

Medical Standard of Care Jurisprudence as Evolutionary Process: Implications Under Managed Care

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Medical malpractice lawsuits are by far the most numerous of the professional negligence cases.¹ Accordingly, the health care community may serve as a paradigm for professional standards of care.² But in the era of "managed health care,"³ does modern medical practice truly comport with the long standing tradition of a professional standard of care privilege? This Article explores the jurisprudential evolution of this standard and endeavors to conceptualize the potential impact of managed care.

In an ordinary negligence case, a jury may find for the plaintiff by concluding that the defendant's conduct fell below a "reasonable man" standard.⁴ Direct evidence of compliance (or lack thereof) with a given standard of care is not ordinarily considered.⁵ The jury merely weighs a given risk against the utility of conduct, which either increases or lessens that risk.⁶ In addition, outside opinions need not impact the jury—the jury applies community standards in drawing upon its collective experience to reach a verdict.⁷

This reasonableness standard does not apply to professionals, such as doctors, lawyers, and accountants.⁸ Professionals must not only "exercise reasonable care in what they do, but [must also] possess a minimum amount of special knowledge and ability."⁹ The jury is usually instructed to consider "the skill and learning commonly possessed by members of a profession in good standing."¹⁰ In professional malpractice cases, it thus considers the standard of "what is customary and usual in a profession."¹¹ This gives the court-recognized professions, most notably the medical profession, the privilege of setting its own standards of practice.¹²

In *Rossell v. Volkswagen of America*,¹³ the court found that a defendant car manufacturer was not entitled to a professional standard of care in a

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product design liability case.¹⁴ In support of its position, the court sets forth a logistical construct to separate professional malpractice cases from “commercial cases:”

The malpractice requirement that plaintiff show the details of conduct practiced by others in defendant’s profession is not some special favor which the law gives to professionals who may be sued by their clients. It is, instead, a method of holding such defendants to an even higher standard of care than that of an ordinary, prudent person.... Such a technique has not been applied in commercial settings, probably because the danger of allowing a commercial group to set its own standard of what is reasonable is not offset by professional obligations which tend to prevent the group from setting standards at a low level in order to accommodate other interests. Thus, it is the general law that industries are not permitted to establish their own standard of conduct because they may be influenced by motives of saving ‘time, efforts or money.’¹⁵

The *Rossell* opinion was written in 1985.¹⁶ Reconsidered in the context of 2002 managed realities, one wonders if our present court system romanticizes the professions in rationalizing a higher, privileged standard of care. Is it not true that business interests heavily influence most modern professions, including health care? If so, is the jurisprudential construct for a “medical professional standard” an anachronism in today’s world (hence ripe for change)?

I. COMMON LAW ORIGINS OF A MEDICAL STANDARD OF CARE

Under the legal system of medieval England, plaintiffs required an official form of action from the royal court (a “writ”) that pertained to particular classes of cases.¹⁷ Prior to the fourteenth century, actionable court complaints were generally based on the writ of trespass, or a variant thereof (e.g., “trespass to the person, to land, or to goods”¹⁸). There was originally no distinction between contract law and tort law.¹⁹ Hence, professional malpractice cases often displayed tension between “breach of covenant” (contract law) and “writ of trespass” against the person or case (tort law).²⁰

The 1300s saw the development of what Professor Prosser described as “the borderland of tort and contract,” specifically involving those persons practicing their professional trade or “calling.”²¹ In *The Oculist’s Case*²² of 1329, the plaintiff’s counsel argued for a breach of covenant action against a physician who failed to keep a promise to successfully treat the plaintiff’s eye disease.²³ The presiding Justice ultimately rejected the contract law approach.²⁴ Instead, he linked the concept of “profession” with “man of

skill," comparing medical healers to farriers who negligently injured horses while shoeing.²⁵ By both tradition and law, one could not (at that time) recover against the farrier; hence, he reasoned, one could not recover against a physician.²⁶

Although the early professional malpractice cases alleged violation of an "assumpsit,"²⁷ the courts generally found action based on "trespass on the case."²⁸ Those professionals serving the public-at-large (often described as engaged in a "calling") were thus held liable under pure tort theory, with breach of covenant merely incidental to the alleged injury.²⁹ Accordingly, in *Tailboys v. Sherman* (1443),³⁰ the presiding justice in a professional negligence case suggests a writ of trespass may arise from a breach of covenant.³¹

The professional standard of care percolated through the socio-legal evolutionary changes of the fourteenth, fifteenth, and sixteenth centuries, when medieval societies were stratified.³² Different professions enjoyed variable degrees of legal status.³³ Prior to the Black Plague of the 1300s, historians note an apparent "absolute" occupational privilege enjoyed by physicians, protecting them against any liability for negligent injury or death.³⁴ Although not codified, this privilege was defined by absence of regulations and hence lack of standards.³⁵ Although medieval England had instituted some urban social regulation by that time, such regulations did not extend to the practice of medicine.³⁶

Seen in the light of physicians' privilege, plaintiffs' attempts to sue under breach of assumpsit may be viewed as clever attempts to bypass judiciary reluctance to hold physicians accountable for negligence. Unfortunately, patients generally failed to obtain written agreements before treatment, which would have been necessary for successful contract litigation.³⁷

Doctors' absolute privilege ended about the same time the chancery's role in issuing writs increased.³⁸ However, some chancellors continued to refuse all writs against doctors, apparently under influence from particular justices on the King's Bench.³⁹ Public health policy concerns likely affected these views.⁴⁰ But what of those doctors who refused to treat patients during the Plague? Although doctors refusing service were arguably liable for "nonfeasance" (not performing a required act), the great need for their services continued to supplant liability for "misfeasance" (performing an act improperly).⁴¹ Thus, the necessities created by a public health catastrophe granted physicians continued privilege against liability.

Since medical practice remained unregulated, courts grappled erratically with the concept of a "standard." In *Stratten v. Swanland* (1374),⁴² a medieval case alleging that the plaintiff's hand was maimed by the

surgeon's negligence, the standard appears to be based on moral fault (e.g., "he tried with due diligence, therefore should not be held guilty"⁴³). There is no discussion of any breached standard of care.⁴⁴ Then, in *Skyrme v. Butolf*,⁴⁵ another fourteenth-century case alleging the failure of a physician to keep his promise to cure a patient's disease, the court discussed the practitioner's actions as contrary to a generally held standard.⁴⁶ This is done in the context of deciding the issue of action based on writ of trespass versus breach of covenant.⁴⁷ The court suggests writ of trespass requires definition of a local standard, whereas a suit based on contract law does not.⁴⁸

By the early 1400s, nonfeasance had become the underlying basis for contract law disputes, while misfeasance remained the basis for action in tort.⁴⁹ But English tort law development subsequently produced a dichotomy—"action upon the case for misfeasance," versus "action upon the case for negligence."⁵⁰ This split was arguably crucial to the synthesis of a professional standard of care construct.⁵¹ According to Sir John Cromyn's *Digest of the Laws of England* (1740),⁵² "action upon the case for misfeasance" pertained to "misadventure."⁵³ It generally did not apply to skilled professionals, appearing closer to relying on our modern "reasonable man" standard of negligence.⁵⁴ By contrast, "action upon the case for negligence" pertained to breach of duties "imposed by law," "imposed by an office," or based upon "customs of the realm," thus seemingly applicable to the professions.⁵⁵

From where did this dichotomy arise? The English courts vacillated between the search for breach of a professional standard, versus evaluation of each individual defendant's skill (as noted in the "moral fault" approach).⁵⁶ Moral fault was arguably easier to adjudicate in an era when standards of knowledge remained ill defined. In the absence of this knowledge, professional negligence based on deviation from a standard could best be defined as deviation from a legally imposed regulatory standard, of which there were few.⁵⁷ Thus the concept of professional standards evolved in concurrence with subsequent government-imposed regulations.⁵⁸ The English aristocracy's desire for skilled professions to serve the public-at-large may have engendered considerable leeway and privilege in the development of these standards, including acquiescence to "custom of the realm."⁵⁹

It was within this context that King Henry VIII, in 1518, created by royal charter the Royal College of Physicians and Surgeons,⁶⁰ seemingly elevating the medical profession above all others in the professional standard of care paradigm. The main purpose of the Royal College, as defined by its Charter, included the granting of licenses to qualified

practitioners and the punishment of unqualified practitioners, including those committing malpractice.⁶¹ Its reach extended to both physicians and apothecaries.⁶² Originally its jurisdiction was confined to London, but an Act of Parliament in 1523 extended the College's power to include all of England.⁶³

The Royal College established licensure methodology and requirements for English physicians and surgeons.⁶⁴ Ultimate authority rested in its "Board of Censors," consisting of the Bishop of London (or Dean of St. Paul), plus four physicians.⁶⁵ Licensure also required approval of a diocese bishop (particularly if a "foreigner" applied), or else a diploma from Oxford or Cambridge University.⁶⁶ The original charter also granted College member physicians an exemption from conscripted services, which were still common at that time (e.g., watchmen and constables).⁶⁷

The Board of Censors acted much as a present day American state medical board, albeit with enhanced power. It possessed judicial authority, and could thus fine or imprison those persons practicing outside of their regulations (e.g., a druggist sending medicine to a sick patient without a doctor's prescription).⁶⁸ They were even allowed to search apothecary shops to ensure no "faulty drugs."⁶⁹ Board members thus held a status on par with judges. Hence the medical profession of that time was entrusted with power to police itself, arguably a reflection of special social status.

The Royal Charter allowed physicians to regulate themselves through self-imposed standards.⁷⁰ Yet the Charter itself alludes to a standard of care only once: "Where any person is condemned by the censors for not well executing, practicing, or using the faculty of physick, he may within fourteen days after notice appeal to the College, and the judgment given on such an appeal shall be final."⁷¹ Further definition of this standard thus lay within the College's discretion.

Review of Victorian era case digests reveals a distinct paucity of recorded medical malpractice cases. *Laws of England* (1920), describing case law through the 1800s, suggests negligence actions against physicians were "rarely successful."⁷² There were occasional exceptions. A surgeon was held "liable for ignorance and lack of skill" in *Slater v. Baker*.⁷³ Later, *Seare v. Prentice*,⁷⁴ stated: "[E]very one who undertakes any office, employment, trust or duty...to perform it with integrity, diligence and skill...if by his want of either of these qualities any injury accrues to individuals, they have therefor [sic] their remedy in damages...."⁷⁵ Still debating contract theory, the court in *Pippin v. Shepard*,⁷⁶ wondered how contractual obligation could be applied to physicians employed by public establishments.⁷⁷ "[I]t could hardly be expected that the governors of an infirmary could bring an action against the surgeon employed by them to attend the child of poor

parents who may have suffered from his negligence and inattention.”⁷⁸ The holding in *Gladwell v. Steggall*,⁷⁹ appears to clarify this point: “The substance of the issue...is that the defendant was employed to *cure* the plaintiff, not that he was employed *by* the plaintiff.”⁸⁰

Physician malpractice cases did occur with greater frequency by the nineteenth century, but judicial holdings tended to favor “the learned professions.”⁸¹ Thus, in *Lanphier v. Phipos*,⁸² the court held that “reasonable skill,” as applied to professionals, is “not [the] highest possible degree of skill.”⁸³ Later, the decision in *Rich v. Pierpont*⁸⁴ set the bar even lower (for medical professionals) with an amorphous standard:

[T]here must have been a want of competent and ordinary care and skill, and to such a degree as to have led to a bad result. A medical man is bound to have that degree of skill which cannot be defined, but which, in the opinion of the jury, is a competent degree of skill and knowledge.⁸⁵

Many of these concepts were subsequently adopted by American jurisprudence.⁸⁶ Further refinement of the English standard of care construct did not occur until the late nineteenth century. Although Parliament’s Medical Act of 1858 facilitated the public’s attempts to distinguish between “qualified” and “unqualified” health practitioners, “qualified” was defined simply as compliance with licensure requirements.⁸⁷ Interestingly, the Act of 1858 did not bar unqualified practitioners from practicing.⁸⁸

The Medical Act of 1886 further codified the requirement for physicians to register with the Royal College, and set a standard of “infamous conduct” as sufficient grounds for removal.⁸⁹ English case law subsequently defined “infamous conduct” as “dishonorable and disgraceful behavior.”⁹⁰ At the same time, cases continued to define the medical standard of care not as the best care, but rather as “ordinary” care.⁹¹

American jurisprudence is arguably a product of English common law’s influence on the colonies, and subsequently on the fledgling United States. Even a century after independence, it was not uncommon for American legal texts to refer to the utility of English cases. Josiah Smith’s *A Manual of Common Law* (1875), an American publication of English cases/legal theory, describes its own contents as “comprising the fundamental principles and the points most usually occurring in daily life and practice.”⁹² Its sole reference to standard of care for medical malpractice displays an ambiguity true to its English origins: “gross unskillfulness or carelessness.”⁹³

In discussing more recent developments in the English law of liability, Professor John Fleming had once noted:

Among the various professional groups, medical men seem to be the most frequent target of tort litigation, and medical malpractice actions furnish a microcosm of prevailing community and courtroom attitudes towards the problem of professional liability. Since the end of [World War II], there has been a noticeable increase in the volume of such actions in England, though it has not nearly attained the proportions endemic in the United States.⁹⁴

II. MEDICAL STANDARD OF CARE IN AMERICAN CASE LAW

The earliest documented American physician malpractice case, *Cross v. Guthery*,⁹⁵ involved a charge of negligence in the performance of a mastectomy.⁹⁶ The court ruled against the physician, reasoning he had set out to perform "with skill and safety" yet did so "in the most unskillful, ignorant and cruel manner, contrary to all the well known rules and principles of practice in such cases."⁹⁷ Later, in *McCandless v. McWha*,⁹⁸ a court defined the standard of care as the physician's obligation "to treat the case with diligence and skill...such reasonable skill and diligence as are ordinarily exercised in [the] profession...such as thoroughly educated surgeons ordinarily employ."⁹⁹

A concurrent case, *Leighen v. Sargent*,¹⁰⁰ set forth a similar standard of reasonable skill, but added, "He does not undertake for extraordinary care or extraordinary diligence, any more than he does for uncommon skill..."¹⁰¹ Further, that court maintained a residual element of contract theory, stating: "In stipulating to exert his skill, and apply his diligence and care, the medical or other professional men contract to use their best judgment..."¹⁰² Although modern emphasis has since settled almost exclusively on negligence theory, the contractual underpinnings of the physician-patient relationship were never entirely abandoned,¹⁰³ and still form the basis of many present-day suits against managed care companies.¹⁰⁴

Although American case law provides variable formulations of the medical professional standard of care, the common elements have been summarized as follows: "(1) A reasonable or ordinary degree of skill and learning; (2) commonly possessed and exercised by members of the profession[;] (3) who are of the same school or system as the defendant[;] (4) and who practice in...similar localities; (5) and exercise of the defendant's good judgment."¹⁰⁵

Physicians who comply with such standards are generally shielded from liability, since compliance is held as evidence of proper care.¹⁰⁶ Doctors are thus better protected from liability as compared to, say,

railroads, merchants, car manufacturers, and the like.¹⁰⁷ Business and industry, on the other hand, may be held liable for negligence even if a plaintiff fails to show any departure from business custom.¹⁰⁸ Then why are doctors protected? While some legal historians have argued that “doctors as a class may be more likely to exert their best efforts than drovers, railroads and merchants,”¹⁰⁹ others conclude that “no other standard is practical,” given the difficulty faced by the courts in determining whether a physician exercised reasonable medical care.¹¹⁰ Plaintiffs must thus rely on expert medical testimony to prove a case.¹¹¹

The term “average” is sometimes used in conjunction with—or in place of—the term “ordinary” in reference to the standards.¹¹² In *Holtzman v. Hoy*,¹¹³ an American court interpreted such terms as referring to an ordinary “good” physician.¹¹⁴ However, courts retain leeway for jury instructions,¹¹⁵ and jurors may thus have variable understandings of these issues. Ordinary/average standards have been translated into “minimum standards” when applied to scientific realms. For example, in *Hazel v. Mullen*,¹¹⁶ a case involving adverse health consequences from an x-ray machine, the plaintiff was unsuccessful despite presenting expert testimony of additional precautionary measures that the defendant may have taken to protect the plaintiff from injury.¹¹⁷ The defendant had demonstrated compliance with a scientifically recognized standard, which relied in large part on the ordinary judgment of the treating physician.¹¹⁸

While expert medical testimony is usually indispensable for establishing a medical standard of care, there are exceptions. For example, such testimony is not required when a patient suffers burns from a hot compress post-operatively,¹¹⁹ or if a physician accidentally knocks a healthy tooth from a patient’s mouth prior to surgery.¹²⁰ Exceptions apply in particular for lapses in care subject to “common knowledge.”¹²¹ The common knowledge standard is applied (often in conjunction with the doctrine of *res ipsa loquitor*) most frequently in cases where foreign objects are left in patients’ bodies during operations.¹²² To utilize such a standard, negligence must be “so grossly apparent that a layman would have no difficulty recognizing it.”¹²³ Application of this rule varies by jurisdiction.¹²⁴

Plaintiffs have attempted to circumvent the professional standard of care when the line between “common knowledge” and “medical knowledge” is blurred. In *Stepakoff v. Kantor*,¹²⁵ a jury found for the defendant psychiatrist in a case alleging negligence for a patient’s suicide.¹²⁶ Plaintiff appealed, claiming that although the psychiatrist may not have breached the ordinary medical standard of care, common sense dictated the need for additional measures, such as involuntary hospitalization, to protect against suicide.¹²⁷ The court affirmed the jury

verdict, holding the standard of care cannot be divided into medical standard on the one hand, and reasonableness standard on the other hand.¹²⁸ It distinguished its ruling from *Tarasoff v. Regents of the University of California*,¹²⁹ a case involving a psychiatrist's duty to protect a third party (not a patient) under a reasonable care (not a professional standard of care) analysis.¹³⁰

Physicians enjoy further protection from liability when they choose between providing two or more appropriate alternative medical treatments. In *Morlino v. Medical Center of Ocean County*,¹³¹ the court found that harm resulting from such a choice does not constitute malpractice, so long as the physician acted with good faith judgment.¹³² This axiom has, however, been subject to modification. *Matthies v. Mastromonaco*¹³³ clarified that the patient, not the physician, must ultimately choose, and the standard of care is breached if the physician fails to inform the patient of all alternative treatments.¹³⁴ These issues may be particularly relevant to lawsuits involving managed care/HMOs.

The first reported malpractice suit against a managed care company was *Wickline v. State of California*,¹³⁵ heard on appeal in 1986. In 1976, Wickline was diagnosed with Leriche's Syndrome, a condition causing blockage of her aortic artery.¹³⁶ She subsequently underwent major surgery in 1977 to alleviate the problem, using a synthetic graft artery.¹³⁷ She experienced major post-operative complications, including vascular spasms, which threatened to cut off blood flow to her legs and raised the specter of lower extremity amputation.¹³⁸ The treating physicians originally had approval from the patient's HMO (Medi-Cal) for a ten-day post-operative stay.¹³⁹ Due to the post-operative complications, her physicians, with assistance from the hospital case management staff, requested an additional eight days in the hospital.¹⁴⁰ Medi-Cal asked their employed-physician consultant to review the case.¹⁴¹ Although Medi-Cal's physician reviewer was not a vascular specialist, and although he never consulted such a specialist, nor ever saw or examined the patient himself, Medi-Cal adopted his recommendation that the patient did not require additional time in the hospital.¹⁴² Her physician thus discharged her home after the initial ten days.¹⁴³ Her right leg became progressively discolored at home, and she was re-hospitalized nine days later.¹⁴⁴ However, it was too late to save her leg, and she ultimately required an above-the-knee amputation.¹⁴⁵ Her physician later testified that she would not have lost her leg had she remained in the hospital as originally requested.¹⁴⁶ The trial court found for the plaintiff, holding Medi-Cal liable for the plaintiff's injuries, pain, and suffering.¹⁴⁷ On appeal, the court reversed, reasoning that the plaintiff's own physician adopted Medi-Cal's decision without sufficient

protest, and was ultimately still responsible for the patient's care when he wrote the order to discharge her home.¹⁴⁸ The court indicated that the physician and hospital had alternative avenues to protect the patient's interest, such as filing a formal appeal with Medi-Cal, or attempting to contact the reviewing physician directly.¹⁴⁹ Hence, Medi-Cal was not liable for the decision to discharge the patient.¹⁵⁰ Further, although the Medi-Cal physician reviewer may not have optimally analyzed the data before him, both he and Medi-Cal purportedly followed pertinent legislated state statutes regarding case review.¹⁵¹ Thus, the court ruled, Medi-Cal was not liable as a matter of law.¹⁵²

But *Wickline* did not completely close the door on managed care liability. The court also stated that "a patient who requires treatment and who is harmed when care which should have been provided is not provided should recover for the injuries suffered from all those responsible for the deprivation of care, including, when appropriate, health care payers."¹⁵³ Thus, managed care entities may be liable when medically incorrect decisions result from flaws in their cost-containment mechanisms.

A subsequent case, *Wilson v. Blue Cross of Southern California*,¹⁵⁴ supported the concept of liability for HMOs and other insurers.¹⁵⁵ In *Wilson*, a psychiatric patient committed suicide after his premature discharge from the hospital.¹⁵⁶ A managed care company's utilization review purportedly pressured the health care providers to discharge him.¹⁵⁷ The insurer argued it was entitled to summary judgment "because there are important public policy considerations which warrant protecting insurance companies and related entities which conduct concurrent utilization review."¹⁵⁸ Unlike *Wickline*, the *Wilson* court noted that despite the physician's decision to discharge the patient, the insurer might also be held at least partially liable if its negligent conduct acted as a substantial factor in causing harm.¹⁵⁹ *Wilson* thus appears to allow a jurisprudential bifurcation between the physician's professional standard of care and an insurer's duty to act under a reasonable standard of conduct.¹⁶⁰

In *Fox v. Health Net*, the plaintiffs used contract theory to successfully sue an HMO that denied coverage for a bone marrow transplant to treat breast cancer.¹⁶¹ The jury awarded \$77 million for punitive damages after finding breach of contract, intentional infliction of emotional distress "through reckless denial of coverage," and actions in bad faith.¹⁶² Under contract theory, there was no need to prove breach of a professional standard of care, only that there was a breach of a *contract* for care.¹⁶³

The employer sponsor of Health Net was a state public school district, hence not protected by the Employee Retirement Income Security Act

(ERISA).¹⁶⁴ ERISA¹⁶⁵ does not allow recovery of monetary damages due to an administrator's purported misconduct in the private sector.¹⁶⁶ This preemption is extended to those managed care health insurers sponsored by private employers.¹⁶⁷ Had the *Fox* case involved a private employer's health plan, the outcome may have been dramatically different. In *Durham v. Health Net*,¹⁶⁸ plaintiff's similar action against a restaurant for monetary damages under ERISA was dismissed.¹⁶⁹

In June 2000, the U.S. Supreme Court ruled "treatment decisions made by a health maintenance organization, acting through its physician employees," are not fiduciary decisions under ERISA.¹⁷⁰ The Court reasoned that Congress never intended to open "the federal courthouse doors for a fiduciary malpractice claim."¹⁷¹ However, in doing so, the Court may have opened the door to additional litigation at the state level.¹⁷² State supreme courts in both New York and Pennsylvania have since affirmed the right of patients to sue their health insurers for negligence, and New Jersey (among other states) has legislated patients' rights to sue employer-paid health plans.¹⁷³

Before the era of managed care, the Washington State Supreme Court endeavored to foster a radical shift in the medical standard of care paradigm. In *Helling v. Carey*,¹⁷⁴ a malpractice action against ophthalmologists, medical expert testimony tried to establish no requirement for routine glaucoma testing for patients less than forty years old.¹⁷⁵ However, the court moved to step outside the traditional legal construct for medical malpractice. Quoting Justice Learned Hand, the court emphasized that "[c]ourts must in the end say what is required; there are precautions so imperative that even their universal disregard will not excuse their omission."¹⁷⁶ Disregarding the expert testimony, the court made its own value judgement: "We therefore hold, as a matter of law, that the reasonable standard that should have been followed under the undisputed facts of this case was the timely giving of [a] simple, harmless pressure test to the plaintiff and that, in failing to do so, the defendants were negligent."¹⁷⁷ The court thus demanded a higher standard than the professional standard, in effect adjudicating strict liability.¹⁷⁸ Although *Helling* is not followed today, it demonstrates the courts' potential to explore nontraditional legal remedies to the standard of care issue.

Consumer dissatisfaction with the present health care system is a popular topic. *TIME* magazine notes:

If you visited a doctor any time recently, you know the routine. You wait an hour for a 10 minute once-over, and you can't get an aspirin tablet or a band-aid—let alone a referral—without six bean counters and a dozen paper pushers eyeballing your entire medical history.¹⁷⁹

Clearly, the health care industry strives to control costs.¹⁸⁰ Managed care entities utilize protocols and guidelines for care, creating average lengths of stay for hospitalizations due to particular conditions, in addition to “cookbook” approaches to both outpatient and inpatient diagnostic and treatment decisions.¹⁸¹ The medical standard of care now competes with financial pressures that threaten to usurp it. Not only must physicians today attend educational seminars to learn of new advances in their field, they now attend classes to learn how to code their procedures to satisfy managed care business pressures.¹⁸² Thus, while physicians of past eras have molded the standard of care unfettered by such concerns, today’s physicians are themselves being molded by corporate/business interests.¹⁸³

The issue remains whether these business/financial interests can effectively and ethically co-exist with an appropriate standard of care. Avedis Donabedian helped develop quality control systems for hospitals and has been described as “the father of quality assurance.”¹⁸⁴ He believes that “healthcare is a sacred mission...a moral enterprise and a scientific enterprise but not fundamentally a commercial one.”¹⁸⁵

III. RECENT LITERATURE ON THE MEDICAL STANDARD OF CARE IN JUXTAPOSITION WITH MANAGED CARE REALITIES

Legal scholars have written hundreds of articles attempting to define and analyze the complex medico-legal interplay between managing medical care and maintaining the quality of that care.¹⁸⁶ Various authors propose to hold managed care entities accountable for their actions in either tort or contract theory.

Wertheimer, for example, argues in favor of the doctrine of respondent superior.¹⁸⁷ She holds HMOs responsible as *de facto* employers of physicians, but points out that HMOs often persuade courts that physicians ultimately make independent decisions.¹⁸⁸ Her solution is to hold HMOs to a reasonableness standard, since “overruling the reasonable exercise of medical judgment is itself negligence.”¹⁸⁹ Thus, if a HMO reasonably denies authorization for care (e.g., when claiming the proposed care is unnecessary), the HMO is protected from liability under a reasonableness doctrine, but if denial is unreasonable, HMOs would be held accountable.

Advocacy for a “reasonableness standard” suggests HMOs have a duty to avoid interfering with the provision of adequate health care to patients. Juries may rule on breach of that duty based upon their own common knowledge and reasoning. But if a “professional” standard of care still exists, how could such a case be effectively tried in court? Surely a HMO would point the finger of responsibility at the ultimate authority—the

treating physician.¹⁹⁰ How could the “professional” standard of a physician be separated from a “reasonable” standard of a HMO, especially when the HMO utilizes protocols developed by medical physician experts with their own professional standards?¹⁹¹ Wertheimer argues that physicians’ decisions are controlled by HMOs and corporate interests to a point where HMOs are setting standards and making it difficult, if not impossible, for doctors to deviate from them.¹⁹²

Danzon discussed the potential “mine field” of managed care liability under tort law, but ultimately rejected the concept:

Health plans should be liable in tort for negligence only in cases of negligent credentialing. Liability for negligent performance should be placed solely on the individual provider, who is usually best placed to make and monitor precautions in the delivery of medical care. Adding liability of plans, under theories of vicarious, agency, or enterprise liability, serves only to add an additional deep pocket defendant. To the extent that this increases the frequency of erroneous findings of liability, the ability of managed care to control insurance-induced overuse and improve efficiency in health care delivery will be obstructed.¹⁹³

While Wertheimer holds HMOs completely responsible for care, Danzon claims it is the providers who bear sole responsibility for decisions.¹⁹⁴ However, Danzon goes on to advocate contract-based claims against managed care entities, in the context of “contract shifting of liability between provider and plans,” as a means of fostering gains in health care economic efficiency.¹⁹⁵ Despite this, she criticizes the *Fox* decision, particularly the punitive damages award, arguing that punitive damages should not be permitted under such a contract theory, and that evidence on incentive based HMO contracts should not be admissible evidence in coverage denial cases.¹⁹⁶ She believes that punitive liability under such circumstances would risk obstructing efficiency in the managed care industry.¹⁹⁷

Hirshfeld seems to advocate a new form of HMO-patient contract:

[H]ealth plans should be required to disclose information to patients about their own outcomes and the techniques that they use to eliminate unnecessary care. This information should be drafted in easily understood language so that patients can decide whether they are comfortable with the combination of price and risk used by the health plan.¹⁹⁸

Yet Hirshfeld claims that patient remedies would still be grounded in tort theory, not contract theory. He advocates enhanced managed care liability

through modification of “the tort of bad faith insurance settlements.”¹⁹⁹ In terms of enterprise liability, he is in agreement with Danzon, noting that such liability could be counterproductive if managed care organizations felt compelled by liability concerns to exert even more control over physicians.²⁰⁰

Hirshfeld’s vision of patient “consent” to managed care restrictions appears to bolster the contract theory construct to managed care liability.²⁰¹ In an earlier article on standard of care issues, Hirshfeld had proposed keeping “patient-oriented” standards as a foundation for practice guidelines in which physicians would be legislatively protected from tort liability.²⁰² But who would draft such guidelines, and how would providers, managed care organizations, and legislators establish a methodology for agreement on scope and/or acceptable deviations from such guidelines?²⁰³

A recent survey of physicians found medical decision-making under managed care to be restricted by “range,” by “degree,” and by “latitude,” suggesting a subtle form of control.²⁰⁴ Arguably, non-overt managed care influences may not be amenable to either legislation or professional guidelines. To illustrate the potential subtlety of the problem, the reader is invited to consider the following hypothetical example:²⁰⁵

Mr. Smith is a sixty-six year-old widower with a history of congestive heart failure and osteoarthritis. He is insured through a Medicare-approved HMO. For several months, he has had difficulty walking due to severe right hip pain. He is informed by his doctor that he needs a hip replacement due to the severity of his arthritis. He agrees to the surgery, and his physician obtains appropriate pre-authorization from the HMO without difficulty. The surgery is performed successfully, and Mr. Smith begins receiving physical therapy in the hospital the next day. However, he feels very fatigued and is easily winded by attempts to walk (even when using a walker). X-rays of his lungs show mild exacerbation of his congestive heart failure, so his cardiac medications are adjusted. Although Mr. Smith no longer feels short of breath, he still tires easily. His physician advises the hospital’s nurse case manager of the patient’s decompensated status.

Let’s say Mr. Smith’s HMO had originally pre-approved a three to four day hospital stay. How had they arrived at that decision? Managed care organizations today contract with data-analysis and accounting firms, seeking statistical justification for clinical pathway decisions, which reduce the costs of diagnosis and treatments.²⁰⁶ These firms, and their analyses, are not necessarily subject to strict scientific scrutiny in an academic setting.²⁰⁷ Although no one at the HMO had examined Mr. Smith, he may be viewed as a statistically average patient undergoing an elective hip replacement.²⁰⁸

The hospital's nurse case manager now calls the HMO's case manager. After playing phone tag for some hours, the conversation may ultimately go something like this:

- HOSP:** Hi Denise. This is Mary from Valley Hospital. I'm calling about Mr. Smith.
- HMO:** Yes, I have his information on the screen here. He should be ready for discharge tomorrow, right?
- HOSP:** Well, we're concerned about his cardiac status. He was in heart failure a couple days ago.
- HMO:** Yes, I remember getting that message on my voice mail. But how is it now?
- HOSP:** The chest x-ray today was clear, but the patient is still easily fatigued when he uses the walker in physical therapy. The doctor doesn't want to discharge him yet.
- HMO:** He should get stronger when he's transferred to the Rehab center.
- HOSP:** I don't know. His daughter was here and she's also concerned.
- HMO:** O.K., here's what we'll do. I'll allow him one extra day in the hospital. Then, if there is no congestion on a repeat chest x-ray, he has to go to rehab.
- HOSP:** His daughter wants him to go to the rehabilitation hospital here in Lakeville.
- HMO:** We don't have a contract with them for these elective cases. He can go to a subacute center.
- HOSP:** You mean one of the local nursing homes with a rehabilitation wing?
- HMO:** Yes. Either Cedar Knolls or Belleville.
- HOSP:** What about Victoria Park? That nursing home has a full time rehabilitation specialist.
- HMO:** Sorry, we don't have a contract with that nursing home. Besides, all he needs is some therapy, and the other places can give him that.
- HOSP:** O.K., Can I have the pre-authorization number?

The hospital nurse case manager now calls the patient's attending physician, Dr. Daye.

- HOSP:** Dr. Daye? This is Mary from Valley Hospital case management.
- DOC:** Hi, how are you?
- HOSP:** Fine. I'm calling you about Mr. Smith. I got pre-authorization from his HMO to get him over to subacute rehab.
- DOC:** I thought the family wanted the rehabilitation hospital down the

street. He would do well there. I send all of our regular Medicare cases there.

HOSP: We can't do it. His HMO only allows subacute rehab at the nursing homes for elective hip surgery.

DOC: O.K., send him to Dr. Clark at Victoria Park.

HOSP: No, the HMO doesn't contract with them.

DOC: Where then?

HOSP: Cedar Knolls or Belleville.

DOC: But those are just regular nursing homes.

HOSP: I don't know what to tell you doctor. The family has already agreed. We're just waiting for your discharge order.

DOC: We're still keeping him for the congestive heart failure, though.

HOSP: The HMO is only giving him one more day. They want him out.

DOC: Who did you speak to?

HOSP: The case manager.

DOC: Is the case manager a doctor?

HOSP: No, but I think she might be a nurse.

DOC: I'll only discharge him with a clear chest x-ray. (hangs up)

Dr. Daye feels frustrated. He had originally wanted to keep Mr. Smith hospitalized two or three more days for observation. However, the Utilization Management coordinator employed by his hospital (a physician named Dr. Duff), has been accusing him of unnecessarily delaying discharges and costing the hospital money. He recently received the following memorandum from Dr. Duff (as did all of the medical staff, not only at this hospital, but at all ten hospitals in the hospital corporation's statewide chain):

We are all affected by Utilization Management decisions—physicians and hospitals alike. We as physicians are busy treating patients and none of us like our decisions being questioned by others, including the UM Committee. However, all of us wish to provide quality care to our patients.

What is the definition of quality? Traditionally it has been defined as the degree to which health services for individuals and populations increase the likelihood of desired health outcome and are consistent with current professional knowledge. In recent years questions of cost and limited resources have entered the equation. You and I know we have to strike a balance so that everyone is happy—patients, other providers, and payers.

Since Utilization Management focuses on providing appropriate care in the appropriate setting at the appropriate time, the UM Committee is really a quality committee. Its main role is to study,

monitor, and report on issues impacting quality in the process of health care delivery; and to educate our physicians to practice in a way that permits good medical decisions, yet minimizes denials and challenges from insurance carriers.

When we concentrate on the outcome, it increases the efficiency of the health care delivery process and quality and patient satisfaction increase while costs decrease. As a result, the market share of our facility will go up.

The idea is simple, but execution is difficult. However, it is doable with collaborative teamwork. We need your support.²⁰⁹

Mr. Smith's chest x-ray is repeated the next day. The radiologist reports: "Clear except for possible mild pulmonary vascular congestion. Follow-up studies if clinically warranted." Dr. Daye sees Mr. Smith on hospital rounds that morning. On examination, his lungs sound clear, but the patient still feels fatigued.

DOC: You started the physical therapy already right?

SMITH: Yeah, but I haven't done much since I've been so tired.

DOC: Well, it says here in the chart that you've been walking up to ten feet with the walker. And the orthopedist says the surgical site is healing well.

SMITH: Yes. He said I can go for rehab as soon as you clear me for discharge.

DOC: O.K., I'll discharge you to rehab today. But make certain you let the staff there know if you have any breathing problems.

SMITH: All right, doc. The HMO covers the rehab, right?

DOC: Yes, so long as you go to either Cedar Knolls or Belleville.

SMITH: I think my daughter already discussed that with the nurse case manager. She already chose Cedar Knolls. Thanks, doc.

Mr. Smith is transported by ambulance to the nursing home, where he receives additional physical therapy. He made progress over the following two weeks, but not as much as his physical therapist had expected. He continued to have problems not only with generalized fatigue, but he also occasionally became short of breath. Nursing staff informed the facility's internist, who saw Mr. Smith twice over the two weeks, ordered another chest x-ray, and adjusted his medications. The chest x-ray still appeared clear. His surgical site was closed and almost completely healed (except for the residual surgical scar). The leg still had some post-operative swelling, and Mr. Smith still complained about hip pain, along with shortness of breath while walking. He could now walk up to one hundred feet with a walker, with no one assisting him.

The HMO case manager then calls the nursing home case manager.

HMO: How's Mr. Smith doing?

NH: Fine, but the therapist feels he could do even better. He still has some pain at the hip.

HMO: How far can he walk?

NH: One hundred feet.

HMO: Without assistance?

NH: Without assistance, but he still needs a walker, and he gets winded very easily.

HMO: Well, he really needs to be discharged home. Walking one hundred feet without assistance meets our criteria for discharge.

NH: But I spoke to the doctor yesterday, and he was thinking of keeping him another week.

HMO: We will not pay for any additional time at your facility. He can get outpatient physical therapy, and his family will have to arrange for home health if they feel he needs it. He meets our criteria for discharge. (The conversation is concluded.)

The nursing home case manager now discusses the situation with the nursing home's chief administrator. The administrator explains to the case manager how important the HMO contract is to the nursing home's financial survival, thus necessitating compliance with HMO guidelines. He expresses concern that the doctor is not looking at the situation from the HMO's point of view (nor the nursing home's point of view), and considers the possibility of contracting alternative doctors to follow patients at the nursing home in the future. He advises his case manager to make appropriate home arrangements for the patient. The case manager then calls the doctor.

NH: We need to send Mr. Smith home. His HMO is cutting him off. I've made arrangements for visiting nurse service, meals-on-wheels, and outpatient physical therapy. I also ordered a walker for him to take home.

DOC: I'll call the nursing station. If his vitals are still normal, we will send him home. His family is O.K. about him going home?

NH: Oh yes! They don't want to have to pay anything out-of-pocket, so they want him home as soon as his HMO time is ended.

DOC: It's too bad, you know. If he had traditional fee-for-service Medicare, he could stay longer.²¹⁰ Does he realize that? You know, if you want, I could send a formal protest to the HMO, and try to go through their appeals process.

NH: I don't think the patient realizes the difference between Medicare and HMO Medicare. Listen, doctor, I really appreciate your cooperation on this. I know we could formally

appeal the HMO's decision, but we don't want to risk losing their business in the future.

DOC: I understand. Look I really think he can go home now. We have had other patients in his situation who we sent home with no problems. With the HMOs, this is the new standard of care. (sighs)

Mr. Smith is discharged home after two weeks at the nursing facility. The following week, he is admitted to the hospital's intensive care unit. Apparently he was having multiple pulmonary emboli (not picked up on routine chest x-rays), along with an infection involving the hip replacement apparatus. In retrospect, his shortness of breath and hip pain should have been investigated more carefully, and may have been noticed and effectively treated had he remained in an inpatient setting.²¹¹

Why did his physicians feel comfortable agreeing with treatment and/or discharge decisions instigated by an insurance carrier? Because the mentality of cost-containment has blurred the definition of quality care/standard of care. Some legal scholars believe the answer to this problem lies in the establishment of a socially and legally recognized forum for "physician advocacy."²¹²

CONCLUSION

Proposed solutions to this standard of care dilemma vary across the spectrum of legal theories and socio-political views. Some legal scholars claim society ultimately demands compliance with the traditional medical professional standard of care,²¹³ while others propose that hospitals, HMOs, and physicians be allowed variable standards of care based upon society's desire to control costs.²¹⁴ Such variable standards could purportedly be applied under tort theory,²¹⁵ or under contract theory.²¹⁶ Regardless of how these variable standard proposals have been constructed, they appear to saddle courts with burdensome cost-versus-benefit inquiries and/or contract analyses of variations at the level of the individual health plans. Proponents of variable standards appear to assume consumer knowledge and acquiescence to a reduced standard of care, which they purportedly "bargained" for.²¹⁷ Does this ring true for the factory worker who obtains HMO coverage for herself and children through her employer? Does Mrs. Jones know that hospital A has a managed care contract that pressures physicians and the hospital to discharge cardiac patients earlier than hospital B?²¹⁸ And intrinsic to this entire issue of "standard of care," is it not contradictory to say the issue is being forced upon the public by the constraints of rising health care costs, while HMO and other corporate

health care interests reap profits through the *de facto* rationing of care to patients?²¹⁹ To some, the beguiling nature of this issue poses a question akin to one of good versus evil: "No one can serve two masters, for either he will hate the one and love the other, or he will be devoted to the one and despise the other. You cannot serve G-d and mammon."²²⁰

Even assuming managed care interests may one day be held accountable for their actions, the question remains: How shall the standard of care be defined? This Article has traced the development of the medical standard of care through 500 years of English and American law. Through a culture of deference to superior medical knowledge, combined with historical happenstance (e.g., the Black Plague and King Henry VIII's desire for a royal-chartered College of Physicians and Surgeons), physicians were placed on society's pedestal, entrusted with setting their own standards of care. Thus, the legal community and courts recognized a medical professional standard, which shielded physicians from much of the liability commonly applicable to business commercial interests. However, recent cost-cutting trends may degrade and corrupt the historical trust granted to physicians. In order to comport with the reality of modern day health care, American jurisprudential constructs on medical standard care must evolve in conjunction with these modern trends. Given the competing views of tort theory versus contract theory, traditional standards versus variable standards, and patient advocacy versus cost-containment, it appears the direction of this evolution remains to be defined.

References

1. WILLIAM PROSSER, LAW OF TORTS § 32 (4th ed. 1971).

2. *Id.*

3. See William M. Sage, *Physicians as Advocates*, 35 HOUS. L. REV. 1529, 1536 (1999) (defining “managed care” as follows: “[A]s a general matter, managed care reduces costs in limiting access to health care professionals and prescreening proposed treatments for appropriateness.”).

4. PROSSER, *supra* note 1.

5. *Id.*

6. *Id.*

7. *Id.*

8. *Id.*

9. *Id.*

10. *Id.*

11. See *id.* (noting the courts have had “a healthy respect...for the learning of a fellow profession, and...reluctance to overburden it with liability based on uneducated judgement”).

12. See *id.* (noting that “[this] result is closely tied in with the layman’s ignorance of medical matters and the necessity of expert testimony”).

13. 709 P.2d 517 (Ariz. 1985) (en banc).

14. *Id.* at 522 (citing PROSSER, LAW OF TORTS, throughout its discussion about a reasonable man standard versus a professional standard of care).

15. *Id.*

16. *Id.* at 517.

17. L.B. CURZON, ENGLISH LEGAL HISTORY 253-54 (1968).

18. *Id.* at 254.

19. WILLIAM LLOYD PROSSER, SELECTED TOPICS ON THE LAW OF TORTS 380-81 (1953) [hereinafter SELECTED TOPICS].

20. See generally J.H. BAKER & S.F.C. MILSOM, SOURCES OF ENGLISH LEGAL HISTORY: PRIVATE LAW TO 1750, at 340-97 (1986).

21. SELECTED TOPICS, *supra* note 19.

22. LI MS. Hale 137 (1), fo. 150 (eyre of Nottingham) (1329), reprinted in BAKER & MILSOM, *supra* note 20, at 340-41.

23. *Id.*

24. *Id.*

25. *Id.*; see also WEBSTER’S INTERNATIONAL DICTIONARY 824 (3d ed. 1976) (defining the British term “farrier” as either a veterinarian, “especially when practicing without full qualification,” or a blacksmith who shoes horses).

26. *The Oculist’s Case*, cited in Hale, *supra* note 22.

27. See BLACK’S LAW DICTIONARY 120 (7th ed. 1999) (defining “assumpsit” as “[a]n express or implied promise, not under seal, by which one person undertakes to do some act or pay something to another”).

28. SELECTED TOPICS, *supra* note 19; see also BLACK’S LAW DICTIONARY, *supra* note 27, at 1509 (explaining “trespass on the case” as follows: “at common law, an action to recover damages that are not the immediate results of a wrongful act, but rather a later consequence. This action was the precursor to a variety of modern-day tort claims....”).

29. SELECTED TOPICS, *supra* note 19, at 382.

30. HLS MS. 169, unfol. (C.P.) (1443), reprinted in BAKER & MILSOM, *supra* note 20, at 395. Although the parties ultimately settled their case (involving the mishandled transport of wine), one justice made the following medical analogy: “If my arm is broken, and I make a covenant with someone to put [a cast on] it, and he does

not do so, whereby my arm is lost, I shall have an action of trespass on my case." *Id.* at 396.

31. *See id.*

32. *See* W.S. HOLDSWORTH, A HISTORY OF ENGLISH LAW 385-86 (1923).

33. *Id.* (stating that "medieval society was regarded as divided into very distinct orders of men...bound by the particular rules which applied to that particular order...considered to be bound by their calling to show a certain degree of skill..."). As noted previously, physicians prior to the fifteenth century were often compared to farriers by ruling justices who refused to hold either profession liable for negligence. *See also* ROBERT C. PALMER, ENGLISH LAW IN THE AGE OF THE BLACK DEATH, 1348-1381, at 190-94 (1993).

34. PALMER, *supra* note 33, at 186.

35. *Id.* at 185-87.

36. *Id.*

37. *Id.* at 187.

38. *See id.* at 188-89 (noting also a brief period after the Black Plague, when physicians accused of malpractice were liable for "criminal mayhem," rather than a civil suit. The chancery ended this short-lived jurisprudential detour by handling such suits as civil matters).

39. *Id.* at 195.

40. *See* HOLDSWORTH, *supra* note 32, at 386.

41. *See* SELECTED TOPICS, *supra* note 19, at 387.

42. Y.B. Hil. 48 Edw. III, fo. 6, pl. 11 (1374), reprinted in BAKER & MILSOM, *supra* note 20, at 360.

43. *Id.*

44. *See id.*

45. Y.B. Tas. 11 Ric. II, p. 223, pl. 12 (1388), reprinted in BAKER & MILSOM, *supra* note 20, at 362 (involving a physician's alleged failure to cure a case of ringworm).

46. *Id.*

47. *Id.*

48. *Id.*

49. SELECTED TOPICS, *supra* note 19, at 388.

50. J.H. BAKER, AN INTRODUCTION TO ENGLISH LEGAL HISTORY 346-50 (2d ed. 1979).

51. *See id.*

52. *See id.* at 346.

53. *Id.*

54. *See id.* at 347-48.

55. *Id.* at 346.

56. *See* BAKER & MILSOM, *supra* note 20, at 362.

57. *See generally* PALMER, *supra* note 33, at 190-94.

58. *See id.*

59. *See* BAKER, *supra* note 50, at 346.

60. *See Royal College of Physicians*, at http://www.rcplondon.ac.uk/college/about_history.htm. (last visited Sept. 29, 2000) (explaining the history and mission of the Royal College of Physicians and Surgeons).

61. *Id.*

62. *Id.*

63. *Id.*

64. *See* 16 CHARLES VINER, A GENERAL ABRIDGMENT OF LAW AND EQUITY 338-45 (2d ed. London, Robinson, Payne & Brooke 1793) (containing reprint of the Royal College original charter, along with legal commentary).

65. *Id.* at 339.

66. *Id.* at 339-41.

67. *Id.* at 341.

68. *Id.* at 344.

69. *Id.* at 343.

70. *Id.* at 344 (indicating the College of Physicians was "impowered to inspect, govern, and censure [physicians]...[The College of Physicians] are Judges of Record...").

71. *Id.* at 345.

72. 8 A. WOOD RENTON, *LAWS OF ENGLAND* 322-51 (1920). Although plaintiffs could allege "gross evidence of want of skill," expert defense witnesses easily refuted such charges. Further, some courts still viewed malpractice as a breach of contract, hence difficult to prove without a written instrument. *See id.*

73. 2 Wils. 359, 95 Eng. Rep. 860 (K.B. 1767), *noted in* Allan H. McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 550 (1959).

74. 8 East 348, 103 Eng. Rep. 376 (K.B. 1807), *noted in* McCoid, *supra* note 73, at 550.

75. *Id.*

76. 11 Price, 400 (1822), *discussed in* FRANCIS H. BOHLEN, *STUDIES IN THE LAW OF TORTS* 92 (1926).

77. *Id.*

78. BOHLEN, *supra* note 76.

79. 5. B (N.C.) 733 (1839), *quoted in* BOHLEN, *supra* note 76.

80. *Id.* at 93.

81. *See* Jay A. Gold, *Reasonable Care: Legal Perspectives on the Doctor-Patient Relationship*, 333 NEW ENG. J. MED. 466 (1995) (describing English law maxim as "Doctor knows best").

82. 8 C&P 475 (1838), *noted in* 33 THE DIGEST: ANNOTATED BRITISH, COMMONWEALTH AND EUROPEAN CASES, 264 (1982) [hereinafter *THE DIGEST*] (a treatise summarizing nineteenth century British case holdings, the specific facts of which are not discussed).

83. *Id.*

84. 3 F&F 35 (1862), *noted in* THE DIGEST, *supra* note 82, at 264-65.

85. *Id.*

86. *See* PROSSER, *supra* note 1.

87. *See* 8 MEWS' DIGEST OF ENGLISH CASE LAW 788 (2d ed. 1925) [hereinafter *MEWS' DIGEST*] (reporting decisions of English,

Scottish, and Irish courts dating back to the nineteenth century).

88. *Id.*

89. *Id.* at 772.

90. *Id.*; *see also* 3 LAW REPORTS, DIGEST OF CASES 3598 (Arthur Paul Stone ed., London, William Clowes & Sons 1892).

91. MEWS' DIGEST, *supra* note 87, at 790.

92. JOSIAH W. SMITH, A MANUAL OF COMMON LAW 1 (Edward Chase Ingersoll ed., Washington City, W.H. & O.H. Morrison, 1875) (quoting from an inscription on the cover page).

93. *Id.* at 442. The author of this treatise was an attorney serving as commissioner in charge of revising the local laws at Washington, D.C., thus furthering the notion of English common law influencing American law well into the nineteenth century. *Id.* at cover page.

94. John G. Fleming, *Developments in the English Law of Medical Liability*, 12 VAND. L. REV. 633, 634-35 (1959). Professor Fleming attributed the trend in part to the advent of an impersonal national health care bureaucracy, born of the British National Service in the late 1940s, as well as increased access to lawyers through utilization of government-funded legal aid programs.

95. 2 Root 90 (Conn. 1794), *discussed in* McCoid, *supra* note 73, at 550.

96. *Id.*

97. *Id.*

98. 22 Pa. (10 Harris) 261, 267-68 (1853), *quoted in* McCoid, *supra* note 73, at 550 n.10.

99. *Id.* at 550.

100. 27 N.H. 460, 469-72 (1853), *quoted in* McCoid *supra* note 73, at 551 n.11.

101. *Id.*

102. *Id.*

103. *See* McCoid, *supra* note 73, at 550.

104. Patricia M. Danzon, *Tort Liability: A Minefield for Managed Care?*, 26 J. LEGAL STUD. 491, 518 (1997) (discussed *infra*).

105. McCoid, *supra* note 73, at 559. The "similar localities" rule has since been modified in most jurisdictions. *E.g.* Vergara v. Doan, 593 N.E.2d 185, 188 (Ind. 1992) (Givan, J., concurring) (explaining that physicians must now practice with the same skill and care of similar practitioners "acting in the same or similar circumstances").

106. Clarence Morris, *Custom and Negligence*, 32 COLUM. L. REV. 1147, 1163-64 (1942) (a comprehensive source of historical information on standard of care and negligence theory).

107. *Id.* at 1164.

108. *Id.*

109. *Id.*

110. *Id.*

111. McCoid, *supra* note 73, at 560; *see also* Aiello v. Muhlenberg Reg'l Med. Ctr., 733 A.2d 433, 441 (N.J. 1999) (noting that professional conduct must be evaluated by the applicable standard of care required of a physician in the same field).

112. McCoid, *supra* note 73, at 559 (seemingly lowering the standard of care required).

113. 8 N.E. 832 (Ill. 1886), *discussed in* McCoid, *supra* note 73, at 559.

114. *Id.*

115. *See* FED. R. EVID. 104, 105 (regarding jury hearings and instructions on admissibility; FED. R. EVID. 702, 703 (regarding judicial discretion for allowing expert testimony); *see also* Daubert v. Merrell Dow Pharmaceuticals, Inc., 509 U.S. 579, 592-93 (1993) (holding judge may act as gatekeeper for inclusion versus exclusion of expert testimony).

116. 32 F.2d 394 (D.C. Cir. 1929).

117. *Id.* at 395-96.

118. *Id.* at 396 (stating there was no evidence that the physician "failed to exercise his best judgment [nor that] he failed to exercise the care and skill ordinarily possessed and exercised by others in the profession").

119. Meyer v. McNutt Hosp., 173 Cal. 156, 158-59 (1916).

120. Brown v. Shortlidge, 98 Cal. App. 352, 355 (1929).

121. Gannon v. Elliot, 19 Cal. App. 4th 1, 6 (1993) (involving a plastic instrument left perioperatively in a hip joint during hip surgery).

122. *See id.* at 7; *see also* Dahlquist, *Common Knowledge in Medical Malpractice Litigation: A Diagnosis and Prescription*, 14 PACIFIC L.J. 133, 136-42 (elaborating on the common knowledge doctrine).

123. Matson v. Naifeh, 595 P.2d 38, 40 (Ariz. 1979) (alleging medical malpractice when treatment for iatrogenic hematoma was delayed, resulting in permanent nerve damage).

124. *E.g.*, Stearrett v. Newcomb, C.A. No. 83C-SE-74, 1988 Del. Super. LEXIS 248, at *6 (Del. Super. Ct., July 20, 1988) (noting that "Delaware does not recognize the 'common knowledge' doctrine").

125. 473 N.E.2d 1131 (Mass. 1985).

126. *Id.* at 1135.

127. *See id.* at 1136.

128. *Id.* at 1135.

129. 551 P.2d 334 (Cal. 1976), *discussed in* Stepakoff, 473 N.E.2d at 1135.

130. *Id.*

131. 706 A.2d 721 (N.J. 1998) (involving alleged negligent prescription of Cipro to a pregnant patient).

132. *Id.* at 734. The court notes, however, that a physician is not "immune from liability [simply if] he or she does his or her best."

133. 709 A.2d 238 (N.J. Super. Ct. App.

Div. 1998), *aff'd*, 733 A.2d 456 (N.J. 1999).

134. *Id.* at 251; *see also id.* at 249 (criticizing arguments that favor physician paternalism, describing such paternalism as “anachronistic”).

135. 239 Cal. Rptr. 810 (Cal. Ct. App. 1986).

136. *Id.* at 812.

137. *Id.*

138. *Id.* at 813.

139. *Id.*

140. *Id.* at 814.

141. *Id.*

142. *Id.*

143. *Id.*

144. *Id.* at 816.

145. *Id.* at 817.

146. *Id.*

147. *Id.* at 810.

148. *See id.* at 818-19 (suggesting the decision to discharge the patient home was within the appropriate medical standard of care).

149. *Id.*

150. *Id.* at 819-20.

151. *Id.*

152. *Id.*

153. *Id.* at 819.

154. 271 Cal. Rptr. 876 (Cal. Ct. App. 1990).

155. *Id.* at 885 (noting that “[t]here remain triable issues of material fact as to [a utilization review company’s] liability for tortious interference with the contract of insurance between the decedent and the [insurance company]...”).

156. *Id.* at 878.

157. *Id.* at 880.

158. *Id.* at 884.

159. *Id.* at 885.

160. *See id. Compare with* Stepakoff v. Kantor, 473 N.E.2d 1131, 1135 (Mass. 1985). *Stepakoff* involved a proposal to divide the standard of care for two aspects

of medical decision-making and conduct, whereas *Wilson* involved bifurcation between physician conduct and HMO conduct.

161. Danzon, *supra* note 104, at 505 (discussing an unpublished case originally noted in David P. Maslen, *Employer Managed Care Liability: Defining and Managing the Risk*, J. COMPENSATION BENEFITS, July-Aug. 1995, at 5.

162. *Id.*

163. *See id.*

164. *Id.* at 517.

165. ERISA is the Employee Retirement Income Security Act of 1974, § 3 (1) (A), 29 U.S.C. § 1002 (1) (A) (1974); *see also* Janet Spicer, *Professional Liability Insurance: The Clinical Environment*, N.J. MED., Aug. 2001, at 41, 42 (explaining that ERISA was promulgated by the late Senator Jacob Javits to encourage large multi-state companies to provide health coverage to their employees. To accomplish this, companies wanted immunity from widely differing regulatory state health care laws. ERISA became law in 1974, exempting all employer-sponsored health plans, including HMOs, from these state laws, even in medical malpractice cases where the plans’ decisions resulted in permanent injury, or even death. Employer-sponsored health organizations thus use ERISA to shield themselves from liability, a tactic that has always engendered controversy.).

166. Danzon, *supra* note 104, at 517.

167. *Id.*

168. *Durham v. Health Net*, No. C-94-3575, 1995 WL 429252 (N.D. Cal. 1995), *aff'd*, 108 F.3d 337 (9th Cir. 1997).

169. *See id.* at *3 (holding that a restaurant employee cannot sue an HMO under ERISA for damages after the HMO withheld a bone marrow transplant for breast cancer).

170. *Pegram v. Herdrich*, 530 U.S. 211, 237 (2000).

171. *Id.*

172. M. Gregg Bloche & Peter D. Jacobson, *The Supreme Court and Bedside Rationing*, 284 JAMA 2776, 2777 (2000) (referring to *Pegram v. Herdrich*, noting "the Court thereby created an opening for myriad state law challenges to health plans' utilization management methods," and "mixed treatment and eligibility decisions are beyond the reach of ERISA's preemptive shield and therefore subject to state lawsuits."); see also Thomas R. McLean & Edward P. Richards, *Managed Care Liability for Breach of Fiduciary Duty After Pegram v. Herdrich: The End of ERISA Preemption for State Law Liability for Medical Care Decision Making*, 53 FLA. L. REV. 1 (2001) (agreeing that *Pegram* facilitates the theory of managed care liability for malpractice).

173. Spicer, *supra* note 165, at 43. But see Editorial, *Curing the Patients' Bill of Rights*, N.Y. TIMES, Sept. 4, 2001, at A22 (indicating recent state patients' rights legislation has yet to yield any successful lawsuits against HMOs).

174. 519 P.2d 981 (Wash. 1974).

175. *Id.* at 983.

176. *Id.*

177. *Id.* at 984 (holding an ophthalmologist to a professional negligence standard that appeared to be akin to strict liability in a malpractice action for failure to diagnosis glaucoma).

178. See BLACK'S LAW DICTIONARY, *supra* note 27, at 926 (defining strict liability as "[l]iability that does not depend on actual negligence or intent to harm, but that is based on the breach of an absolute duty to make something safe").

179. Steve Lopez, *The Single-Doctor HMO: A Small Town Dumps its Provider for a Rebel*

Medic, TIME, Feb. 26, 2001, at 8 (reporting a physician who dropped out of all HMOs as stating: "I'm tired of doing the wrong things as a doctor. I want to do the right things for a while...").

180. James C. Robinson, *The End of Managed Care*, 285 JAMA 2622, 2622 (2001) (stating that "[m]anaged care embodies an effort by employees, the insurance industry, and some elements of the medical profession to establish priorities and decide who gets what from the health care system.... The strategy of giving with one hand while taking away with the other, of offering comprehensive benefits while restricting access through utilization review, has infuriated everyone involved.").

181. *See id.*

182. *Emergency Conference on the Final Stark II Regulations*, Apr. 2001 (pamphlet publicizing such a coding conference for physicians); see also Mary LeGrand, *Using CPT Frequency Reports to Analyze E&M Use*, N.J. MED., Feb. 2001, at 35 (noting that "understanding utilization patterns can assist the physician in determining whether significant differences exist between the physician's billed services and group or national norms").

183. See, e.g., *Direct to Consumer Advertisements for Glucophage XR*, MED. LETTER, Mar. 19, 2001, at 25. Business interests are not confined to managed care organizations and large hospital chains: Pharmaceutical companies are an additional source of influence over medical standard of care. A nonprofit medical publication recently discussed a new diabetes drug being advertised directly to patients (as well as to doctors). The "new" drug is a modified version of an old drug. At least one scientific study showed the new drug to have more adverse side effects than the old drug. Why then is the new drug

being aggressively marketed over the chemically similar old drug? The medical publication points out that the older drug is now off patent and will soon be available as a much cheaper generic drug. Thus, the "new" drug will remain on patent and will remain a potential source of profit for pharmaceutical companies.

184. *Enter-stumbling?*, N.J. MED., Feb. 2001, at 1, 2.

185. *Id.*

186. Such writings are not confined to legal publications. See, e.g., Gregory Webster, *Serving Two Masters: Medical Practice vs. Administrative Ethics*, 282 JAMA 1678, 1678-79 (1999) (arguing that "[s]ociety should expect physicians, as professionals, to be able to make responsible decisions about the allocation of medical resources"); see also Leslie Ray, *Linking Professional and Economic Values in Health Care Organizations*, 10 J. CLINICAL ETHICS 216-23 (1999) (proposing an "ethical" approach for addressing the tension between controlling the cost of care and maintaining quality of service).

187. Ellen Wertheimer, *Ockham's Scalpel: A Return to a Reasonableness Standard*, 43 VILL. L. REV. 321, 323 (1998). She argues that physicians in fact do not make independent decisions under managed care, because managed care length-of-stay decisions are integral to patient care, influence physician judgment, and violate the purported prohibition against the corporate practice of medicine. *Id.* at 325-31.

188. *Id.*

189. *Id.* at 358.

190. As noted in *Wickline*, discussed *supra*.

191. Spicer, *supra* note 165, at 43 (stating that "doctors in most states still bear the majority of the burden. When a

plan obstructs proper treatment, physicians can even be punished for not fighting back against the HMO. Therefore, doctors who do not appeal bad decisions put themselves in a vulnerable position."); see also Megan L. Sheetz, Note, *Toward Controlled Clinical Care Through Clinical Practice Guidelines: The Legal Liability for Developers and Insurers of Clinical Pathways*, 63 BROOK. L. REV. 1341, 1345 n.4 (1997) (noting that HMO fears of increased liability from practice utilization standards can be minimized by using the word "guidelines" instead of "standards," to specify "permissive" rather than "mandatory" directives for providers, thus keeping ultimate liability in the sphere of the providers). Managed care organizations are also advised to make their guidelines "vague," to help them prove "that a physician made poor decisions." *Id.* at 1345 n.4.

192. See Wertheimer, *supra* note 187.

193. Danzon, *supra* note 104, at 518-19.

194. *Id.*

195. *Id.* at 519.

196. See *id.* at 510-11.

197. *Id.*; see also Sheetz, *supra* note 191, at 1345 n.4.

198. Edward B. Hirshfeld & Gail H. Thomason, *Medical Necessity Determinations: The Need for a New Legal Structure*, 6 HEALTH MATRIX 3, 50 (1996). Hirshfeld is the Director of the Health Law Division of the Office of General Counsel of the American Medical Association. *Id.* at 3.

199. *Id.* at 51.

200. See *id.*

201. See *id.* at 34 n.88, 41 n.103 (citing two articles pertinent to the standard of care in this context: Clark C. Havinghurst [sic], *Altering the Applicable Standard of Care*, 49 LAW & CONTEMP. PROBS. 265, 274-75 (1986) ("arguing that patients should have room to choose the physician standards

they feel are most appropriate at an early point in their insurance transaction”), 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 (1994) (“proposing to reform medical malpractice laws to allow variations in the standard of care”).

202. Edward B. Hirshfeld, Commentary, *Should Ethical and Legal Standards For Physicians be Changed to Accommodate New Models for Rationing Health Care?*, 140 U. PA. L. REV. 1809, 1845-46 (1992).

203. Hirshfeld may have subsequently changed his 1992 proposal, as evidenced by his announcement of the AMA's position in 1993: “[O]ut of respect for the evolution of medicine, the AMA is concerned that making a set of practice guidelines mandatory standards of care would stifle innovation and the dissemination of medical advances.” Edward Hirshfeld, *Use of Practice Parameters as Standards of Care and in Health Care Reform: A View from the American Medical Association*, 19 J. QUALITY IMPROVEMENT 322, 323 (1993).

204. See AMERICAN ACADEMY OF PHYSICAL MEDICINE AND REHABILITATION, ADAPTING TO A MANAGED CARE WORLD 33 (1995) (listing managed care impingement on critical decision-making as including “the degree of follow-up care that can be ordered without prior approval,” “the range of services that can be provided in the current visit,” “the latitude in prescribing medications,” and the freedom to admit patients to hospitals, keep patients hospitalized, utilize ancillary services, and refer patients for subspecialty care).

205. Any similarity to specific persons or actual events is purely coincidental.

206. See generally JAMES M. SCHIBANOFF, HEALTH CARE MANAGEMENT GUIDELINES 2

(1999) (published by Milliman & Robertson, Inc., a business/accounting firm, this book purports to “provide a reasonable approach to implementing health care management”).

207. See *id.* at 3 (listing the names of twelve physicians and six registered nurses who participated with the formulation of the published medical care guidelines. With the exception of input from university-affiliated pediatricians, there is no indication of any university involvement, nor any listing of backgrounds and qualifications.).

208. See *id.* at 80 (publishing managed care guidelines with stated goal of having patients stay only three days after hip replacement surgery, with no elaboration on the numerous variables/co-morbidities that could influence and extend the need for continued hospitalization). Interestingly, this book includes a disclaimer from the publishers, entitled “M & R Disclaimer,” including statements that the company “does not warrant that the guidelines are free from all errors and omissions. M & R disclaims all express and all implied warranties.... As the author and publisher of this publication, Milliman & Robertson is not involved in providing medical services or dispensing medical advice. Milliman & Robertson disclaims any and all liability arising out of the information provided in this publication.” *Id.* at 2.

209. This text is quoted from an actual hospital memorandum on file with author. The name of the hospital has been omitted for reasons of confidentiality.

210. See 42 C.F.R. § 409.33 (2001) (listing criteria required for continuation of skilled nursing and rehabilitation services under the Medicare program).

211. See 2 CAMPBELL'S OPERATIVE

ORTHOPAEDICS 2324-25 (Allen S. Edmonson & A.H. Crenshaw eds., 6th ed. 1980) (listing potential postoperative complications after hip surgery, including infection and pulmonary embolism).

212. See generally Sage, *supra* note 3.

213. See Carl Giesler, *Managers of Medicine: The Interplay Between MCOs, Quality of Care, and Tort Reform*, 6 TEX. WESLEYAN L. REV. 31, 59 (1999) (stating that “[o]nly tort liability will force MCOs to incorporate the socially determined standard of care levels into their medical service decisions. Currently, managed care consumers bear the cost of sub-standard care stemming from MCO treatment decisions. Tort law would make MCOs suffer the consequences of their decisions that impinge on medical care, thereby transferring the costs of substandard care. Accordingly, MCOs would have to incorporate those costs in their calculations of whether the benefits of a particular treatment justified its expense.”). *Id.* at 59.

214. Barbara A. Noah, *The Managed Care Dilemma: Can Theories of Tort Liability Adapt to the Realities of Cost Containment?*, 48 MERCER L. REV. 1219, 1251 (1997) (advocating a “cost-defense” for tort actions against hospitals and managed care organizations/physicians, claiming that the cost to society should be weighed as a factor when determining whether a given treatment should or should not have been provided).

215. *Id.*

216. Frankel, *supra* note 201, at 1327 (“This would require a legal regime that allowed beneficiaries and insurers to bargain over the duty of care in the insurance contract and that encouraged courts to defer to that bargain. Plan beneficiaries could establish a more restrictive standard of care (or even a more

generous one, should they be willing to pay for it) through contract language that either explicitly defined the decision rule to be applied in cases alleging negligent medical injury or made reference to a set of medical guidelines or practice protocols as a way of defining the procedures that a physician is obligated to provide to a given patient.”).

217. Surprisingly, a recent ethics journal article advocated a business-like standard of care (reasonableness standard) for primary care physicians in managed care settings, yet failed to explore the issues of true patient knowledge and agreement. See Bernard Friedland, *Managed Care and the Expanding Scope of Primary Care Physicians’ Duties: A Proposal to Redefine Explicitly the Standard of Care*, 26 J.L. MED. & ETHICS 100-12 (1998). In a commentary reply that rejected Friedland’s proposal, Gerard Hickson noted: “Patients would probably like to know [if] their physicians will be held to a lower standard for a given procedure...[y]et experience with patients’ understanding of the fine print does not suggest that informed decision-making will result.” See Gerard Hickson, *Commentary: Don’t Let Primary Care Physicians Off the Hook So Easily*, 26 J.L. MED. & ETHICS 113, 114 (1998) (advocating an approach “for all parties engaged in health care services delivery, including physicians, hospitals and payers, to share risk for any adverse outcome”). Hickson, however, expresses faith in the “productive setting of offices of quality improvement” of hospitals and managed care organizations, a faith that some physicians may view as misguided given the presence of potentially corrupting business interests. See *id.*

218. See SCHIBANOFF, *supra* note 206, at 196-97 (publishing managed care guidelines with the stated goal of keeping

hospital stays for heart attack victims to just three days); *see also* New York Evening News Report (ABC television broadcast, Mar. 14, 2001). A press conference was called by an attorney for thirty-eight physicians who received notices from their hospital that their patients' average length-of-stay was considered unacceptably long. One such letter shown on the broadcast indicated that a cardiovascular surgeon's patients exceeded the average stay by 1.44 days. The physicians were advised to submit a written plan to the hospital for reducing their patients' length-of-stay, or risk losing their hospital privileges. A surgeon with more than fifteen years experience lamented that he was only trying to treat his patients with necessary care, to make certain they were well enough to go home before writing a discharge order.

219. Joseph Azzolina, *Hospital Stay Prompts Plans for Study of How HMOs Can Be Overhauled*, ASBURY PARK PRESS, Mar. 23, 2001, at A19 (stating that "patients, doctors and hospitals are being taken to the cleaners by the HMOs, while this critical health-care system is being degraded in the process.... Every day we wait to take action is another day a patient is denied proper medical care and doctors and hospitals carry an ever increasing financial burden.... I didn't fully understand the magnitude of their problems until I wound up in the hospital. We must act now before more people are hurt by this unworkable health care system.").

220. *See* Kenneth R. Pedroza, Note, *Cutting Fat or Cutting Corners, Health Care Delivery and its Respondent Effect on Liability*, 38 ARIZ. L. REV. 399, 399 (1996) (quoting the New Testament, Matt. 6:24, in reference to physicians trying to serve both patient interests and cost cutting interests).