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The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium

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The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium

Philip G. Peters, Jr.*

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According to conventional wisdom, tort law allows physicians to set their own standard of care. While defendants in ordinary tort actions are expected to exercise reasonable care under the circumstances, physicians traditionally have needed only to conform to the customs of their peers.

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However, judicial deference to physician customs is eroding. Gradually, quietly and relentlessly, state courts are withdrawing this legal privilege. Already, a dozen states have expressly rejected deference to medical customs and another nine, although not directly addressing the role of custom, have rephrased their standard of care in terms of the reasonable physician, rather than compliance with medical custom.

Even more important than the raw numbers is the trend revealed by the decisions. The slow but steady judicial abandonment of deference to medical custom began in earnest in the 1970s, continued in the 1980s, and retained its vitality through the 1990s. Showing no signs of exhaustion, this movement could eventually become the majority position.

Furthermore, many of the states that theoretically continue to defer to custom actually apply the custom-based standard of care in a way that operates very much like a reasonable physician standard. As a consequence, the malpractice law described in the hornbooks and taught in many Torts and Health Care Law classes only vaguely resembles malpractice law as it operates in many courts.

This disassociation between the law in books and the law in action has gone, thus far, undetected. Yet, it gradually is reshaping the foundations of malpractice law. This Article documents this ongoing transformation of the malpractice standard of care and explores its likely origins and implications.

Part I of this Article outlines the conventional understanding of medical malpractice law. Part II then describes the quiet movement away from custom that has occurred in the past few decades. Part III explores the possible reasons for this dramatic and fundamental revision of basic malpractice law, and Part IV outlines some of its implications.

I. The Conventional Understanding

In ordinary tort cases, the defendant's compliance with custom is admissible, but not binding on the jury.¹ In defense of this rule, Justice Holmes explained that "[w]hat usually is done may be evidence of what ought to be done, but what ought to be done is set by the standard of reasonable prudence, whether it usually is complied with or not."² In the famous case of *The T.J. Hooper*,³ Judge Learned Hand noted that "a whole calling may have unduly

1. See RESTATEMENT (SECOND) OF TORTS § 295A (1975) (stating custom is factor but not controlling in determination of whether actor is negligent); W. PAGE KEETON ET AL., PROSSER AND KEETON ON TORTS § 33, at 193-96 (5th ed. 1984) (explaining bearing of custom upon standard of reasonable care).

2. *Texas & Pac. Ry. v. Behymer*, 189 U.S. 468, 470 (1903).

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

lagged in the adoption of new and available devices."⁴ These sentiments are so widely shared that there is no minority rule.⁵

Physicians, and sometimes other professionals,⁶ have been treated much more favorably. As the Prosser and Keeton hornbook explains, traditional tort law "gives the medical profession . . . the privilege, which is usually emphatically denied to other groups, of setting their own legal standards of conduct, merely by adopting their own practices."⁷ Although physicians are expected to behave reasonably, the reasonableness of their conduct is determined by ascertaining their compliance with customary practices.⁸

Judicial deference to customary clinical practices concretely alters the task of the jury in a medical malpractice case. Under a custom-based standard of care, the relevant inquiry is not whether the defendant behaved like a reasonable person or even whether she behaved as a reasonable physician, but instead whether the defendant conformed with customary practices. Consequently, the jury's inquiry is positive, rather than normative. In theory at least, the jury determines what the customary practice *is*. It does not decide what the custom *ought* to be. The law assigns this latter normative judgment

4. The T.J. Hooper, 60 F.2d 737, 740 (2d Cir. 1932).

5. RESTATEMENT (THIRD) OF TORTS: GENERAL PRINCIPLES, COUNCIL DRAFT NO. 1, Reporter's Notes to § 11, cmt. b (1998).

6. Some courts have extended the custom-based standard of care to other professions. *See, e.g.*, *Osborn v. Irwin Mem'l Blood Bank*, 7 Cal. Rptr. 2d 101, 121 (Ct. App. 1992) (noting application of rule to physicians, nurses, and lawyers); *McCarty v. Mladineo*, 636 So. 2d 377, 381 (Miss. 1994) (noting that rule applies to physicians, lawyers, and accountants); *Doe v. American Red Cross Blood Servs.*, 377 S.E.2d 323, 326 (S.C. 1989) (holding that rule applies to all professions furnishing skilled services for compensation); *Matter of Yemmanur*, 447 N.W.2d 525, 528 n.3 (S.D. 1989) (stating standard applies to all professions).

7. KEETON ET AL., *supra* note 1, § 32, at 189.

8. *See, e.g.*, *Osborn*, 7 Cal. Rptr. 2d at 125 (describing custom as majority rule); PATRICIA DANZON, *MEDICAL MALPRACTICE: THEORY, EVIDENCE AND PUBLIC POLICY* 16, 139-40 (1985) (stating deviation from reliance on custom standard is "rare"); BARRY R. FURROW ET AL., *HEALTH LAW* § 6-2, at 361 (1995) (same); DAVID M. HARNEY, JR., *MEDICAL MALPRACTICE* 89 (1973) (stating custom defines standard of care); KEETON ET AL., *supra* note 1, § 32, at 189 (same); SYLVIA LAW & STEVEN POLAN, *PAIN AND PROFIT: THE POLITICS OF MALPRACTICE* 7, 101 (1978) (same); CLARENCE MORRIS & C. ROBERT MORRIS, JR., *MORRIS ON TORTS* 55 (2d ed. 1980) (stating custom is rule in medical malpractice); James A. Henderson, Jr. & John A. Siliciano, *Universal Health Care and the Continued Reliance on Custom in Determining Medical Malpractice*, 79 CORNELL L. REV. 1382, 1384 (1994) (same); Alan H. McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 560, 605-06 (1959) (same); Clarence Morris, *Custom and Negligence*, 42 COLUM. L. REV. 1147, 1147, 1158 (1942) (stating custom normally should define standard of care); Theodore Silver, *One Hundred Years of Harmful Error: The Historical Jurisprudence of Medical Malpractice*, 1992 WIS. L. REV. 1193, 1212 (stating custom determines standard of care). Similarly, the Second Restatement of Torts states that the physician must "exercise the skill and knowledge normally possessed" by other physicians. RESTATEMENT (SECOND) OF TORTS § 299A (1965) (emphasis added).

to the medical profession collectively. Because the issue to be decided is *what* physicians do, not *why* they do it, evidence of the ineffectiveness of customary practices sometimes is excluded from evidence.⁹ As a California court explained in *Osborn v. Irwin Memorial Blood Bank*,¹⁰ "professional prudence is defined by actual or accepted practice within a profession, rather than theories about what 'should' have been done."¹¹

The *Osborn* case illustrates the hurdle that this custom-based standard of care imposes upon the malpractice plaintiff. In *Osborn*, the plaintiff offered proof that the defendant had failed to follow recommendations and admonitions contained in the professional literature. Yet, the court would not permit the case to reach the jury without proof that these recommendations "had actually become the norm within the profession."¹² Absent proof of departure from custom, the plaintiff could not prevail.

Not surprisingly, this remarkable rule has spawned a number of subsidiary doctrines that limit or explain its operation. They include the following:

1. The requirement of expert testimony to educate the jury about customary clinical practices.¹³
2. The "two schools of thought" or "respectable minority" rule which precludes liability when physicians are divided among two or more respectable schools of thought, and the defendant satisfies the tenets of one.¹⁴
3. The locality rules, now loosened substantially, which determine the source of the binding customary norms.¹⁵

9. See, e.g., *Schneider v. Revici*, 817 F.2d 987, 990-91 (2d Cir. 1987) (stating evidence of effectiveness of treatment is irrelevant); cf. FURROW ET AL., *supra* note 8, at 361 (noting that defendants normally do not offer evidence of effectiveness).

10. 7 Cal. Rptr. 2d 101 (Ct. App. 1992).

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

12. *Id.* at 127.

13. See FURROW ET AL., *supra* note 8, at 365-67 (stating expert testimony is required to establish customary practice); KEETON ET AL., *supra* note 1, § 32, at 189 (same).

14. See, e.g., *Downer v. Veilleux*, 322 A.2d 82, 87 (Me. 1974) ("[A] physician does not incur liability merely by electing to pursue one of several recognized courses of treatment."); *Haase v. Garfinkel*, 418 S.W.2d. 108, 114 (Mo. 1967) (stating there can be difference of opinion among competent physicians); FURROW ET AL., *supra* note 8, at 382-84 (describing "respectable minority" defense).

15. At one time, the plaintiff had to show that the defendant had deviated from local custom. Most courts no longer make local custom the benchmark, opting instead to measure the defendant against the standards in similar localities or nationwide. See, e.g., WILLIAM J. CURRAN ET AL., *HEALTH CARE LAW AND ETHICS* 343-44 (1998) (discussing loosening of locality rule); FURROW ET AL., *supra* note 8, at 360 (stating national standard is majority rule).

4. The "error in judgment" rule insulating reasonable treatment decisions that have had bad outcomes.¹⁶
5. The "best judgment" cases requiring physicians with unique information to use it regardless of customary norms.¹⁷
6. The experimental protocol cases permitting patients to consent to non-customary experimental treatments, at least when conventional care is ineffective.¹⁸
7. The consent to unorthodox medicine cases allowing the patient to opt out of conventional treatment.¹⁹
8. The "common knowledge" cases permitting plaintiffs' verdicts despite the absence of expert testimony and despite evidence that the physician complied with customary standards.²⁰
9. Endless refinements of the phrasing of the standard of care (e.g., does it require "average" skill,²¹ the skill of a physician in "good standing,"²² etc.).²³

16. *E.g.*, *Capolino v. New York City Health & Hosps. Corp.*, 605 N.Y.S.2d 87, 88 (App. Div. 1993) (ordering new trial because "error in judgment" jury instructions were not given); *Silver*, *supra* note 8, at 1193 (noting existence of "best judgment" principle). The modern trend may be to abandon this doctrine because it merely restates the need to prove negligence in addition to a bad outcome and it may confuse the jury by suggesting that any good faith judgment is immune. *See, e.g.*, *Ouellette v. Subak*, 391 N.W.2d 810, 813-16 (Minn. 1986) (concluding "honest error in judgment" instruction is inappropriate); *McCourt v. Abernathy*, 457 S.E.2d 603, 606 (S.C. 1995) (noting "error in judgment" instruction may confuse jury).

17. *E.g.*, *Toth v. Community Hosp.* 239 N.E.2d 368, 373 (N.Y. 1968) (stating physician may be negligent if he fails to employ expertise); *Burton v. Brooklyn Doctors Hosp.*, 452 N.Y.S.2d 875, 879-80 (App. Div. 1982) (same).

18. *E.g.*, *Karp v. Cooley*, 493 F.2d 408, 423-24 (5th Cir. 1974) (stating patient's informed consent precludes finding of negligence for experimental procedure); BARRY R. FURROW ET AL., *HEALTH LAW: CASES, MATERIALS AND PROBLEMS* 206 (3d ed. 1997) (same).

19. *See Schneider v. Revici*, 817 F.2d 987, 995 (2d Cir. 1987) (allowing assumption of risk defense in action against provider for unconventional cancer treatments).

20. *See, e.g.*, *Leonard v. Watsonville Community Hosp.*, 305 P.2d 36, 42 (Cal. 1956) (permitting case to reach jury because counting instruments is matter of common knowledge); *Ault v. Hall*, 164 N.E. 518, 522-23 (Ohio 1928) (permitting sponge count issue to go to jury despite evidence that physician complied with custom); FURROW ET AL., *supra* note 8, at § 6-2, at 368 (describing common knowledge exception); KEETON ET AL., *supra* note 1, § 32, at 189 (same).

21. *E.g.*, KEETON ET AL., *supra* note 1, § 32, at 187 (stating "average" is not preferred phrasing of standard of care).

22. *E.g.*, *Gridley v. Johnson*, 476 S.W.2d 475, 481 (Mo. 1972) (stating "good standing" is misleading); RESTATEMENT (SECOND) OF TORTS § 299A (1965) (phrasing standard of care in terms of "good standing").

23. *See* FURROW ET AL., *supra* note 8, § 6-2, at 362 (describing various ways of stating standard of care); KEETON ET AL., *supra* note 1, § 32, at 187 (describing preferred phrasing of standard of care).

For purposes of understanding the customary standard of care, the most important of these subsidiary malpractice rules is the respectable minority doctrine. Typically called either the "respectable minority rule" or the "two schools of thought" rule,²⁴ this doctrine ostensibly permits physicians to choose among respectable schools of medical thought without fear of liability. In Pennsylvania, for example, "where competent medical authority is divided, a physician will not be liable if in the exercise of his judgment he followed a course of treatment supported by reputable, respectable, and reasonable medical experts."²⁵ The respectable minority rule arises out of judicial unwillingness to choose among conflicting schools of thought when physicians themselves cannot reach a consensus.²⁶

To summarize, physicians theoretically are insulated from liability both when they comply with an established custom and when respectable medical opinion is divided. In principle, plaintiffs are not free to litigate what the custom ought to be or which school of thought is superior. In the words of one often-quoted opinion, "[P]hysicians and surgeons must be allowed a wide range in the exercise of their judgment and discretion. The law will not hold a physician guilty of negligence . . . unless it be shown that the course pursued was clearly against the course recognized as correct by the profession generally."²⁷ In theory, therefore, the plaintiff who hopes to prevail must prove that the defendant's conduct on the day in question fell entirely outside of all common practices.

Although tort law's traditional deference to customary medical practices has generated both heated criticisms²⁸ and pointed defenses,²⁹ courts and

24. See, e.g., *DiFilippo v. Preston*, 173 A.2d 333, 337 (Del. 1961) (stating defendant's choice of one of two acceptable techniques was not negligence); *Hood v. Phillips*, 554 S.W.2d 160, 164 (Tex. 1977) (describing "respectable minority" rule); *FURROW ET AL.*, *supra* note 8, § 6-5, at 250.

25. *Furey v. Thomas Jefferson Univ. Hosp.*, 472 A.2d 1083, 1089 (Pa. Super. Ct. 1984). Haavi Morreim offers the example of a physician choosing among several acceptable treatments for breast cancer, including radical or modified radical mastectomy, or lumpectomy, with accompanying variations of radiation or chemotherapy. E. Haavi Morreim, *Cost Containment and the Standard of Medical Care*, 75 CAL. L. REV. 1719, 1735 (1987).

26. See RESTATEMENT (SECOND) OF TORTS § 299A, cmt. f (1965) ("The law cannot undertake to decide technical questions of proper practice over which experts reasonably disagree.").

27. *McPeak v. Vanderbilt Univ. Hosp.*, 229 S.W.2d 150, 152 (Tenn. Ct. App. 1950) (quoting *Bailey v. St. Louis-S.F. Ry. Co.*, 296 S.W. 477, 479 (Mo. Ct. App. 1927)).

28. See, e.g., HARNEY, *supra* note 8, at 90 (stating customary practice should be only one factor in determining standard of care); Randall Bovbjerg, *The Medical Malpractice Standard of Care: HMOs and Customary Practice*, 1975 DUKE. L. J. 1375, 1377-78, 1394-95 (criticizing law's deference to customary medical practice); Patricia M. Danzon, *Tort Liability: A Minefield for Managed Care?*, 26 J. LEGAL STUD. 491, 493, 508 (1997) (same); Herman C. Fala, *The Law of Medical Malpractice in Pennsylvania*, 36 U. PITT. L. REV. 203, 213-14 (1974) (stating that

commentators alike have assumed that the custom-based standard of care is nearly universal. While commentators faithfully acknowledge the infamous Washington case of *Helling v. Carey*,³⁰ which rejected reliance on custom in favor of a reasonability test, they typically characterize it as an aberrant deviation from the norm.³¹ Thus, one prominent authority concludes that only on "rare occasions" can the plaintiff proceed without proof that the defendant deviated from customary norms.³² Another scholar concluded that custom-based standards were "well-nigh universal."³³ In fact, Richard Epstein concluded that the consensus in favor of custom became stronger after

customs should not be conclusive); Henderson & Siliciano, *supra* note 8, at 1382-89 (criticizing continued reliance on custom); John Kimbrough Johnson, Jr., *An Evaluation of Changes in the Medical Standard of Care*, 23 VAND. L. REV. 729, 745, 747 (1970) (same); Joseph H. King, Jr., *In Search of a Standard of Care for the Medical Profession: The "Accepted Practice" Formula*, 28 VAND. L. REV. 1214, 1236-41 (1975) (same); Silver, *supra* note 8, at 1193 (criticizing continued reliance on custom). See generally Morreim, *supra* note 23 (explaining that custom does not account for scarcity of resources and cost containment); E. Haavi Morreim, *Stratified Scarcity: Redefining the Standard of Care*, 17 LAW, MED. & HEALTH CARE 356 (1989) (same); E. Haavi Morreim, *Stratified Scarcity and Unfair Liability*, 36 CASE W. RES. L. REV. 1033 (1986) (same); John A. Siliciano, *Wealth, Equity, and the Unitary Medical Malpractice Standard*, 77 VA. L. REV. 439 (1991) (same).

29. See, e.g., RICHARD A. EPSTEIN, TORTS § 6.2, at 140-41 (1999) [hereinafter EPSTEIN, TORTS] (supporting law's deference to custom in medical malpractice); James Henderson, Jr., *Expanding the Negligence Concept: Retreat from the Rule of Law*, 51 IND. L.J. 467, 492-95 (1976) (describing dangers of straying from custom standard in medical malpractice cases); McCoid, *supra* note 8 (defending custom standard); Morris, *supra* note 8, at 1164-65 (same); Richard N. Pearson, *The Role of Custom in Medical Malpractice Cases*, 51 IND. L.J. 528 (1976) (same); Jeffrey J. Rachlinski, *A Positive Psychological Theory of Judging in Hindsight*, 65 U. CHI. L. REV. 571, 574, 608-13 (1998) (concluding custom avoids hindsight bias). See generally Richard A. Epstein, *The Path to The T. J. Hooper: The Theory and History of Custom in the Law of Tort*, 21 J. LEGAL STUD. 1 (1992) [hereinafter Epstein, *The Path to The T.J. Hooper* (describing history of custom in tort law).

30. 519 P.2d 981 (Wash. 1974). For the facts of *Heiling*, see *infra* notes 36-42 and accompanying text.

31. See, e.g., FURROW ET AL., *supra* note 8, at 361 n.16 (stating other states have rejected *Helling*); FURROW ET AL., *supra* note 18, at 178 (same); KEETON ET AL., *supra* note 1, § 32, at 219 n.21 (stating *Helling's* reasonability test goes against general trend); Rachlinski, *supra* note 27 at 611 n.166 (stating custom standard is majority rule).

32. FURROW ET AL., *supra* note 8, at 361. This treatise correctly suggests that many of the early cases rejecting deference to custom were "common knowledge" cases. *Id.* at 368. However, it oversimplifies the early cases in two respects. First, those opinions did not expressly limit their holdings to common knowledge cases. Second, many of the early cases involved complex activity. See, e.g., *Lundahl v. Rockford Mem'l Hosp. Ass'n*, 235 N.E.2d 671, 673 (Ill. App. Ct. 1968) (describing defendant's failure to diagnose plaintiff's hemorrhoids); *Favalova v. Aetna Cas. & Sur. Co.*, 144 So. 2d 544, 546-47 (La. Ct. App. 1962) (describing injuries plaintiff received during x-ray process).

33. Pearson, *supra* note 29, at 528.

Helling.³⁴ Although a couple of authors have hinted that support for customary standards may be weakening, they cite only one or two states as having joined Washington.³⁵ The reality is quite different.

II. *The Quiet Trend away from Custom*

Judicial deference to physicians' customs is quietly eroding. By the beginning of 1999, a dozen states had expressly refused to be bound by medical customs. Nine additional states, while not explicitly rejecting deference to custom, had chosen to phrase the duty owed by physicians in terms of reasonability, rather than compliance with medical customs. In addition, the steady pattern of defections from the custom-based standard of care over the past several decades suggests that more states will follow.

Furthermore, many of the states that continue to endorse a customary standard of care in principle do not appear to police adherence very closely. It is fairly common for plaintiffs in these states to reach a jury even when their experts have stated only that the defendant's conduct is not "acceptable" or "appropriate" or fails to meet the "standard of care." The experts in these cases have not been required to demonstrate that the defendant deviated from an established custom. As a result, it is misleading to suggest that a successful malpractice plaintiff must prove that the defendant physician has deviated from all common practices or even to make the more narrow claim that compliance with customary norms provides a complete defense. The truth is more complex.

A. *Helling in Perspective*

Every student of health law reads the 1974 Washington case *Helling v. Carey*.³⁶ In that case, Barbara Helling contended that her ophthalmologist had failed to give her a simple test that would have detected her glaucoma.³⁷ Her experts conceded that doctors did not routinely administer this test to patients her age.³⁸ The jury then returned a verdict for the defendant, which the Washington Supreme Court reversed. Not satisfied to rule that compliance

34. EPSTEIN, TORTS, *supra* note 29, at 141.

35. See FURROW ET AL., *supra* note 18, at 153-54 (citing Wisconsin case); KEETON ET AL., *supra* note 1, Supp. 1988 at 30 n.53 (citing Minnesota and Virginia cases).

36. 519 P.2d 981 (Wash. 1974).

37. *Helling v. Carey*, 519 P.2d 981, 981-82 (Wash. 1974).

38. *Id.* at 982. This concession may not have been accurate. See Jerry Wiley, *The Impact of Judicial Decisions on Professional Conduct: An Empirical Study*, 55 S. CAL. L. REV. 345, 361 (1982) (suggesting that testimony given about absence of routine testing of younger patients was wrong).

with customary practices was not an absolute defense, the court also held that failure to administer routine glaucoma tests to all patients was negligent as a matter of law.

The *Helling* decision generated volumes of commentary. It came in the midst of the 1970s malpractice insurance crisis, and most of the reaction was critical and even alarmist. In fact, the decision reportedly caused some insurers to withdraw from the medical malpractice market.³⁹ The scholarly literature has generally assumed that *Helling* is a rogue case,⁴⁰ rejected even in Washington by a subsequent enactment of the state legislature.⁴¹ One scholar concluded that, despite *Helling*, the consensus in favor of customary standards "has, if anything, grown stronger in recent years."⁴²

These interpretations of *Helling* are only half correct. In one respect, the *Helling* decision was and remains genuinely aberrant. No other court has endorsed the Washington Supreme Court's decision to take the issue of medical negligence away from the jury and to rule, without the benefit of expert testimony, that a customary practice is negligent as a matter of law.⁴³ This aspect of *Helling* was deeply flawed and has justly contributed to its reputation as a rogue case.

However, *Helling's* rejection of customary norms was not aberrant. Not only has *Helling's* rejection of customary standards survived in Washington with the eventual blessing of the legislature,⁴⁴ but many other courts have

39. See CURRAN ET AL., *supra* note 15, at 383.

40. See, e.g., FURROW ET AL., *supra* note 18, at 178 (suggesting that only "small number of cases" have rejected customary standards and that they all involved common knowledge cases in which expert testimony was not necessary); LAW & POLAN, *supra* note 8, at 118 (concluding that *Helling's* uniqueness is attested to by volume of commentary that it generated); Eric E. Fortess & Marshall B. Kapp, *Medical Uncertainty, Diagnostic Testing and Legal Liability*, 13 LAW, MED. & HEALTH CARE 213, 215 (1985) (describing case as "anomaly"). Most of the commentary was unfavorable. See CURRAN ET AL., *supra* note 15, at 383 (stating *Helling* created storm of legal criticism); KENNETH R. WING ET AL., THE LAW AND AMERICAN HEALTH CARE 684 (1998) ("The response to *Helling* was largely unfriendly.").

41. The state legislature's attempt to reverse *Helling* was sidestepped in a subsequent case. See *Gates v. Jensen*, 595 P.2d 919, 921, 924 (Wash. 1979) (concluding *Helling's* rule applies after legislative enactment). However, later legislation appears to have adopted the court's reasonable care test. WASH. REV. CODE § 7.70.040 (1998). See *Harris v. Groth*, 663 P.2d 113, 116-18 (Wash. 1983) (stating that later legislation has adopted *Helling* standard).

42. EPSTEIN, TORTS, *supra* note 29, at 141.

43. This part of the holding was limited to its facts even in Washington. See *Meeks v. Marx*, 550 P.2d 1158, 1162 (Wash. Ct. App. 1976) (stating negligence normally is jury question). In addition, Washington now requires expert testimony on reasonable care "[a]bsent exceptional circumstances such as were present in *Helling*." *Harris v. Groth*, 663 P.2d 113, 120 (Wash. 1983).

44. See *supra* note 41 (describing legislature's eventual endorsement of *Helling* standard).

reached the same conclusion. Although few of these courts have expressly relied on *Helling*, perhaps because of its notoriety, many have agreed with its rejection of customary standards.

This distinction between *Helling*'s rejection of the customary standard of care and its ruling on the facts as a matter of law has eluded some observers. Multiple authors, for example, cite the California case of *Barton v. Owen*⁴⁵ as having rejected *Helling*.⁴⁶ Yet, *Barton* actually endorsed *Helling*'s refusal to defer to customary norms. It only rejected the notion that courts should rule on reasonability as a matter of law.⁴⁷ Said the court:

We fully agree with the plaintiff's contentions on the connection between custom and due care. However, we fail to see how this leads to the conclusion that, because a custom may be negligent, such negligence can be found as a matter of law.⁴⁸

Washington was neither the first state to reject custom-based standards nor the last.

B. States Expressly Rejecting a Custom-Based Standard of Care

Seventeen states have appellate cases that explicitly reject deference to custom in medical malpractice cases. In at least twelve of those states, the cases rejecting custom-based standards appear to be authoritative today.⁴⁹

The Illinois Supreme Court first rejected custom in a famous 1965 hospital negligence case, *Darling v. Charleston Community Memorial Hospital*.⁵⁰ Custom, it concluded, never should be conclusive because a profession could adopt unreasonable habits.⁵¹ Since 1968, the Illinois intermediate appellate courts have extended this reasoning to cases against physicians.⁵²

45. 139 Cal. Rptr. 494 (Ct. App. 1977).

46. See Epstein, *The Path to The T.J. Hooper*, *supra* note 29, at 37 n.84 (stating that *Barton* rejects *Helling*); FURROW ET AL., *supra* note 8, at 361 n.16 (same); WING ET AL., *supra* note 40, at 684 (same).

47. See *Barton v. Owen*, 139 Cal. Rptr. 494, 501-02 (Ct. App. 1977) (stating expert testimony is required to constitute basis for due care).

48. *Id.* at 498-99.

49. In two states (Florida and Minnesota) the leading cases are from intermediate appellate courts. In three others (Louisiana, Ohio and Texas) the *clearest* rejection of custom has come from intermediate appellate courts.

50. 211 N.E. 2d 253 (Ill. 1965).

51. *Darling v. Charleston Community Mem'l Hosp.*, 211 N.E. 2d 253, 257 (Ill. 1965).

52. *E.g.*, *Chiero v. Chicago Osteopathic Hosp.*, 392 N.E.2d 203, 209 (Ill. App. Ct. 1979) ("[G]eneral custom is not conclusive."); *Lundahl v. Rockford Mem'l Hosp. Ass'n*, 235 N.E.2d 671, 674 (Ill. App. Ct. 1968) ("It is entirely possible, as pointed out by the Supreme Court in the case of *Darling v. Charleston Community Memorial Hospital* . . . that what is the usual or customary procedure might itself be negligence.").

In *Chiero v. Chicago Osteopathic Hospital*, for example, the court explained the subsidiary role of custom:

In a professional malpractice case, such as here, where expert testimony is required to establish the requisite standard of care, evidence that a defendant's conduct conformed with local usage or general custom is indicative of due care; it is not, however, conclusive. It may be overcome by contrary expert testimony (or its equivalent) that the prevailing custom or usage itself constitutes negligence.⁵³

In 1996, the Illinois Supreme Court confirmed that compliance with customary standards is not conclusive in actions against medical professionals.⁵⁴

In Louisiana, a 1962 intermediate appellate court decision concluded that "conformity with the standard of care observed by other medical authorities . . . cannot be availed as a defense in a malpractice action when the criterion relied upon is shown to constitute negligence."⁵⁵

53. *Chiero*, 392 N.E.2d at 209.

54. *Advincula v. United Blood Servs.*, 678 N.E.2d 1009, 1027-28 (Ill. 1996) (stating, in action against blood bank, that custom was not conclusive even for medical professionals and favorably citing *Chiero* and *Lundahl* on this point).

55. *Favalora v. Aetna Cas. & Sur. Co.*, 144 So. 2d 544, 550 (La. Ct. App. 1962). Louisiana uses a two-tiered standard of care. See *Meyer v. St. Paul-Mercury Indem. Co.*, 73 So. 2d 781, 786 (La. 1954) (announcing two-tiered standard). Physicians must possess the skill usually possessed by other physicians and also use reasonable care in the application of their skill. *Id.* Before *Favalora*, Louisiana case law interpreted this test to protect physicians who complied with customary norms. See *id.* at 787-88 (applying test favorably to defendant physicians). Thereafter, however, intermediate courts in Louisiana have concluded that this two-tier test permits a plaintiff to challenge a proven custom if the custom is proven to be negligent. This interpretation first was enunciated in *Favalora v. Aetna Casualty & Surety Co.*, 144 So. 2d 544, 550 (La. Ct. App. 1962) ("[C]onformity with the standard of care observed by other medical authorities in good standing in the same community cannot be availed of as a defense in a malpractice action when the criterion relied upon is shown to constitute negligence."). It subsequently has been treated as authoritative. See, e.g., *Davis v. Duplantis*, 448 F.2d 918, 920-21 (5th Cir. 1971) (refusing to apply *Favalora* without expert testimony about negligence); *George v. Travelers Ins. Co.*, 215 F. Supp. 340, 344 (E.D. La. 1963) (citing *Favalora* favorably); *Barbella v. Touro Infirmary*, 596 So. 2d 845, 848 (La. Ct. App. 1992) (holding *Favalora* to be inapplicable when plaintiff fails to meet burden of proving standard of care); *Slack v. Fleet*, 242 So. 2d 650, 656 (La. Ct. App. 1970) (refusing to apply *Favalora* in absence of adequate proof of failure to use reasonable care). But see *Ware v. Medical Protective Ins. Co.*, 621 So.2d 54, 57-58 (La. 1993) (holding that standard is what is "ordinarily" done). The legislature adopted the judicial two-tiered standard in 1975, in LA. REV. STAT. § 9:2794 (West 1997), as follows:

In a malpractice action based on the negligence of a physician . . . the plaintiff shall have the burden of proving: (1) The degree of knowledge or skill possessed or the degree of care *ordinarily exercised* by physicians . . . licensed to practice in the state of Louisiana and actively practicing in a similar community or locale and under similar circumstances; and where the defendant practices in a particular

In addition, Pennsylvania, Ohio, and Oklahoma all had decisions rejecting deference to custom prior to the *Helling* decision in 1974. In each of these jurisdictions, however, the current authority of those decisions is unclear.⁵⁶

Then came *Helling*. Three years later, the Texas Supreme Court explicitly rejected customary standards in *Hood v. Phillips*.⁵⁷ In *Hood*, the court defined Texas's new malpractice standard of care as what a "reasonable and prudent" physician would do, rather than what customarily was done.⁵⁸ A subsequent case affirmed that "custom or practice . . . is not conclusive on the issue of the standard of care We see no reason for a different rule in medical malpractice cases" ⁵⁹

In the 1980s, courts in Florida,⁶⁰ Mississippi,⁶¹ Minnesota,⁶² and Wyoming⁶³ rejected deference to medical customs. Courts in Colorado,⁶⁴ the Dis-

specialty and where the alleged acts of medical negligence raise issues peculiar to the particular medical specialty involved, then the plaintiff has the burden of proving the degree of care ordinarily practiced by physicians . . . within the involved medical specialty. (2) That the defendant either lacked this degree of knowledge or skill or *failed to use reasonable care and diligence*, along with his best judgment in the application of the skill.

LA. REV. STAT. § 9:2794 (West 1997) (emphasis added). The statute has been construed as codifying prior case law. *See Leyva v. Iberia Gen. Hosp.*, 643 So. 2d 1236, 1238 (La. 1994) (stating that statute codified *Meyer*).

56. The law in those states is discussed in detail later in this subsection. *See infra* text at notes 69-98.

57. 554 S.W.2d 160, 165 (Tex. 1977).

58. *Hood v. Phillips*, 554 S.W.2d 160, 165 (Tex. 1977). In addition, the court rejected the respectable minority rule because it "could convey to a jury the incorrect notion that the standard for malpractice is to be determined by a poll of the medical profession." *Id.*

59. *Kissinger v. Turner*, 727 S.W.2d 750, 755 (Tex. App. 1987).

60. *See Doctors Mem'l Hosp., Inc. v. Evans*, 543 So. 2d 809, 812 (Fla. Dist. Ct. App. 1989) (citing *Nesbitt v. Community Health*, 467 So. 2d 711, 714 (Fla. Dist. Ct. App. 1985)) (disregarding customary methods test and emphasizing prudent person standard).

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

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

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

64. *State Bd. of Med. Exam'rs v. McCroskey*, 880 P.2d 1188, 1194 (Colo. 1994) (citing *United Blood Servs. v. Quintana*, 827 P.2d 509, 512 (Colo. 1992)) (finding rebuttable presumption that adherence to customary practices provides reasonable standard of care).

trict of Columbia,⁶⁵ Nevada⁶⁶ and Wisconsin⁶⁷ did so in the 1990s. Although customary standards continue to benefit from a rebuttable presumption of reasonability in Colorado and Nevada, the plaintiff can rebut this presumption simply by offering expert testimony establishing that the prevailing custom is deficient.⁶⁸ The jury then decides whether the customary practice constitutes due care.⁶⁹

In addition to these twelve states, four additional states have appellate decisions expressly rejecting customary standards: Pennsylvania, Ohio, California, and Oklahoma.⁷⁰ However, the current law in these states is unclear. As a result, these states cannot be classified as "reasonable physician" states at this time. Nevertheless, the presence of appellate decisions in these states rejecting customary standards further illustrates the breadth of judicial disenchantment with the traditional, customary standard of care.

The Pennsylvania Supreme Court rejected custom-based standards in *Incollingo v. Ewing*.⁷¹ Responding to a defendant's argument for a customary

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

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

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

68. *Brown*, 858 P.2d at 396 n.5. In that case, the plaintiff did not attempt to prove that the prevailing standard in the blood banking community was deficient. As a result, the court's statement on this issue is dictum. *Id.* at 396 nn.4-5. The court did not mention the Nevada statute, which uses language from both tests, but appears to call for customary standards. NEV. REV. STAT. § 41A.009 (1997) (defining medical malpractice as failure to "use the reasonable care, skill or knowledge ordinarily used under similar circumstances").

69. See *Quintana*, 827 P.2d at 521 (emphasizing jury's role in determining whether customary standard constitutes due care).

70. A fourth state, New York, has a case rejecting custom in very narrow circumstances. In the well-known case of *Toth v. Community Hospital at Glen Cove*, New York's highest court stated that the usual deference to customary standard must yield when "a physician fails to employ his expertise or best judgment . . ." *Toth v. Community Hosp.*, 239 N.E.2d 368, 372-73 (N.Y. 1968). In that case, the plaintiff alleged that the defendant negligently supervised the hospital nursing staff during the administration of oxygen to a premature baby. *Id.* at 370. The nurses administered the oxygen at the customary rate, rather than at the safer, lower rate the defendant had ordered, resulting in blindness to the child. *Id.* Said the court, "There is no policy reason why a physician, who knows or believes there are unnecessary dangers in the community practice, should not be required to take whatever precautionary measures he deems appropriate." *Id.* at 373. Since this decision, however, the New York Court of Appeals has made no further inroads in developing the customary standard of care. Given the narrow context in which the court rejected customary norms, New York cannot yet be treated as a reasonable care state.

71. 282 A.2d 206, 217 (Pa. 1971).

standard, the court said "[t]his would be to say that as long as a course of conduct, however unreasonable by ordinary standards, is the norm for the group, all members of the group are thereby insulated from liability so long as they do not deviate therefrom."⁷² That standard, it continued, "is not the law."⁷³ The Pennsylvania Supreme Court subsequently clouded the issue by endorsing a version of the respectable minority rule.⁷⁴ However, as long as the jury ultimately determines whether the defendant's school of thought was respectable, Pennsylvania's law remains compatible with a reasonable physician standard.

In the 1928 case of *Ault v. Hall*,⁷⁵ the Ohio Supreme Court expressly rejected reliance on custom in a foreign object case.⁷⁶ In that case, the defendant physician relied on the customary practice of delegating the counting of sponges to the sponge nurse.⁷⁷ Said the court: "[C]ustom will not justify a negligent act or exonerate from a charge of negligence."⁷⁸ Because *Ault* was a "common knowledge" case in which the court permitted the jury to reach a decision without expert testimony, some commentators have concluded that the court's rejection of a custom-based standard of care is limited to common-knowledge cases.⁷⁹ Yet, nothing in the court's pointed rejection of a customary standard of care suggests that its holding on the standard of care is limited to common knowledge cases.⁸⁰ Furthermore, a 1963 Ohio intermediate court of appeals decision declined to limit *Ault* to common knowledge cases. *Morgan v. Sheppard*⁸¹ applied the holding in *Ault* to a more complex malpractice case in which the plaintiff had presented expert testimony. Customary standards, said the court, "do not furnish a test which is controlling on the

72. *Incollingo v. Ewing*, 282 A.2d 206, 217 (Pa. 1971); see *Donaldson v. Mafucci*, 156 A.2d 835, 838 (Pa. 1959) (requiring both skills usually possessed by physicians and also care and judgment of reasonable man); Fala, *supra* note 28, at 213-14.

73. *Incollingo*, 282 A.2d at 217.

74. *Jones v. Chidester*, 610 A.2d 964, 965 (Pa. 1992) (recognizing "respectable minority" defense if employed by "considerable number of recognized and respected" physicians). Other authors believe that the law of Pennsylvania remains unclear. FOWLER V. HARPER ET AL., *THE LAW OF TORTS* § 17.3 n.6 (2d ed. 1986); Pearson, *supra* note 29, at 532-33. *But see* Fala, *supra* note 28, at 213-14 (concluding that Pennsylvania law does not make customs conclusive).

75. 164 N.E. 518 (Ohio 1928).

76. *Ault v. Hall*, 164 N.E. 518, 523 (Ohio 1928).

77. *Id.* at 519.

78. *Id.* at 523 ("Long-continued careless performance of a duty by any trade, business or profession will not transform negligence into due care.").

79. See, e.g., FURROW ET AL., *supra* note 8, § 6-2, at 368; Pearson, *supra* note 29, at 550-52.

80. *Ault*, 164 N.E. at 522-23.

81. 188 N.E.2d 808 (Ohio Ct. App. 1963).

question of negligence."⁸² Instead, physicians must "exercise that degree of care which a reasonable and prudent person in the same profession or calling would have exercised."⁸³ By 1963 (a decade before *Helling*), Ohio seemed to have rejected a custom-based standard.

Since then, however, the standard of care in Ohio has been clouded by inconsistent language in subsequent decisions by the Ohio Supreme Court. The confusion began in *Bruni v. Tatsumi*.⁸⁴ Parts of the court's decision reaffirm the reasonable physician standard. The court, for example, held that the standard of care for medical specialists is "that of a reasonable specialist . . . in the light of present day scientific knowledge in that specialty field"⁸⁵ and that general practitioners must provide the care that "a physician of ordinary skill, care and diligence" would have provided.⁸⁶ These tests appear to permit a plaintiff to reach the jury with testimony that the defendant's care did not meet the standards of a "reasonable" physician. Proof of breach of custom does not appear to be essential. This reading is also consistent with the court's favorable citation of *Ault*. However, the court also said that physicians must exercise "the average degree of skill, care and diligence exercised" by other physicians, and the court made reference to "recognized" and "prevailing" standards.⁸⁷ These later statements cast doubt on the court's commitment to a reasonability standard of care.

The court's language in *Berdyck v. Shinde*⁸⁸ is similarly confusing. First, the court described the physician's obligation as one of "good practice" consistent with a reasonable physician test and "the care and skill reasonable in light of their superior learning and experience."⁸⁹ Yet, the court arguably was sympathetic to a customary standard of care when it said that physicians must "employ that degree of skill, care and diligence that a physician or surgeon of the same medical specialty would employ in like circumstances."⁹⁰ The same confusing language appears in *Littleton v. Good Samaritan Hospital & Health Center*,⁹¹ in which the court both said that the standard of care is "dictated by

82. *Morgan v. Sheppard*, 188 N.E.2d 808, 816 (Ohio Ct. App. 1963).

83. *Id.*

84. 346 N.E.2d 673 (Ohio 1976).

85. *Bruni v. Tatsumi*, 346 N.E.2d 673, 675 (Ohio 1976) (rejecting strict locality rule for specialists), *aff'd*, *Berdyck v. Shinde*, 613 N.E.2d 1014, 1020-21 (Ohio 1993) (quoting at length from syllabus in *Bruni*).

86. *Bruni*, 346 N.E.2d at 677.

87. *Id.* at 676.

88. 613 N.E.2d 1014 (Ohio 1993).

89. *Berdyck v. Shinde*, 613 N.E.2d 1014, 1020-21 (Ohio 1993).

90. *Id.* at 1021 (citing *Bruni*, 346 N.E.2d at 676).

91. 529 N.E.2d 449 (Ohio 1988).

custom," and at the same time quoted *Bruni* for the proposition that physicians must behave like a "reasonable specialist" and "a physician of ordinary skill, care and diligence."⁹² Obviously, Ohio is a difficult state to classify.

Apparently, the jury instructions in Ohio use the reasonability language from *Bruni*.⁹³ In trial courts that use these instructions, experts for plaintiffs will not have to prove that the defendant deviated from customary practices. As a result, it is tempting to classify Ohio as a reasonable care state, but this Article has not done so because of the ambiguity in the cases.

In California, two lines of intermediate appellate court decisions directly considered the issue and reached contrary conclusions.⁹⁴ A 1994 decision by the California Supreme Court failed to eliminate the confusion.⁹⁵ On the one hand, the court explained that the "professional" nature of the action merely identified the special knowledge and skill that might be a "circumstance" affecting the "ordinary prudence" expected of the professional.⁹⁶ This part of the court's opinion is consistent with a reasonable physician standard of care. On the other hand, the court's introductory discussion of the standard of care favorably cited both ordinary care language and customary care language from its earlier opinions without acknowledging the inconsistency.⁹⁷ As a result,

92. *Littleton v. Good Samaritan Hosp. and Health Ctr.*, 529 N.E.2d 449, 455-56 (Ohio 1988).

93. *See Tirpak v. Weinberg*, 499 N.E.2d 397, 400 (Ohio Ct. App. 1986) (articulating jury instructions).

94. *Compare Dincau v. Tamayose*, 182 Cal. Rptr. 855, 867 (Ct. App. 1982) (rejecting reliance on custom), and *Barton v. Owen*, 139 Cal. Rptr. 494, 498 (Ct. App. 1977) (same), with *Wilson v. Irwin Mem'l Blood Bank*, 18 Cal. Rptr. 2d 517, 524 (Ct. App. 1993) (deferring to custom), and *Osborn v. Irwin Mem'l Blood Bank*, 7 Cal. Rptr. 2d 101 (Ct. App. 1992) (same). The approved jury instructions for the Superior Court of Los Angeles County use a custom-based standard. COMMITTEE ON STANDARD JURY INSTRUCTIONS, CIVIL, OF THE SUPERIOR COURT OF LOS ANGELES COUNTY, CALIFORNIA, CALIFORNIA JURY INSTRUCTIONS—CIVIL, BOOK OF APPROVED JURY INSTRUCTIONS § 6.00.1 (BAJI 8th ed. Pocket Part 1999) ("use the care and skill ordinarily exercised").

95. *See generally Flowers v. Torrance Mem'l Hosp. Med'l Ctr.*, 884 P.2d 142 (Cal. 1994) (failing to eliminate confusion regarding standard of care).

96. *Id.* at 145.

97. Because of the procedural posture of the case, the court did not rule directly on the relevance of customary norms. *Id.* at 147. After declaring that the testimony of the plaintiff's expert witness was "defective," the trial court granted summary judgment for the defendant. *Id.* at 144. The court of appeals reversed because the defendants had failed to dispute a theory of "ordinary" negligence. *Id.* The California Supreme Court concluded the defendants' conduct should be measured by only one standard of care commensurate with the risk posed by the circumstances. It said that: "[W]hether the cause of action is denominated 'ordinary' or 'professional' negligences or both, ultimately only a single standard [of care] can obtain under any given set of facts and any distinction is immaterial to resolving a motion for summary judgment." *Id.* at 146. Thus, the court reversed the judgment of the intermediate appellate court

California's standard of care will remain unclear until this ambiguity is resolved.⁹⁸

Finally, Oklahoma has a 1936 case expressly rejecting reliance on custom.⁹⁹ That case, however, never has been cited regarding the standard of care and a more recent case may silently overrule it.¹⁰⁰ Currently, Oklahoma should be treated as a customary care state.

To recap, twelve states have expressly refused to defer to custom in medical malpractice cases.¹⁰¹ Pennsylvania probably rejects custom as well, although a recent case clouds the issue. In three additional states, the case law is conflicting or ambiguous. Overall, a quarter of the states currently decline to defer to medical customs and several others have at least one appellate opinion advocating such a shift.

and remanded the case for application of a single standard of care. The court did not specifically state whether this single standard of ordinary care would, for physicians, be defined by compliance with customary practices. *Id.* at 147.

98. The California Civil Code does not contain a definition of malpractice, but it does define a malpractice immunity in terms of reasonable care.

No health care provider shall be liable for professional negligence or malpractice for any occurrence or result solely on the basis that the occurrence or result was caused by the natural course of a disease or condition, or was the natural or expected result of a *reasonable treatment* rendered for the disease or condition.

CAL. CIV. CODE § 1714.8 (West 1998) (emphasis added).

99. See *McBride v. Roy*, 58 P.2d 886, 888 (Okla. 1936) ("[C]ustom and usage are not necessarily determinative of whether proper care was used, but they help considerably on the question.").

100. See *Karriman v. Orthopedic Clinic*, 516 P.2d 534, 538 (Okla. 1973) (finding that physicians must have "learning, skill, and experience *ordinarily possessed* by others of the profession").

101. In two states (Florida and Minnesota) the only authoritative cases are from intermediate appellate courts. *Supra* notes 60 and 62. In two others (Louisiana and Texas) the *clearest* rejection of custom has come from intermediate appellate courts. See *supra* notes 55 and 59. In all of these twelve states except Nevada, courts have refused to defer to the customs of physicians, not merely hospitals (whose duties might more readily be defined in terms of reasonable care). In Nevada, the rejection of a custom-based standard occurred in a blood bank case, and the Nevada appellate courts have not yet been asked to apply it in a case involving physicians. See *Brown v. United Blood Servs.*, 858 P.2d 391, 396 n.5 (Nev. 1993). In Colorado and the District of Columbia, the first cases rejecting conclusive reliance on custom involved blood banks, but the holdings have since been applied to physicians. See *State Bd. of Med. Exam'rs v. McCroskey*, 880 P.2d 1188, 1194 (Colo. 1994) (holding that physician customs are not conclusive); *United Blood Servs. v. Quintana*, 827 P.2d 509, 518 (Colo. 1992) (rejecting custom in blood bank case); *Cleary v. Group Health Assn., Inc.*, 691 A.2d 148, 156 (D.C. 1997) (applying reasonable physician standard); *Ray v. American Nat'l Red Cross*, 696 A.2d 399, 404 (D.C. 1996) (rejecting custom in blood bank case). However, the Nevada court stated expressly that it was applying and defining the "professional" standard of care—the same standard of care that applies to physicians. See *Brown v. United Blood Servs.*, 858 P.2d 391, 395-96 (Nev. 1993).

C. States Phrasing the Standard of Care in Terms of Reasonability

Nine additional states have cases or statutes phrasing the malpractice standard of care in terms of what a reasonable physician would do, rather than what customarily is done. Unlike the jurisdictions described in the previous section, however, these states do not have judicial opinions explicitly rejecting deference to medical customs.

In Indiana, for example, physicians must use the care "exercised by reasonably careful, skillful, and prudent practitioners."¹⁰² In Maryland, the duty owed is that of a "reasonably competent practitioner."¹⁰³ Similar language is used in Kentucky,¹⁰⁴ Oregon,¹⁰⁵ Virginia,¹⁰⁶ West Virginia,¹⁰⁷ and,

102. *Vergara v. Doan*, 593 N.E.2d 185, 187 (Ind. 1992); *see Oelling v. Rao*, 593 N.E.2d 189, 191 (Ind. 1992) (holding that plaintiff's expert must establish what reasonable doctors similarly situated would have done).

103. *Shilkret v. Annapolis Emergency Hosp. Ass'n*, 349 A.2d 245, 253 (Md. 1975).

104. *See Mitchell v. Hadl*, 816 S.W.2d 183, 185 (Ky. 1991) (requiring "degree of care and skill which is expected of a reasonably competent practitioner"); *accord Reams v. Stutler*, 642 S.W.2d 586, 588 (Ky. 1982) (same); *Blair v. Eblen*, 461 S.W.2d 370, 373 (Ky. 1970) (same). Some ambiguity arguably remains because *Blair* in 1970 said that "we will leave determination of the standard to the medical profession and not the lay courts." *Blair*, 461 S.W.2d at 373. The more recent cases, however, use a reasonability test. When I practiced in Kentucky, it was common-place to ask experts whether the defendants had violated "the standard of care" without further defining the standard.

105. *See OR. REV. STAT. § 677.095* (1997) (defining degree of care as "that degree of care, skill and diligence that is used by ordinarily careful physicians . . . in the same or similar circumstances in the community . . . or a similar community"); *Rogers v. Meridian Park Hosp.*, 772 P.2d 929, 933 (Or. 1989) ("[A] physician must *always* exercise reasonable care.").

106. VA. CODE ANN. § 8.01-581.20 (1992) ("[T]he standard of care by which the acts or omissions are to be judged shall be that degree of skill and diligence practiced by a reasonably prudent practitioner in the field of practice or speciality in this Commonwealth."); *Raines v. Lutz*, 341 S.E.2d 194, 196 (Va. 1986) ("Health care providers are required by law to possess and exercise only that degree of skill and diligence practiced by a reasonably prudent practitioner in the same field of practice or specialty in Virginia."); *accord Bryan v. Burt*, 486 S.E.2d 536 (Va. 1997) (stating physician must demonstrate degree of skill and diligence employed by reasonably prudent practitioner).

107. W. VA. CODE § 55-7B-3 (1994). The West Virginia Code states:

The following are necessary elements of proof that an injury or death resulted from the failure of a health care provider to follow the accepted standard of care: (a) The health care provider failed to exercise that degree of care, skill, and learning required or expected of a reasonable, prudent health care provider . . . in the same or similar circumstances.

Id. But see Tennant v. Marion Health Care Found., Inc., 459 S.E.2d 374, 393 (W. Va. 1995) (finding that erroneous instruction was not prejudicial); *Howe v. Thompson*, 412 S.E.2d 212, 215-17 (W. Va. 1991) (allowing instruction that contained elements of both reasonability and custom). In 1994, a federal court concluded that West Virginia would reject a custom-based standard of care. *Doe v. American Nat'l Red Cross*, 848 F. Supp. 1228, 1233-34 (S.D.W. Va. 1994).

more ambiguously, in New Hampshire.¹⁰⁸ Montana uses reasonability language to describe the duty owed by general practitioners,¹⁰⁹ although its test for specialists uses language ordinarily associated with a custom-based standard of care.¹¹⁰ Interestingly, legislation codifies this reasonability standard of care in four of the states: New Hampshire, Oregon, Virginia, and West Virginia.

In Vermont a statute contains text consistent with both tests, but ultimately it seems to require the care of a reasonably prudent physician. The statute defines the duty of care as "[t]he degree of knowledge or skill possessed or the degree of care *ordinarily exercised by a reasonably skillful, careful, and prudent* health care professional."¹¹¹ In *Rooney v. Medical Center Hospital of Vermont, Inc.*,¹¹² the state's highest court held that the statute "measures the defendant doctor's conduct against what a reasonable doctor would have done."¹¹³

The law in Michigan and Arizona is less clear. The Michigan Supreme Court has repeatedly used reasonability language. In *Locke v. Pachtman*,¹¹⁴ for example, the court stated that the duty was "what a reasonably prudent surgeon would do."¹¹⁵ Yet, the commitment of the lower appellate courts to that standard is still uncertain. In *Beadle v. Allis*,¹¹⁶ the court stated that a reasonability instruction requested by the plaintiff "was an accurate statement of the law," but nonetheless permitted the trial court to rely exclusively on the

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

109. See *Chapel v. Allison*, 785 P.2d 204, 210 (Mont. 1990) (requiring "the standard of care of a 'reasonably competent general practitioner acting in the same or similar community . . . in the same or similar circumstances'" (quoting *Shikret v. Annapolis Emergency Hosp. Ass'n*, 349 A.2d 245 (Md. 1975))).

110. See *Aasheim v. Humberger*, 695 P.2d 824, 826 (Mont. 1985) (approving of jury instructions requiring "skill and learning possessed by other doctors in good standing, practicing in the same speciality and who hold the same national board certification").

111. 12 VT. STAT. ANN. § 1908(1) (1999) (emphasis added).

112. 649 A.2d 756, 760 (Vt. 1994).

113. *Rooney v. Medical Ctr. Hosp.*, 649 A.2d 756, 760 (Vt. 1994); accord *Short v. United States*, 908 F. Supp. 227, 236 (D. Vt. 1995) (quoting *Rooney*).

114. 521 N.W. 2d 786 (Mich. 1994).

115. *Locke v. Pachtman*, 521 N.W.2d 786, 791 (Mich. 1994); see also *Naccarato v. Grob*, 180 N.W.2d 788, 791 (Mich. 1970) (requiring care of "reasonable specialist practicing in the light of present day scientific knowledge").

116. 418 N.W.2d 906 (Mich. Ct. App. 1987).

"standard" custom-based jury instruction.¹¹⁷ And in *Cleveland v. Rizzo*,¹¹⁸ the court's dictum described the standard as the skill "ordinarily possessed."¹¹⁹ As a result, Michigan cannot yet be classified as a reasonability state.

Finally, an Arizona statute requires physicians to exercise the "care . . . expected of a *reasonable, prudent* health care provider."¹²⁰ This language certainly suggests a reasonability test. Yet, the state courts appear to assume (without addressing the issue) that the standard of care remains customary.¹²¹ They certainly could reverse that position if a plaintiff directly raised the issue.¹²² In the meantime, the customary standard of care has not been enforced vigilantly. In one reported case, for example, the plaintiff was able to reach the jury with expert testimony that the defendant's conduct was not "reasonable."¹²³ Despite these mixed signals, this Article classifies Arizona as a custom state because that appears to be the current judicial understanding.

In total, nine states have phrased their standard of care for physicians in terms of reasonability, rather than custom. The shift to a "reasonable physi-

117. *Beadle v. Allis*, 418 N.W.2d 906, 911 (Mich. Ct. App. 1987).

118. 298 N.W.2d 617 (Mich. Ct. App. 1980).

119. *Cleveland v. Rizzo*, 298 N.W.2d 617, 620 (Mich. Ct. App. 1980). Michigan's standard of care is especially difficult to pin down because the standard is stated slightly differently in a state statute, standard jury instructions and state court rulings. The statute, passed in 1978, requires the plaintiff to prove that the defendant failed to meet "the recognized standard of acceptable professional practice" or, if a specialist, "the recognized standard of care within that speciality." MICH. COMP. LAWS § 600.2912a (West 1986). A 1993 amendment adds the words "or care" after the word "practice." MICH. COMP. LAWS § 600.2912a (West Supp. 1999). The form jury instructions calls for liability when the physician fails "to do something which [physician] of ordinary learning, judgment, or skill . . . would do." SJI2d 30.01, *cited in* *Swanek v. Hutzel Hosp.*, 320 N.W.2d 234, 237 (Mich. Ct. App. 1982). However, the state supreme court has, since 1970, repeatedly characterized the standard of care as what a "reasonably prudent" physician would do, as indicated in the text.

120. ARIZ. REV. STAT. § 12-563 (1989) (emphasis added).

121. *See* *Rossell v. Volkswagen of America*, 709 P.2d 517, 522-23 (Ariz. 1985) (finding that manufacturers are not governed by customary standard of care, although physicians are); *Bell v. Maricopa Med. Ctr.*, 755 P.2d 1180, 1182 (Ariz. Ct. App. 1988) ("[T]he reasonable man standard is therefore replaced by a standard based upon the usual conduct of other members of the defendant's profession . . . [T]he plaintiff must present evidence of this accepted professional conduct to enable the jury to determine the applicable standard.").

122. The outcome will turn on the court's interpretation of the word "expected." The Arizona courts will have to decide whether the standard of care is determined by what is expected by society of a reasonably prudent doctor or, instead, whether it is governed by what is expected by other physicians of a reasonably prudent physician. The former interpretation intuitively makes more sense in the absence of specific evidence that the legislature meant to delegate rule-making authority to physicians. *See* *Harris v. Robert C. Groth, M.D., Inc.*, P.S., 663 P.2d 113, 117 (Wash. 1983) (concluding that "'expected by society' is the proper reading").

123. *See* *McGrady v. Wright*, 729 P.2d 338, 341 (Ariz. Ct. App. 1986) (noting that directed verdict on whether physician acted reasonably was inappropriate).

cian" standard of care is *potentially* very significant. The "reasonable physician" standard of care is the same test employed in the states that have expressly rejected a custom-based standard. Although it continues to be physician-based, the reasonable physician standard potentially differs from a custom-based standard of care in one crucial respect. It asks what a reasonable physician would have done, not what is usually done. Juries still will stand in the shoes of the physician but only to hold the defendant to the standard of care expected of a person with special skills,¹²⁴ not to immunize physicians who follow the pack. As a consequence of this change, juries may hear jury instructions describing the standard of care in terms of reasonability, rather than compliance with custom, and judges may permit plaintiffs to reach a jury without proving that the defendant failed to do what most physicians do.

Will the phrasing of the standard of care in reasonable-physician terms actually have this effect? It already has. In Indiana, for example, the courts have approved jury instructions using a reasonable physician standard.¹²⁵ In Vermont, too, the state supreme court has endorsed the use of the reasonable physician standard in jury instructions.¹²⁶ Oregon's supreme court has not directly faced the issue, but its discussion of improper jury instructions in a 1989 case strongly suggests that the jury is to be given the issue of reasonable care.¹²⁷

The reasonable-physician test also has shaped the testimony required of the plaintiff's experts. In Indiana, for example, the plaintiff's expert must state "what other reasonable doctors similarly situated would have done."¹²⁸ Michigan law appears to operate in a similar fashion.¹²⁹ Furthermore, in West Virginia, a federal district court, applying the professional standard of care, refused to grant a summary judgment against a plaintiff whose experts chal-

124. *E.g.*, *Advincula v. United Blood Servs.*, 678 N.E.2d 1009, 1020 (Ill. 1996) (discussing how professional's skill, care, and expertise are incorporated into reasonable person standard).

125. *See Miller v. Ryan*, 706 N.E.2d 244, 248 n.4 (Ind. Ct. App. 1999) (approving trial court instruction using reasonable physician test).

126. *See Rooney v. Medical Ctr. Hosp.*, 649 A.2d 756, 760 (Vt. 1994) (disapproving of "error in judgment" language, but approving reasonable care language in challenged jury instruction).

127. *See Rogers v. Meridian Park Hosp.*, 722 P.2d 929, 933 (Or. 1989) (overturning verdict for defendant anesthesiologist because jury instruction wrongly suggested that physician's duty to "exercise reasonable judgment" depended on existence of "reasonable differences of opinion").

128. *Oelling v. Rao*, 593 N.E.2d 189, 191 (Ind. 1992).

129. *See Locke v. Pachtman*, 521 N.W.2d 786, 791 (Mich. 1994) (stating than expert must explain "what a reasonably prudent surgeon would do, in keeping with the standards of professional practice").

lenged the customary practices of the blood-banking industry as dilatory.¹³⁰ In addition, anecdotal evidence from Kentucky and New Hampshire suggests that they, too, refuse to defer to medical customs.¹³¹

Nevertheless, it is certainly possible that some of the reasonable-physician states ultimately will conclude that reasonable physician behavior is defined by customary practices.¹³² The possibility that some of these states will eventually return to a customary standard of care is heightened by the fact that a few of these states shifted to reasonability language by virtue of tort reform statutes that presumably were not intended to make litigation easier for plaintiffs. Other states judicially rephrased their standard of care when they abandoned the locality rule.¹³³ Neither context suggests a conscious intent to modify the basic, underlying standard of care. When Indiana abandoned the locality rule, for example, the court described its redrafting of the standard of care as "a relatively modest alteration of existing law."¹³⁴

Thus far, however, the evidence from states like Indiana indicates that the change in terminology has been accompanied by a genuine change in the standard of care.¹³⁵ When the nine reasonable-physician states are combined with the dozen states expressly rejecting custom-based standards, over forty percent of the states now have moved to a reasonable-physician standard of care. In addition, several others states, like Pennsylvania, Ohio, Arizona, Michigan, and California, have some authority favoring a reasonable-physician standard and could easily join the others.

130. *Doe v. American Nat'l Red Cross*, 848 F. Supp. 1228, 1234 (S.D.W. Va. 1994). The West Virginia law on jury instructions is less clear. *See Tennant v. Marion Health Care Found., Inc.*, 459 S.E.2d 374, 393 (W.Va. 1995) (finding that jury instruction with erroneous language on standard of care was not prejudicial).

131. In Kentucky, where I practiced for several years, plaintiff's experts commonly testified only that the defendant's conduct had not met the "standard of care." Lawyers in New Hampshire report a similar experience.

132. Courts using a custom-based standard of care typically characterize the custom-based standard of care as an interpretation of the reasonable care standard, not a deviation from it. *See supra* note 8.

133. *E.g.*, *Vergara v. Doan*, 593 N.E.2d 185, 187 (Ind. 1992) (noting that locality is one of several factors); *Shilkret v. Annapolis Emergency Hosp. Ass'n*, 349 A.2d 245, 253-54 (Md. 1975) (same); *Chapel v. Allison*, 785 P.2d 204, 210 (Mont. 1990) (same).

134. *Vergara*, 593 N.E.2d at 188.

135. Whether the state retains some deference to medical customs will not be certain until plaintiffs in these states challenge conduct that complies with an undisputed custom. When plaintiffs challenge conduct that conforms to one of several common approaches, trial courts appear to let the jury decide if the defendant's approach was reasonable. *See infra* text at notes 136-46. Thus, a lawsuit is not likely to test whether the state continues to give some deference to medical customs unless the plaintiff has challenged an undisputed custom.

The prospect that other states will follow is born out by the steady rate at which states have made the shift. In the 1980s, Florida, Mississippi, Minnesota, and Wyoming rejected customs, and New Hampshire, Oregon, Virginia, and West Virginia adopted a reasonable-physician standard. In the 1990s, Colorado, the District of Columbia, Nevada, and Wisconsin rejected conclusive reliance on custom-based standards, and Indiana adopted a reasonable-physician standard. There is no sign that the movement away from custom-based standards has run out of momentum.

D. Failure to Enforce the Customary Standard of Care

Even in jurisdictions that continue to endorse a customary standard of care, courts often give experts a considerable amount of latitude in the phrasing of their testimony. They do not insist that these experts prove that a prevailing custom existed and that the defendant deviated from it. In a Georgia case, for example, the court accepted an affidavit from the plaintiff's expert merely stating that the defendant "departed from reasonable surgical care."¹³⁶ Similarly, an Hawaii court allowed a plaintiff to avoid a nonsuit with testimony that "[m]y opinion is that there should have been some extra signs besides the pulse."¹³⁷ In Arizona, too, a plaintiff reached the jury with testimony that the defendant's conduct was not "reasonable."¹³⁸ Similar examples exist in many other states purportedly retaining a customary standard of care.¹³⁹ Although some courts have been stricter,¹⁴⁰ a fair amount of fudging appears to be taking place. In the courthouse, plaintiffs often reach juries without proof of deviation from customary norms.

These cases warn us not to overestimate the extent to which custom, rather than reasonability, provides the actual standard of care in those states that ostensibly endorse a customary standard of care. Many courts do not insist on the descriptive (quantitative) proof of prevailing practices implicit in a custom-based test and, instead, allow experts to offer evaluative (qualitative) testimony about appropriate care. When the defendant and her experts

136. *Sanders v. Ramo*, 416 S.E.2d 333, 335 (Ga. Ct. App. 1992).

137. *Lyu v. Shinn*, 40 Haw. 198, 206 (1953).

138. *McGrady v. Wright*, 729 P.2d 338, 341 (Ariz. Ct. App. 1986).

139. *E.g.*, *Heirs v. Lemley*, 834 S.W.2d 729, 733 (Mo. 1992) (accepting testimony about defendant's "failure to exercise that degree of skill and learning that an ordinarily careful and prudent physician would have exercised"); *McCourt v. Abernathy*, 457 S.E.2d 603, 605 (S.C. 1995) (affirming judgment based on expert's testimony that defendant had deviated from "the standard of care").

140. *E.g.*, *Downer v. Veilleux*, 322 A.2d 82, 86-88 (Me. 1974) (rejecting testimony that defendant's conduct was "bad practice"); *Kortus v. Jensen*, 237 N.W.2d 845, 851 (Neb. 1976) (rejecting testimony that plaintiff's expert would have acted differently).

disagree with the plaintiff's experts, the jury chooses between them, just as it does in other complex, expert-aided torts actions, such as those involving airplane design or architectural negligence.

In theory, of course, the "respectable minority" rule should protect physicians in cases in which physicians differ. The purpose of the rule is to prevent the jury from deciding which approach is best.¹⁴¹ However, courts typically allow the jury to decide whether the defendant's school of thought is "respectable." Although a few courts have directed verdicts for defendants,¹⁴² a close reading of the respectable minority cases reveals that a directed verdict is uncommon unless the plaintiff either has no expert,¹⁴³ or the plaintiff's expert fails to establish a prima facie case, as where the plaintiff's expert states only that the defendant did not do what the expert would have done and does not testify that the defendant's conduct fell below the applicable standard of care.¹⁴⁴ As long as the plaintiff's expert testifies that the defendant's conduct did not meet the standard of care, then the jury decides whether the defendant's approach was malpractice.¹⁴⁵ As a consequence, the modern function of the respectable minority instruction is to remind the jury that more than one approach may be reasonable, not to take the case away from the jury.¹⁴⁶

The twentieth century judicial retreat from reliance on local customs in favor of a standard based either on national standards or the standards of similar localities may have accentuated this tendency toward loose application of the custom-based standard of care.¹⁴⁷ Given the variations in physician

141. See *supra* text accompanying notes 24-25 (explaining respectable minority rule).

142. E.g., *Hamilton v. Hardy*, 549 P.2d 1099, 1102 (Colo. Ct. App. 1976) (noting that trial court granted dismissal when medical authority was divided), *overruled by* State Bd. of Med. Exam'rs v. McCroskey, 880 P.2d 1188, 1194 (Colo. 1994); *Remley v. Plummer*, 79 Pa. Super. 117, 120-21 (Super. Ct. 1922) (noting that trial court directed verdict on divided medical practice).

143. See, e.g., *Duckworth v. Bennett*, 181 A. 558, 559 (Pa. 1935) (affirming directed verdict when plaintiff did not have expert).

144. See, e.g., *Kortus v. Jensen*, 237 N.W. 2d 845, 851-52 (Neb. 1976) (holding testimony by plaintiff's expert about what he would have done did not constitute proof of malpractice).

145. See, e.g., *Sprowl v. Ward*, 441 So. 2d 898, 900 (Ala. 1983) (upholding jury verdict for defendant); *Watson v. McNamara*, 424 N.W.2d 611, 612 (Neb. 1988) (*per curiam*) (holding that respectable minority rule does not preclude verdict for plaintiff if her expert contends that defendant violated standard of care); *Jones v. Chidester*, 610 A.2d 964, 967-68 (Pa. 1992) (holding that case goes to jury if plaintiff has made prima facie case despite testimony from defendant's expert that defendant's approach was respectable); *Furey v. Thomas Jefferson Univ. Hosp.*, 472 A.2d 1083, 1091 (Pa. Super. Ct. 1984) (holding that, where plaintiff's and defendant's experts each believed that other's approach would be malpractice, jury should decide after being instructed that both approaches could be found to be proper).

146. See, e.g., *Furey*, 472 A.2d at 1091 (stating that jury could find both approaches reasonable).

147. See *supra* text accompanying note 15 (noting disfavor of locality rules).

practice patterns across the country, the notion of a national custom is far less plausible than the notion of a local custom. Dr. Jack Wennberg, who did the pioneering work on this topic, found the following:

[A] resident of New Haven, Connecticut, is about twice as likely to undergo a coronary bypass operation as is a resident of Boston; for carotid endarterectomy, the risks are the other way around. The numbers of knee and hip replacements per capita are much more common among Bostonians, while New Havenites experience substantially higher risks for hysterectomy and back surgery.¹⁴⁸

Customs, therefore, vary widely from one community to another. In addition, variability in patients, illnesses, and possible therapeutic responses often will make the notion of an established custom a quaint fairy tale.¹⁴⁹ The economic stratification of patients also acts as a barrier to the formation of stable customs.¹⁵⁰

Furthermore, even when a widely favored approach actually exists, ascertaining that custom at a reasonable cost may be impossible. In the real world of malpractice litigation, expert witnesses speak from their experience and the readily available literature. They do not know (and typically could not hope to know) the actual percentage of physicians who would act as the defendant did under the specific circumstances posed by the patient's condition. Perhaps cognizant of these obstacles to proof of deviation from established custom, courts often do not require such proof.

To describe the standard of care in these courts as custom-based is to paint an incomplete and misleading image of the law in action. When no undisputed custom exists, the jury decides whether the defendant behaved reasonably. Many physicians, of course, already know this fact from their own experience. That experience may help to explain why physicians are not comforted by the special protection theoretically conferred upon them by a custom-based standard of care.

E. Summary

The era of uniform deference to physician norms clearly is over. Modern malpractice law is moving slowly away from a custom-based standard of care

148. Jack E. Wennberg, *Improving the Medical Decision-Making Process*, 7 HEALTH AFFAIRS 99, 99 (1988).

149. See MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS 84-88 (1997) (concluding that individual treatment decisions are complex and individualized); Henderson & Siliciano, *supra* note 8, at 1390 (concluding that "highly differentiated nature of medical problems" is obstacle to formation of useful medical custom); McCoid, *supra* note 8, at 584 (stating that "there is no standard patient").

150. See Henderson & Siliciano, *supra* note 8, at 1393-94 ("[E]conomic stratification of the patient population precludes formation of a stable unitary custom.").

and toward a reasonable physician standard. The movement has been gradual and persistent. And it is not over.

The present state of affairs is complicated, but the trend is clear. One quarter of the states expressly have rejected deference to customary standards. Another twenty-percent have rephrased their standard of care in terms of reasonability rather than custom. Although the commitment of this last group of states has yet to be tested directly, these states certainly cannot be classified as custom-based states. In addition, confusing or contradictory case law in seven other states precludes confident classification.¹⁵¹ That leaves fewer than half of the states with law that clearly endorses a custom-based standard of care. Even in these states, the authority of the custom-based standard of care often is illusory. Many courts in states with a custom-based standard do not appear to enforce it. The hegemony of custom-based standards is over.

Will more states move to a reasonability standard? Given the addition of eight states in the 1980s and five more in the 1990s, that seems like a reasonable prediction.

F. A Caution About Interpretation

The classifications undertaken here required the personal interpretation of judicial and legislative text. Even under ideal circumstances, a considerable amount of discretion is inherent in this endeavor. Many of the judicial opinions surveyed for this Article had a proclivity for unclear or inconsistent language, sometimes using terms from both tests interchangeably. Indeed, American courts historically have believed that compliance with customary practice *defined* reasonable care for professionals. As a result, the language used in many opinions contains elements of both formulations.

When I have read the cases, I have tried to discern whether the language of the court, taken as a whole but with deep respect for specific phrases, contemplates a standard of care based on *what physicians actually do* or whether, instead, the language would permit the jury to decide what a *reasonable physician would have done*. This distinction is the difference between deciding what physicians "do" and determining what they "ought to do." It often is a subtle line and is reflected, for example, in the difference between the burden of proving deviation from "accepted" practice (custom) and deviation from "acceptable" (not necessarily customary) practice. Examples

151. See *supra* text accompanying notes 71-74 (noting ambiguities in Pennsylvania); *supra* notes 75-98 (noting inconsistencies in California and Ohio); *supra* notes 99-100 (noting ambiguities in Oklahoma); *supra* notes 120-23 (noting inconsistencies in Arizona); *infra* notes 159-60 (noting inconsistencies in Georgia and Iowa).

of customary terminology include tests that oblige physicians to conform with "usual" or "accepted"¹⁵² practices or to use such care as physicians "ordinarily have and exercise."¹⁵³ Examples of reasonable care terminology include not only the phrasing described above but also tests that judge physicians by what an "ordinarily careful physician" would do¹⁵⁴ or requiring the care that is "ordinarily exercised by a reasonably skillful, careful, and prudent health care professional."¹⁵⁵

This Article uses a functional test for ascribing meaning to these texts by asking whether the stated test would enable a plaintiff's attorney to avoid dismissal by offering the testimony of an expert who disapproves of the defendant's actions but does not testify about actual prevailing practices. If the stated test seems likely to permit expert testimony that the defendant's conduct was "inappropriate," "unreasonable," or "unacceptable," then this Article classifies that state as a reasonable care state.

152. See *Aiello v. Muhlenberg Reg'l Med. Ctr.*, 733 A.2d 433, 438 (N.J. 1999) (using "accepted" interchangeably with "normally"); see also Joseph H. King, Jr., *In Search of a Standard of Care for the Medical Profession: The "Accepted Practice" Formula*, 28 VAND. L. REV. 1213, 1236 (1975) (proposing that standard of "accepted" care be employed as alternative to either the custom-based standard or reasonable care standard). Professor King seems to contemplate that any challenge against customary practices would have to be based on authoritative medical studies or a respected body of medical opinion. If so, then his "accepted practice" test would be much more protective of physicians than a reasonable physician test. The test would permit attack of unreasonable norms that are out-of-date, but not necessarily unreasonable norms prompted by provider self-interest. In effect, it would represent a twist on the respectable minority rule. Plaintiffs could not challenge majority practices unless a respectable minority of physicians also condemned them.

As yet, there is little evidence that courts are adopting an "accepted practice" standard as a distinct third standard of care. The most likely jurisdiction to do so may be King's home state of Tennessee. See TENN. CODE ANN. § 29-26-115(A) (1980) (stating that claimant in malpractice action shall prove "the recognized standard of acceptable professional practice in the profession"). Yet, it is not clear that the Tennessee courts have applied this test differently from a customary care test. See, e.g., *Lewis v. Hill*, 770 S.W.2d 751, 754 (Tenn. Ct. App. 1988) (excluding testimony about what expert would do and his opinion of what should have been done); King, *supra*, at 1236 n.101 (noting that how courts will interpret statute remains to be seen).

153. E.g., ALA. CODE § 6-5-484 (1993) (requiring care ordinarily exercised in similar case); ALASKA STAT. § 09.55.540 (Michie 1996) (requiring care "ordinarily exercised . . . by health care providers in the field").

154. See OR. REV. STAT. § 677.095 (1997) ("A physician . . . has the duty to use that degree of care . . . that is used by ordinarily careful physicians."). The phrase "ordinarily prudent" often is used interchangeably with "reasonable" in ordinary negligence cases. See RESTATEMENT (SECOND) OF TORTS § 283 cmt. c (1975) (describing reasonable man as "ordinarily prudent").

155. VT. STAT. ANN. § 1908 (1999). *But see infra* text accompanying note 157 (discussing "care . . . expected of a reasonable, prudent health care provider").

In a number of states, the ambiguities precluded classification. Recall the preceding discussion of Pennsylvania, California, Ohio and Arizona.¹⁵⁶ Arizona, for example, has a statute that requires physicians to use the "care . . . expected of a *reasonable, prudent* health care provider."¹⁵⁷ This language certainly suggests a reasonability test. Despite the statute, however, this Article does not classify Arizona as a reasonable physician state because that does not appear to be the current judicial understanding.¹⁵⁸ In two other states, Georgia¹⁵⁹ and Iowa,¹⁶⁰ the governing language is very ambiguous, too murky to classify confidently. Despite this effort to interpret the cases cautiously, the subjectivity involved in these interpretations means that readers should treat the numbers stated here only as preliminary estimates.

In addition to the subjectivity inherent in interpreting the cases, this survey was limited by its reliance on published opinions and statutes. Because of this reliance, it cannot reflect the understandings and practices of trial bench and bar in the various jurisdictions. Their understandings will determine how malpractice law actually operates.

As a result, this survey should be understood only as a first cut at understanding our evolving malpractice case law. Further research is necessary, especially regarding trial practices in the individual states. Nevertheless, the findings reported here illuminate a significant and previously unrecognized evolution in doctrine—a trend that has shown no signs of abating. Even if the numbers reported here are partially discounted to account for the uncertainties in the classification process, they remain strikingly different from the conventional understanding of modern malpractice law.

III. Explaining the Shift

The courts rejecting a custom-based standard of care typically observe that any industry can have some unreasonable customs. They have not,

156. See *supra* text accompanying notes 75-98 (California and Ohio); *supra* notes 71-74 (Pennsylvania); *supra* notes 120-23 (Arizona).

157. ARIZ. REV. STAT. § 12-563 (1989) (emphasis added).

158. See *supra* text accompanying note 120 (addressing test in Arizona).

159. Georgia has both a statute and a case that appear to prefer reasonability to custom. See GA. CODE ANN. § 51-1-27 (1996) (requiring "reasonable degree of skill and care"); *Pace v. Cochran*, 86 S.E. 934, 936 (Ga. 1915) (noting that "recognized methods . . . may be considered" along with other evidence). However, the more recent cases have not given the statute this interpretation. *E.g.*, *Killingsworth v. Poon*, 307 S.E.2d 123, 125 (Ga. Ct. App. 1983) (stating test as care ordinarily employed by profession generally); *Chapman v. Radcliffe*, 162 S.E. 651, 652 (Ga. Ct. App. 1932) (same); *Fincher v. Davis*, 108 S.E. 905, 906 (Ga. Ct. App. 1921) (same).

160. See *Speed v. State*, 240 N.W.2d 901, 908 (Iowa 1976) (requiring "such reasonable care and skill as is exercised by the ordinary physician of good standing" (quoting *McGulpin v. Bessmer*, 42 N.W.2d 121, 128 (Iowa 1950))).

however, explained why this argument is more persuasive in the last quarter of this century than it was in the first three. Part of the explanation probably lies in the public's widespread loss of faith in medicine and other institutions and part in the larger movement of late twentieth century tort law toward an unencumbered reasonability regime.

A. Judicially Stated Rationales

The courts expressly rejecting deference to custom in medical malpractice typically have reiterated the basic tort notion that an industry is not permitted to set its own standard of care.¹⁶¹ Often, the opinions repeat Judge Hand's argument that "a whole calling may have unduly lagged in the adoption of new and available devices."¹⁶² "Negligence," said the Wyoming Supreme Court, "cannot be excused on the grounds that others practice the same kind of negligence."¹⁶³ Otherwise, said the Colorado Supreme Court, "the profession itself would be permitted to set the measure of its own legal liability, even though that measure might be far below a level of care readily attainable."¹⁶⁴ The unstated conclusion in these opinions is that deference to customary standards would place the profession above the law.¹⁶⁵ The solution to the problems posed by the complexity of medical malpractice cases, courts have concluded, is the same one employed in other complex tort actions.¹⁶⁶ Courts can require that the plaintiff offer expert testimony to educate the jury.¹⁶⁷

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

162. *The T.J. Hooper*, 60 F.2d 737, 740 (2d Cir. 1932), cert. denied, 287 U.S. 662 (1932).

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

164. *United Blood Servs. v. Quintana*, 827 P.2d 509, 520 (Colo. 1992), aff'd, 827 P.2d 509 (Colo. 1992).

165. See, e.g., *id.* (noting that courts, not profession, decide due care (quoting *The T.J. Hooper*, 60 F.2d at 740)); *Darling v. Charleston Community Mem'l Hosp.*, 211 N.E.2d 253, 257 (Ill. 1965) (same).

166. See, e.g., *Ray v. American Nat'l Red Cross*, 696 A.2d 399, 403 (D.C. 1996) (noting that custom is also inconclusive in complex commercial transactions where expert testimony is required (citing *Beard v. Goodyear Tire & Rubber Co.*, 587 A.2d 195, 199 (D.C. 1991)); *Kissinger v. Turner*, 727 S.W.2d 750, 755 (Tex. Ct. App. 1987) ("We see no reason for a different rule in medical malpractice cases.").

167. See, e.g., *Ray*, 696 A.2d at 404 (requiring plaintiff to produce expert testimony); *Vassos v. Roussalis*, 625 P.2d 768, 772-73 (Wyo. 1981) (stating that experts are needed to explain technical conduct to jury).

The courts have not, however, explained why the once-persuasive arguments made in favor of a custom-based standard no longer are convincing.¹⁶⁸ Their failure to explain the timing of this shift is disappointing because a plausible argument can be made that the custom-based standard of care no longer is desirable. For example, these courts have not discussed the modern research proving that physician practices vary considerably from one locale to another, making talk of national customs seem naive.¹⁶⁹ Nor have the courts defended their abandonment of customary standards as a way of freeing cost-conscious, socially responsible physicians from the profligate overtreatment encouraged by fee-for-service reimbursement.¹⁷⁰ Neither have they suggested that a reasonability test is necessary to protect patients from the customs that managed care plans might otherwise be tempted to adopt. Indeed, the opinions reveal little conscious awareness of the revolutionary structural changes that currently are occurring in medicine.

Why then are courts withdrawing a privilege once conferred upon the medical profession? Although many factors may play a role in this shift in standards, loss of faith in the "professionalism" of medicine is probably an important one. Another is the movement of tort law away from specialized duties.

B. An Unspoken Loss of Trust

Over the second half of this century, courts appear to have lost their faith that physicians are sufficiently different from engineers, truck drivers, product manufacturers and other businesses to justify the many special legal privileges previously accorded physicians. Gradually, the courts have stripped physicians of many of the legal privileges that once set them apart, such as "profes-

168. Advocates of custom-based standards believe that they offer advantages such as superior administrability, resistance to hindsight bias, escape from the cognitive limits of the jury, market-based identification of efficient safety levels, and a reduced burden on the medical profession. See KEETON ET AL., *supra* note 1, at 189 (discussing custom based standard); see also *supra* note 29 (citing sources defending custom-based standard).

169. See *supra* text accompanying notes 152-55 (describing impediments to customary practices).

170. Commentators have debated whether the customary standard of care is a threat to these physicians. Compare Mark A. Hall, *The Malpractice Standard Under Health Care Cost Containment*, 17 LAW, MED. & HEALTH CARE 347, 348-49 (1989) (expressing confidence that doctrines like respectable minority rule would protect these physicians), with Danzon, *supra* note 28, at 493 (noting conflict between custom-based standard of care and cost-efficiency), E. Haavi Morreim, *Medicine Meets Resource Limits: Restructuring the Legal Standard of Care*, 59 U. PITT. L. REV. 1, 5 (1997) (noting conflict between custom-based standard and cost-reform), and Jonathan J. Frankel, Note, *Medical Malpractice Law and Health Care Cost Containment: Lessons for Reformers from the Clash of Cultures*, 103 YALE L.J. 1297, 1302 (1994) (stating that custom-based standard of care would make cost-based reform risky).

sional" immunity from the antitrust laws and protection from "corporate" competition. Modern tort law's reluctance to allow physicians to determine their own standard of care is merely the most recent manifestation of this larger trend away from special privileges.

1. *Privilege and Trust*

One hundred fifty years ago, physicians enjoyed neither exalted social status nor legal privilege.¹⁷¹ In tort law, they were held to the same standard of reasonable care applied to other negligence actions.¹⁷² During the ensuing one hundred years, however, the status and power of physicians changed dramatically. They obtained unprecedented social authority and virtually unregulated power over both the practice of medicine and its finances.¹⁷³ Their claim to authority arose from a combination of expertise and trustworthiness.¹⁷⁴

As Paul Starr noted in his highly-regarded sociological study of the medical profession, medicine increasingly was perceived as, and eventually became, a profession based on advances in science and technology.¹⁷⁵ Scientific knowledge was respected and provided a powerful claim to authority.¹⁷⁶

At the same time, physicians differentiated themselves from other schools of healing by adopting an ethical code that affirmed the supremacy of patient interests over more base economic concerns.¹⁷⁷ Medicine's formal dedication to patient welfare was essential to its achievement of "professional" status.

Sociologists studying the emergence of professions in this country have concluded that expertise alone was insufficient unless accompanied by a

171. See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 81-92 (1982) (providing historical analysis of physician status and privilege).

172. See Silver, *supra* note 8, at 1205-11 (stating that physicians were held to standard of ordinary care).

173. See STARR, *supra* note 171, at 142 (noting rise of authority and status).

174. See *id.* at 15 (describing authority of physicians); David Mechanic, *The Functions and Limitations of Trust in the Provision of Medical Care*, 23 J. HEALTH, POL., POL'Y & L. 661, 664 (1998) (linking authority to trust); William M. Sullivan, *What Is Left of Professionalism After Managed Care?*, HASTINGS CENTER REP., Mar.-Apr. 1999, at 7, 8 (1999) (noting trust in standards of profession).

175. STARR, *supra* note 171, at 4, 18-19, 141-42 (linking medicine to science and technology).

176. At the same time, the urbanization and industrialization of American life necessitated increasing reliance on experts. *Id.* at 18. As people came to trust science, they desired the advice of experts like physicians. *Id.* at 18-19.

177. See Edward B. Hirshfeld & Gail H. Thomason, *Medical Necessity Determinations: The Need for a New Legal Structure*, 6 HEALTH MATRIX 3, 8 (1996) (stating that development of ethical code differentiated physicians).

"service rather than profit orientation."¹⁷⁸ Only then could the occupation obtain the social and legal privileges associated with the professions.¹⁷⁹ This fidelity to the customer distinguishes a profession from a trade. As Talcott Parsons stated in his classic work, *The Social System*:

The "ideology" of the [medical] profession lays great emphasis on the obligation of the physician to put the "welfare of the patient" above his personal interests, and regards "commercialism" as the most serious and insidious evil with which it has to contend . . . This attitude is, of course, shared with the other professions, but it is perhaps most pronounced in the medical case than in any single one except perhaps the clergy.¹⁸⁰

Over the early decades of this century, physicians adroitly converted their professional status into social, economic and legal privileges.¹⁸¹ Starr describes this era as one of both the "surrender of private judgment" and the emergence of professional "sovereignty."¹⁸² Nowhere is the surrender of judgment more obvious than in judicial deference to medical customs.¹⁸³

Deference to prevailing practices was not the only legal privilege conferred upon physicians. Physicians also were widely believed to be immune from the anti-trust laws.¹⁸⁴ Furthermore, the prohibitions on "corporate practice" protected them from HMO-like competition.¹⁸⁵ In this era of physician sovereignty, trust in physicians substituted for legal supervision.¹⁸⁶

178. STARR, *supra* note 171, at 15.

179. See *Mechanic*, *supra* note 174, at 667 (viewing medicine as "selfless endeavor"); Sullivan, *supra* note 174, at 8 (noting that professional was expected to subordinate financial gain).

180. TALCOTT PARSONS, *THE SOCIAL SYSTEM* 435 (1951). Under this view of the doctor-patient relationship, physicians were on the patient's side and did not view their relationship with the patient as an arms-length transaction. See Pearson, *supra* note 29, at 536 (describing traditional view of physician-patient relationship).

181. See STARR, *supra* note 171, at 142 (noting that physicians capitalized on new conditions); Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 445-47 (1988) (describing many legal victories enjoyed by physicians).

182. STARR, *supra* note 171, at 10, 23.

183. See Pearson, *supra* note 29, at 537 (discussing how focus on patients, not profits, led to judicial deference).

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

185. See *People v. Pacific Health Corp.*, 82 P.2d 429, 430 (Cal. 1938) (stating that corporations may not engage in practice of medicine); STARR, *supra* note 171, at 198-234 (describing struggle of physicians to avoid corporate dominance).

186. See Pearson, *supra* note 29, at 537 (finding no need for court supervision of physicians and reasoning that profession is able to police itself). Privilege also had its costs. For instance, the physician's status as a professional prohibited her from disclaiming tort liability. See Gary T. Schwartz, *Medical Malpractice, Tort, Contract and Managed Care*, 1998 U. ILL.

An abiding trust in the professionalism and faithfulness of physicians resonated throughout the early legal commentary defending or explaining the customary standard of care. In his 1942 article *Custom and Negligence*, for example, Clarence Morris expressed his confidence that doctors as a class were "more likely to exert their best efforts than drovers, railroads and merchants."¹⁸⁷ Similarly, in Allan McCoid's classic 1959 article on the medical standard of care, McCoid contended that physicians "should be free to operate in the best interests of the patient."¹⁸⁸ Post-hoc judicial supervision, he feared, would interfere with that freedom and thus prevent doctors from practicing sound medicine. In an earlier piece, McCoid concluded that courts assume "that the doctor is exercising his skill for the benefit of the patient [and] inasmuch as this assumption is a basic tenet of medical science it seems a proper one."¹⁸⁹

Later commentary echoed the same themes. In his 1976 defense of custom-based norms, Richard Pearson summarized the underlying logic of the rule as follows: "There is no need for courts to act as a source of pressure to compel the medical profession to give adequate consideration to patient safety and well-being, since the forces that operate within the medical profession make such extra-professional pressure unnecessary."¹⁹⁰ Prosser, too, believed that the rule rested on "the healthy respect which the courts have had for the learning of a fellow profession, and their reluctance to overburden it with liability based on uneducated judgment."¹⁹¹ Another scholar, James Henderson, concluded that "[a]n important reason for allowing the medical profession to set its own standards is that courts can assume these standards are adequate to protect the interests of patients."¹⁹²

Even today, courts retaining a custom-based standard of care emphasize their respect for their fellow professionals. "We defer," said the South Carolina Supreme Court, "to the collective wisdom" of physicians.¹⁹³ Likewise, the Kansas Supreme Court based its ruling on its faith in "the medical profession's own recognition of its obligation to maintain its standards."¹⁹⁴

L. REV. 885, 889 (noting that physician's status as professional rendered invalid contractual disclaimer of liability).

187. Morris, *supra* note 8, at 1164.

188. McCoid, *supra* note 8, at 608.

189. Allan H. McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 MINN. L. REV. 381, 431-32 (1957).

190. Pearson, *supra* note 29, at 537. He also notes that this trust is eroding. *Id.* at 537-38.

191. KEETON ET AL., *supra* note 1, § 32, at 189.

192. Henderson, *supra* note 29, at 926.

193. *Doe v. American Red Cross Blood Servs.*, 377 S.E.2d 323, 326 (S.C. 1989).

194. *Natanson v. Kline*, 350 P.2d 1093, 1107 (Ka. 1960).

The most interesting discussion of the rationale for custom-based standards appears in a 1985 Arizona product liability decision. In *Rossel v. Volkswagen of America*,¹⁹⁵ Volkswagen contended that its automobile designers were professionals whose conduct should be measured against industry norms. Unpersuaded, the Arizona Supreme Court explained that it would delegate its standard-setting power "only when the nature of the group and its special relationship with its clients assures society that those standards will be set with *primary regard to protection of the public*, rather than to such considerations as increased profitability."¹⁹⁶

To be sure, faith in physicians is not the only rationale courts offer for their deference to physician norms. Courts also emphasize the difficulty of judicially supervising highly complex medical judgments and the burden that a standard based on reasonability might impose on the profession. However, their willingness to defer to the customs of physicians, while not deferring to the customs of other scientific occupations, like architects, engineers, and aircraft designers, suggests a special confidence that physicians will place patient welfare over profits and other conflicting interests.

2. *The Public's Loss of Trust*

Popular faith in medicine has declined in the last fifty years. This loss of trust may help to explain why courts are less willing now than in years past to defer to medical customs.

Since 1966, the Roper Center for Public Opinion Research has tracked how confident Americans are about leaders in various fields. In the initial year of the survey, Americans had a 73% level of confidence in medicine, well above the average for other fields (40%).¹⁹⁷ However, the confidence level in medicine has decreased fairly steadily ever since and in 1993 was at an all time low of 22%.¹⁹⁸ The year 1993 marked the first time that the average level of confidence of other fields (23%) surpassed that of medicine.¹⁹⁹

In a 1993 American Medical Association survey, 69% of the respondents felt that doctors were "too interested in making money" and 70% believed that "people are beginning to lose faith in doctors."²⁰⁰ Both figures reflected an increase of roughly 10% since the early 1980s, when the questions were first

195. 709 P.2d 517 (Ariz. 1985).

196. *Rossel v. Volkswagen of Am.*, 709 P.2d 517, 523 (Ariz. 1985) (emphasis added).

197. Robert J. Blendon et al., *Bridging the Gap Between Expert and Public Views on Health Care Reform*, 269 JAMA 2573, 2576 fig. 4 (1993).

198. *Id.*

199. *Id.*

200. AMERICAN MED. ASS'N, PUBLIC OPINION ON HEALTH CARE ISSUES 21-22 (1993).

posed. In a 1992 AMA survey, 56% of respondents believed that "doctors don't care about people as much as they used to."²⁰¹ That figure has remained fairly stable since the early 1980s.²⁰²

Money appears to play a role in the rise of cynicism. In a 1996 national poll, 82% of respondents believed that medical care had become a big business and that the industry put profits ahead of patients.²⁰³ In addition, Americans feel that they do not receive much value for their health care dollar. In one study, for example, a question asked respondents to rank the value of 50 purchases, such as televisions, restaurants, and credit charges.²⁰⁴ Of the 50 categories, hospital charges ranked last, health insurance ranked 46th, and doctors' fees ranked 41st.²⁰⁵ The 1992 AMA study uncovered similar sentiments. In that study, 68% of the people polled disagreed with the view that "doctors fees are usually reasonable."²⁰⁶ This figure was 10-20% higher than it was during the 1980s.²⁰⁷ By 1997, 75% felt that doctors' fees usually were not reasonable.²⁰⁸ Based on polls like these, researchers believe that physicians and the health care industry are losing the respect of the public.

Scholars, too, have been less sympathetic to physicians as the century has progressed. Medical ethicists, sociologists, and historians no longer routinely take the viewpoint of physicians. Instead, their work has increasingly depicted the medical profession as "dominating, monopolizing [and] self-interested."²⁰⁹

This loss of trust in physicians parallels a general decline in the public's trust of others.²¹⁰ For example, one study found that the proportion of people who believe that most people are trustworthy fell from 58% in 1960 to 37% in 1993.²¹¹ Another survey found that the proportion of Americans who have

201. AMERICAN MED. ASS'N, PHYSICIAN AND PUBLIC OPINION ON HEALTH CARE ISSUES 25 (1992).

202. *Id.* at 26.

203. National Coalition on Health Care, *How Americans Perceive the Health Care System: A Report on a National Survey*, 23(4) J. HEALTH CARE FINANCE 12, 17 tbl. 3 (Summer 1997).

204. Blendon et al., *supra* note 197, at 2576 fig. 3.

205. *Id.*

206. AMERICAN MED. ASS'N, *supra* note 200, at 25.

207. *Id.* at 26.

208. AMERICAN MED. ASS'N, PUBLIC OPINION ON HEALTH CARE ISSUES 4 (1997).

209. STARR, *supra* note 171, at 392. Feminists have been especially critical of organized medicine. *See id.* at 391-93 (noting feminist criticisms of medical profession).

210. *See* Blendon et al., *supra* note 197, at 2576 fig. 4 (noting general erosion of trust); David Mechanic, *Changing Medical Organization and the Erosion of Trust*, 74 MILBANK Q. 171, 171-72 (1996) (same).

211. Mechanic, *supra* note 210, at 171-72 (citing S.M. Lipset, *Malaise and Resiliency in America*, 6 J. DEMOCRACY 4 (1995)).

a great deal of confidence in American institutions fell from 40% in 1965 to 23% in 1993.²¹² This general trend certainly has influenced the public's loss of trust in medicine.

In addition, medicine itself has undergone changes that may have accentuated the problem. Increasingly, medicine is delivered by for-profit institutions.²¹³ Furthermore, physicians themselves often are entrepreneurs with assembly-line waiting rooms and remunerative procedures. Doctors sometimes run ancillary businesses that call into question the hoary image of unerring attention to patient welfare. Most recently, managed care has begun to restrict the freedom of patients to choose their own physicians and the physicians' freedom to choose their preferred treatment.²¹⁴

Other factors may also play a role. For example, patients are more sophisticated about medicine and the media has made them more aware of medical error.²¹⁵ Increasingly, hired specialists with whom patients have no prior relationship provide medical treatment for Americans.²¹⁶ In addition, Americans feel threatened by medical care cost increases.²¹⁷ It also is perceived as limiting access to costly treatments.

Cumulatively, these phenomena help to explain why medical professionals have lost the extraordinary level of confidence that they enjoyed thirty

212. Blendon et al., *supra* note 197, at 2576 fig. 4.

213. See Mechanic, *supra* note 210, at 172, 178. A recent study indicates that not-for-profit HMOs had uniformly better outcomes data than for-profit HMOs. See David U. Himmelstein et al., *Quality of Care in Investor-Owned vs. Not-for-Profit HMOs*, 282 JAMA 159, 159 (1999) (concluding that "[i]nvestor-owned HMOs deliver lower quality of care than not-for-profit plans"). Nonprofit HMOs also have characteristics that are more likely than those of for-profit HMOs to engender trust. Among these characteristics are the presence of community board members and a reduced ability to profit from their patients. See John V. Jacobi, *Mission and Markets in Health Care: Protecting Essential Community Providers for the Poor*, 75 WASH. U. L.Q. 1431, 1467-68 (1997) (listing trust-inspiring characteristics of nonprofit HMOs).

214. See generally GEORGE ANDERS, *HEALTH AGAINST WEALTH: HMOs AND THE BREAK-DOWN OF MEDICAL TRUST* (1996) (describing consumer experiences with HMOs); Bradford H. Gray, *Trust and Trustworthy Care in the Managed Care Era*, HEALTH AFF., Jan.-Feb. 1997, at 34 (discussing prospective sources of trust in HMOs); David Mechanic, *Managed Care as a Target of Distrust*, 277 JAMA 1810 (1997) (discussing public distrust of HMOs).

215. See Fala, *supra* note 28, at 252 (discussing heightened sophistication of American patients); Mechanic, *supra* note 210, at 172 and 178-79 (same). The public is also less mystified by the mysteries of medicine. See Fala, *supra* note 28, at 252 (noting increased public awareness of medical techniques).

216. See Fala, *supra* note 28, at 252 (noting demise of family doctor and rise of specialists); Pearson, *supra* note 29, at 537 (citing U.S. DEP'T OF HEALTH, EDUC., AND WELFARE, REPORT OF THE SECRETARY'S COMM'N ON MEDICAL MALPRACTICE 3 (1973)) (noting rise of specialists and sub-specialists). Pearson also notes that the public hears frequent reports about Medicare fraud and unnecessary surgery. Pearson, *supra* note 29, at 537.

217. Blendon et al., *supra* note 197, at 2574.

years ago. As the public becomes even more aware of the financial incentives that managed care systems give to physicians to make them cost conscious, this deference may erode even more.²¹⁸

This loss of trust has occurred even though most Americans view their own care as satisfactory. A number of surveys have found a personal satisfaction rate above 70%.²¹⁹ Researchers have hypothesized that respondents, although happy with their own care, worry about the care provided to others.²²⁰ Other scholars speculate that increased public pessimism arises out of fears about the availability of care for themselves in the future.²²¹ Americans are, it seems, both satisfied with the past and frightened about the future.²²² This ebbing of stature does not mean that Americans dislike physicians.²²³ However, it does mean that physicians have lost much of their priesthood and, with it, their claim to special legal privileges.

Even more important than the raw numbers is the trend revealed by the decisions. The slow but steady judicial abandonment of deference medical custom began in earnest in the 1970s, continued in the 1980s, and retained its vitality through the 1990s. Showing no signs of exhaustion, this movement could become the majority position early in the next century.

3. *Judicial Trust and the Loss of Privilege*

Judges, too, are less willing to trust physicians to regulate themselves. Over the past forty years, courts have abandoned many of the important legal privileges once conferred upon the medical profession. For example, physi-

218. See *Mechanic*, *supra* note 210, at 179 (opining that managed care may further erode trust in physicians).

219. See Blendon et al., *supra* note 197, at 2575 (placing satisfaction rate at 74%); Lawrence R. Jacobs & Robert Y. Shapiro, *Public Opinion's Tilt Against Private Enterprise*, HEALTH AFF., Spring 1994, at 285, 286-87 (placing satisfaction rate at over 80%); National Coalition on Health Care, *supra* note 203, at 13 tbl. 1 (73% agree or somewhat agree). One study found that only 10% had lost faith in their own doctors, but 70% felt that "people" were losing faith in physicians. Jacobs & Shapiro, *supra*, at 288.

220. See Jacobs & Shapiro, *supra* note 219, at 288-89 (noting public concern over quality of health care provided to others).

221. See Robert J. Blendon et al., *Understanding the Managed Care Backlash*, HEALTH AFF., July-Aug. 1998, at 80, 81 (arguing that Americans feel their HMOs will fail them). We base our fears on the publicized misfortunes of a few. *Id.*

222. Cf. Ross K. Goldberg, *Regaining Public Trust*, HEALTH AFF., Nov.-Dec. 1998 at 138, 138 (noting one managed care executive's explanation that, "[W]e are left to pine for a time when physicians made house calls and pizza didn't.").

223. To the contrary, the public still seems to sympathize with physicians, at least in the context of medical malpractice actions. See Philip G. Peters, Jr., *Hindsight Bias and Tort Liability: Avoiding Premature Conclusions*, ARIZ. ST. L.J. (forthcoming) (reviewing evidence of anti-plaintiff bias in medical malpractice actions).

cians once were assumed to be immune from the antitrust laws; however, that privilege ended in 1975.²²⁴ Earlier in this century, courts protected physicians from corporate competition through the "corporate practice" doctrine.²²⁵ That doctrine since has withered and is ignored widely.²²⁶ In addition, HMO enabling acts have blunted its sting.²²⁷ Thirty years ago, physicians had few restrictions on their business arrangements. Today, state and federal laws prohibit or limit self-referral, referral fees, and other forms of financial fraud and abuse.²²⁸

Tort law has undergone a similar transition. Courts no longer allow physicians to take shelter behind local customs.²²⁹ Instead, the norms of physicians in similar communities or, in the case of specialists, national standards, govern medical duties.²³⁰ In the 1970s, courts recognized the doctrine of informed consent, which obligates physicians to share their decision-making power with their patients.²³¹ This trend has affected hospitals, also, as they have lost their long-standing, de facto freedom from vicarious or direct malpractice liability.²³² From this perspective, it is the longevity of the custom-based standard of care that is remarkable, not its current loss of support.

224. See *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 787 (1975) (finding no antitrust exemption for professionals); CURRAN ET AL., *supra* note 15, at 1277-78 (discussing this finding).

225. See FURROW ET AL., *supra* note 8, § 5.10, at 285-90 (discussing corporate practice doctrine).

226. See *id.* at 290-91 (noting that corporate practice doctrine rarely is enforced).

227. E.g., Health Maintenance Organization Act of 1973, 42 U.S.C. §§ 300(e)-300(e)(9) (1994). See Thomas L. Greaney, *How Many Libertarians Does it Take to Fix the Health Care System?*, 96 MICH. L. REV. 1825, 1830 n.12 (1997) (reviewing RICHARD A. EPSTEIN, *MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE?* (1997)) (noting that enactment of HMO Act signalled Congress's conception of health care as industry, rather than profession).

228. See generally FURROW ET AL., *supra* note 18, at 618-20.

229. See, e.g., *Hall v. Hilbun*, 466 So. 2d 865, 871 (Miss. 1985) (requiring Mississippi doctors to follow national standards of care, not local ones); FURROW ET AL., *supra* note 8, § 6.2, at 360 (discussing standard of care for general practitioners).

230. See FURROW ET AL., *supra* note 8, § 6.2, at 360 (discussing standard of care for general practitioners).

231. See, e.g., *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 317 P.2d 170, 181 (Cal. Ct. App. 1957) (discussing duty of doctor to reveal facts "necessary to form the basis of [a patient's] intelligent consent"); FURROW ET AL., *supra* note 8, § 6.2, at 409-47 (discussing informed consent). The shift away from physician autonomy is most prominent in those jurisdictions that use a disclosure standard based, not on what medical custom would require doctors to disclose, but rather on what a reasonable patient would want to know under the circumstances. See, e.g., *Canterbury v. Spence*, 464 F.2d 772, 779-85 (D.C. Cir. 1972) (applying patient-based standard); Fala, *supra* note 28, at 253 (noting disclosure standard based on patient expectation, rather than on medical custom).

232. See, e.g., *Darling v. Charleston Community Mem'l Hosp.*, 211 N.E.2d 253, 257 (Ill. 1965) (finding that plaintiff can hold hospital responsible for malpractice of its staff); FURROW ET AL., *supra* note 8, § 7.1-7.3, at 448-67 (discussing hospital liability).

The lesson of history is that expertise is not sufficient to preserve legal privilege. The expertise of physicians is more advanced than ever before. Judicial scrutiny of medical decisions has never been more difficult. Technical expertise alone, however, provides a much less powerful claim to public legitimacy than expertise combined with a credible promise that the patient's interests will come first.²³³

C. The General Trend in Tort Law Towards a Single Standard of Reasonable Care

The weakening of support for a special standard of care for professionals also is consistent with the gradual movement of twentieth century tort law away from an array of special duties and immunities tailored for specific social contexts and toward a general and more flexible obligation of reasonable care.²³⁴ For example, the law has partially or totally abrogated charitable and family immunities that once insulated many people from negligence liability.²³⁵ Courts and legislatures also have modified special duty rules like those governing rescue,²³⁶ landowner obligations,²³⁷ and recovery for emotional distress²³⁸ in ways that expose more parties to the general duty of reasonable care.

Until now, experts have believed that the law governing medical malpractice litigation escaped this general movement toward a single standard of reasonable care.²³⁹ That belief was mistaken. As the professional paradigm has weakened, the custom-based standard of care gradually is yielding to the fundamental tort standard of reasonable care under the circumstances.

233. See Sullivan, *supra* note 174, at 10 (opining that professional legitimacy rests on trust, not merely on scientific knowledge). Elliott Krouse views this regulation of medicine as part of a general tendency to bring professions within the control of the state. ELLIOTT KROUSE, *THE DEATH OF THE GUILDS* 36-49 (1996).

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

235. See KEETON ET AL., *supra* note 1, § 131-35, at 1032-73 (surveying immunities).

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

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

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

239. See *supra* text accompanying notes 28-35, 42-45 (noting widely held belief that medical malpractice recovery depends on showing deviation from medical custom).

IV. Implications

What does the evidence of an evolving standard of care augur for the future?

1. *Malpractice law may merge with the fabric of negligence law.* Only a decade ago, the American Law Institute and prominent legal scholars were articulating the case for regulating medical malpractice disputes with a unique regime of no-fault, exclusive enterprise liability.²⁴⁰ Although this idea had considerable merit, it never generated significant judicial or legislative support. In the meantime, the courts gradually are removing the cornerstone upon which the distinct field of malpractice law has been built – the customary standard of care. If more courts join this trend, malpractice law will merge into the basic fabric of negligence law.

2. *Judges and juries will have a heightened responsibility to scrutinize expert testimony.* In a world free of the restrictions implicit in a custom-based standard of care, the temptation to employ professional experts whose views are well outside of the mainstream will entice plaintiffs' lawyers. As a result, judges and juries will have an important responsibility to scrutinize closely the credentials and testimony of the plaintiffs' experts.

3. *Physicians and their managed care plans may have more freedom to abandon the costly practices produced by fee-for-service medicine.*²⁴¹ If

240. See REPORTERS' STUDY, THE AMERICAN LAW INSTITUTE, 2 ENTERPRISE RESPONSIBILITY FOR PERSONAL INJURY 487-516 (1991) (outlining rationale for no-fault medical malpractice compensation system); PAUL C. WEILER ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION 145-52 (1993) (same).

241. Although at least one commentator has suggested that doctrines like the respectable minority rule would provide courts with the flexibility to protect cost-effective care, e.g., Hall, *supra* note 170, courts have not yet employed these doctrines to protect deviations from customary practices motivated by economic, rather than therapeutic, concerns. See Jonathan J. Frankel, Note, *Medical Malpractice Law and Health Care Cost Containment: Lesson for Reformers from the Clash of Cultures*, 103 YALE L.J. 1297, 1326 n.104 (1994) (commenting that courts do not use respectable minority rule to deviate standard of care for economic reasons). During the fee-for-service era, the medical standard of care was widely believed to sanction the use of all means available, without regard to cost. See, e.g., Frankel, *supra*, at 1301 (noting that under fee-for-service system, doctors provided care that yielded "some positive benefit" but was not socially cost-effective); Note, *Rethinking Medical Malpractice Law in Light of Medical Cost-Cutting*, 98 HARV. L. REV. 1004, 1009-10 (1985) (commenting that ability of doctors to bill third parties for patient care encourages them to order "all potentially relevant procedures"). Commentators concerned about the capacity of custom-based standards to accommodate cost-conscious medicine typically have recommended that courts enforce contractual waivers of the customary standard of care. See, e.g., Clark Havighurst, *Altering the Applicable Standard of Care*, 49 LAW & CONTEMP. PROBS. 265 (1987) (advocating allowing consumers to consent to deviations in customary standards in return for lower prices); Henderson & Siliciano, *supra* note 8, at 1392-93, 1396-1400 (arguing that strict inability to modify standard of care contractually is inconsistent with already existing variance in healthcare based on ability to pay). Judicial adoption of a reasonable-physician standard of care provides an alternative means of protecting

courts define reasonable physician behavior in the same risk-utility terms with which they have defined reasonable care in ordinary tort actions,²⁴² then cost-conscious changes in clinical practices will be defensible (albeit risky) even if they depart from fee-for-service customs. If, for example, new studies prove that past practices are not beneficial, then conscientious physicians who abandon them can defend themselves without fear that they will fall outside of the "respectable minority" rule.

4. *The reasonable physician standard may establish a floor below which cost containment practices cannot descend absent an enforceable agreement to modify the standard of care.* America has left the task of taming health care costs to the marketplace.²⁴³ Tort liability certainly will be a part of any comprehensive strategy for policing that marketplace. A reasonable physician standard of care provides the flexibility needed to evaluate customs imposed on patients by managed care organizations.

5. *Judicial resistance to contractual modification of the standard of care could weaken as the public begins to view medicine as more of a business than a profession.* If commercialization deprives physicians of their protective standard of care, it also might free them to modify or escape their duty of care via contract.²⁴⁴

6. *Courts will admit evidence regarding the costs and benefits associated with medical treatment decisions.* Because prevailing practices no longer will be an irrefutable proxy for reasonable care, courts will expect plaintiffs and defendants to explain the reasons why the defendant's action was or was not reasonable, just as the parties do in all other complex tort litigation.

7. *Courts will need to reconcile their old armory of malpractice doctrines with a reasonable-physician standard of care.* It will be necessary to harmonize doctrines such as the respectable minority rule and the honest error in judgment rule with the reasonable-physician standard of care.²⁴⁵ Alternatively, the doctrines simply may fall into obsolescence.

conscientious physicians and managed care plans. Furthermore, unlike contractual standards, the proposed standard does not pose the risk that the poorest patients will receive no protection.

242. See, e.g., *United States v. Carroll Towing Co.*, 159 F.2d 169 (2d Cir. 1947) (suggesting that reasonableness requires balancing of risk and utility); RESTATEMENT (SECOND) OF TORTS § 291 (1975) (same). The malpractice cases have not yet defined their terms.

243. See Henry M. Greenberg, *American Medicine Is on the Right Track*, 279 JAMA 426, 427 (1998) (noting that marketplace is attempting to control healthcare costs). Perhaps, legislatures consider cost-control projects too painful to undertake.

244. See Schwartz, *supra* note 186, at 889 (explaining prohibition on waiver of liability as product of professional ideal).

245. See, e.g., *Hood v. Phillips*, 554 S.W.2d 160, 165 (Tex. 1977) (rejecting respectable minority rule); *Nowatske v. Osterloh*, 543 N.W.2d 265, 276 (Wis. 1996) (allowing jury to decide if both choices are acceptable).

8. *This shift in standards conceivably could produce more defensive medicine and thereby interfere with efforts to control health care spending.* Physicians are likely to view a reasonable care test as more vague than a custom-based test. The uncertainty that this standard of care introduces could, under the right circumstances, promote over-investment in accident avoidance.²⁴⁶

V. Conclusion

Ten years ago, the American Law Institute and prominent legal scholars were examining the case for treating medical malpractice as a unique field governed by a unique no-fault liability regime. In the meantime, courts have been moving away from a separate field of malpractice law and toward the integration of medical malpractice cases within the broader fabric of general negligence law.

There is no longer a judicial consensus favoring deference to customary standards. By the beginning of 1999, a dozen states had expressly refused to be bound by medical customs. Nine additional states, while not explicitly rejecting deference to custom, had chosen to phrase the duty owed by physicians in terms of reasonability, rather than compliance with medical customs. In addition, several other states, like Pennsylvania, Ohio, Arizona, Michigan, and California, have some authority favoring a reasonable-physician standard and could easily join the others. Because of the subjectivity involved in interpreting the law in all of these states, the numbers reported here should be treated as preliminary estimates only. Nevertheless, they illuminate a quiet and persistent shift in doctrine that has gone largely unnoticed.

Even more important than the number of states that have retreated from custom-based norms is the evidence that this movement toward a reasonable-physician standard has not abated. The process began in the 1970s and has continued through the 1990s. The steady pattern of defections from the custom-based standard of care over the past several decades suggests that more states will follow.

At present, fewer than half of the states clearly endorse a custom-based standard of care. Even in these states, the custom-based standard of care often is not enforced unless the plaintiff directly challenges an undisputed custom. When no undisputed custom exists, the jury decides whether the defendant behaved reasonably. As a result, custom plays a much less important role in these states than doctrine would suggest.

246. See generally John E. Calfee & Richard Craswell, *Some Effects of Uncertainty on Compliance with Legal Standards*, 70 VA. L. REV. 965 (1984) (arguing that uncertainty about standards of care leads to inefficiency); Jason Scott Johnston, *Uncertainty, Chaos, and the Torts Process: An Economic Analysis of Legal Form*, 76 CORNELL L. REV. 341 (1991) (same).

We will probably never know exactly why this quiet abandonment of custom-based standards began. However, we do know that tort law is only one of many legal fields in which courts have recently stripped professional privileges away from physicians. Part of the explanation for this may lie in declining public faith that medicine is special. As medicine becomes, and is perceived as, more business-like, Americans and their judges may be less willing to defer to the norms of health care providers.

Another part of the explanation for the shift toward a reasonable-physician standard probably lies in the movement of late twentieth century tort law toward a generalized duty of reasonable care. As physicians lose their secular priesthood, they become more vulnerable to this larger legal current.

This ongoing change in the legal standard of care has important and complex policy considerations. The Author intends to address the policy implications of the changing legal standard of care in a future article.

NOTES
