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When Patients Say No (To Save Money): An Essay on the Tectonics of Health Law

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The ultimate aim of health care public policy is good care at good prices. Managed care stalled at achieving this goal by trying to influence providers, so health policy has turned to the only market-based option left: treating patients like consumers. Health insurance and tax policy are now pressuring patients to spend their own money when they select health plans, providers, and treatments. Expecting patients to choose what they need at the price they want, consumerists believe that market competition will constrain costs while optimizing quality. This classic form of consumerism is today's watchword.

This Article evaluates this ideal type of consumerism and the regulatory mechanism of which it is essentially an example—legally mandated disclosure of information. We do so by assessing the crucial assumptions about human nature on which consumerism and mandated disclosure depend. Consumerism operates in a variety of contexts in a variety of ways with a variety of aims. To assess so protean a thing, we ask what a patient's life would really be like in a consumerist world. The literature abounds in suppositions about how medical consumers should behave. We look for empirical evidence about how real people actually buy health plans, choose providers, and select treatments.

We conclude that consumerism, and thus mandated disclosure generally, are unlikely to accomplish the goals imagined for them. Consumerism's prerequisites are too many and too demanding. First, consumers must have choices that include the coverage, care-takers, and care they want. Second, reliable information about those choices must be available. Third, information must be put before consumers, especially by doctors. Fourth, consumers must receive the information. Fifth, the information must be complete and comprehensible enough for consumers to use it. Sixth, consumers must understand what they are told. Seventh, consumers must be willing to analyze the information. Eighth, consumers must actually analyze the information and do so well enough to make good choices.

Our review of the empirical evidence concludes that these prerequisites cannot be met reliably most of the time. At every stage people encounter daunting hurdles. Like so many other dreams of controlling costs and giving patients control, consumerism is doomed to disappoint. This does not mean that consumerist tools should never be used. It means they should not be used unadvisedly or lightly, but discreetly, advisedly, soberly, and in the fear of error.

ARTICLE CONTENTS

I. INTRODUCTION	745
II. THE GATHERING STORM.....	750
III. THE PLAUSIBLE SOLUTIONS: WAIVER AND ASSUMPTION OF RISK	757
A. PARSING THE DOCTRINE.....	757
B. ILLUSTRATING PROBLEMS WITH THE DOCTRINE.....	762
IV. THE SOLUTION FROM LEGAL ETHICS.....	768
V. A SOLUTION: RESOURCE-VARIABLE STANDARDS	770
VI. CONCLUSION	776
A. WHY THIS PUZZLE MATTERS	776
B. OTHER PUZZLES	777
C. THE PLATES.....	779



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I. INTRODUCTION

The parts of health law, one might say, rest on neighboring tectonic plates. On one plate is the law of malpractice. On an adjoining plate is the law of bioethics—the law that regulates the ethical affairs of patients, including their relationships with doctors and the way their medical decisions are made. On still another contiguous plate is the law of health economics, which has been concerned in recent decades with controlling costs.

Each part of health law has not just its own central purposes but also its own basic assumptions.¹ For years each part developed quite independently, so that one area impinged little on the others. Recently, however, the development of the law has increasingly brought the plates together. This has produced tremors, but the seismic potential of these encounters has gone unnoticed. We write to draw attention to this potential, to ways it is changing health law, and to questions it increasingly presents. We do so through a case study of one tectonic encounter—a patient who says no to standard-of-care treatment because of its cost and then sues in malpractice when harm results. This conflict springs directly out of health policy’s new mantra, “consumer-directed health care,” but before we tell that story, we first sketch each health care field and how it grew.

The law of malpractice developed when the doctor was the director of the patient’s care.² Paternalism was the norm; doctors were the experts. Medicine, like all professions, governed itself and set its own standards; doctors, like all professionals, decided how to do their work. The doctor’s

* We are grateful for the support of a Robert Wood Johnson Foundation Investigator Award in Health Policy Research. We thank Michael Green for helpful comments. For the reasons described in Richard A. Posner, *Goodbye to the Bluebook*, 53 U Chicago L Rev 1343 (1986), we follow the University of Chicago Manual of Legal Citation, as updated by *The University of Chicago Law Review Style Sheet for Volume 76*, online at http://lawreview.uchicago.edu/resources/style_sheet.html.

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¹ See Einer Elhauge, *Allocating Health Care Morally*, 82 Cal L Rev 1449, 1452 (1994).

² See generally Nancy M.P. King, Larry R. Churchill, and Alan W. Cross, eds, *The Physician as Captain of the Ship: A Critical Reappraisal* (D. Reidel 1988).

role as director of care was sustained by the culture of medicine. It set standards of craft skill. It taught craft pride. It committed doctors to a fiduciary obligation to make the patients' welfare their lodestar. Patients were supposed to recognize this and respond by following doctors' orders. When patients sued for malpractice, the standard of performance was (and is) set by the minima the profession established, and those standards were (and are) identified by the expert testimony of a member of the profession.

Today, however, the patient is—at least in principle—the director of care. This is the essence of the law of bioethics, whose soul is the principle of autonomy—the principle that patients have the right to make decisions about their treatment.³ Doctrinally, this principle is embodied in the law of informed consent, which requires the patient's approval of any treatment and hence permits the patient to refuse any treatment. When professional medical standards clash with patients' preferences, the latter are generally supposed to prevail.⁴

Much of the law of bioethics has been about the patient's right to refuse treatment that doctors recommend. An illuminating example is end-of-life decision making. One sign of how much things have changed is that the history of that issue has been forgotten. Earlier in our lifetimes, the conventional view was that doctors had to sustain human life as long as medically possible.⁵ In the last few decades, however, refusing life-sustaining treatment has gone from seeming like a kind of suicide to "death with dignity" by exercising the "right to die." The law's program has become helping patients to stop treatment, not keeping them from dying prematurely. For example, it has become public policy to encourage patients to write "advance directives" that are supposed to allow them to decide prospectively what treatment they would want should they be seriously ill and incompetent to make their own decisions.⁶ The assumption is that the advance directive usually will require ending treatment.

Some of this legal movement has been through case law, some through statutes. But, significantly, much has been through constitutional law. From *Quinlan*⁷ on, courts have said patients have some kind of

³ See Carl E. Schneider, *The Practice of Autonomy: Patients, Doctors, and Medical Decisions* (Oxford 1998).

⁴ See Jerry Menikoff, *Demanded Medical Care*, 30 Ariz St L J 1091, 1091 (1998) ("Patient autonomy" is now accepted as the gold standard for ethical decision-making when recommended care conflicts with a patient's wishes.").

⁵ For a review of the relevant law and culture, see Yale Kamisar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*, 42 Minn L Rev 969, 979–980 (1958). For a review of law at the end of life as it was and is, see Marsha Garrison and Carl E. Schneider, *The Law of Bioethics: Individual Autonomy and Social Regulation* 190–325 (West 2003); Carl E. Schneider, *The Road to Glucksberg*, in Carl E. Schneider, ed, *Law at the End of Life: The Supreme Court and Assisted Suicide* 11 (University of Michigan 2000).

⁶ See, for example, the Patient Self Determination Act, 42 USC § 1395cc(a) (2000).

⁷ *In the Matter of Karen Quinlan*, 355 A2d 647,662–64 (NJ 1976).

constitutional right to refuse treatment even if refusal means death. *Bouvia*⁸ exemplifies this tendency: “The right to refuse medical treatment is basic and fundamental. It is recognized as a part of the right of privacy protected by both the state and federal constitutions. . . . Moreover, . . . there is no practical or logical reason to limit the exercise of this right to ‘terminal’ patients.”⁹ The Supreme Court has declined to call physician-assisted suicide a right, but it has said refusing life-sustaining medical treatment is a constitutionally protected liberty interest.¹⁰

Our third tectonic plate supports the law of health care finance. America has two health care crises: It spends too little, and it spends too much. Too little, because it notoriously leaves almost fifty million people uninsured and, less notoriously, tens of millions under-insured. Too much, because it notoriously devotes far more of its GDP (over 16 percent) than any comparable country to health care without buying appreciably better health.¹¹

We long for a solution to the first crisis, but we address the second. The cost crisis is impressively intractable. Medical spending has outstripped inflation for decades, and for decades, attempts to restrain those costs have—essentially—failed. Some of the forces that drive prices look irrepressible, like ever-improving (and ever-costlier) technology. But exuberant expenditure is also built into the culture of American medicine. Particularly salient aspects of that culture are physicians’ understanding of their duties to their patients, patients’ assumptions about the care they are entitled to, and the law’s regulation of medicine.¹²

It has now become public policy for the law to help change a culture of medicine that routinizes extravagance and depreciates thrift. Managed care was once the predominant way of promoting that policy, but the current favorite is “consumer-driven health care” (more simply, consumerism). Its principal tenet is that medical spending will be better controlled and rationalized if patients pay for more treatment out-of-pocket and are told about the costs and benefits of different treatments so they may make thrifty choices.¹³ As the Secretary of Health and Human Services puts it, “We have a better option, to provide [people] with reliable information about the cost and quality of their care. When given that kind of

⁸ *Bouvia v Superior Court*, 225 Cal Rptr 297 (Cal Ct App 2 Dist 1986).

⁹ *Id.* at 301–02.

¹⁰ *Washington v Glucksberg*, 521 US 702, 723–28 (1997).

¹¹ See generally Mark A. Hall, Mary Anne Bobinski, and David Orentlicher, *Health Care Law and Ethics* 43–60 (Aspen Pub, 7th ed, 2007).

¹² See generally Clark C. Havighurst and Barak D. Richman, *Distributive Injustice(s) in American Health Care*, 69 L & Contemp Probs 7 (Autumn 2006) (demonstrating the systematic unfairness in way America finances, regulates, and dispenses healthcare).

¹³ For general description and critique, see Timothy Stoltzfus Jost, *Health Care at Risk: A Critique of the Consumer-Driven Movement* (Duke 2007); Amy B. Monahan, *The Promise and Peril of Ownership Society Health Care Policy*, 80 Tulane L Rev 777 (2006).

information, we know that consumers will make decisions that drive costs down and the quality up.”¹⁴

Consequently, employers and individuals are buying insurance with notably higher copayments and deductibles than ever before.¹⁵ High-deductible insurance is promoted by a generous tax shelter for health-savings accounts to help defray these out-of-pocket costs.¹⁶ In these ways, public policy asks patients to decide whether a treatment is worth paying for and to bear the consequences when they decide improvidently. In short, the patient is to be the director of care financially as well as medically.

So we have three bodies of law that developed independently. The law of malpractice assumes that the doctor is the director of care; the law of bioethics assumes that the patient is; the law of health care finance at first assumed the former (under one version of managed care), or neither (under another version of managed care), but now assumes the latter. Crucially, treating these three bodies of law differently is increasingly difficult and damaging. To return to our opening metaphor, these tectonic plates are pressing tighter against each other, and something has to give. Our principal goal is to identify this development so that it can be assessed and managed.

We use as our example a particularly significant conflict in today's health policy—the tension between malpractice liability and patient-driven cost control. The law of malpractice pushes costs up, if only because the more thorough the care, the less plausible the suit. But the policy of consumerism is to press costs down. Consumerism attributes authority to the patient, as the law of bioethics long has. Malpractice law keeps the pressure on the doctor. These differences create tectonic tension.

We will study this conflict among the laws of malpractice, bioethics and health finance through one element of that tension—the puzzle of how the doctor should respond to a patient who says no for financial reasons. The most acute instantiation of this conflict is a patient suing a doctor for substandard care where the patient refused recommended care because it seemed too expensive, even though the patient could have afforded it.

This puzzle is like a Rubik's cube—the right result is obvious, but the

¹⁴ Robert Pear, *Bush Proposes Linking the Medicare Drug Premium to Beneficiaries' Income*, NY Times (Feb 16, 2008).

¹⁵ Jason S. Lee and Laura Tollen, *How Low Can You Go? The Impact of Reduced Benefits and Increased Cost Sharing*, W2 Health Aff W229, W229–30 (June 19, 2002), online at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.229v1>.

¹⁶ Richard L. Kaplan, *Who's Afraid of Personal Responsibility? Health Savings Accounts and the Future of American Health Care*, 36 McGeorge L Rev 535, 553–54 (2005); Edward J. Larson and Marc Dettmann, *The Impact of HSAs on Health Care Reform: Preliminary Results After One Year*, 40 Wake Forest L Rev 1087, 1116 (2005).

path to it is obscure. For example: A patient presents with a bad knee.¹⁷ The doctor thinks it's a sprain, but it could be a torn ligament. If the latter, further tearing needs to be prevented. To find out which it is, the doctor recommends an \$800 MRI scan. The patient is not poor and could find the money. But the patient calculates that the possible benefit does not justify the certain cost. The worst happens (this being a law professor's hypothetical): the ligament tears. Can the patient sue for malpractice? Surely not. What else was the doctor to do? Practically, ethically, and legally, physicians cannot make patients accept treatment. Practically, patients can just walk out or stay home. Ethically, the principal principle of medical ethics is patient autonomy, the principle that patients have the right (and perhaps even the duty) to decide what medical treatment to accept.¹⁸ Legally, that ethical right is embodied in the doctrine of informed consent. And legally, treating patients against their will invites a battery or false imprisonment suit. The entire "right to die" edifice assumes that professional standards yield when autonomous patients refuse even the most essential of services, however capricious their reason seems.¹⁹

The correct result is to absolve the doctor, yet much in the culture of medicine and the law of malpractice is in tension with providing suboptimal care. Ethically, patients' resources are not supposed to affect the medical standard of care.²⁰ The American Medical Association's Council on Ethical and Judicial Affairs cheerfully announces that "[e]thically, the standard of care cannot depend on the patient's ability to pay."²¹ Legally, malpractice law holds doctors to the profession's standard of care, a standard that patient refusals may imperil. The standard can vary somewhat, but not explicitly for ability to pay.²² Some tort claims can be waived, but black-letter doctrine bars doctors from requiring patients to

¹⁷ For similar and contrasting scenarios, see Peter D. Jacobson and Michael R. Tunick, *Consumer-Directed Health Care and the Courts: Let the Buyer (And Seller) Beware*, 26 Health Aff 704, 707–10 (May/June 2007); Saul Weiner, "I Can't Afford That!" Dilemmas in the Care of the Uninsured and Underinsured, 16 J Gen Int Med 412 (2001).

¹⁸ See generally Schneider, *The Practice of Autonomy* (cited in note 3).

¹⁹ Also making the connection between the "right to die" and refusing treatment for financial reasons, see J.F. Turner, et al, *Physicians' Ethical Responsibilities Under Co-Pay Insurance: Should Potential Fiscal Liability Become Part of Informed Consent?*, 6 J Clinical Ethics 68, 72 (Spring 1995); Christine K. Cassel, *Doctors and Allocation Decisions: A New Role in the New Medicare*, 10 J Health Polit, Pol, & L 549, 552–53 (1985).

²⁰ As one doctor (and lawyer) writes, "Customizing care on the basis of a patient's insurance coverage is . . . wrong. When patients are sick and vulnerable, they expect their physicians to be their advocates for optimal care, not for some minimalist standard." William M. Sage, *Physicians as Advocates*, 35 Houston L Rev 1529, 1533–34, 1536 (1999), quoting Jerome P. Kassirer, *Managing Care—Should We Adopt a New Ethic?*, 339 New Eng J Med 397 (1998).

²¹ American Medical Association Council on Ethical and Judicial Affairs, *Retainer Practices*, 3 (CEJA Report 3 - A-03) (2003).

²² The law "presumes that there is a unitary standard of care that . . . physicians owe all patients . . . regardless of their financial resources." E. Haavi Morreim, *Cost Containment and the Standard Of Medical Care*, 75 Cal L Rev 1719, 1725, 1757 (1987).

waive malpractice liability.²³ Some tort claims fail when plaintiffs have assumed a risk, but while doctors may have such a defense, it is perilous and burdensome, since it creates the “nightmare scenario”²⁴ of having to convince a jury that the patient really said “no” and had really been adequately informed.

Despite these possible liabilities, few contingency-fee lawyers will want to sue doctors who comply with the patient’s request to provide cost-conserving care: the available defenses make large settlements or verdicts unlikely. But the way the law frames these defenses matters because of the prominence that doctors’ perception of the law has in their relationships with patients. We saw this a generation ago when doctors were told to honor patients’ rejection of life-sustaining treatment. Doctors invoked liability concerns to resist patient directions they disagreed with.²⁵ So, the law had to tell doctors not only that their fears were unfounded, but that they were legally and ethically obligated to honor patients’ wishes to refuse treatment. Similarly, in the consumerist era, if doctors fear that judges and juries will not honor cost-based defenses, they will be well armed and motivated to resist cost-driven reductions in optimal care, especially when their own incomes may also be on the line.

Therefore, health law must somehow permit doctors to honor patients who say no to save money. Even though this legal puzzle arises rarely and will never be common, the lack of clarity in how the law can and should achieve this result is a problem.²⁶ The doctrinal route to the obvious solution affects the burdens and standards of proof that influence how safely a doctor may accept or anticipate a patient’s no and therefore how well doctors can cooperate with the consumerist mechanisms increasingly favored by health care policy. And most consequentially, our analysis teaches us something about the tectonic friction between the laws of malpractice, bioethics, and health care finance.

II. THE GATHERING STORM

The law should recognize more clearly a patient’s authority and a doctor’s leeway to limit care to conserve resources. But how, exactly? When patients insist on saving money by choosing suboptimal treatments,

²³ See notes 94–108 and accompanying text.

²⁴ E. Haavi Morreim, *High-Deductible Health Plans: New Twists on Old Challenges from Tort and Contract*, 59 Vand L Rev 1207, 1225–26 (2006).

²⁵ Discussing this attitude, see Mildred Z. Solomon, et al, *Decisions Near the End of Life: Professional Views on Life-Sustaining Treatments*, 83 Am J Pub Health 14, 14–15 (1993); Leonard H. Glantz, *Withholding and Withdrawing Treatment: The Role of the Criminal Law*, 15 L, Med & Health Care 231, 231, 235–36, 240 (1987).

²⁶ See Jacobson and Tunick, 26 Health Aff at 708 (cited in note 17) (“Currently, physicians would be vulnerable to liability for an adverse outcome attributable to ordering suboptimal treatment.”). But see Morreim, 59 Vand L Rev at 1226 (cited in note 24) (“A strong body of case law appears to protect physicians from liability where patients freely make informed decisions to forego care due to cost.”).

doctors are in a quandary: Should they push for “yes,” or does “no” mean “no”? Doctors may think it safer to threaten to refuse service altogether unless a patient agrees to the best treatment. That is legal.²⁷ But is it ethical? Decent? Useful? Kind? Since the patient is the director of care, perhaps doctors should just acquiesce into “no.” After all, urging more expensive treatment can be seen as unconscionably pursuing a doctor’s selfish interest in his own or his colleagues’ financial benefit. But to fulfill the duty of informed consent, perhaps doctors should press patients with more information about the benefits of the treatment the doctor recommends. Yet pressing information on patients could be seen as pressuring patients to betray their true preferences.

Doctors indeed have considerable resources for cajoling or even bullying patients into agreement. One study of doctors’ responses to hospital patients who said no described a “spectrum of forcefulness” ranging from “forceful persuasion” (telling patients they have no choice) to patients being “coaxed and wheedled.”²⁸ In interviews, physicians gave examples of pushing reluctant patients to accept treatment that ranged from persuasion to manipulation to coercion. One doctor told a woman who balked at a mammogram that he was scheduling one anyway. Another called a taxi to take a patient to the hospital to prevent her from going home. Yet another doctor enlisted family members in convincing recalcitrant patients. Still another doctor asked a patient who was reluctant to leave her grandchild to come in for an exam, “but who will take care of your grandchild if you die?” In sum, doctors dance a delicate dance to accommodate patients’ ambivalent wants and ambiguous needs, and their own. How far should doctors deploy these techniques when patients refuse care to save money?

For decades, the law did not much care. Inability to pay was frequent a century ago,²⁹ but it affected malpractice little because medicine could do little.³⁰ During the century before widespread insurance (roughly 1850–1950), most suits arose from treatment done badly, not treatment

²⁷ See text accompanying note 139.

²⁸ Paul S. Appelbaum and Loren H. Roth, *Patients Who Refuse Treatment in Medical Hospitals*, 250 JAMA 1296, 1299 (1983).

²⁹ For extensive historical reviews of the burdens of medical costs, see generally Herman Miles Somers and Anne Ramsay Somers, *Doctors, Patients, and Health Insurance: The Organization and Financing of Medical Care* 208–10 (1961); Committee on Costs of Medical Care, *Medical Care for the American People* (Chicago 1932).

³⁰ As one historian summarized, in the nineteenth century “no special aids to diagnosis were available to any physician, no therapeutics beyond bleeding, cupping, and administration of drugs. Surgery was ordinarily limited, for rich and poor alike, to the treatment of lacerations and fractures, the reduction of occasional dislocations, the lancing of boils and abscesses.” Charles E. Rosenberg, *Social Class and Medical Care in Nineteenth-Century America: The Rise and Fall of the Dispensary*, 29 J Hist Med & Allied Sci 32, 41 (1974).

foregone.³¹ Thus, in the nineteenth century, orthopedics was the greatest source of malpractice liability—not so much because doctors failed to mend limbs as because they aggressively and disastrously treated what had once been left to nature’s healing.³² Similarly, new sources of liability a century ago were childbirth injuries caused by aggressive intervention, adverse reactions to prescription drugs, and burns from x-rays.³³ Before modern medicine, treatments were not especially expensive. Therefore, patients who could afford care had less reason than now to say no because of cost. When they did, they were hard pressed to show that they were worse off.

Since the 1970s, however, most patients have been insured for most medical costs.³⁴ Insurance has helped make litigation for omitted treatments more common. For example, suits now allege that doctors failed to use expensive diagnostic technologies, technologies that insurance has largely paid for. As technology proliferates while insurance shrinks, doctors increasingly find patients unwilling to pay for measures they recommend. Nevertheless, in modern times, courts have not had to ask whether medical standards may vary according to willingness to pay because, for roughly half a century, most medical services have been mostly insured for most patients.³⁵ Thus neither patients nor physicians have had much economic reason to selectively limit care.³⁶

Resource questions are especially likely where uninsured patients are indigent. For the law to tell poor patients that “you get what you pay for” would mean imposing virtually no lower limit on a doctor’s performance.³⁷

³¹ See Andrew A. Sandor, *The History of Professional Liability Suits in the United States*, 163 JAMA 459, 465 (1957) (“Orthopedic problems accounted for 90% of all reported cases to 1900, and still heads the list as one of the major professional liability hazards.”).

³² Kenneth DeVille, *Medical Malpractice in Twentieth Century United States: The Interaction of Technology, Law, and Culture*, 14 Intl J Tech Assess in Health Care 197, 199–200 (1998); Kenneth Allen DeVille, *Medical Malpractice in Nineteenth-Century America: Origins and Legacy* 24, 32 (NYU 1990).

³³ See Neal C. Hogan, *Unhealed Wounds: Medical Malpractice in the Twentieth Century* 99, 103–04 (LFB 2003).

³⁴ Health insurance covered more than half of hospital costs beginning in the 1950s. Ronald Andersen and Odin W. Anderson, *A Decade of Health Services: Social Survey Trends In Use and Expenditure* 92 (University of Chicago Press 1967). Insurance covered more than half of physicians’ costs beginning in the late 1960s. Paul J. Feldstein, *Health Care Economics* 251–52 (Delmar 5th ed 1999).

³⁵ In support, see 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, 1317 (1994).

³⁶ Cassel, 10 J Health Polit, Pol & L at 551 (cited in note 19) (arguing that because of insurance, as “more expensive interventions became available, the financial constraints on their use were removed”).

³⁷ See *Becker v Janinski*, 15 NYS 675, 677 (1891).

Whether the patient be a pauper or a millionaire, whether he be treated gratuitously or for reward, the physician owes him precisely the same measure of duty, and the same degree of skill and care. He may decline to respond to the call of a patient unable to compensate him; but if he undertake the treatment of such a patient, he cannot defeat a suit for malpractice, nor mitigate a recovery against him, upon the principle that the skill and care required of a

Judges are loath to have tort law ratify the social injustice of unaffordable health care.³⁸ Although some nineteenth-century courts lowered the liability standard from negligence to gross negligence for charity care, others did not.³⁹ And in the twentieth century, courts have rejected charitable immunity for hospitals.⁴⁰

“Bargaining” for half a loaf of care means little if the only alternative is no loaf. When this situation affected only a few patients, it seemed practical to set a standard of care that applied to the great majority of suits. Since most suits were brought by insured patients, the default rule treated all patients as if money were no object.⁴¹ True, this elevated standard may have deterred physicians from taking on indigent patients or helping strangers in distress, but courts have assumed that physicians would respond out of a sense of professional obligation.

In short, during the golden age of health insurance, resource issues rarely affected malpractice cases. But when they did, courts sometimes let resource constraints justify sub-optimal care. Two such cases involved public institutions with exiguous budgets, and both recognized that resources influence the standard of care. In *Moss v Miller*, a prisoner alleged that the prison doctor had negligently failed to refer him to a specialist for an eye injury.⁴² A jury instruction and a lawyer’s closing statement suggested that prison doctors are subject to a lower standard of care. The appellate court disagreed. Doctors in penitentiaries “are held to the same standard of care as [other doctors]. To hold otherwise would be to abandon reason and common sense.” Nevertheless, the court acknowledged that the prison’s scanty resources “may well have a negative effect on the ability to deliver medical services.” And the court held that prison doctors “should not be held liable for injuries resulting from these

physician are proportioned to his expectation of pecuniary recompense. Such a rule would be of the most mischievous consequence; would make the health and life of the indigent the sport of reckless experiment and cruel indifference.

Id at 677.

³⁸ See Notes, *Rethinking Medical Malpractice Law in Light of Medicare Cost-Cutting*, 98 Harv L Rev 1004, 1018–19 (1985) (“Courts, meanwhile, have been reluctant to second-guess the profession’s standards, and on the rare occasions that they have done so, it has been to impose a higher standard.”).

³⁹ *Becker*, 15 NYS at 677 (“Even though [] the defendant was not to be paid for his attendance, he was still bound in law to treat the plaintiff with the requisite skill and the requisite care.”).

⁴⁰ See *President and Directors of Georgetown College v Hughes*, 130 F2d 810, 814, 827 (DC Cir 1942) (observing that “[t]he rule of immunity is out of step with the general trend of legislative and judicial policy”). Physicians rarely have the gumption to claim charitable immunity, but when they do, they too are denied. *University of Virginia Health Services Foundation v Morris, Va*, 657 SE2d 512, 522 (Va 2008). Also, courts have consistently ruled that physicians undertake a duty of care even when they receive no consideration. Elmer D. Brothers, *Medical Jurisprudence: A Statement of the Law of Forensic Medicine* 146 (CV Mosby 1914); P.S. Atiyah, *Medical Malpractice and the Contract/Tort Boundary*, 49 L & Contemp Probs 287, 289 (Spring 1986).

⁴¹ E. Haavi Morreim aptly refers to this as the law’s “artesian” standard, referring to a seemingly bottomless well of medical resources. E. Haavi Morreim, *Holding Health Care Accountable* 86, 93 (Oxford 2001).

⁴² 625 NE2d 1044, 1047 (Ill App Ct 1993).

constraints.”⁴³ In other words, as we read the case, the prison doctor was not liable for substandard care caused by scarce resources but was obliged to practice as skillfully as resources permitted.

Rogers v Okin spoke even more sympathetically about how resources could limit liability.⁴⁴ Was it “reasonable medical practice” for doctors in a state psychiatric hospital to use psychotropic medication so much? The court thought it *was* relevant “to consider the medical resources and support facilities available to the defendants at the Boston State Hospital.” Its “resources were barely adequate.” It dealt primarily “with the most disturbed and potentially violent patients, those for whom local mental health clinics could not care.” Its salaries “were not competitive with private institutions such as McLean’s Hospital.” State hospitals like it often had half “the staff-patient ratio of private hospitals.”⁴⁵ And the care its doctors could provide was limited in ways the doctors could not control. “Like front line surgeons, they were required to work with what they had.” The court agreed with the American Psychiatric Association that it would be “unjust and unreasonable . . . to hold psychiatrists personally and individually responsible for resource deficiencies that are actually the responsibility of society. Such a decision would only deter qualified psychiatrists from working in the very setting where they are most needed.”⁴⁶

These two cases have never been judicially followed, discussed, or contradicted. They are *sui generis*. Tangentially relevant are a few decisions that make medical resources relevant in deciding which local circumstances to consider in determining the prevailing standard of care under the “similar locality” rule. These decisions generally mention medical resources only in passing, and most refer to the availability of medical facilities and equipment.⁴⁷ Other decisions depreciate resource considerations.⁴⁸ Nor were resource considerations relevant to the law’s

⁴³ Id at 1051.

⁴⁴ 478 F Supp 1342, 1384 (D Mass 1979), aff’d in relevant part, rev’d in other respects, *Rogers v. Okin*, 634 F2d 650 (Ct App Mass, 1980).

⁴⁵ Id at 1384 & n 60. The court added: “In addition to staffing deficiencies, the May and Austin physical plants were anything but models. Their heating systems were archaic and unreliable. Seeping steam caused cracked and peeling paint. Inadequate lighting cast a gloomy pall. Their horse trough type bathing facilities were termed ‘Dickensian’ . . .” Id at 1385.

⁴⁶ Id at 1385 (footnote omitted).

⁴⁷ The leading decision is *Hall v Hilbun*, 466 So2d 856, 873 (Miss 1985) (“[T]he physician’s duty of care must take into consideration the quality and kind of facilities, services, equipment and other resources available.”). See also *Primus v Galgano*, 329 F3d 236, 241 (1st Cir 2003) (“[I]t is permissible to consider the medical resources available to the physician as one circumstance in determining the skill and care required.”), quoting *Brune v Belinkoff*, 235 NE2d 793 (Mass 1968). *Hall v Hilbun* has been widely influential in health law casebooks and academic commentary, but has rarely been cited by courts for this point.

⁴⁸ For instance, *Moss v Miller*, 625 NE2d 1044, 1051 (Ill App Ct 1993), discussed in text at note 1456, rejected the consideration of limited resources in prisons under the similar locality standard.

original adoption of the locality standard of medical liability.⁴⁹

Legislatures have been similarly quiet or ambivalent. Some states have shielded physicians from personal liability when they serve low-income patients, but only when working in designated indigent-care clinics.⁵⁰ Many states have reduced liability from negligence to gross negligence for “Good Samaritan” physicians (who respond to emergencies without expecting payment),⁵¹ but the primary purpose is not shielding doctors for harms caused by patients’ restricted resources. A Medicare statute provides some immunity to physicians who comply with practice guidelines aimed at reducing costs.⁵² However, doctors must exercise “due care in all professional conduct taken . . . in compliance with or reliance upon such” guidelines, which clouds the statute’s meaning and blunts its significance.⁵³ Perhaps for these reasons, the statute has never been tested in a reported decision.⁵⁴

Malpractice law began to encounter the cost-control campaign a quarter-century ago. Managed care was then the principal way costs of medical care were to be contained and its quality improved. This raised an inevitable question: If HMOs or government insurers limit payments, may doctors and hospitals reduce proportionately the quality of their services? This question has garnered volumes-more academic analysis than judicial attention. Dozens of articles debated how courts should respond to managed care;⁵⁵ only a few courts spoke.⁵⁶ There are several reasons.

⁴⁹ See DeVille, 14 Intl J Tech Assess in Health Care at 199 (cited in note 32).

⁵⁰ Paul A. Hattis, *Overcoming Barriers to Physician Volunteerism: Summary of State Laws Providing Reduced Malpractice Liability Exposure for Clinician Volunteers*, 2004 U Ill L Rev 167, 168 (2004); John L. Brown, Note, *Statutory Immunity for Volunteer Physicians: A Vehicle for Reaffirmation of the doctor’s Beneficent Duties—Absent the Rights Talk*, 1 Widener L Symp J 425, 428 (1996).

⁵¹ Danny R. Veilleux, Annotation, *Construction and Application of “Good Samaritan” Statutes*, 68 ALR4th 294, 307 (1989).

⁵² 42 USC § 1320c-6(c).

⁵³ See Leah S. Crothers, Note, *Professional Standards Review and the Limitation of Services: An Interpretation of the Effect of Statutory Immunity on Medical Malpractice Liability*, 54 BU L Rev 931, 934–35 (1974) (“Because statutory immunity is conditioned upon the exercise of due care, opportunities still exist for the imposition of common law liabilities upon a physician or provider who has nevertheless complied with [the guidelines].”) (footnote omitted); Kenneth W. Kleinman, Comment, *PSRO: Malpractice Liability and the Impact of the Civil Immunity Clause*, 62 Georgetown L J 1499, 1506 (1974) (“Unless [the guideline] standards are both specific and encompassing and constitute a codification of the standard of care rather than merely review screening criteria, the immunity provision is meaningless.”).

⁵⁴ Also, Medicare agencies and contractors have in fact issued almost no cost-containment guidelines despite this encouragement. See James F. Blumstein, *Medical Malpractice Standard-Setting: Developing Malpractice “Safe Harbors” As a New Role for QIOs?*, 59 Vand L Rev 1017, 1039–41 (2006); Mark A. Hall, *The Defensive Effect of Medical Practice Policies in Malpractice Litigation*, 54 L & Contemp Probs 119, 136–38 (Spring 1991).

⁵⁵ In 1975, Randall Bovbjerg wrote the definitive analytical work on the application of malpractice doctrine to HMOs, Randall Bovbjerg, *The Medical Malpractice Standard of Care: HMOs and Customary Practice*, 1975 Duke L J 1375. In 1981, the *Texas Law Review* published a lengthy debate among James Blumstein, Rand Rosenblatt, and Peter Schuck about precisely this issue. James F. Blumstein, *Rationing Medical Resources: A Constitutional, Legal, and Policy Analysis*, 59 Tex L

First, managed care was not as tenacious as some had feared and others had hoped. Bludgeoned by the market and eviscerated by regulation,⁵⁷ managed care never really penetrated the “no man’s land”⁵⁸ of cutting costs for clearly beneficial care.⁵⁹ Second, defense lawyers prudently avoided raising insurer-imposed economizing as a defense lest their clients seemed more concerned for their purses than their patients.⁶⁰ (Financial issues more often have been raised by plaintiffs pressing for punitive damages.)⁶¹ Finally, ERISA pre-empts suits against employer-funded managed care organizations,⁶² which accounts for most private insurance, and ERISA itself imposes no obstacle to rationing care.⁶³ The few remaining arenas where suits might have arisen produced, for various technical reasons, no

Rev 1345 (1981); Rand E. Rosenblatt, *Rationing “Normal” Health Care: The Hidden Legal Issues*, 59 Tex L Rev 1401 (1981); Peter H. Schuck, *Malpractice Liability and the Rationing of Care*, 59 Tex L Rev 1421 (1981). More recently, see, for example, E. Haavi Morreim, *Holding Health Care Accountable* at 33–34 (cited in note 41); Frankel, Note, 103 Yale L J 1297 (cited in note 35); Maxwell J. Mehlman, *The Patient-Physician Relationship in an Era of Scarce Resources: Is There a Duty to Treat?*, 25 Conn L Rev 349 (1993); Laura Athens Mellas, *Adapting the Judicial Approach to Medical Malpractice Claims Against Physicians to Reflect Medicare Cost Containment Measures*, 62 U Colo L Rev 287 (1991); John A. Siliciano, *Wealth, Equity, and the Unitary Medical Malpractice Standard*, 77 Va L Rev 439 (1991); Mark A. Hall, *The Malpractice Standard Under Health Care Cost Containment*, 17 L, Med & Health Care 347 (1989); Andrea Jean Lairson, Comment, *Reexamining the Physician’s Duty of Care in Response to Medicare’s Prospective Payment System*, 62 Wash L Rev 791, 803 (1987); Robert C. Macaulay, Jr., *Health Care Cost Containment and Medical Malpractice: On a Collision Course*, 21 Suffolk U L Rev 91, 118 (1987); Barry R. Furrow, *Medical Malpractice and Cost Containment: Tightening the Screws*, 36 Case W Res L Rev 985 (1986); Frank H. Marsh, *Health Care Cost Containment and the Duty to Treat*, 6 J Leg Med 157, 169 (1985); Note, *Rethinking Medical Malpractice Law in Light of Medicare Cost-Cutting*, 98 Harv L Rev 1004 (1985); Marshall B. Kapp, *Legal and Ethical Implications of Health Care Reimbursement by Diagnosis Related Groups*, 12 L, Med & Health Care 245, 252 (1984).

⁵⁶ See Peter Jacobson, *Strangers in the Night: Law and Medicine in the Managed Care Era* 138–53, 177–83 (Oxford 2002).

⁵⁷ Mark A. Hall, *The Death of Managed Care: A Regulatory Autopsy*, 30 J Health Polit, Pol, & L 427 (2005).

⁵⁸ Clark C. Havighurst and James F. Blumstein, *Coping with Quality/Cost Trade-Offs in Medical Care: The Role of PSROs*, 70 Nw U L Rev 6, 63 (1975).

⁵⁹ See generally Symposium, *Is the Health Care Revolution Finished?*, 65 L & Contemp Probs 1 (Autumn 2002) (providing a comprehensive discussion of the evolution of managed care).

⁶⁰ Mark A. Hall and Gail Agrawal, *The Impact of State Managed Care Liability Statutes*, 22 Health Aff 138, 143–44 (2003).

⁶¹ It is noteworthy, though, that courts have resisted this move lest focusing on financial motivation unduly prejudice juries against doctors. For example, *Shea v Esensten*, 622 NW2d 130, 136 (Minn Ct App 2001) (“[I]n the absence of any plausible link between the financial evidence and the patient’s treatment, the district court in this case did not abuse its discretion in excluding the evidence.”); *Madsen v Park Nicollet Medical Center*, 419 NW2d 511, 515 (Minn Ct App 1988) (finding financial motive evidence “only marginally relevant, and potentially very prejudicial”), *revd* on other grounds by 431 NW2d 855 (Minn 1988). But see *Neade v Portes*, 739 NE2d 496 (Ill 2000) (finding “issues concerning [treating physician’s] financial gain go to his credibility”). See generally Paul R. Sugarman and Valerie A. Yarabus, *Admissibility of Managed Care Financial Incentives in Medical Malpractice Cases*, 34 Tort & Ins L J 735 (1999).

⁶² *Aetna Health Inc v Davila*, 542 US 200 (2004).

⁶³ See *Pegram v Herdrich*, 530 US 211, 220, 233–34 (2000) (finding that Congress has supported HMO practices which necessarily include “some incentive connecting physician reward with treatment rationing”).

definitive judicial position on whether tort law allows medical standards to bend to insurers' cost constraints.⁶⁴

In sum, malpractice law has not developed good ways to handle resource problems, and there is cause to worry whether it leaves the world safe for consumerism. So we next search for solutions to that problem. We first investigate two immediately plausible solutions—waiver of liability and assumption of risk. We conclude that both describe reasonable justifications for doctors to say yes to patients who say “no”, but both these solutions place too great a burden on doctors to justify their decision and on juries to evaluate it. We then learn that law deals handily with the same problems in legal malpractice by recognizing lawyers' ability to tailor services to clients' means. We adapt that solution to the medical problem. Briefly, law should regard the resource component of the legal standard as a matter of contract (so that doctors may safely say yes to patients who say no). Only the skill and care component should give rise to fiduciary-based tort scrutiny. We close with some lessons our example teaches about the tectonic collisions in the law of health care.

III. THE PLAUSIBLE SOLUTIONS: WAIVER AND ASSUMPTION OF RISK

The simplest solution to our puzzle is that penny-pinching patients either waive claims for harms resulting from treatments they refuse or assume the risk of such harms.⁶⁵ Both solutions state plausible reasons doctors might say yes to patients who reject even good advice. However, neither solution works well enough.

A. Parsing the Doctrine

Contractual waiver and express assumption of risk are the legal theories hospitals recruit when they ask patients to acknowledge that they are leaving against medical advice (“A.M.A.”).⁶⁶ This practice is commonplace,⁶⁷ and costs are one reason patients sometimes leave

⁶⁴ For example, *Neade*, 739 NE2d 496 (refusing to recognize a cause of action for breach of fiduciary duty, separate from simple medical negligence, created by an HMO physician's conflict of interest); *Muse v Charter Hospital of Winston-Salem, Inc.*, 452 SE2d 589 (NC Ct App 1995) (finding hospital liable for interfering with physician's medical judgment by requiring psychiatric patient to be discharged when his insurance ran out); *Wickline v State*, 239 Cal Rptr 810 (Cal Ct App 1986) (finding no issue presented on medical negligence when Medicaid limited hospital stay to four rather than eight days because plaintiff's expert, who was also the treating physician, testified that four days was not substandard). Several juries have awarded very large punitive damages against HMOs for denying necessary care, but these decisions were not appealed. Hall, Bobinski, and Orentlicher at 316 (cited in note 11).

⁶⁵ See generally Morreim, 75 Cal L Rev at 1753–55 (cited at note 22).

⁶⁶ See generally *Admitting and Discharge*, in *Hospital Law Manual*, § 4-12 at 54 (Aspen 1992).

⁶⁷ See Saul N. Weingart, Roger B. Davis and Russell S. Phillips, *Patients Discharged Against Medical Advice From a General Medicine Service*, 13 J Gen Int Med 568 (1998); David Barton Smith

hospitals early.⁶⁸ So can the A.M.A. precedent resolve the dilemma of patients who say no to save money? It cannot.

First, an A.M.A. discharge means terminating treatment, not continuing it suboptimally. A.M.A. forms are used to deter suits alleging that a hospital has abandoned its patient, not to alter or waive the standard of care. Ending treatment is a clean legal resolution because it abrogates both the contractual basis of the treatment relationship and any provider duty.

Second, even if A.M.A. forms worked legal magic, many physicians would rightly reject them. Responding to medicine's first malpractice crisis, some nineteenth-century doctors conditioned treatment on bonded promises not to sue. This worked legally, but it faded away because professional societies thought it hurt the doctor-patient relationship.⁶⁹ Similarly, some primary-care physicians we interviewed knew it might be legally effective to ask refusing patients to sign liability-waiver forms, but they rarely did so (except to make a point with a recalcitrant patient) because it seemed confrontational. Instead, they usually noted the patient's refusal and reasoning in the chart. Our observations are consistent with the largest study of treatment refusals in hospitals, which found that, of 105 hospital patients refusing at least one item of treatment, only one such patient "actually signed out [A.M.A.]"⁷⁰

When the patient who says no to costly care is still the doctor's patient, has the patient waived liability by saying no? Or, has the patient assumed the risk? Either claim makes sense, but they share a defect. Each is an affirmative defense, so doctors must prove its exacting elements. Therefore, affirmative defenses rarely keep a malpractice case from the jury. For instance, in suits by Jehovah's Witnesses where surgeries went badly after patients refused blood transfusions, courts have hesitated to allow assumption of risk as a pre-emptive defense. Instead they want juries to sort out whether the harm was due to lack of blood or to the doctor's surgical negligence.⁷¹

and Joel Leon Telles, *Discharges Against Medical Advice At Regional Acute Care Hospitals*, 81 Am J Pub Health 212 (1991).

⁶⁸ See Patricia Green, et al, *Why Patients Sign Out Against Medical Advice (AMA): Factors Motivating Patients to Sign Out AMA*, 30 Am J Drug & Alcohol Abuse 489, 491 (2004) (the majority of patients at one hospital who left early did so for personal reasons including financial obligations); Zy Aliyu, *Discharge Against Medical Advice: Sociodemographic, Clinical and Financial Perspectives*, 56 Intl J Clinical Practice 325 (2002) (patients without health insurance are more likely to leave early); Julie E. Connelly and Courtney Campbell, *Patients Who Refuse Treatment in Medical Offices*, 147 Archives Int Med 1829, 1831-32 (1987) (costs were reason for refusing recommended treatments in two of twenty-three cases studied).

⁶⁹ DeVille, *Medical Malpractice in Nineteenth-Century America* at 178-81 (cited in note 32).

⁷⁰ Paul S. Appelbaum and Loren H. Roth, *Patients Who Refuse Treatment in Medical Hospitals*, 250 JAMA 1296, 1299-1300 (1983).

⁷¹ For example, *Estate of Reinen v Northern Arizona Orthopedics, Ltd*, 9 P3d 314 (Ariz 2000); *Corlett v Caserta*, 562 NE2d 257 (Ill App Ct 1990).

The defenses of waiver or assumption of risk expose a doctor to unsettling legal uncertainty. But so what? In tort law, controverted facts and conflicting equities are standard, as are unpredictable juries. What is special here, though, is that, if doctors are to accommodate themselves to the cost-control project that is now public policy, doctors need clearer ethical guidance and firmer legal defenses when patients say no to save money.

Furthermore—and this is critical—good doctors do not see the patient’s “no” in isolation. Rather, they see it in terms of their entire relationship with the patient. That is, good doctors look not just at any single treatment; they look at their overall ability to help a patient. This is what doctors regularly do. Patients all the time choose substandard care, they just don’t do it explicitly. They do it by failing to comply with treatments to which they have nominally agreed.⁷² Doctors who refused to treat patients who tacitly insisted on substandard care would keep few patients.

Courts in similar malpractice contexts caution against liability rules that encourage doctors to coerce or abandon patients. For instance, in *Newell v Corres* the court overturned a verdict for a patient whose jaw failed to heal because he refused to have it wired shut.⁷³ The trial court had “ignored the dilemma confronting a physician” when a patient who needs immediate care refuses standard treatment: “If the physician advises the patient to ‘go elsewhere,’ he risks potential liability for abandoning his patient; if he provides an ‘adequate,’ albeit less than ideal, treatment, as here, he can also incur malpractice liability.”⁷⁴

Similarly, *Forman v. Pillsbury*⁷⁵ overturned a verdict in favor of a patient who died from a toxic drug reaction that was not caught in time, stating: “A doctor cannot compel a patient to come to the office for treatment, nor can a doctor force a patient to follow his recommendations outside the office. In fact, few patients would appreciate the type of paternalistic intrusiveness plaintiff’s proposed rule requires.”⁷⁶ And *Shorter v Drury* held that a release signed by a Jehovah’s Witness patient who refused a blood transfusion was not against public policy because the

⁷² See E. Vermeire, et al, *Patient Adherence to Treatment: Three Decades of Research. A Comprehensive Review*, 26 J Clinical Pharmacy & Therapeutics 331, 334 (2001) (“[P]oor compliance is to be expected in 30–50% of all patients, irrespective of disease, prognosis or setting.”).

⁷³ 466 NE2d 1085, 1090 (Ill App Ct 1984).

⁷⁴ Id (citation omitted).

⁷⁵ 753 F Supp 14 (D DC 1990).

⁷⁶ Id at 19. Similarly, in *Mecham v McLeay*, 227 NW2d 829, 832 (Neb 1975), the court allowed a contributory negligence defense (in a case involving delay in diagnosing anemia) based on a patient’s failure to return for a follow-up appointment, noting that, otherwise, “we would be required to say that [the physician] had a duty, in some indefinable method by coercion, threats, or pressure to prevail upon the plaintiff to report back to him and the hospital for the further necessary tests to complete the diagnosis.”

only alternative was for doctors and hospitals to refuse care altogether based on patients' religious beliefs.⁷⁷

It has become public policy to change the culture of medicine, to encourage doctors to offer thrifty care, and to place patients under an economic gun to consider costs in evaluating tests and treatments. What role should courts play in such a transition? Should they try to calibrate doctors' affirmative defenses to malpractice claims to protect patients during the transition? The short answer is that doing so may keep doctors from responding appropriately to the changing world in which they work. Here, the best truly is the enemy of the good.

For instance, E. Haavi Morreim argues for a "best": that a physician in a managed-care organization who invokes a resources defense in malpractice litigation should "be required specifically to demonstrate the nature and severity of his fiscal constraints."⁷⁸ Morreim's standards of specificity are onerous. The demonstration could include, for example: "providing information about the hospital's overall economic situation, its uncompensated care burden, the needs of the plaintiff-patient compared with other patients' needs at the time, the policies developed within the hospital and elsewhere to cope with fiscal limits, and perhaps even the pressures that have been personally applied to the physician-defendant."⁷⁹

Apparently recognizing the agonies of proving all this, Morreim thinks that "some new rules of discovery might be needed, along with more detailed legal specification of the physician's burdens of evidence and persuasion." And that is not all: "The physician should further demonstrate that alternatives to the substandard care were not readily available."⁸⁰

The arguments for the best—for active common-law supervision of the changing culture of medicine—are obvious. They are the arguments for malpractice liability itself. There are many reasons doctors might provide inadequate care. Malpractice liability is supposed to deter doctors from falling below the standard and to compensate patients who have been injured by doctors who do fall below it. If the law frets too much about other policies, the basic purposes of malpractice law may be thwarted.

Nevertheless, we have here a kind of situation that is more common than lawyers like to think—one in which finely-tuned defenses and burdens of proof are too clumsy to work decently during a period of institutional and cultural change. For the policy of making patients

⁷⁷ 695 P2d 116, 121 (1985).

⁷⁸ Morreim, 75 Cal L Rev at 1757 (cited in note 24).

⁷⁹ *Id*

⁸⁰ Still not all: "[A]n adequate rebuttal to the presumption of standard care would require that the physician demonstrate not only that his resources are limited, but also that he and his institution are making good use of the resources they do have." *Id* at 1757–58, 1762.

consumers to succeed, doctors must be able to accept or anticipate “no” without undue danger. The kind of legal regime Morreim and others advocate prevent doctors from accommodating the new world of patients as economic as well as medical directors of care.

Waiver and assumption of risk have another defect. Even when one of these defenses is established, some courts recognize only a partial defense, one that apportions the liability baby.⁸¹ Interestingly illustrative is *Newell*. A young man whose jaw was broken in a mugging refused to have his mouth wired shut for six weeks and instead chose treatment that let him eat and speak. It failed. He sued. He won a directed verdict because no expert would say the alternative treatment met the standard of care. The appellate court reversed and allowed the doctor to defend his “substandard” care by showing the patient’s own “negligence” in refusing the better treatment. However, “under comparative negligence principles a patient’s refusal may not be a complete defense, it is a factor to be weighed by the jury in determining the relative degree of negligence attributable to the parties.”⁸² But what doctor will want to predict how juries will make such decisions?

Assumption of risk has yet another defect. Patients may not assume a risk unless they understand it. Some cases set a mountainous hurdle for proving that a patient was adequately informed.⁸³ If courts rigorously apply informed-consent law to assumption of risk, “[o]nly in rare circumstances would a patient be considered to have assumed the risk of negligent medical treatment”⁸⁴ because “most patients’ knowledge of medicine does not permit them to understand these risks.”⁸⁵ This is why most successful assumption-of-risk defenses involve treatments with pretty obvious perils, like refusing blood transfusions during surgery or trying unorthodox cancer treatment.

⁸¹ See, for example, *Charell v Gonzalez*, 251 AD2d 72, 673 NYS.2d 685 (NY App Div 1998) (affirming verdict that reduced physician’s liability 49 percent because a cancer patient opted for nutritional therapy rather than radiation and chemotherapy); *Shorter*, 695 P2d 116 (affirming jury’s reduction of liability by 75 percent for Jehovah’s Witness who had refused blood transfusion). Apportionment of liability is even more likely in jurisdictions that have merged assumption of risk into a more general approach to comparative fault that also includes contributory negligence. For instance, courts sometimes apportion liability when patients fail to return for follow-up appointments. See, for example, *Mecham*, 227 NW2d 829. See generally Kurtis A. Kemper, Annotation, *Contributory Negligence, Comparative Negligence, or Assumption of Risk, Other than Failing to Reveal Medical History or Follow Instructions, as Defense in Action Against Physician or Surgeon for Medical Malpractice*, 108 ALR5th 385 (2003).

⁸² 466 NE2d at 1090.

⁸³ See the discussion below of *Truman v Thomas*, 611 P2d 902, 906–07 (Cal 1980) in the text accompanying notes 102–19.

⁸⁴ Sharon W. Murphy, Comment, *Contributory Negligence in Medical Malpractice: Are the Standards Changing to Reflect Society’s Growing Health Care Consumerism?*, 17 U Dayton L Rev 151, 162 (1991).

⁸⁵ Angela Roddey Holder, *Medical Malpractice Law* 310 (Wiley 1978).

Waiver law makes it even harder for a doctor to establish a defense.⁸⁶ In an influential decision, the California Supreme Court said a hospital may not exempt itself “from any standard of due care.”⁸⁷ Scholars have debated at length whether, short of complete immunity, parties to a medical transaction may alter the standard of care, as by reducing liability from a negligence to a gross-negligence standard.⁸⁸ Pointing to cases that enforce agreements to arbitrate medical disputes,⁸⁹ some scholars argue that accepting lower-cost insurance amounts to agreeing to a lower standard of care.⁹⁰ These arguments are untested in the courts. Even if they made sense under managed-care insurance, they make little sense for dealings between individual patients and doctors.⁹¹ Managed-care contracts are negotiated by large institutions before the need for treatment. Bedside negotiations with individual patients look much more like the contracts of adhesion that lead courts to call tort waivers unconscionable or contrary to public policy.⁹²

B. Illustrating Problems with the Doctrine

We have been arguing that the two obvious solutions to our doctrinal puzzle—waiver of suit and assumption of risk—look doctrinally plausible but turn out to make it too risky for doctors to say yes to patients who say no. Why does this matter? Why not make doctors explain themselves to juries and accept whatever responsibility for the bad outcome the jury thinks is just? After all, juries do not seem to be hostile to doctors.⁹³

We have given two kinds of answers to that question. First, malpractice law should not impede the patient-directed economies the policy of cost control now tries to promote. Second, when the patient is the director of care, actual doctors dealing with actual patients face such a battery of tactical and ethical problems that the law is little able to evaluate intelligently a doctor’s acceptance of a patient’s no.

Two well-known cases illustrate the points we have just made. They show how the waiver and assumption-of-risk defenses keep malpractice

⁸⁶ For a review of the cases, see William H. Ginsburg et al, *Contractual Revisions to Medical Malpractice Liability*, 49 L. & Contemp. Probs 253 (Spring 1986).

⁸⁷ *Tunkl v Regents of University of California*, 383 P.2d 441, 448 (Cal 1963).

⁸⁸ See, for example, Clark C. Havighurst, *Private Reform of Tort-Law Dogma: Market Opportunities and Legal Obstacles*, 49 L. & Contemp. Probs 143 (Spring 1986).

⁸⁹ For example, *Madden v Kaiser Foundation Hospital*, 552 P.2d 1178 (Cal 1976).

⁹⁰ For example, Clark C. Havighurst, *Health Care Choices: Private Contracts as Instruments of Health Reform* (AEI 1995).

⁹¹ See Jacobson and Tunick, 26 Health Aff. at 708 (cited in note 17).

⁹² See generally Dan B. Dobbs, *The Law of Torts* 542 (West 2000); Restatement (Second) of Torts § 496B (ALI 2008); Restatement (Third) of Torts: Apportionment of Liability § 2, comment (e) (2000). See also Mark A. Hall and Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 Mich. L. Rev. 643 (2008), which discusses unconscionability in the context of negotiating payment terms for medical care.

⁹³ Philip G. Peters, *Doctors & Juries*, 105 Mich. L. Rev. 1453 (2007).

law from comporting with consumerist policies. And they show how challenging it is for legal institutions to write rules that will guide doctors' decisions and judge their actions appropriately, or even intelligibly, in the complex human and medical situation when patients say no to save money.

Our first example is *Schneider v Revici*.⁹⁴ A breast-cancer patient sought out Dr. Revici because he used "non-invasive methods that have not been adopted by the medical community." He agreed to treat her with selenium and diet.⁹⁵ She signed a waiver that said, "I fully understand that some of the treatment procedures and medications are still investigatory awaiting further research and submission for F.D.A. approval. . . . I am aware that the practice of medicine is not an exact science and I acknowledge that no guaranties have been made to me as to the results of the treatment procedures and medications. . . . I therefore release Dr. Emanuel Revici from all liabilities to me I am here because I wish to try the Revici methods and preparations for disease control."⁹⁶

The treatment failed, and "Mrs. Schneider finally underwent a bilateral mastectomy at Sloan-Kettering . . . followed by sixteen months of conventional chemotherapy." She sued.⁹⁷ The court held that "[t]he form signed by Mrs. Schneider lacks the precision required by New York law" to qualify as a covenant not to sue. Although the trial court had erred in refusing to "allow the jury to consider express assumption of risk as an affirmative defense,"⁹⁸ the court permitted the defense only to the extent of instructing the jury, even though the patient had signed an explicit waiver of liability.⁹⁹

Dr. Revici's version of the story suggests how perplexing the doctor's situation can be when patients exercise their now-undoubted right to make their own treatment decisions. Mrs. Schneider had apparently come to Dr. Revici after hearing him discuss his therapy on the radio. He was avowedly a doctor who used "'non-toxic,' non-invasive methods that have not been adopted by the medical community." He had her sign "a detailed consent form" in which she said she fully understood "that some of the treatment procedures and medications are still investigatory awaiting further research and submission for F.D.A. approval." Dr. Revici testified that he had discussed "every point" with Mrs. Schneider because he knew

⁹⁴ 817 F.2d 987 (2d Cir. 1987).

⁹⁵ Id. at 989–90. Although Dr. Revici was called a "quack," subsequent studies have shown that some version of his treatment in fact inhibits several types of cancer. In one study, the compound he used cut cancer deaths in half. The benefit was so dramatic, the researchers felt compelled to halt the placebo wing of the study. Graham Colditz, *Selenium and Cancer Prevention: Promising Results Indicate Further Trials Required*, 276 JAMA 1984 (1996).

⁹⁶ *Revici*, 817 F.2d at 21 n.1.

⁹⁷ Id. at 990.

⁹⁸ Id. at 993, 996.

⁹⁹ The same court reached a similar outcome in a case involving the same doctor but where there was no waiver/consent form. See *Boyle v Revici*, 961 F.2d 1060 (2d Cir. 1992).

“that Mrs. Schneider was not telling me the truth when she told me that . . . she didn’t see any other doctor before me . . .” She had also apparently falsely told him that she had not had a mammogram. Finally, his records showed (although she denied it) that he had advised her four times to “have the tumor surgically removed.”¹⁰⁰

Assuming these facts are true, what should Dr. Revici have done? He had a patient who had come to him because she wanted the kind of care he offered. He had reason to think she was not being honest with him, as many patients are not with their doctors. He advised her to have conventional treatment but continued to provide the treatment she preferred. He went through the legal forms as best he knew how. In retrospect, he would have been better off firing her as a patient. Is this what the law should be encouraging him to do, in a world of patient rights and consumer choice?

For a yet fuller sense of how the law confounds the professional and human situation behind the doctrines we have been discussing, we re-examine a famous case—*Truman v Thomas*.¹⁰¹ First, the California Supreme Court’s version of the facts.¹⁰² Dr. Thomas was Mrs. Truman’s primary physician for six years. He repeatedly urged her to have a pap smear, but he never explicitly told her the risks of not having one. In October 1969, a gynecologist discovered that Mrs. Truman had cervical cancer. Within a year, she died. At trial, “expert testimony was presented which indicated that if Mrs. Truman had undergone a pap smear at any time between 1964 and 1969, the cervical tumor probably would have been discovered in time to save her life.”¹⁰³

The jury’s special verdict found Dr. Thomas “free of any negligence that proximately caused Mrs. Truman’s death.”¹⁰⁴ The California Supreme Court, however, reversed, essentially because the plaintiffs were entitled to an instruction telling the jury that it “could reasonably conclude that Dr. Thomas had a duty to inform Mrs. Truman of the danger of refusing the test because it was not reasonable for Dr. Thomas to assume that Mrs. Truman appreciated the potentially fatal consequences of her conduct.”¹⁰⁵

The Court of Appeal’s more detailed facts suggest how harsh Dr. Thomas’s problem was. He was presumably not looking just at the pap smear issue. Rather, it was just one of many things he was trying to accomplish with Mrs. Truman. And considering the pap smear alone, he had to find the best way to induce her to cooperate, despite her enduring

¹⁰⁰ 817 F2d at 989–90 & n 1.

¹⁰¹ 611 P2d 902 (Cal 1980).

¹⁰² Given the procedural posture of the case, the court interpreted the facts in the light most favorable to the plaintiffs.

¹⁰³ *Truman*, 611 P2d at 904.

¹⁰⁴ *Id* at 905.

¹⁰⁵ *Id* at 907.

resistance.

Mrs. Truman first consulted Dr. Thomas for care in her second pregnancy. She said she had had a pap smear within the past year. Dr. Thomas told her on many occasions to have a pap smear, but she persistently declined or procrastinated: “As I said many times with Rena, when we were doing pelvics, I would say, ‘Rena, you should have a pap smear now,’ and for various reasons she put it off. . . . [W]e already had the equipment there and ready to do it and we always tried to tell girls to have one every year.” Medical records showed that Dr. Thomas was doing ten to twenty pap smears each month for his patients, and his nurse said “it was his normal custom and practice persistently to urge young child bearing women to submit annually to a pap smear.”¹⁰⁶

Several times when Mrs. Truman asked for birth control pills, Dr. Thomas said he would not prescribe them unless she had “a pelvic and a pap smear.” One of these times she said she couldn’t afford it. He replied: “‘We just bought a boat from your husband’” (who had a local boat shop), and he continued, “‘Surely you can come in and have a complete examination and have a pelvic and a pap smear and then we’ll give you the birth control pills and everything,’ and she said she just couldn’t afford it, could she come in for the pelvic and get the birth control pills and come back later for the pap smear, the complete examination.”¹⁰⁷ Dr. Thomas agreed, but despite her promise, Mrs. Truman “didn’t seem to get around” to having the test.¹⁰⁸

Dr. Thomas said he was trying to persuade Mrs. Truman not just to have a pap smear, but also to have a complete physical, including a blood test and a breast examination. Once, when Dr. Thomas prescribed medication for a urinary tract infection, he told Mrs. Truman to come back for a complete examination. But when he saw her again for similar difficulties, “she was having her menstrual period and was unable to allow us to proceed with the pelvic exam or a complete exam and again asked to [delay].”¹⁰⁹

In April 1969, Mrs. Truman saw an urologist, who found an extremely rough cervix and a heavy vaginal discharge. The urologist told her how grave this looked and advised her to see a gynecologist. Mrs. Truman wanted to wait. The urologist saw her in June, July, and August, but she still put off visiting a gynecologist. Finally, in October, the urologist himself arranged for Mrs. Truman to see the gynecologist, who diagnosed her disease.

In sum, from Dr. Thomas’s point of view, Mrs. Truman knew what a

¹⁰⁶ Id at 753.

¹⁰⁷ Id at 754.

¹⁰⁸ Id.

¹⁰⁹ Id.

pap smear was (since she had had one); he repeatedly urged her to have a pap smear; she repeatedly declined; he demonstrated the pap smear's importance by offering to defer his fee, by pestering her to have one, and by threatening to withhold other services if she didn't. As the appellate court observed, Mrs. Truman "continually told defendant she would have a pap smear done shortly in connection with a complete physical examination," so that there "was never a direct express refusal by her to follow the recommendation; there was only procrastination."¹¹⁰ And procrastination seems to have been Mrs. Truman's unbreakable pattern, even when faced with alarming evidence of deadly illness.

Given the standard view of informed consent,¹¹¹ given the patient as director of care, the court's decision to allow suit looks straightforward. Patients make their own decisions; doctors should give them the data they need to do so. Whether to have a pap smear is a medical decision. Therefore, the patient needs all relevant information about its usefulness. *Quod erat demonstrandum*. And aren't screening decisions exactly the kind of choices patients need good—even statistical—information about, since there are lively controversies among experts about the value of many such tests?¹¹²

Truman shows just how dangerous a doctor's encounter with malpractice law can be when a patient says no. Dr. Thomas apparently exerted himself admirably to persuade his patient to good sense in the face of her prolonged and frustrating refusal. But because he did not utter the particular words the California Supreme Court imagined would have changed Mrs. Truman's mind, Dr. Thomas's case was remanded for, presumably, another trial (or a disadvantageous settlement).

The California Supreme Court seems to have accepted the position of the dissenting judge on the Court of Appeal: "Can it be doubted that, had the decedent in this case known that for \$6 and mild discomfort she could discover the existence of cervical cancer and thus survive, she would have taken the test? Central to her failure to take the test was a clear lack of understanding of the significance of the doctor's recommendation."¹¹³ This is just laughable. First and least, Dr. Thomas had a point when he argued that the purpose of pap smears is well known, and it is standard law that doctors need not tell patients well-known things. Second, how could Mrs. Truman have failed to realize the test's importance? Dr. Thomas

¹¹⁰ Id at 760 n 3.

¹¹¹ *Cobbs v Grant*, 502 P2d 1, 10–11 (Cal 1972), is not only the relevant California precedent but also one of the best known informed-consent cases.

¹¹² For a survey of the literature making such exigent arguments about informed consent for screening, particularly in the context of mammography, see Peter H. Schwartz and Eric M. Meslin, *The Ethics of Information: Absolute Risk Reduction and Patient Understanding of Screening*, 23 J Gen Int Med 867 (June 2008).

¹¹³ *Truman*, 155 Cal Rptr at 762.

nagged her for several years about having one. Surely she perceived that he thought the pap smear was necessary even if she did not know exactly why. Third and most significantly, the court's view of how patients think is desperately simple-minded. People frequently fail to follow medical advice even when treatment is easy and they know its value. The standard estimate, for example, is that patients take medications as prescribed only about half the time.¹¹⁴

Especially, people routinely resist discovering serious medical problems. For example, those who know cancer's danger signs are *likelier* to postpone seeing a physician than those who do not.¹¹⁵ Even the chronically ill may feel as Tim Brookes does: "[T]o seek medical treatment is to admit the disease . . . [and to] have our chronic fallibility, our mortality, exposed."¹¹⁶ So one physician postponed investigating his own cancer symptoms: "I wondered why I had been so foolish. . . . I had acted like many of my patients had, accepting the [less worrisome] diagnosis to avoid facing something else."¹¹⁷ Reynolds Price is typical: "Inquisitive to a fault though I'd been all my life, some deep-down voice was running me now. Its primal aim was self-preservation. *Don't make them tell you, and it may not happen. Whatever they tell you may be wrong anyhow. Stay quiet. Stay dark.*"¹¹⁸

Ultimately, Mrs. Truman probably did not know herself why she said no. Was money the issue? Was fear? Had Dr. Thomas exacerbated her fear, would she have changed her opinion or confirmed it? People are not the robots the law imagines. They are a riot of reason and unreason, and good doctors work sympathetically and tactfully with the riot they encounter.

In sum, neither of the two standard defenses fits the relational dynamics of consumerist patients who refuse some of their doctors' recommendations but receive other treatment. Doctors need something better than to have their attempts to respond to patients' requests second-guessed by courts with little grasp of the doctor's actual dilemmas, with an impoverished sense of how real patients think, and with too dogmatic a doctrine. Doctors need guidance about whether and when it is safe to provide less-than-optimal, and perhaps "substandard," treatment in order to save their patients' money. Doctors need all this not for themselves, but for the sake of the public policy of consumerist health care.

¹¹⁴ Vermeire, et al, 26 J Clinical Pharmacy & Therapeutics at 331, 334 (cited in note 73).

¹¹⁵ See Raymond Rink, *Delay Behavior in Breast Cancer Screening*, in J.W. Cullen, B.H. Fox, and R.N. Isom, eds, *Cancer: The Behavioral Dimensions* 23 (Raven 1976).

¹¹⁶ Tim Brookes, *Catching My Breath: An Asthmatic Explores His Illness* 39 (Times Books 1994).

¹¹⁷ Edward E. Rosenbaum, *The Doctor: When the Doctor is the Patient* 52 (Ballantine 1988).

¹¹⁸ Reynolds Price, *A Whole New Life* 11 (Atheneum 1994).

IV. THE SOLUTION FROM LEGAL ETHICS

If lawyers are thoughtful about anything, it is the law that governs themselves. Therefore, their position on whether professional obligations can be limited to fit clients' budgets should be instructive. And it is. Briefly, the law of lawyering distinguishes between the standard of care and the quantity of resources devoted to a case. Lawyers' basic obligations of skill and attentiveness do not depend on clients' resources, but the time and money they devote to a case may be tailored to a client's budget. In other words, lawyers cannot justify laziness, sloppiness, or foolishness simply because clients are poor or parsimonious, but they can work fewer hours, do less research, take fewer depositions, forego experts, use simpler documents, and the like. Lawyers need not lower their professional standards this way, but they may. In fact, they usually do. There is almost always more work that could be done on a problem than is justifiable economically from the client's viewpoint.

The law of lawyering is not quite this unambiguous. It says piously, for instance, that lawyers should be "zealous" in their advocacy and "diligent" in their representation.¹¹⁹ Nor may the client waive the basic duty of competence.¹²⁰ But these duties clearly are limited by the client's willingness to pay. Three leading scholars say:

[L]awyers and clients normally should be able to agree that the lawyer will commit more or less time and energy to the client's cause, assume more or less responsibility, and generate more or less in the way of legal fees. For example, by obtaining an agreement from the client to limit the objectives to be sought, the lawyer can tailor the representation to fit the lawyer's time or inclination, as well as the client's pocketbook.¹²¹

¹¹⁹ ABA, *Annotated Model Rules of Professional Conduct* Rule 1.3 Comment 1 (ABA 5th ed 2003).

¹²⁰ *Id.* Rule 1.2 Comment 7.

¹²¹ Geoffrey C. Hazard, Jr., W. William Hodes, and Peter R. Jarvis, *The Law of Lawyering* § 5.10 (Aspen 3d ed 2008 Supp). Two other respected scholars agree that:

[T]he means that a lawyer may or must use in the course of that representation can also be contractually regulated—and frequently are. A lawyer and client can agree that the lawyer will spend no more than a set amount of time or money defending a lawsuit, studying a contract or will, or researching the title to a piece of property. More often though, lawyers and clients decide matters like these as they arise. A lawyer will consult a client before engaging an expert witness or beginning a research project that is likely to require a good deal of time.

David A. Hyman and Charles Silver, *And Such Small Portions: Limited Performance Agreements and the Cost/Quality/Access Trade-Off*, 11 *Georgetown J Legal Ethics* 959, 969 (1998). And yet another sums things up:

[T]ort law does not insist that Volkswagens be as safe as Volvos, nor does it require that a Legal Aid attorney handle a client's matrimonial problems in the same manner as would Donald Trump's team of lawyers. . . . Indeed, in the legal malpractice context, the concept that the amount of service owed a client is dependent upon the amount of service that the client has agreed to pay for is virtually unquestioned.

Similarly, the *Model Rules of Professional Conduct* permit a client to “exclude specific means that might otherwise be used to accomplish the client’s objectives . . . [if] the client thinks [they] are too costly.” Such limitations are a “factor to be considered when determining the legal knowledge, skill, thoroughness and preparation reasonably necessary for the representation.”¹²² This rule provides “a framework within which lawyers may expand access to legal services by providing limited but nonetheless valuable legal services to low or moderate-income persons who otherwise would be unable to obtain counsel.”¹²³ The *Restatement (Third) of the Law Governing Lawyers* likewise recognizes that “for some clients the costs of more extensive services may outweigh their benefits.”¹²⁴ A corporation might wish to litigate a case within a budget that requires “conducting limited discovery, which could materially lessen the likelihood of success.” A person might wish to pay only for a thirty-minute review of a tax return, though this might not uncover all the possible problems.¹²⁵ As long as the clients know the risk of these limitations, they are allowable, the Restatement explains, because the clients obtain something of benefit and because they may, if they wish, purchase more assistance.¹²⁶

The only relevant area of real controversy is whether liability insurers can limit retained lawyers to a set budget. Because an insurer-paid defense is on behalf of the policyholder, this three-party situation is trickier—it is closer to the problems presented by managed-care insurance than to the problems of consumer-directed care. This is because the defense lawyer has competing loyalties to the policyholder and the insurer. The weight of opinion appears to permit insurers to limit defense expenses if the lawyer reasonably believes that competent representation is still possible and if the policyholders are adequately informed (so they can pay for additional effort or other lawyers if they wish).¹²⁷ In other words, the law of

Siliciano, 77 Va L Rev at 481 & n 138 (cited in note 55).

¹²² ABA, *Model Rules* Rule 1.2 Comments 6 & 7 (cited in note 120).

¹²³ Id Rule 1.2 Annotation subsection (c). See also Mary Helen McNeal, *Redefining Attorney-Client Roles: Unbundling and Moderate-Income Elderly Clients*, 32 Wake Forest L Rev 295 (1997) (arguing for unbundling legal services to allow low-income clients to hire attorneys only to provide discrete functions).

¹²⁴ 1 Restatement (Third) of the Law Governing Lawyers § 19 Comment (b) (ALI 2000).

¹²⁵ Id §19, Illustrations 1 & 2. See also ABA, Standing Committee on Ethics and Professional Responsibility, *Formal and Informal Opinions 1983–1998* Informal Opinion 85-1515 (ABA 2000) (permitting lawyers to provide simple wills from booth at the state fair); Task Force on Lawyer Business Ethics, *Statements of Principles*, 51 ABA Bus L 1303, 1312 (1996) (noting that a client can decide that “a ‘leave-no-stone-unturned’ approach is appropriate, or [that] the client prefer[s] to accept some risk in order to avoid some of the costs attendant to such an approach”).

¹²⁶ 1 Restatement (Third) of the Law Governing Lawyers § 19 Illustrations 1 and 2 (ALI 2000). See also Fred C. Zacharias, *Limited Performance Agreements: Should Clients Get What They Pay For?*, 11 Georgetown J Legal Ethics 915, 921(1998) (“[T]he agreement must be voluntary, relatively informed, and within the bounds of reason.”).

¹²⁷ 2 Restatement (Third) of the Law Governing Lawyers § 134 Illustration 5 (ALI 2000).

lawyering hesitates only at the point of allowing policyholders to authorize third party insurers to set cost constraints on their joint behalves. Because this in fact is permitted, *a fortiori* clients may set their own constraints directly. Two estimable scholars analogize this rule directly to limited medical services:

[P]eople are free to buy less than a “gold-plated” attorney. . . . [W]hen buying liability insurance, [insureds] may prefer to pay for less expensive lawyering, just as consumers of health insurance increasingly choose cost savings over unlimited expensive medical care. We believe that just as doctors should not have exclusive authority to define how much medical care consumers must buy, lawyers should not be able to employ professional responsibility law to control the amount of legal services insureds must buy.¹²⁸

V. A SOLUTION: RESOURCE-VARIABLE STANDARDS

Law should allow consumer-driven physicians to honor patients’ cost-motivated preferences, but doctors should not automatically do so. Instead, they should decide individually how low to go and how strenuously to urge patients to accept the recommended care.¹²⁹ Professional ethics bar physicians from providing care that is less than “competent,”¹³⁰ and they enjoin physicians to refuse to “violate fundamental personal values, standards of scientific or ethical practice, or the law.”¹³¹ Legally, physicians may terminate care for any reason, including money, but only at a non-critical point in the treatment when patients can find alternative care.¹³² These principles usually leave doctors free to fire patients who insist on care the doctor thinks intolerably substandard.¹³³

¹²⁸ Charles Silver and Kent Syverud, *The Professional Responsibilities of Insurance Defense Lawyers*, 45 Duke L J 255, 362–63 (1995).

¹²⁹ For instance, one study found that Dutch oncologists are more willing to pressure or persuade patients if they refuse treatment with a curative rather than palliative goal. Titia van Kleffens, Berna van Baarsen, and Evert van Leeuwen, *The Medical Practice of Patient Autonomy and Cancer Treatment Refusals: A Patients’ and Physicians’ Perspective*, 58 Soc Sci & Med 2325 (2004). We found similar attitudes in our more limited pilot interviews with primary physicians. They were more willing, for example, to help patients choose cheaper but less effective medication for arthritis than for heart conditions.

¹³⁰ AMA, *Principles of Medical Ethics* § 1 (2001), online at http://www.ama-assn.org/ama/upload/mm/369/2001_principles.pdf (visited Oct 25, 2008).

¹³¹ Joseph A. Carrese, *Refusal of Care: Patients’ Well-Being and Physicians’ Ethical Obligations*, 296 JAMA 691, 694 (2006).

¹³² Jerry Menikoff, *Demanded Medical Care*, 30 Ariz St L J 1091, 1111–12 n 49 (1998); Mark A. Hall, *A Theory of Economic Informed Consent*, 31 Ga L Rev 511, 528–33 (1997); Edward B. Hirshfeld, *Should Ethical and Legal Standards for Physicians Be Changed to Accommodate New Models for Rationing Health Care?*, 140 Pa L Rev at 1839–41; Mathew Robert Gregory, *Hard Choices: Patient Autonomy in an Era of Health Care Cost Containment*, 30 Jurimetrics J 483, 499 (1990).

¹³³ See, for example, *Matthies v Mastromonaco*, 709 A2d 238, 253 (NJ Super App Div 1998), aff’d 733 A2d 456 (NJ 1999) (“If the patient selects a course, even from among reasonable alternatives,

But for consumerism to succeed, the law must protect providers who continue to treat patients who decline to pay for optimal treatment. Legal scholars have already shown how that might be accomplished under existing principles: by separating the resource component from the skill component of the standard of care.¹³⁴ These scholars suggest that the medical malpractice standard that developed under comprehensive insurance conflates two distinct components: (1) the resources physicians devote to helping a patient, such as treatments, facilities, diagnostic technologies, and medications, and (2) the skill and care doctors employ in using these resources.¹³⁵

Historically, resources were limited by the primitive state of medicine. Therefore, earlier statements about the consistency of medical standards across patients of different financial means applied mainly to the skill and care component.¹³⁶ And still today, physicians think of themselves as following an unvarying standard of carefulness. Consider, for instance, how the former head of Medicare explained this point to physicians. Posing to doctors a scenario of discovering just before performing surgery that they would be paid sixty percent less than they had thought, he asks “Will you do it any less well?” and then quickly notes that most doctors “will appropriately take umbrage at the very question . . . and insist that their actual performance in surgery would be no different at the lower fee than the higher.” Nor do doctors volunteering “to provide free services at a local clinic or in a third world refugee camp [perform] at a lower professional level, or [provide] a lower quality service—although the practice environment may be of lower, or at least different, quality.” In short, to say “that a professional paid 2x will perform significantly better than if he is paid x is to describe behavior that is inherently

which the physician regards as inappropriate or disagreeable, the physician is free to refuse to participate and to withdraw from the case upon providing reasonable assurances that basic treatment and care will continue. In such circumstances, there can be no liability for the refusal.”). But see Menikoff, 30 Ariz St L J 1091 (cited in note 134) (arguing that doctors are free to refuse care that is *more* costly than a minimally acceptable standard).

¹³⁴ The first article to draw this distinction was Randall R. Bovbjerg and William G. Kopit, *Coverage and Care for the Medically Indigent: Public and Private Options*, 19 Ind L Rev 857, 916 (1986) (“Partly through an unfortunate linguistic coincidence, the legal standard of “care,” which originally meant the degree of carefulness required to be non-negligent, has come to mean also what services themselves are appropriate. Some rethinking seems called for here.”). Others who further developed this idea include E. Haavi Morreim, *Holding Health Care Accountable* at 80–82 (cited in note 41); Frankel, Note, 103 Yale L J 1297 (cited in note 35); Siliciano, 77 Va L Rev 439 (cited in note 55); E. Haavi Morreim, *Stratified Scarcity: Redefining the Standard of Care*, 17 L, Med & Health Care 356 (1989).

¹³⁵ This distinction is similar to that in products liability between conscious design choices and manufacturing defects. James A. Henderson, Jr. and John A. Siliciano, *Universal Health Care and the Continued Reliance on Custom in Determining Medical Malpractice*, 79 Cornell L Rev 1382, 1385 n 16, 1396 n 48 (1994).

¹³⁶ See, for example, *Becker v Janinski*, 15 NYS 675 (NYCP 1891), quoted in note 37, which concerned a physician who failed to attend properly to a woman who had miscarried.

unprofessional.”¹³⁷

As medicine advanced, however, the resource aspect of the standard of care became relevant. The law could have set resource standards using either contract or tort doctrine. Because tort law almost necessarily applies to the care and skill component, the simpler solution historically was to apply tort law to both components. Moreover, contract principles were largely inapposite to the resource component when neither doctor nor patient controlled most resource constraints. These constraints were imposed mainly by geography or facilities or by managed-care insurance. When insurance requires that patients set their own limits, contract principles play a greater role in establishing doctors’ legal obligations. Therefore, today, the skill component still raises tort issues, but resource commitments are best interpreted through contract.¹³⁸

A contractual approach is fully consistent with the legal understanding that contract defines a doctor’s basic obligations at the outset of the relationship. For instance, doctors can specify that they are responsible only for some aspects of a case and not others, or that they will provide only office-based but not hospital care.¹³⁹ Similarly, contract principles should allow doctors to agree to limit the resources they use. Within those boundaries, tort law asks how well the resources are employed, but it does not ask whether it was good or bad medicine to agree to patients’ wishes to limit options.

One doctrinal glitch with this contractual approach is that, traditionally, doctors’ legal obligations begin when they take a case. Simply agreeing to see a patient or beginning a diagnosis can initiate a relationship.¹⁴⁰ This hair-trigger formation of the medical relationship contrasts with the rules for legal services.¹⁴¹ Lawyers and their potential clients generally have time to confer before deciding whether and how the lawyer should represent the client. Because medical care can be urgent, doctors and patients do not always have this luxury. In addition, once people become patients, they often have a series of problems which cannot be anticipated. Lawyers are more likely to be hired for single episodes. Also, doctors may not freely drop a case after it is evaluated.¹⁴² Instead,

¹³⁷ He attributes this to Uwe Reinhardt. Bruce C. Vladeck, *If Paying for Quality Is Such a Bad Idea, Why Is Everyone for It?*, 60 Wash & Lee L Rev 1345, 1369–70 (2003).

¹³⁸ See Morreim, *Holding Health Care Accountable* at 91 (cited in note 41); Siliciano, 77 Va L Rev at 440 & n 6 (cited in note 55).

¹³⁹ Annotation, *Liability of Physician Who Abandons Case*, 57 ALR2d 432 (1958).

¹⁴⁰ See generally Richard J. Kohlman, *Existence of Physician and Patient Relationship*, 46 Am Jur 2d Proof Facts 373, 379 (1986); Steven E. Pegalis, 1 *American Law of Medical Malpractice* § 2.3 (1980).

¹⁴¹ See Silver and Syverud, 45 Duke L J at 290 (cited in note 129) (emphasizing extent to which scope of responsibility for legal services is defined in first instance by retainer agreement, rather than this agreement limiting pre-existing obligation).

¹⁴² See, for example, *Harris v Griffin*, 612 SE2d 7 (Ga Ct App 2005).

they must treat patients who cannot readily find other care. Therefore, the solution for lawyers—that limitations on the representation are usually specified in advance—will not work reliably for doctors. They, and their patients need to determine what measures are affordable as diagnosis and treatment unfold.¹⁴³

Expecting doctors to do what they can with limited resources reconciles seemingly inconsistent doctrines. Contract law cannot be used to waive the basic tort standard of care because it includes the mandatory-skill component. Contractually limiting the resources available for treatment does not absolve a doctor from the duty of care in employing those resources. Speaking of a unitary standard of care obscures this important distinction; untangling these two components of medical standards helps to clarify which part is contractable and which is not.

Distinguishing competence failures and resource failures can surely be taxing. Nevertheless, the distinction is quite comprehensible, and it is generally consistent with the law we have reviewed.¹⁴⁴ The only decision that might appear contrary actually recognizes this distinction. *Moss v. Miller* held that the basic standard of care should not be lower for prisoners.¹⁴⁵ But the court's conclusion that resource "constraints, while interfering with proper medical care, do not lessen the standards required of the medical arts practitioner"¹⁴⁶ makes sense only if one distinguishes the skill-and-care from the resource component of the legal standard. The same is true of the federal statute which says that following Medicare's cost-containment guidelines protects doctors from negligence liability *if* they "exercised due care in all professional conduct."¹⁴⁷ This statute is incoherent if the standard of care is all-encompassing, but it can make sense because the statute's cost-sensitive guidelines can be applied either skillfully or carelessly.

Legal scholars generally agree that medical resources should be separated from the general standard of care, but they differ on how to disentangle the complex components of clinical behavior. Some analysts think the law should simply distinguish *what* is done from *how* it is done and apply the general standard of care only to the latter.¹⁴⁸ However, doctors can make negligent mistakes in both arenas whatever their resources. For instance, doctors might forego essential diagnostic or

¹⁴³ Consistent with our recommendation, the Emergency Medical Treatment and Active Labor Act allows hospital emergency rooms to decide whether or not to transfer a patient after they conduct a mandatory initial screening evaluation. 42 USC § 1395dd.

¹⁴⁴ Text at notes 42–46.

¹⁴⁵ 625 NE2d 1044, 1051 (Ill App Ct 1993).

¹⁴⁶ *Id.*

¹⁴⁷ 42 USC § 1320c-6.

¹⁴⁸ Frankel, Note, 103 Yale L J at 1323 (cited in note 35); Bovbjerg and Kopit, 19 Ind L Rev at 916 (cited in note 135).

treatment measures simply because they did not realize their necessity. Morreim, the leading advocate of the resource distinction, goes a step further. She argues that when a test is omitted, liability should turn on the doctor's reasons: "If the physician simply did not know the test was needed, the basic problem would still concern [negligent] expertise." But "if the physician knew the testing was indicated but did not order it because the patient's insurer refused to pay, the situation poses a resource issue." So "[o]nly a careful factual investigation can determine, in any given case, whether an expertise or a resource deficiency, or both, or neither, caused the patient's adverse outcome."¹⁴⁹

This raises the concerns we canvassed earlier regarding affirmative defenses.¹⁵⁰ Detailed evaluations of doctors' reasoning are just what to avoid. First, no factfinder—judge, jury, expert panel—can reliably figure out years later exactly what mix of motives animated a physician's decision; the relationship between patient, doctor, and decision will too often be too complex and wholly misremembered. This is one of *Truman's* lessons. Second, as we have argued, malpractice law needs to make it palpably safe for physicians to promote the consumerism that is now public policy. Having different liability rules for each component of a medical decision is complicated enough. Varying those rules for each type of insurance (conventional versus managed-care versus high-deductible) and each mix of motives would mystify judges and juries and justify doctors in their (otherwise often unjustifiable) contempt for the law and its surreality.

A simpler approach would diminish these difficulties. It would judge a patient's treatment under a professional negligence standard that accounts for patient-imposed resource limitations. Such limitations would not reduce the minimal skill and attentiveness required, but they would let doctors provide thriftier treatment to some patients than others—as long as the overall care is within professional norms. One way to accomplish this is through more active use of the "respectable minority" or "schools of thought" doctrine.¹⁵¹ This doctrine is usually only an affirmative defense for physicians who subscribe to alternative medical philosophies. It could be adapted to allow doctors to accommodate patients' varying financial situations. This should be permitted as long as each patient receives treatment that is acceptable under some legitimate school of thought. Conceived this way, it becomes the plaintiff's burden to show not just that the doctor departed from the dominant school of thought, but instead that

¹⁴⁹ Morreim, *Holding Health Care Accountable* at 82 (cited in note 41).

¹⁵⁰ Text at notes 71–92.

¹⁵¹ See, for example, Mark A. Hall, 54 L. & Contemp. Probs. at 129 (cited in note 54); Mark A. Hall, *The Malpractice Standard Under Health Care Cost Containment*, 17 L. Med. & Health Care 347 (1989).

the treatment is supported by *no* respectable professional point of view. This recasting of the plaintiff's burden would better protect doctors who adopt different practice styles to accommodate their patients' financial choices.

The schools-of-thought and the resource-context approaches to the standard of care make sense for discretionary decisions not to recommend care, but not for patients who adamantly refuse treatment all doctors would advise. When that happens, we return to the core dilemma in its strongest form: May a doctor provide substandard treatment to a patient who selectively refuses more expensive care, where the doctor's only alternatives are to fire the patient or insist that the patient accept unwanted treatment? This problem is not well handled by subjecting to negligence law all treatment refusals directed by patients. Instead, such patient-directed decisions should be regarded as contractually determined.

A remaining problem with the contractual approach is that fiduciary principles strongly influence how contract principles apply to medical decisions.¹⁵² Informed-consent law is the leading example. But, as we saw earlier, if full-bore informed consent applied to treatment refusals, doctors could rarely honor them without strenuously trying to talk patients out of their decisions. Doctors may behave this way, and sometimes should, but adversarial medicine and heavy-handed sales techniques should hardly be legally required.

Stringent informed-consent standards should not be applied to cost-motivated treatment refusals for still another reason. Normally, informed consent applies to treatment for which the doctor may charge a fee but which poses risks for the patient. When recommended treatment is *refused*, the stakes are turned. Patients assert themselves to guard against medical risk and cost, contrary to the doctor's professional inclinations and economic interests. Because doctors have incentives to convince patients to say yes, the law need not scrutinize how vigorously they did so.

For all these reasons, the law should take at face value any evidence that patients refused treatment. Law should not require special evidence or proof of informed refusal, assumption of risk, or waiver of liability. The doctor must allege and prove that the patient refused treatment, but if the preponderance of the evidence shows actual patient refusal, that should end liability issues arising from the omitted treatments.¹⁵³ When patients have not refused a treatment, doctors should still be able to defend themselves

¹⁵² See generally Maxwell J. Mehlman, *Fiduciary Contracting: Limitations on Bargaining Between Patients and Health Care Providers*, 51 U Pitt L Rev 365 (1990).

¹⁵³ Absent extraordinary circumstances, these might include species of fraud or negligence in misrepresenting the nature and purpose of proposed treatments. Also, uninsured patients require special consideration because they may have no realistic ability to pay and so their treatment refusals are less voluntary. For further analysis of that scenario, see Siliciano, 77 Va L Rev 439 (cited in note 55).

(under an accommodating version of the “schools of thought” rule) by showing that they did a decent job considering the resources at hand. This may require expert testimony but avoids requiring that doctors document a specific patient refusal for each omitted item.

VI. CONCLUSION

A. Why This Puzzle Matters

Our principal task in this Article is to show how the tectonic plates supporting the laws of malpractice, bioethics, and health care finance are colliding in ways that will require adjustments in legal doctrine. We have seen that when patients want to say no to save money, doctors must be able to acquiesce, but incentives created by the law of malpractice counsel otherwise. We have used our malpractice puzzle as one example of the kinds of conflicts that are arising in the new tectonic world and of how answers might be worked out. But this puzzle is also worth solving for itself.

Physicians and their professional organizations have long and lavishly overestimated liability threats,¹⁵⁴ especially in response to market changes that threaten their professional environment. For instance, doctors dreadfully exaggerated the legal risks of telemedicine and of managed-care gatekeeping.¹⁵⁵ Under high-deductible health insurance and other consumerist arrangements, doctors have principled reason to fear suits. This perception could create the reality of actual resistance to patient-imposed cost pressures, and these reactions themselves will drive professional and legal norms. Therefore, the law should state clearly and early the legal consequences of patients’ cost-motivated refusals.

The need for the law to do so is considerably sharpened by the fact that our old method of cost control—managed care—is being supplemented by consumerist attempts to control medical costs. That presents our Rubik’s cube puzzle—should doctors be liable if they accept a patient’s refusal of recommended treatment? We know the answer must be no. That is the answer the law of bioethics demands. That is the answer the law of health care finance currently demands. But that is the answer the law of malpractice makes difficult. The standard defenses of waiver and assumption of risk do not suffice because they are affirmative defenses that expose doctors to too much litigation burden and risk. Under the public policy of consumer-driven cost control, doctors must be able to accept a patient’s “no.” Therefore, we recommends the simple legal rule that no

¹⁵⁴ Michelle M. Mello and Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 Tex L Rev 1595, 1609 (2002).

¹⁵⁵ Mark A. Hall, Ralph A. Peeples, and Richard W. Lord, Jr., *Liability Implications of Physician-Directed Care Coordination*, 3 Annals Fam Med 115, 119 (2005).

means no.

Our position should mitigate physicians' legitimate concerns by freeing them from the travails of an affirmative defense. Yet our position protects patients' interests, in three principal ways. First, doctors cannot insist on waiving the basic, minimum standard of skill, care, and attentiveness, no matter how little patients will pay. Second, if patients do not specifically refuse recommended treatments, doctors are liable if they do not treat patients reasonably, following at least some respectable school of thought. Finally, freeing doctors to adapt treatment to patients' cost preferences will lessen any legal reason doctors might assert for refusing patients who cannot or will not pay top dollar.

We may be seen as letting doctors off the hook too easily. Sustaining the quality of medical care is surely difficult. And neither the law nor the profession deals adequately with incompetent doctors. But that is no reason to make malpractice law unreasonable or unresponsive to all other public policies. True, this attitude must occasionally lead to unrequited injury, but that cost is outweighed by the costs of the alternatives.

B. Other Puzzles

We have just begun a conversation about a subject—tectonic clashes—rich in such puzzles. For instance, even our little malpractice exercise can be extended impressively. Our puzzle asks what to do if a patient says no. But should a doctor always have to ask for a yes or a no? Can a doctor anticipate a no?

In the easiest case, a doctor knows a patient well enough to know that the patient will decline some kinds of desirable treatments for cost reasons. Need the doctor go through the form of explaining the choice and soliciting the no? On one view, the law of bioethics relieves the doctor of that duty. If patients really are the directors of care, they should be able to choose the kind of interactions with doctors they want. They should be able to choose a doctor who anticipates their preferences without hectoring them with unnecessary and unwanted choices and explanations. And of course the law of health care finance thrusts in the same direction, since it wants to proliferate thrifty consumers.

Now take the next step. The doctor does not know the patient well enough to anticipate a no. But the doctor does not mention a possibly desirable treatment for cost reasons. This may seem *prima facie* unacceptable. Mustn't patients always be offered such a choice? In fact, in ordinary medical practice, patients are continually kept in the dark about all the possibilities. Differential diagnoses normally include nasty but unlikely possibilities. But doctors do not mention them and do not suggest

testing for them partly for cost reasons.¹⁵⁶ They heed the old adage: when you hear hoofbeats, think horses, not zebras. Sometimes it really is a zebra, but good doctors don't rule out every possible zebra.

Screening tests are a good example of this problem. There is evidence that some screens are cost-effective. There is evidence that some screens are not. The evidence about other screens is controvertible. Ordinarily, a doctor is presumably obliged to offer the first kind of screen. Is the doctor also obliged to offer the third kind? That is what some of the groups that write guidelines for practicing physicians say. For example, when advisory committees of specialists could not decide whether Prostate Specific Antigen ("PSA") screening was worthwhile, they said doctors should present the choice to patients.¹⁵⁷

This certainly fits one understanding of the law of bioethics. This is the understanding we might pejoratively describe as the "menu" version of the doctor's role. Here are all your choices. Here is information about all the choices. Would you like the PSA screen today? But on the view of bioethics we hinted at a moment ago, a doctor might conclude this is not the relationship with physicians that patients actually want. They may want doctors who sort through the mass of choices it might be fruitful for them to make and select the choices worth presenting. This could mean excluding choices doctors thought financially improvident or foolish.

This description of the doctor's role conforms to one understanding of what the law of health care finance might call for. Thrifty consumers know that an expensive car has useful safety features cheaper cars do not. But they also see little point in learning about the marvels of Volvos they cannot afford. Thrifty patients may not see a point in hearing about a lot of tests and treatments that might conceivably do them some good but that their doctor thinks are not worth the cost to them.

Furthermore, doctors cannot offer their patients all the choices that might benefit them. They simply don't have time. For example, it is physically impossible for doctors to offer patients all the preventive medicine that authoritative guidelines call for.¹⁵⁸ Therefore, doctors

¹⁵⁶ Simon N. Whitney and Laurence B. McCullough, *Physicians' Silent Decisions: Because Patient Autonomy Does Not Always Come First*, 7 *Am J Bioethics* 33 (2007).

¹⁵⁷ For a critical study of what happens when doctors actually try to present the PSA choice to patients, see Carl E. Schneider and Michael H. Farrell, *Information, Decisions, and the Limits of Informed Consent*, in Michael Freeman and Andrew D.E. Lewis, eds, *Law and Medicine* 108 (Oxford 2000). For an illustration of what happens when they do not present the choice, see Daniel Merenstein, *Winners and Losers*, 291 *JAMA* 15 (2004).

¹⁵⁸ One study "demonstrates that it is not feasible for physicians to deliver all of the services recommended by the USPSTF [US Preventive Services Task Force] to a representative panel of patients." And "[d]ecreasing the panel size is not a very practical or realistic solution; a 50% reduction in panel size is needed to reduce the time requirement to approximately 4 hours a day." Kimberly S.H. Yarnall et al, *Primary Care: Is There Enough Time for Prevention?*, 93 *Am J Pub Health* 635, 637 (2003). To put the problem another way: "Current practice guidelines for only 10 chronic illnesses require more time than primary care physicians have available for patient care overall." Truls Østbye

routinely face zero-sum choices about how to spend their time with patients, and they routinely deny patients choices it would be good for them to have because the time to do so is flatly not there. Seen in this way, the law of informed consent, like the law of health care finance, presents rationing issues. They each rest on a separate tectonic plate. When these plates clash, we must find some accommodation that allows each its due.

C. The Plates

When malpractice law developed, doctors were the directors of their patients' care. Doctors are members of a profession which, like all professions, requires mastering an abstruse body of learning. This creates an "asymmetry of knowledge" between the professional and the client. Because the client lacks the expertise to evaluate the professional, the professional works autonomously, using professional expertise to assess and assist the client. The client must trust the professional. The profession must make it safe to trust the professional by educating, licensing, and disciplining its members. When this fails, when the professional betrays the profession's standards, the law provides a remedy in a malpractice action. Still, the standard by which the professional is judged is the standard set by the profession itself (as represented by expert testimony).

As long as the tectonic plates remained separate, this standard view of malpractice made sense. And there remains much truth in this picture of professions and the law of malpractice. However, in the laws of bioethics and health care finance, much has changed. The doctor is no longer the director of care; the patient is. Doctors are supposed to minimize the "asymmetry of knowledge" by telling patients what they need to know to make their own decisions. It is not just the relationship between doctor and patient that is supposed to have changed. It is the relationship between the profession and society. Medical care is organized bureaucratically, and the behavior of physicians is shaped by systematized standards and by administrative regulation. Some of this is intended to improve the quality of medical care, but much of it is addressed to the continuing crisis of costs. For many years, both goals were to be served by managed care.

Malpractice law set a unitary standard for practice (the professional standard) to be enforced by the profession and by tort law. When doctors were the directors of care, it made sense to hold them to the professional standard. Now doctors have not just ceded some authority to patients; their authority has also been diminished by regulators, insurers, and employers. All this makes conventional malpractice law increasingly out of touch with the way that doctors do their work and work with their patients.

et al, *Is There Time for Management of Patients with Chronic Diseases in Primary Care?*, 3 *Annals Fam Med* 209 (2005).

Managed care first exposed this problem to easy view. It deliberately diffused responsibility for medical decisions among employers, insurers, health care institutions, providers and patients. In particular, it sought to influence and control doctors but not to take responsibility away from them. Malpractice law was still trying to cope with this diffusion of authority when another idea arose—that medical spending will be better controlled and rationalized if patients, at least in principle, are the directors of care. In sum, the relations between doctors and patients have become the subject of constant policy making, especially because doctors are key to any effort to control apparently uncontrollable medical costs. But law and policy cannot do so well unless here—as in so many other places—we recognize that the interaction of health law's component parts is an indispensable part of intelligent policy analysis.