SCHOOL OF LAW
CASE WESTERN RESERVE UNIVERSITY

Case Western Reserve Law Review

Volume 36 | Issue 4 Article 16

1986

Commentary: Stratified Scarcity and Unfair Liability

E. Haavi Morreim

COMMENTARY: STRATIFIED SCARCITY AND UNFAIR LIABILITY

*E. Haavi Morreim**

INTRODUCTION

PROFESSOR FURROW offers three basic arguments supporting his conclusion that physicians should not be explicitly permitted to invoke costs as a defense to substandard care.[1] First, he suggests that cost constraints need not imply diminished quality of care. Inordinate concern with the uncertainties of medicine has in some cases led to the overuse of medical technology, which produces iatrogenic injuries and diagnostic false positives, leading, in turn, to further needless and sometimes harmful interventions. Further, by working with—and sometimes against—hospitals and other institutional providers, physicians can help to identify more efficient ways of delivering care and where necessary can combat those allocation mechanisms which work to patients' disadvantage. Cost considerations are not alien to standards of care; they need only to be incorporated in benign ways.

Second, Professor Furrow argues that the law already permits considerable shelter for the inclusion of cost concerns into standards of care. Since the standard of care in tort law mirrors medical practice by appealing to prevailing custom, an economic shift downward in custom will be reflected in commensurately reduced tort standards. Moreover, there are several ways in which economical deviations from custom are permitted. Where a physician can demonstrate that his more conservative approach leads to comparable medical results, a court may accept this deviation from custom as a respectable minority approach, as a legitimate use of the physician's best judgment where medical standards vary, or as a clinical innovation. In addition, the available resources caveat of the local-

* Assistant Professor, College of Medicine, University of Tennessee, Memphis. B.A., St. Olaf College (1972); M.A. (1976), Ph.D. (1980), University of Virginia.

The author acknowledges with gratitude the helpful comments provided by Barry Furrow, J.D.; Robert Banks, J.D.; William Appelgate, M.D.; Alan Bisno, M.D.; Rand Rosenblatt, J.D., and Dan Brock, Ph.D.

1. Professor Furrow also largely rejects costs as a defense for hospital liability. However, in my Commentary, I shall focus only on the issue as it concerns physicians.

ity rule can excuse the failure to use a technology which is not locally available. And, where patients agree at the time of entry into a particular health care delivery system (e.g., an HMO) to abide by its cost-control provisions, the informed consent rule offers some shelter where those provisions are carried out in good faith, medically credible ways.

Finally, Professor Furrow argues that society will be better served if tort law maintains pressures on health care providers to view patient welfare as the top priority. The battles of cost containment should be fought not at the bedside but rather in administrative offices, in board rooms, and in legislative chambers. To permit cost constraints as a liability defense may make it too easy for physicians to compromise patient care instead of undertaking the effort to streamline medical standards and to improve resource availability and allocation.

There is much here with which we can agree. Previously, lush third-party reimbursement policies, together with physicians' discomfort about medical and legal uncertainties, engendered medical practices which probably are considerably inflated above the requirements of good health care. Surely, "less" does not necessarily mean "worse" in medical care. Likewise, physicians ought stubbornly to resist abridging their fiduciary commitments to patients in order to serve third parties' economic interests. The forces of cost containment have advocates aplenty; if the patient does not have his own physician as his advocate, he may have no one.

However, I shall argue that Professor Furrow's analysis skirts an important class of cases whose exigencies we must face squarely. Not all physicians will be able to meet economic constraints harmlessly by streamlining clinical routines, and not all battles against administrators and legislators can be won. As I shall show in Section I, economic constraints in health care are not distributed uniformly throughout society, but rather fall especially hard upon the poor—a situation of "stratified scarcity." As a result, those physicians who attend the poor will, at times, have no choice but to provide care which falls below the standards of the majority. Traditional legal escape hatches identified by Professor Furrow are closed to these physicians and, as a consequence, they may be held legally liable for factors largely outside their control. This situation constitutes what I shall call "morally unfair legal liability." In Section II, I will explore this notion of unfair liability, arguing that, although in some situations unfair liability may be justified, we cannot entirely justify imposing it in these circumstances.

I. STRATIFIED SCARCITY

A. *Economic Factors*

Health care expenditures in the United States have increased dramatically in recent years—out of control, some would argue. Per capita expenditures have nearly trebled since 1950,[2] rising from five to eleven percent of the Gross National Product (GNP) since 1960.[3] Of special interest, Medicare's Hospital Fund could be bankrupt by as early as 1992, salvageable only if current levels of service are cut by some twenty percent or if funding is commensurately increased.[4] This economic pressure is sure to be compounded by budget cutbacks as Congress attempts to reduce the national deficit. At the same time, powerful lobbying efforts are beginning to expand Medicare's coverage to include both organ transplants and broader reimbursement for catastrophic disease.[5]

Medicaid services for the nation's indigent are unlikely to fare better. Costs, as elsewhere in the health care industry, have spiraled rapidly upward, and states have taken numerous measures to limit their expenses.[6] Further, new pressures are prompting Medicaid to expand its eligibility guidelines. Not all indigent people are eligible for Medicaid coverage, with specific criteria varying from state to state.[7]

Until the recent past, those who were not covered were accommodated in the health care system through "costshifting," under which providers raised their charges to paying patients in order to cover indigent-care losses. However, this device is now disappearing as insurance companies and corporations, anxious to reduce their own burgeoning health care outlays, are removing themselves from the reach of cost shifting through such special arrangements as preferred provider organizations, health maintenance organiza-

2. *See* H. AARON & W. SCHWARTZ, THE PAINFUL PRESCRIPTION (1984).

3. *See* Thurow, *Learning to Say 'No'*, 311 NEW ENG. J. MED. 1559, 1569 (1984).

4. *See Panel Warns of Medicare Bankruptcy in Mid-90's*, Am. Med. News, Apr. 11, 1986, at 9.

5. *See* Blumenthal, Schlesinger, Drumheller & the Harvard Medicare Project, *The Future of Medicare*, 314 NEW ENG. J. MED. 722 (1986); *Panel to Advise HHS on Catastrophic Plans*, Am. Med. News, Mar. 14, 1986, at 20; McIlrath, *Catastrophic Plans in Spotlight*, Am. Med. News, Mar. 7, 1986, at 1, 40, 41; *Medicare to Fund Some Heart Transplants*, Am. Med. News, July 18, 1986, at 18.

6. *See Study Cites Innovative State Actions to Control Hospital/Cost*, Am. Med. News, June 14, 1985, at 25-26; Scheier, *States Eye DRG Pay for Medicaid*, Am. Med. News, Sept. 6, 1985, at 2, 22.

7. *See* Blendon, Aiken, Freeman, Kinkman-Liff & Murphy, *Uncompensated Care by Hospitals or Public Insurance for the Poor: Does it Make a Difference?*, 314 NEW ENG. J. MED. 1160, 1161 (1986).

tions, and independent practice associations.[8] As a result, an estimated thirty to thirty-five million medically uninsured people must now be either included within existing indigent-care programs, find new sources of help, or do without.[9]

The conclusion here is not difficult to draw. Resources with which to care for the poor are significantly less than those available to care for the nonpoor, and this situation is likely to be exacerbated in the future. Economists have suggested that we may see the emergence of as many as four tiers of health care: "tourist class" care for those on government support, "business class" care for employees of corporations, "boutique medicine" for the wealthy, and, at the bottom, possibly little or no care for those who lack support from anyone.[10] We face not a uniform, society-wide scarcity of health care resources, but "stratified scarcity," as constraints on resources become increasingly severe with descending socioeconomic status.

B. *Risk Trade-Offs*

To some extent, perhaps generally, physicians who attend the poor can cope with resource scarcity in just those ways which Professor Furrow has identified. They can ferret out the excesses in clinical routines, and they can battle for more equitable allocation. Such efforts are arguably an important part of physicians' fiduciary responsibilities, and they must be energetic and unrelenting to avert needless diminutions in the quality of care.

And yet there are limits. So long as there are distinctly fewer economic resources for the care of indigent people, their physicians will be more constrained than other physicians. The differences will not necessarily be dramatic, as in the textbook rationing cases which ask us to decide who shall receive a lifesaving resource and

8. *See* McIlrath, *Uncompensated Care Needs More Attention*, Am. Med. News, Oct. 4, 1985, at 32.

9. *See* Cancila, *Care of Indigents Called Critical Issue*, Am. Med. News, Feb. 21, 1986, at 1, 30; Scheier, *Burden of Indigent Care Shifted to States*, Am. Med. News, Jan. 3, 1986, at 6, 7; Scheier, *Medically Indigent Get New Aid*, Am. Med. News, Jan. 10, 1986 at 2, 34. For a discussion of the ways in which California's recent Medi-Cal cutbacks have adversely affected access and quality of health care for the indigent, see Schneider & Stern, *Health Maintenance Organizations and the Poor*, 70 NW. U.L. REV. 90, 127 (1975); Waitzkin, *Two-Class Medicine Returns to the United States*, 2 LANCET 1144 (1984); Lurie, Ward, Shapiro & Brook, *Termination from Medi-Cal—Does it Affect Health*, 311 NEW ENG. J. MED. 480 (1984); Lurie, Ward, Shapiro, Gallego, Vahaiwalla & Brook, *Termination of Medi-Cal Benefits*, 314 NEW ENG. J. MED. 1266 (1986).

10. *See* Scheier, *State Role in Caring for Needy Is Seen Increasing*, Am. Med. News, Aug. 23, 1985, at 2, 16; Thurow, *Medicine Versus Economics*, 313 NEW ENG. J. MED. 611 (1985).

who will be sent away to his doom. Rather, we are more likely to see simply a shift in the ways in which risks and benefits are weighed. Professor Furrow aptly describes one side of this balance. Where physicians engage in overly aggressive diagnostic and therapeutic interventions in order to ease their uncertainties, iatrogenic harms can result, and diagnostic false positives can lead to further needless interventions. If physicians are willing both to undertake research to reduce such uncertainties (e.g., providing clearer indications for such procedures as tonsillectomy and hysterectomy) and to tolerate a higher measure of ambiguity in the clinical setting, many of these injuries and needless expenses could be avoided.

There is, however, another side. Insofar as they are undertaken in order to reduce uncertainty, these "marginal" tests and therapies aim to avoid another sort of harm: failure to help the patient, either by failure to diagnose or by failure to treat adequately. Thus, although eliminating such interventions can reduce the risk of iatrogenic injury to some patients, the risk of failing to help other patients reciprocally increases. And it is usually impossible to know in advance whose welfare is being traded for whose. Thus, when a physician engages in "minimal medicine," as Professor Furrow has labelled it, he may in fact compromise the care of his own patient for the sake of other patients' medical or economic benefit. This is not to say that such tradeoffs cannot or should not be made—only that they must be acknowledged and directly addressed.

Insofar as their more limited resources constrain them to practice even more "minimal" medicine than their more well-funded brethren, the physicians who attend the poor will be forced to make comparatively more of these tradeoffs. And they will more often be "guilty" of failure to help. Some examples will illustrate.

—Public General Hospital (PGH) has no CT scanner of its own, and so must refer its patients who need this resource to the private hospital across town. That hospital, however, will only accept a limited number of PGH patients since, after all, this service is provided largely as a charity, and the private hospital's charity budget is not unlimited. Physicians at PGH, therefore, must limit the number of patients for whom they request CT to those in the most urgent need, particularly on evenings and weekends when the private hospital has reduced staff. Inevitably, there will be indigent patients at PGH who, if they were private, paying patients, would receive a CT scan, but who in fact will not on the grounds that other PGH patients are in greater need. In some of these cases, the patient's illness will as a result remain undiagnosed and inade-

quately treated. Because the standard controlling when a CT scan is clinically indicated at the private hospital and elsewhere would have encompassed such patients, their care, or lack of care, is substandard.

While we can suggest, with Professor Furrow, that computerized tomography is perhaps overused, we must still reckon with the fact that, once the medical community agrees upon more conservative indications for its use, the patients at PGH will almost certainly still be subject to a yet more conservative protocol. And some PGH patients will suffer as a result.[11]

—Patient Smith is admitted to PGH with symptoms suggesting possible meningitis. Physician Jones performs a lumbar puncture, knowing that its culture results may be negative, since the patient's local medical doctor placed him on antibiotics before referring him to PGH. Therefore, Dr. Jones must simply choose an antibiotic which he hopes will eradicate the organism. The infection could be viral, in which case no antibiotic will be of use. And the infection may not be meningitis. Dr. Jones must, however, presume that there may be a bacterial meningitis and must initiate treatment, since untreated meningitis can lead quickly to major morbidity or to death.

An ordinary, inexpensive antibiotic, such as penicillin, would probably suffice, since it is broad spectrum and capable of treating the most common organisms in adults. However, since the organism is unidentified, Dr. Jones is uncertain. At more affluent hospitals, many physicians would routinely prescribe a third-generation cephalosporin, since they, too, are broad spectrum, but enter the cerebro-spinal fluid more easily, and can deal especially well with the more obstinate gram-negative organisms. However, physicians at PGH must hesitate. These latter antibiotics can cost the hospital well over a thousand dollars for an adult's ten-day course, just for the drug alone. In addition, PGH has a policy which discourages the use of a third-generation cephalosporin under these conditions. PGH only stocks a certain amount of such expensive commodities, and they must be shepherded carefully. Dr. Jones could, if he insisted, obtain the expensive antibiotic for his patient. But as he and his colleagues at PGH have agreed, it is best to save these for cases where the need is clear. If it is used in this case, the supply may not

11. Another side of this problem is that PGH patients receive their diagnostic evaluations more slowly than patients elsewhere. Lesser availability of testing equipment can lead to longer waiting periods and, thereby, to further medical deterioration before a diagnosis is made and treatment initiated.

be there for patients who more clearly need it. Furthermore, if PGH physicians routinely started using the restricted drugs in the less than clear cases such as this one, then the supply would surely run short.[12]

One can argue, as does Professor Furrow, that third-generation cephalosporins are generally overused—giving rise to the danger of creating resistant organisms and to the resulting need for still stronger, more expensive antibiotics. However, it is quite possible that more conservative criteria would still recommend that physicians prescribe the cephalosporin when he suspects meningitis of unknown etiology. If this is the case, then the physicians at PGH will still sometimes be practicing substandard medicine. Admittedly, most of their patients will recover anyway. But occasionally a patient will suffer grave neurological damage, or perhaps die, because of an inadequately treated infection.

C. *Medical and Moral Factors*

It has been suggested in response to such cost-containment dilemmas that people other than the physician ought to make the tradeoff decisions. The physician should be guided, so the argument goes, solely by the benefit of his patient, while others should impose the economic limitations upon him. In this way, the physician can offer the patient his undivided loyalty.[13] In concert with this view, Professor Furrow suggests, for example, that hospitals and other health care institutions should now be the "primary care giver," bearing principal responsibility for allocation policies and for medical error. Physicians can thereby be substantially freed from the need to engage in "bedside budget balancing."

Hospitals can, of course, establish useful guidelines for cost-ef-

12. One might argue that the physician should initiate treatment with the more potent antibiotic until laboratory culture results return information about the infectious organism's identity. However, those results may be falsely negative, as indicated in the example. Where this is so, or where the lab services are slow or unreliable, the physician must still decide under diagnostic uncertainty whether to use the antibiotic in borderline cases such as this, or to reserve it for a clearer need.

13. *See* Levinsky, *The Doctor's Master*, 311 NEW ENG. J. MED 1573 (1984); R. VEATCH, A THEORY OF MEDICAL ETHICS (1981). Veatch, for example, believes that we should make it "impossible for the physician to order the sixth stool guaiac." *Id.* at 285. He is referring to a 1975 study by Neuhauser and Lewicki which showed that in screening for colon cancer, the marginal cost of the sixth serial guaiac test is $50 million for each new cancer detected. *See* 239 NEW ENG. J. MED. 226. Veatch goes on to argue that the physician should not be responsible for eliminating interventions of even infinitesimal benefit on grounds of costs; others must make such decisions. *See also* Veatch, *DRGs and the Ethical Reallocation of Resources*, 16 HASTINGS CENTER REP., June 1986, at 32.

fective care. Some, for example, have developed a two-tier pharmacy system under which the most expensive medications can be prescribed only by physicians of the relevant subspecialties, who in turn develop criteria to guide their decisions. Thus, a general practitioner would have to consult with the infectious disease service if he wished his patient to receive an expensive antibiotic.

Up to a point, such guidance is desirable. Economically effective, medically benign cost containment is probably best achieved through collective reasoning and concerted action rather than through individuals' idiosyncratic economic reasoning implemented at the bedside.

However, such guidelines are of limited value. Medicine is entirely too complex, uncertain, and rapidly changing, and patients are too diverse in their physical, psychological, and value structure, to permit any committee, computer, or cookbook to designate precisely which interventions are medically and economically warranted under which circumstances. Ultimately, health care is not delivered by administrators or by boards of directors to groups of patients; it is provided by individual physicians to individual patients. There is no substitute for the professional observation, interpretation, and judgment which can only be exercised by the individual physician in the clinical setting. Any administrator who routinely proposed to dictate such daily details as which patients should receive how many chest X-rays or lab studies, who needs invasive monitoring, or who can be safely discharged, would be practicing medicine in the physician's stead. In the final analysis, physicians must largely retain the clinical authority to pursue the interests of each patient as an individual, determining both which interventions to offer to whom and when to warrant exceptions to applicable guidelines.

By implication, however, the existence of resource scarcity means that not every patient can receive every optimally desirable intervention and that whoever has the power to say "yes" will also bear some responsibility to say "no." Although in any individual case the physician can attempt to secure fully optimal care for his own patient—as, for example, by bypassing local policy and prescribing the expensive antibiotic in the second example discussed above—justice requires that if a distribution plan is fair and effective, those physicians subject to it should try to comply with its restrictions in good faith most of the time. Excessive exceptions can quickly destroy even the best of allocation plans. And this means that, at times, the physician must say no to his own patients even

where he knows that he could, with appropriate cajoling of co-workers or embellishment of facts, secure benefits for them which the system could not possibly afford to all other similarly situated patients.[14]

It is a responsibility from which the physician morally must not shrink. Justice requires that, where resources are scarce, each person avail himself of them in ways that do not unduly deplete them for others' use. Thus, physicians ought not to dip excessively into common resources to secure their own patients' welfare, even for the admittedly important sake of their fiduciary commitment to patients. Neither should the physician seek to relinquish his clinical control—i.e., to escape the responsibility of saying no by systematically inviting others to place restrictions on his clinical decision making so that he can absolve himself of the conflicts involved in weighing patients' interests against competing economic concerns. To do this would be to forsake one of the most important moral commitments of the professional relationship. In order to be responsible to his patients' needs, the physician must first BE RESPONSIBLE.[15] He must ensure that he is in a position to aid his patients, and this requires that he retain as much clinical authority as possible. Thus, to state the reciprocal: to avoid the uneasy task of saying "no" would require relinquishing the power to say "yes."

This fact—namely, that the physician is unavoidably a key agent of resource allocation who must sometimes say no even where he could probably secure the good in question—will prove to be of tremendous importance as we consider below how the legal system should respond to physicians who practice under the most seriously limited resources.

---

14. For further discussion of these justice issues see Morreim, *Cost Containment: Issues of Moral Conflict and Justice for Physicians*, 6 THEORETICAL MED. 257 (1985). For further discussion of hospitals' increasing assumption of liability for medical error, see Note, *Rethinking Medical Malpractice Law in Light of Medicare Cost-Cutting*, 98 HARV. L. REV. 1004 (1985). The author recommends adopting a rebuttable presumption that hospitals be held jointly liable wherever inadequate care has led to injury. Whatever the theoretical merits of this approach, and whatever the benefit to physicians' insurance companies as they share more of the damage assessments with hospital defendants, physicians themselves will be helped little by this plan. They must still ultimately make the specific health care decisions for each patient, and therefore must still bear responsibility before the law. Their liability is not changed, only the range of company with whom they share that liability.

15. For further discussion of the professional ethics of medicine, see E. PELLEGRINO & D. THOMASMA, A PHILOSOPHICAL BASIS OF MEDICAL PRACTICE (1981). For further discussion of the highly individual nature of clinical practice, see Gorovitz & MacIntyre, *Toward a Theory of Medical Fallibility*, 1 J. MED. & PHIL. 51 (1976).

D. *Legal Factors*

Where physicians are able to economize on care in the medically benign ways discussed by Professor Furrow, they can appeal to an assortment of legal devices for judicial blessing. As we shall now see, however, those devices are of little or no avail for the physicians whose economically necessitated deviations from custom lead not to a comparable, but to a lesser, quality of care.

1. *Custom*

Even if physicians as a group are able to shift downward their customs as Professor Furrow suggests (traversing a legally hazardous transition period in which early efforts will expose individual physicians to potentially substantial liability),[16] those physicians who attend the poor are likely to be left behind. So long as scarcity of health care resources is stratified, with significantly less available for the poor, and so long as this group is numerically a minority of the population, then a legal reliance upon the majority's custom in establishing standards of care is sure to leave these physicians vulnerable. The law will expect them to deliver a level of care which their resources simply will not afford.

2. *Respectable Minority, Best Judgment, and Clinical Innovation*

The traditional means by which the legally acceptable exceptions to custom are drawn will likewise be of little help. Courts accept the actions of a respectable minority, as well as the best judgment or clinical innovations of individual physicians, only so long as these serve the basic principle by which standards of medical care are set in tort law: the patient's welfare must be promoted at least as well by the variant care as by the custom. Courts have permitted or required changes in prevailing practices only to improve or preserve quality of care, never (knowingly) to diminish it.[17]

16. *See* Kapp, *Legal and Ethical Implications of Health Care Reimbursement by Diagnosis Related Groups*, 12 LAW, MED. & HEALTH CARE 245, 250 (1984); Bovbjerg, *The Medical Malpractice Standard of Care: HMOs and Customary Practice*, 1975 DUKE L. J. 1375, 1377; Blumstein, *Rationing Medical Resources: A Constitutional, Legal, and Policy Analysis*, in PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, 3 SECURING ACCESS TO HEALTH CARE 349 (1983).

17. *See, e.g.*, Helling v. Carey, 519 P.2d 981, (Wash. 1974); The T.J. Hooper, 60 F.2d 737 (2d Cir. 1937); Note, *supra* note 14, at 1018.

3. *Informed Consent*

Neither will the informed consent rule suffice, contrary to those who advocate its use in this context.[18] In principal, these advocates suggest, informed consent in this setting can enhance patient autonomy and preserve the fiduciary relationship. As the physician informs the patient that a particular intervention is medically desirable but not available under his health care coverage, the patient can then decide whether to purchase the intervention using his personal resources or whether to try politically to alter the rule under which the resource is denied.

Unfortunately, this theory works only when both of two conditions are fulfilled: the resource unavailability must be the product of outside parties' decisions rather than of the physician's own drawing of priorities among limited resources; and the patient must have sufficient funds to purchase the care or enough political influence to alter the policy. Where the patient cannot alter the situation, his autonomy is not necessarily enhanced by the knowledge that his care is inferior. And where it is the physician himself who has decided (however justifiably) that the resource is better used elsewhere, physician-patient trust may be jeopardized, not enhanced.

> *"Ms. Jones, I just want you to know that this hospital is truly second-rate— inadequate nursing staff, badly outdated diagnostic facilities, and such. And although I think you'd benefit quite a bit from physical therapy, I've decided not to prescribe it for you— they're awfully busy, you know, and other patients need it more than you. Just thought you'd like to know. . ."*

While Professor Furrow shares this skepticism concerning the helpfulness of the informed consent rule in this context of clinical decision making, he is more optimistic about the prospects of informing patients *at the point of entry* about the particular cost-containment policies of the health care plan which they contemplate joining. This optimism is not entirely warranted. It is all very well for an HMO to announce that it intends to save money by keeping patients healthy and by caring for them on an outpatient basis whenever it is safe to do so. However, it is impossible to enumerate in advance for the prospective plan participant all the specific cost tradeoffs which might affect him. First, except where the patient

18. *See, e.g.*, Blumstein, *supra* note 16, at 389ff; Kapp, *supra* note 16, at 251; Marsh, *Health Care Cost Containment and the Duty to Treat*, 6 J. LEGAL MED. 157, 177-78 (1985); A. HOLDER, MEDICAL MALPRACTICE LAW 285 (2d ed. 1978); Miller v. Kennedy, 11 Wash. App. 272, 522 P.2d 852 (Wash. 1974).

already has a chronic illness, it may be impossible to predict which particular illnesses he will likely develop, and thus equally impossible to discuss in advance the sort of cost savings which might be contemplated for his personal care. Therefore, if the thirty-nine-year-old man in Professor Furrow's first example had not yet developed his cardiac arrhythmias upon initial entry into the HMO, it is unlikely that he would have discussed this particular cost-benefit decision in advance. If he develops the illness after becoming a member, the cost discussion will not fit Professor Furrow's model. The man has enrolled relying on the representation that the HMO will provide all his needed medications, yet now it asks him to agree to a somewhat less-than-optimal therapy in order to save the corporation some money. While the patient may perhaps decide that it is prudent for him to consider the HMO's fiscal welfare, we surely cannot say that he agreed up front to such a tradeoff.

Other important facts about the particular health care plan are also unlikely to be revealed, partly because there are too many of them and perhaps occasionally because they are not too savory. For example, the unrevealed statistic may be that an HMO's designated hospital performs fewer than 100 coronary bypass operations per year, thus exposing its patients to considerably higher levels of risk than hospitals who perform them more routinely.[19] And again, as above, unless the particular nature of the cost tradeoff has been quite explicitly discussed in advance, it is difficult to argue that the patient has agreed to it simply by virtue of his joining the organization.

4. *The Locality Rule*

Neither can the physician be rescued by the "resources caveat" of the locality rule.[20] While this rule can, for example, excuse an obstetrician for failure to perform ultrasonography in a high-risk pregnancy where no ultrasound equipment is available within a reasonable distance, the locality concept does not apply to resource variations within a particular locality. More specifically, while it speaks to the unavailability of resources, the rule does not encompass conscious decisions to refrain from using available resources—regardless how justified those decisions may be morally and economically. Nor does it encompass variations in the quality of care

19. *See* Cancila, *HCFA Data Release Gets Mixed Reactions*, Am. Med. News, Mar. 28, 1986, at 1, 32.

20. *See* Hall v. Hilbun, 466 So. 2d 856, (Miss. 1985).

which arise, not from the patient's geographic location, but from his socioeconomic station.

5. *Loss of a Chance*

Finally, the "loss of a chance" doctrine not only is unlikely to help the physician, but could in principle threaten to thwart cost-containment efforts quite systematically. As noted in Section IB above, efforts to reduce costs by "streamlining" medicine carry certain tradeoffs. To reduce the use of a particular marginal intervention may reduce iatrogenic injuries and diagnostic false positives in some patients, but only at the cost of failing to help other patients. These latter patients could invoke the "loss of a chance" doctrine to argue that, but for the deviation from custom, their illnesses would have been better diagnosed and treated, thus averting whatever harms occurred from this failure. In this way, virtually any attempt toward "minimal medicine" could be stopped cold in its tracks.

E. *Summary*

Though all physicians face legal risks as they cope with cost constraints, physicians who attend the poor are likely to be in a virtually impossible predicament. With fewer resources available to care for their patients than those available to the majority of patients, these physicians will nevertheless be legally held to the level of care offered to that majority. Thus, these physicians are quite sure to be subjected to what I shall call "morally unfair legal liability." They will be held legally liable for the medical consequences of economic decisions to which they had no reasonable alternative. They will be penalized for a failure to do the virtually impossible. Morally and legally, this situation presents a challenge from which we must not shrink.

II. UNFAIR LIABILITY

A. *The Concept*

Ever since Massachusetts Chief Justice Lemuel Shaw asked in 1850 whether Mr. Kendall was at fault when he accidentally struck Mr. Brown while separating two fighting dogs, American tort law has incorporated a systematic interest in the moral notion of blameworthiness.[21] In distributing the costs of mishaps, it seems morally

21. *See* Brown v. Kendall, 60 Mass. (6 Cush.) 292 (1850); *see also* G. WHITE, TORT LAW IN AMERICA: AN INTELLECTUAL HISTORY 14-16 (1980); Williams, *Abandoning Medical Malpractice*, 5 J. LEGAL MED. 549, 554.

inappropriate that an innocent victim should suffer a loss which was culpably caused by someone else's intentional or negligent conduct.[22]

It is a challenge, of course, to define "fault." We might, for example, look for a subjective standard of personal moral blameworthiness, or alternatively for a more objective standard of appropriate conduct.[23] Nevertheless, we can usually agree on the more clear-cut cases, as where a surgeon consumes a substantial quantity of alcohol just prior to operating on a patient. We may not know just how to define fault but, like obscenity, we usually know it when we see it.[24]

Reciprocally, and more important for our purposes, we can also agree that there is such a thing as "morally unfair legal liability," or "unfair liability". In the paradigmatic situation, liability is imposed on a defendant who could not possibly have foreseen or avoided the mishap. Some applications of the doctrine of *respondeat superior*, for example, may be morally unfair. Where an employer has taken every reasonable precaution to screen his employees before hiring, and trains and supervises them closely during employment, he is hardly blameworthy when one of them suddenly and unexpectedly goes berserk and drives the company truck through the fruit stand to which he was to deliver a load of produce.

The unfairness of holding the employer liable anyway inheres in the fact that he could not reasonably have averted the mishap. It would be literally impossible for him to control all the physical movements of each employee, and it would be unreasonable to expect him to hire someone to supervise every employee every minute of each day (and to hire someone else to supervise the supervisor as well. . .). "Ought implies can," as Kant has said, and the notion of blameworthiness in this context presupposes that the person has the power and responsibility to control the outcome—that he could and should have done otherwise and, if he had, the problem would not have occurred. Where this condition is not satisfied, the liability seems morally unfair.

---

22. *See* Keeton & O'Connell, *Why Shift Loss?*, in PHILOSOPHY OF LAW 389 (J. Feinberg & H. Gross eds. 1975); Harper & James, *Accidents, Fault and Social Insurance*, in FREEDOM AND RESPONSIBILITY 267 (H. Morris ed. 1961); Wasserstrom, *Strict Liability in the Criminal Law*, in FREEDOM AND RESPONSIBILITY, *supra*, at 273; Coleman, *Moral Theories of Torts: Their Scope and Limits: Part I*, 1 LAW & PHIL. 371, 373 (1982); ARISTOTLE, NICHOMACHEAN ETHICS Book V (T. Taylor trans. 1918).

23. *See* Coleman, *supra* note 22, at 375; Keeton & O'Connell, *supra* note 22, at 389.

24. *Cf.* Jacobellis v. Ohio, 378 U.S. 184, 197 (1964) (Stewart, J., concurring).

B. *Justified Unfair Liability*

To say that an imposition of liability is morally unfair, however, does not necessarily mean that it is unjustified. Law is a crude instrument, and it is impossible to write laws which will assure just and fair results with every application. To require a unanimous jury of twelve members for a criminal conviction, for example, will still result in a few convictions of the innocent. But to require unanimity among twenty or thirty people would, while convicting fewer innocents, unduly encumber the legal system while allowing many more dangerous and guilty offenders to go free. In short, it would be unfair to society.[25]

As some unfair liability is inescapable, it may also be argued that some of it can be philosophically justified. Strict liability with respect to abnormally dangerous activities, for example, has been defended on the ground that it provides extra incentive for those introducing these risks to take superior precautions.[26] Similarly, strict liability for defective products is defended on the ground that corporations can guard against risks and absorb losses better than individuals.[27]

Admittedly, whether the concept of strict liability—liability in the absence of fault in the form of intent or negligence—can be philosophically justified in either criminal or civil law is highly controversial.[28] Fortunately, we need not resolve that issue here, nor explore the equally knotty question of whether tort law ought to be based on some comprehensive moral framework.[29] For our purposes, we need only specify the three prerequisites which would be minimally necessary—whether or not any set of conditions could be sufficient—in order to justify unfair liability.

First, there must be some important social aim served by the overall rule of liability. Thus, the rule of *respondeat superior* is

25. *See* Wasserstrom, *supra* note 22, at 277-78.

26. *See* Marshall v. Ranne, 511 S.W.2d 255 (Tex. 1974) (owner of vicious hog strictly liable); Rylands v. Fletcher L.R. 3 H.L. 330 (1868); Koos v. Roth, 652 P.2d 1255 (Or. 1982); Harper & James, *supra* note 22, at 268-69; Wasserstrom, *supra* note 22, at 276.

27. *See* Williams, *supra* note 21, at 564-65; MacPherson v. Buick Motor Co., 217 N.Y. 382, 111 N.E. 1050 (1916); Escola v. Coca Cola Bottling Co., 24 Cal.2d 453, 150 P.2d 436 (1944); Greenman v. Yuba Power Products, 27 Cal. Rptr. 697, 377 P.2d 897 (1962); for a critical review of the strict liability principle, see Prosser, *The Assault Upon the Citadel*, 69 YALE L.J. 1099 (1960).

28. Wasserstrom, *supra* note 22; Harper & James, *supra* note 22; Calabresi, *The Fairness of the Fault System*, in FREEDOM AND RESPONSIBILITY, *supra* note 22, at 392-95; Coleman, *Moral Theories of Torts: Their Scope and Limits: Part II*, 2 LAW & PHIL. 5, 29 (1983).

29. *See* Williams, *supra* note 21, at 565; Coleman, *supra* note 22; Coleman, *supra* note 28; Steiner, *Putting Fault Back into Products Liability*, 1 LAW & PHIL. 419 (1982).

designed to urge employers toward careful employment practice. Second, there must be no reasonable way to write the liability rule so as to avoid those cases in which the liability is imposed unfairly. For example, while we generally hold competent adults responsible for their conduct, and while we refrain from holding incompetent individuals responsible, we must draw some sort of line between the two. And we can be sure that, wherever we draw that line, there will be borderline cases. As a result, we will inevitably apply the adult standard of "ordinary prudence" to some individuals whose intellectual capacities are at once too low to function quite normally, yet too high to warrant a designation of incompetence.[30] Third, the merits of the social objective must outweigh the disadvantages of imposing the unfair liability. For example, we might inquire whether the liability rule has the effect of placing undue burdens upon socially desirable activities.[31]

C. *Unjustified Unfair Liability*

Professor Furrow argues that physicians ought not to be permitted to plead prohibitive costs as a defense in malpractice litigation. He states that, because medical practices are currently extravagent, they can be trimmed in medically benign, even beneficial, ways. This trimming, he suggests, can be accommodated by such traditional legal devices as the appeal to the "respectable minority," "best judgment," and "clinical innovation" exceptions to the majoritarian custom standard of care. Where this approach works as advertised, we need not worry about unfair liability, for the physician will not be held liable at all so long as his more conservative practices produce comparable quality of care. However, I have argued in this Commentary that this analysis essentially neglects an important group of cases: those in which the physician has essentially no choice but to render substandard care.

With respect to these cases, Professor Furrow offers another line of argument. It is socially desirable to maintain legal pressure on physicians, lest they too readily compromise patients' interests in the name of costs and refrain from actively seeking new economical ways to deliver quality health care. He argues, in other words, that the first criterion of justification—namely, that there be an important social goal—is satisfied by the value of preserving physicians'

30. *See* Keeton & O'Connell, *supra* note 22, at 389.

31. *See* Harper & James, *supra* note 22, at 269; Wasserstrom, *supra* note 22, at 278; Steiner, *supra* note 29, at 420.

fiduciary commitment to serve their patients' welfare above others', and by the general value of maintaining the highest possible quality of health care. Regarding the second criterion—that the unfair liability cannot reasonably be avoided—he suggests that to allow costs as a defense in any form would represent a serious threat to the above two social values. In a sense, it is a wedge argument, implying that if compromise were made in this area, it would be very difficult to draw the necessary limits. Finally, his argument regarding the third criterion—that the social objective must outweigh the price paid by the individuals held unfairly liable—is the implied sum of his position regarding the first two. If there is any liability unfair to the physician (a point not actually conceded, since the concept is not directly discussed), it is surely outweighed by the importance of each patient's having confidence that his physician can be trusted as a personal advocate who will deliver at least the minimum level of good health care.

Unfortunately, Professor Furrow's position cannot withstand scrutiny.

1. *Empirical Rebuttals*

Professor Furrow argues that holding physicians liable for all instances in which they deliver substandard care will lead to the following results:

a. physicians will be encouraged to practice medicine more conservatively as they avoid the over-interventions that lead to iatrogenesis;

b. physicians will be deterred from under-providing care, as they will still be held liable for care which does not produce medically comparable results; and

c. such litigation may help to expose difficult issues of cost containment to the public, where health care priorities can be considered and perhaps improved.

On the following bases, we must challenge these empirical conjectures. None of these rebuttals is offered as decisive or as proven, nor is it essential to so offer. The more important arguments are moral, which follow. Nevertheless, we can at least cast considerable doubt upon his empirical claims.

Points "a" and "b" are in tension. According to a study conducted by the American Medical Association in 1983, physicians spend approximately fifteen billion dollars per year in the practice

of defensive medicine.[32] Extra tests and procedures are undertaken, not because they are medically essential or even optimal, but to ensure that no diagnoses are missed, that no potential cures are lost. They are designed, in other words, to ensure that no one can possibly accuse the physician of underserving his patient (goal "b").[33] If tort liability has indeed had this impact, it is difficult to see how that same pressure can simultaneously cause physicians to abandon these practices of aggressive care in order to reduce concomitant iatrogenesis (goal "a"). Part of the problem here is that Professor Furrow has provided no data to indicate just what proportion of malpractice litigation actually arises from iatrogenesis specifically produced by medically marginal interventions. If that percentage is quite small, then we have little reason to conclude that Professor Furrow's tort pressures will in fact yield significant reductions of medical injury.[34]

Professor Furrow presumes that tort pressure will persuade the physicians who attend the poor to maintain quality care despite fiscal constraints. Where these physicians actually have the option to do so—where their scarcity of resources is not severe—then perhaps the pressures will work as intended. However, the worrisome cases are those in which resource constraints leave the physician with literally no choice but to practice substandard medicine. And these, the very cases with whose justice we are concerned, are not amenable to such pressure. "Ought" presupposes "can."

Although Professor Furrow argues that such tort pressures will help to bring issues of cost-versus-quality tradeoffs into the public arena for discussion, quite the reverse may happen. By refusing to permit costs as a defense, courts would expressly prohibit the presentation of evidence concerning cost constraints and their impact on health care. If anything, it is more reasonable to believe that permitting, not refusing, entry of economic information into malpractice litigation will help to bring these concerns before the public.

There is serious danger of unduly burdening a desirable social activity. The knowledge that legal liability may attach for substandard care, even where it was literally impossible to deliver standard care, may chill many physicians' willingness to care for the poor at all. So long as physicians are free to choose whom they will accept

32. *See* Zuckerman, *The Costs of Medical Malpractice*, 3 HEALTH AFF., Fall 1984, at 128; Bovbjerg, *supra* note 16, at 1397.

33. *See* Note, *supra* note 14, at 1012.

34. *See id.* at 1013-14.

for care,[35] and are not required to serve the poor against their will,[36] the poor as a group stand to be seriously underserved.[37] Thus, Professor Furrow's position may fail to satisfy the third criterion of justified unfair liability: an acceptable balance between the merits of the social goal to be promoted and the price which must be paid in order to promote that goal.

2. *Moral Rebuttal*

These empirical questions lead us to our first moral challenge regarding Professor Furrow's position. An unsound empirical case constitutes a moral hazard. Even if we can in principle justify unfair liability in the name of social goals, we need at least to ensure that those goals are likely to be attained by the means employed. To the extent that this outcome is questionable, we are less able to justify the price that must be paid by the individual physicians exposed to unfair liability.

Other moral arguments stand largely independent of the empirical question. To begin with, the health care tradeoffs which Professor Furrow asks courts to accept are not so different from those which he asks them to reject. As noted in Section IB, practicing cost-conserving medicine by reducing marginally useful interventions will inevitably trade the welfare of some patients (via failure-to-help) for the welfare of other patients (via averting iatrogenic harm). There is little difference between this sort of tradeoff, which Professor Furrow endorses, and a more directly economical one, in which a useful but marginal intervention is foregone for one patient in order to save money and resources for other patients' benefit. If the former health-for-health tradeoff is to be endorsed by the courts, it is not entirely clear why the latter health-for-health-resources trade should be penalized.

Another moral argument concerns the second criterion of justi-

35. *See* Marsh, *supra* note 18, at 161; A. HOLDER, *supra* note 18, at 1-3, 372.

36. This freedom has recently been somewhat curtailed in Massachusetts, as Governor Dukakis secured the enactment of a provision that conditions licensure on acceptance of Medicare assignment. This law has been upheld by United States District Court Judge Robert Keeton but will be appealed to the federal appeals court by the Massachusetts Medical Society and by the American Medical Association. *See* LeMaitre, *Massachusetts MDs in a State of Siege*, Am. Med. News, Mar. 7, 1986, at 16; Rust, *Medicare Assignment Tied to Licensure*, Am. Med. News, June 20, 1986, at 1, 33. Note, however, that the law does not require Massachusetts physicians to accept Medicare patients. It means only that they may not bill their Medicare patients beyond the fees they are paid by the government program.

37. *See* Note, *supra* note 14, at 1019. Interestingly, while Professor Furrow acknowledges this argument in his article, he offers no rebuttal.

fied unfair liability—namely, the impossibility of avoiding the unfair liability in the pursuit of the social goal. While we cannot here offer a specific proposal, we can at least plausibly suppose that the worst instances of unfair liability can be avoided. We can, under carefully delimited conditions, permit a physician to invoke economic constraints as an explicit malpractice defense.

In order to describe those limited conditions, we may invoke what is perhaps the most basic notion in tort law, the concept of reasonableness. More precisely, we may appeal to Justice Hand's formulation of the elements of reasonableness.[38] He asks us to weigh the seriousness and the likelihood of the harm we wish to avoid against the burdens incurred in avoiding that harm.

That formula has interesting implications for our inquiry. The harm we wish to avoid here is primarily a failure to help the indigent patient as the physician delivers substandard and inadequate care. Where resources are plentiful, the burden of avoiding the harm is, simply, the cost of adequate or standard care. Where resources are scarce, however, that burden arguably must include other costs. Most important, we must consider the costs of lost opportunity for other patients, as the resources used for the one patient are no longer available to those others. Thus, where resources are seriously limited, avoiding the harm of substandard care for one patient may seriously burden other patients' care. Under the Hand formula, it may therefore be entirely reasonable to consider economic constraints in determining physicians' duties under tort law.

This need not mean reducing the fiduciary physician-patient relationship to a mere balancing of each patient's needs against the competing wants and interests of others. The physician's primary obligation to his patient can remain legally, as well as morally, strong if costs are permitted as a defense only under the most clearly serious circumstances. If our moral aim in permitting costs to be a defense is to avoid placing unfair liability upon those physicians who truly had no option but to offer substandard care, then we may rightly insist that those who would use this defense clearly demonstrate the lack of reasonable alternatives. Their burden must be a heavy one, lest important fiduciary obligations and quality of health care be needlessly damaged.[39]

38. *See* United States v. Carroll Towing Co., 159 F.2d 169 (2d Cir. 1947).

39. In this use of the Hand formula, I differ sharply with the purely economic theories of tort offered by Posner and Danzon. *See* R. POSNER, ECONOMIC ANALYSIS OF LAW (1977); P. DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY (1985). Both recommend weighing the economic costs of accidents against the economic

Such justifications, arguably, should be found not only in terms of the relevant economic facts, but also in terms of the policies and guidelines which may be morally and medically justified in light of them. These policies ought to be properly the product, not of individual physicians engaging in ad hoc bedside-budget-balancing based on idiosyncratic economic theories, but of collective investigation and thoughtful consensus among physicians and others in the health care setting. Such policies, of course, cannot be binding, nor can they be precise enough to dictate clinical care. Each physician must still be left to use his judgment concerning how to apply such policies and when to seek exceptions for certain patients. Neither will the policies always be formal or written. Where medical technology or local resources are changing rapidly, informal agreements or shared routines may be more practical.

However articulated, the physician should be permitted to appeal to such policies and routines, and to the justifications whereby they were wrought, as he defends why his admittedly suboptimal care ought to be legally accepted.[40]

Because allocation of scarce resources is preferably implemented

---

costs of prevention in order to determine the threshold of liability. That is, determine which accidents are "worth avoiding" and which are not. In this way society can (ideally, at least) use the tort system to generate the most economically efficient, optimally cost-justified level of accidents and safety.

Rand Rosenblatt and others have identified some of the enormous problems associated with the cost-benefit analysis required for such an approach. *See* Rosenblatt, *Health Care, Markets, and Democratic Values*, 34 VAND. L. REV. 1067 (1981). I would only add here that to invoke the Hand formula does not necessarily commit us to considering only economic benefits and burdens, nor to translating all benefits and burdens into economic terms for a simple numeric balancing. We might instead argue that, in malpractice law, special weight should be accorded the physician-patient fiduciary relationship. The physician must not simply balance his patients' interests against others' and defer to competing needs whenever they are larger. Rather, the physician must presume to serve his own patients' welfare unless the burdens of doing so (including costs of lost opportunity where others are denied badly needed resources) are truly excessive.

It is unlikely that we can develop any tidy formula to identify just when we have reached "excessive." Judgment and values, more than computation, are required. The need for such judgment is no stranger to the law, however, and this approach can honor a very important noneconomic value: physicians' fiduciary obligations.

Interestingly, in his book, THE ECONOMICS OF JUSTICE (1981), Richard Posner acknowledges that not all important legal values can be encompassed within his economic theory of law as a vehicle for maximizing wealth in society. He notes, for example, that the Equal Protection proscription of racial discrimination cannot be accounted for adequately on grounds of economic efficiency. *See id.* at 378, 385-86. Instead, we must supplement economic principles of justice with noneconomic values. As noted above, I argue similarly that physicians' fiduciary obligations may represent another sort of noneconomic value which must be weighed in any balancing of patients' rights against competing interests.

40. For further discussion of such policies, see, e.g., Eddy, *Clinical Policies and the*

through well-considered policies and practice patterns than through ad hoc individual decisions, courts ought not to require that the physician demonstrate an attempt to bypass such policies on his pa-

Quality of Clinical Practice, 307 NEW ENG. J. MED. 343 (1982); Wong & Lincoln, *Ready! Fire! . . . Aim!*, 250 J. A.M.A. 2510 (1983).

While it is not my purpose to recommend a specific legal device for the utilization of such a cost defense, three possibilities come to mind. Each has its own strengths and weaknesses.

(1) The physician could appeal to the practices and policies of other providers under similar economic circumstances. This approach has been recommended, for example, for application to HMOs. *See* Bovbjerg, *supra* note 16. Analogously, Knotterus describes, though does not endorse, separate standards for Medicare or Medicaid providers as a genre of "respectable minority." *See* Knotterus, *California Negotiated Care: Implications for Malpractice Liability*, 21 SAN DIEGO L. REV. 455, 466 (1984). Or similarly, a physician practicing at an inner-city public hospital might refer to other such hospitals. However the reference group might be chosen, the central idea is that, in a variant of the locality rule, we will still appeal to prevailing custom, albeit circumscribed according to economic rather than to geographic factors.

The chief advantage of such an approach is that it would still judge physicians' care on the basis of a larger reference group. By preserving the traditional appeal to custom, such an approach might be relatively easier to implement than the alternatives suggested below. In addition, by appealing to fairly broad reference groups, standards of care would be less likely to incorporate local idiosyncrasies, and more likely to be the product of well-founded collective judgments.

Unfortunately, this may still represent inadequate protection for the fiduciary relationship and for quality health care. To absolve economically pressed physicians from being judged according to more affluent, mainstream standards may invite these physicians to deliver needlessly inferior care, safe in the knowledge that so long as others in their situation do likewise, all will have legal sanctuary.

(2) As was the hope for their PSRO-ancestors, PROs could develop specific standards of care for various kinds of health care delivery. Malpractice immunity would then be granted to those physicians who comply. This immunity, initially built into PSRO legislation, has been retained in the new PRO plan. *See* 42 U.S.C. § 1320c-6(c) (1982).

In theory at least, this approach has the advantage of releasing physicians from the pressure to engage in medically useless "defensive medicine," while still monitoring standards of quality care. However, the drawbacks are numerous.

First, such guidelines would have to be virtually infinitely long and complex in order to cover every possible medical situation—and updated almost daily, as medical science rapidly changes. The logistical, practical problems would be prohibitive.

Second, even if detailed guidelines were developed, there must be ample room for exceptions. For reasons discussed in Section IA and IB *supra*, "cookbook" medicine can be seriously dangerous by failing to take into account: the inadequacies of medical science; the nearly infinite biological variability of the human organism; and the special social and moral concerns of a profession which requires such physical and psychological intimacy as does medicine.

Third, it is quite likely that any standards promulgated by PROs would be too stringent to accommodate the economic exigencies of physicians who care for the poor. If so, then these physicians would be systematically trapped into legal peril by their inability to conform to those higher, now formally catalogued, standards.

Fourth, it is legally unclear just what sort of conduct would be immunized by such provisions. And so long as there is this uncertainty, physicians are unlikely to feel sufficiently protected to abandon their expensive practices of defensive medicine.

For further discussion of this option, see Blumstein, *supra* note 16, at 392; Note, *supra* note 14, at 1011-12; Havighurst & Blumstein, *Coping with Quality/Cost Trade-offs in Medical*

tient's behalf. He must not be obligated to prove that he "pressed the system" to its utmost or "skirted the rules" on behalf of his patient in order to demonstrate that he had no reasonable choice but to offer substandard care. If a justified policy endorses a particular, and admittedly substandard, plan of care as the best available under the circumstances, then appropriate compliance with that policy ought equally to be considered as justified. Thus, if Public General Hospital can only afford to hospitalize patients with uncomplicated myocardial infarction for five days, instead of the more prevalent seven to ten, then it should be sufficient for the physician to show that this local policy was well justified and that his own patient's myocardial infarction was properly classified as "uncomplicated."

The legal concept of reasonableness may be employed in another moral argument. One of Professor Furrow's principal arguments against permitting costs as a defense is that it would be unreasona-

Care: The Role of PSROs, 70 NW. U.L. REV. 6 (1975); Crothers, *Professional Standards Review and the Limitation of Health Services*, 54 B.U.L. REV. 931 (1974).

(3) Finally, the physician might be offered the option of pleading a special exemption to the usual standard of care using a "rebuttable presumption" approach. In every case it would be presumed that this physician owed her patient exactly the same standard of care as his colleagues owe their patients. This presumption, however, could be rebutted with appropriate arguments to demonstrate that, in this particular case, the physician could not have been reasonably expected to meet that standard. As the physician attempts to offer this defense, others' actions under similar economic circumstances could serve as evidence that his conduct was justified, but would not define the standard of care owed. Also relevant would be evidence concerning the particular hospital's financial circumstances, local physicians' policies or shared beliefs concerning reasonable or necessary ways in which to economize on care, and so forth.

This approach provides a strong emphasis on preserving physicians' fiduciary obligations to patients and to maintaining quality care—the degree of strength depending on the magnitude of the burden which the physician must meet in order to be exempted from the prevailing standard. It also permits flexibilty and a sensitivity to the special circumstances of each case.

On the other hand, this approach may be difficult to implement in litigation, as substantial and complicated economic information would necessarily be added to the already heavy burden of supplying and digesting complex medical information. Further, it may be difficult for juries to identify the majority standard against which the "reasonableness" of the physician's departure would be measured—i.e., to determine whether the economic exigencies really posed a burden from which he could not reasonably escape. Finally, evidentiary questions would have to be answered. For example, should the plaintiff be allowed access to the economic data which the defendants intend to offer, so that he can search for appropriate rebuttal information?

In sum, there are impressive philosophical, legal, and practical obstacles to instituting a suitable mechanism which would enable physicians to find legal refuge from unfair liability. Nevertheless, as argued in the text of the Commentary, there are powerful reasons to persist in the search. Such knotty problems are not foreign to our legal system. We must simply determine in what direction, in principle, we ought to proceed and then devise the best mechanisms we can, recognizing that perfection is unattainable.

ble for society to stage the battle between the competing interests of cost containment versus quality health care directly in patients' hospital rooms. Such conflicts ought not, he argues, to be resolved at the personal expense of indigent patients.

This argument, however, may be extended. Why is it morally preferable to stage that battle at the personal expense of physicians? Professor Furrow expects the physician not merely to discuss and research ways of delivering more cost-efficient care (an important obligation with which it would be difficult to disagree), but also to harangue hospital administrators, cajole corporate officers, lobby legislators, fight city hall, and place his own personal professional and financial welfare in jeopardy. And he must do so, presumably, every time resource constraints threaten his patients' welfare, since no exceptions will relieve him of his obligation to deliver fully standard care. Surely at some point this constant combat on patients' behalf becomes morally supererogatory. And yet, should his efforts fail, Professor Furrow's physician should expect to spend still more time, now in court, and should expect to be personally penalized for failing to reverse single-handedly the government or corporate policies which worked to his patient's detriment.[41]

III. CONCLUSION

Ultimately, the problem with which we are reckoning probably will not admit of a fully satisfactory resolution. It reflects a deeper, likely irreconcilable tension between major societal values: our wish to promote health care by expanding its quality and availability despite the enormous expense of doing so, and our wish to promote goals other than health care, such as permitting citizens to retain as much of their hard-earned wages as possible. To impose limits on the availability of health care resources is to create scarcity. And to draw the limits in a way that leaves less available for the poor than for others is to create a *stratified* scarcity which leads in turn to another, probably equally irreconcilable, social tension.

Stratified scarcity can be eliminated in either of two ways: (1) eliminate the scarcity by devoting unlimited resources to health care, so that all citizens may have whatever they need, or (2) eliminate the stratification. The former is economically, politically, and

41. Whereas in 1966 one-half of personal health care in the United States was paid for directly by consumers, by 1982 government paid for 40% of the total tab with corporations paying for another 30% as part of their fringe benefits for employees. *See* Levit, 6 HEALTH CARE FIN. REV., Summer 1984, at 4, *summarized in* 3 MED. BENEFITS 1-4 (1986).

probably also morally untenable. We can only devote literally limitless resources to health care by seriously short-changing other national needs. The latter course would probably require some sort of socialized medicine, under which all citizens would be guaranteed a certain level of health care. Even this, however, would not erase the stratification. So long as there are wide differences among citizens' overall socioeconomic status, and so long as we permit those who can afford it to buy more-than-minimal health care, we will still have stratified health care.[42] More important for our legal question, as long as standards of care are delineated by appeal to prevailing (majority) custom, and as long as the poor remain numerically a minority, then the medical care delivered on the bottom stratum will by definition be substandard.

In the end, the poor are likely to come up with the short straw no matter how the legal issue is resolved, as these larger social questions remain unresolved. They will have decreased quality of care, or lesser access, or both. To permit physicians to plead costs as a defense, even under very limited circumstances, is fraught with moral, medical, and legal hazards. It says, in effect, that "although this injury produced by substandard care would be a tort if inflicted on a wealthy person, it is not sufficient cause to award damages if perpetrated upon a poor person." The poor as individuals would undoubtedly suffer, as their access to legal remedy for their injuries is curtailed. Further, we must take very seriously Professor Furrow's argument that a too-easy escape hatch for substandard care may encourage the physician to be medically and morally lazy, and to fail to place proper primacy upon his fiduciary obligations.

And yet, to deny such a defense altogether is to penalize the physician personally for society's inability to reconcile its conflicting values. And ultimately, without any room for such a defense, the poor as a group may be penalized as well by physicians' diminished willingness to care for them at all.

42. James Blumstein would likely agree with this point, as he argues that variations in the availability and quality of health care are a product, not so much of the health care system, but of broader features of society's income distribution. *See* Blumstein, *supra* note 16, at 355; *see also* Blumstein, *Distinguishing Government Responsibility in Rationing Public and Private Medical Resources*, 60 TEX. L. REV. 899 (1982).