere. The patient sees a doubling of survival odds, while society may see a meager ten percent increase.

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<sup>312</sup> See WASHINGTON INSIDER'S FOCUS, *supra* note 287; Robert Pear, *White House Plans H.M.O.—Medicare Rules*, N.Y. TIMES, Sept. 16, 1998, at A29 (proposing consumer protections, including availability of specialists, anti-gag rules, mandatory appeals process for denied treatments and disclosure requirements); Susan Brink, *HMOs Were the Right Rx: Americans Got Lower Medical Costs—But also More Worries*, U.S. NEWS & WORLD REP., Mar. 9, 1998, at 48 (reporting survey showing that 58% of the population worry that they may be denied a medical procedure).

<sup>313</sup> Mark Schlesinger, *Countervailing Agency: A Strategy of Principled Regulation Under Managed Competition*, 75 MILLBANK Q. 1 (1997).

<sup>314</sup> *Id.* at 3-7. Schlesinger argues that managed competition expands the scope of the patient-doctor relationship because the patient now relies on the doctor to be an advocate for the patient in front of utilization review boards. *Id.* The quality of doctoring is dependent not only on the doctor's medical knowledge and technique, but also on the doctor's ability to effectively maneuver within the bureaucracy. See Barry R. Furrow, *The Ethics of Cost-Containment: Bureaucratic Medicine and the Doctor as Patient-Advocate*, 3 NOTRE DAME J.L. ETHICS & PUB. POL'Y 187 (1988).

<sup>315</sup> Debate exists regarding the direction of future costs of health care and the influence of managed care. See, e.g., Ron Winslow, *Health Care Costs May Be Heading Up Again*, WALL ST. J., Jan. 21, 1997, at B1; Sheila Smith et al., *The Next Ten Years of Health Spending: What Does the Future Hold?*, 17:5 HEALTH AFF., Sept./Oct. 1998, at 128 (noting that health care spending is expected to rise as a share of the Gross National Product from 13.6% in 1996 to 16.6% in 2007 and that recent changes toward managed care will "slightly moderate" the rate of growth).

Schlesinger's solution to this dilemma is regulation that recognizes a "countervailing agency" at work in managed care.<sup>316</sup> Under this theory, the doctor functions as an agent for the individual patient, whereas MCO administrators function as agents for society and its interest in controlling costs.<sup>317</sup> A theory of "countervailing agency" assures the patient that the doctor's primary interest remains the patient and that the doctor's allegiance to the patient does not vary according to the terms of the patient's contract with the MCO.<sup>318</sup> The countervailing agency theory thus appears more favorable than other forms of vicarious liability in its ability to maintain medicine's autonomy. A court that allows vicarious liability of an MCO based on ostensible agency labels as reasonable a patient's belief that an MCO engaged in the practice of medicine.

## 2. Direct Corporate Liability—Utilization Review

MCOs often use utilization review to control costs. Utilization review is the process by which, either prospectively or retrospectively, MCOs review medical procedures and determine the medical necessity of various treatments, including hospital admissions and the lengths of hospital stays. *Wickline v. State of California* was one of the first cases to consider how the law should treat claims alleging damage from a utilization review decision that affected medical treatment.<sup>319</sup> Mrs. Wickline, the patient, had a complicated post-operative course after placement of an arterial graft.<sup>320</sup> The patient's vascular surgeon requested that California's Medical Assistance Program ("Medi-Cal") grant an additional eight days in the hospital.<sup>321</sup> Based on information provided on a form, Medi-Cal rejected the request and instead approved an additional four days in the hospital.<sup>322</sup> After four days, Mrs. Wickline was discharged.<sup>323</sup> Nine days later, she was readmitted to the hospital because of severe pain.<sup>324</sup> Several days later, surgeons amputated Mrs. Wickline's leg after conservative measures failed to restore circulation.<sup>325</sup> Mrs.

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<sup>316</sup> Schlesinger, *supra* note 313, at 2-4.

<sup>317</sup> *Id.*

<sup>318</sup> *Id.*

<sup>319</sup> *Wickline v. State*, 239 Cal. Rptr. 810 (Cal. Ct. App. 1986).

<sup>320</sup> *Id.* at 820.

<sup>321</sup> *Id.* at 813.

<sup>322</sup> *Id.* at 814.

<sup>323</sup> *Id.* at 816.

<sup>324</sup> *Id.*

<sup>325</sup> *Id.* at 811.

Wickline argued that Medi-Cal's denial of the requested additional days in the hospital led to her complications and the amputation of her leg.<sup>326</sup>

The appellate court held that Medi-Cal was not liable for Mrs. Wickline's injuries. The court understood the underlying issue, stating: "While we recognize, realistically, that cost consciousness has become a permanent feature of the health care system, it is essential that cost limitation programs not be permitted to corrupt medical judgment."<sup>327</sup> The court reasoned that in Mrs. Wickline's case, an examination of the standard of practice answered the principal issue of "who bears responsibility for allowing a patient to be discharged from the hospital."<sup>328</sup> Both parties agreed that the patient's treating physician must "decide the course of treatment that was medically necessary to treat the ailment."<sup>329</sup> Moreover, the sides agreed that the treating physician had the responsibility to determine the length of stay.<sup>330</sup> Mrs. Wickline's doctor was in a better position than a physician utilization reviewer to make such determinations.<sup>331</sup> Wickline's doctor testified that he knew that he could have attempted a further extension from Medi-Cal, but that after the initial four-day extension, he made the medical judgment to discharge Mrs. Wickline to her home.<sup>332</sup>

The *Wickline* court acknowledged liability for third-party payors for medically inappropriate decisions stemming "from defects in the design or implementation of cost containment mechanisms as, for example, when appeals made on a patient's behalf for medical or hospital care are arbitrarily ignored or unreasonably disregarded or overridden."<sup>333</sup> The court did not specify the kind of factual scenario needed for liability to extend to the third-party payor, nor the viability of a cause of action for medical malpractice. The *Wickline* opinion is laudable because it maintains the distinction between doctors and third parties to the doctor-patient relationship, and it does not undermine the physicians' authority and ability to do their jobs. The court recognized that a doctor practices medicine, and that third parties to the relationship—such as managed care reviewers—do not.

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<sup>326</sup> *Id.* at 820.

<sup>327</sup> *Id.*

<sup>328</sup> *Id.* at 819.

<sup>329</sup> *Id.*

<sup>330</sup> *Id.*

<sup>331</sup> *Id.*

<sup>332</sup> *Id.*

<sup>333</sup> *Id.*

### B. Enterprise Liability

Policymakers and scholars debated the merits of enterprise liability during the debates over the Clinton health care plan.<sup>334</sup> One particularly contested issue was the proposal to abolish physician liability and substitute enterprise liability.<sup>335</sup> Professors Kenneth Abraham and Paul Weiler, in their 1994 article advocating a hospital-based system of enterprise liability, explain that, "[t]he basic idea of enterprise-based tort liability lies at the heart of the centuries-old doctrine of respondeat superior, which makes firms liable for the torts of their workers."<sup>336</sup> Supporters of enterprise liability make convincing arguments about its applicability in today's increasingly integrated health care system. These supporters argue that enterprise liability is better suited to the new health care environment.<sup>337</sup> As control shifts away from doctors and toward MCOs, fairness dictates accountability for these enterprises.<sup>338</sup> In addition, managed care enterprises are in a better position to ensure quality. The advocates of enterprise liability point out that many patients' injuries result from system errors, and enterprise liability would encourage a more systems-oriented approach to reducing future injuries.<sup>339</sup> Also, enterprise liability would promote a collaborative relationship between medical personnel and MCOs.<sup>340</sup>

Unlike Abraham and Weiler's proposal for hospital enterprise liability based on the principles of classic respondeat superior, some commentators envision a "new world" where enterprise liability would rest on contract theory. In this new world, no medical malpractice would exist because "medical injuries must come to be regarded as violations of a health care contract rather than tortious offenses against the person."<sup>341</sup>

Both of these approaches fall short. The proposal for hospital-based liability rooted in respondeat superior relies on the inaccurate, if appealing,

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<sup>334</sup> See Abraham & Weiler, *supra* note 205, at 382; William Sage et al., *Enterprise Liability for Medical Malpractice and Health Care Quality Improvement*, 20 AM. J.L. & MED. 1 (1994). Academicians continue to discuss the topic of enterprise liability. See, e.g., Gregory Keating, *The Idea of Fairness in the Law of Enterprise Liability*, 95 MICH. L. REV. 1266 (1997) (utilizing Kantian social contract theory to support enterprise liability for enterprises in a position to spread costs of non-negligent accidents among those who benefit from the activity of the enterprise).

<sup>335</sup> See Abraham & Weiler, *supra* note 205, at 382.

<sup>336</sup> *Id.* at 383-84.

<sup>337</sup> See *id.* at 382-85; see also Sage et al., *supra* note 334, at 10.

<sup>338</sup> Sage et al., *supra* note 334, at 9-12.

<sup>339</sup> See Abraham & Weiler, *supra* note 205, at 405, 434-35; Sage et al., *supra* note 334, at 12-15.

<sup>340</sup> See Abraham & Weiler, *supra* note 205, at 403-06; Sage et al., *supra* note 334, at 12-15.

<sup>341</sup> Sage et al., *supra* note 334, at 27.

presumption that hospitals practice medicine. Other legal theories, such as direct corporate liability for negligence for matters other than medical malpractice, exist to encourage hospitals to implement quality-enhancing measures. The proposal that contractual enterprise liability can replace tort causes of action for patients injured by medical malpractice, also misses the mark.<sup>342</sup> The legal recognition of medical malpractice as a claim reserved for injured patients against practitioners of medicine serves several valuable purposes. First, it helps define and reinforce the doctor-patient relationship. Second, it assures patients that a doctor's allegiance, although perhaps eroded, still lies more with the patient than with the MCO.<sup>343</sup> Third, it acknowledges the societal and medical norm that emphasizes the standard of care. Finally, the existence of medical malpractice as a cause of action reflects the prohibitive character of medicine's autonomous rule against medical malpractice.

## V. CONCLUSION

Managed care has changed medicine's landscape. The organizational structure of managed care allows it to effectively address certain issues, such as cost and certain aspects of quality and injury prevention. Nevertheless, many health care professionals criticize the values and rules of managed care. The medical world's intense reaction to the growth of managed care is not simply due to personal economic stakes or increased bureaucratic burdens. Instead, many doctors react aggressively to the threat managed care poses to medicine's ability to create and administer its own rules.

Medicine's autonomous laws work in many ways. The first step is the medical community's creation and maintenance of a coherent group.

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<sup>342</sup> See generally Keating, *supra* note 334, at 1266 (arguing that the years of economically based scholarship on enterprise liability failed to completely explain and justify the theories and cases of enterprise liability). Instead, considerations of fairness explain much of enterprise liability and Keating explains the shortcomings of placing exclusive faith in economic and contract based theories of enterprise liability:

Prior writings notwithstanding, social contract theory cannot simply cede authority over the terms of reasonable risk imposition to the institution of contract law in either its market or its bargaining form. Ceding these matters to contract law makes matters of justice into questions of preference, and turns matters of right into questions of power.

*Id.* at 1275.

<sup>343</sup> But cf. Marc A. Rodwin, *Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System*, 21 AM. J.L. & MED. 241 (1995). The fiduciary responsibility physicians have for patients has always been limited compared to other fiduciary relationships. *Id.* at 242-51. Recent changes in health care will only limit the appropriateness of the fiduciary metaphor for a physician's relationships with patients. *Id.* at 251.

Indoctrination and continual tests of allegiance to the group begin in medical school and continue through residency and practice. Medicine takes its second step toward successful lawmaking in the consensus-building process of determinations of appropriateness for various medical treatments. Such undertakings result in a scientific gloss to the standard of care. Part of the medical community's administration of the standard of care includes a strong prohibition against medical malpractice. Importantly, the foundation of the prohibition lies in medicine's autonomous law rather than the formal law. Finally, the medical community protects its autonomous laws by various means, including the dissemination of empirical research attacking the formal legal system's treatment of medical malpractice. Courts, legislatures and others ought to recognize that the prohibitive characteristics of medicine's rule against medical malpractice benefit patients and the administration of health care generally.

The law's recognition of medicine's autonomous law enriches and improves legal theory and practice because it supports an accurate description of how health care is administered at the bedside and in the minds of doctors. Some of the past rules and practices of medicine needed improvement, and continue to need improvement, while others are best left alone. The legal system ought to be circumspect when examining novel claims for liability in today's health care environment. A thoughtful recognition of medicine's autonomous laws will allow the legal system to better understand what to change and what to leave alone.