Does Tort Law Stifle Innovative Medical Treatments?

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Anna B. Laakmann, When Should Physicians Be Liable for Innovation?, 36 **Cardozo L. Rev.** 913 (2015).

The interaction between medical malpractice law and the provision of health care is the subject of an ongoing policy debate. Do physicians practice "defensive medicine" to avoid being sued? Does the high cost of liability insurance or the looming threat of unfounded malpractice claims drive physicians from particular specialties or regions of the country? These issues have dominated the debate for years. Recently, another issue has gained prominence. Does malpractice law deter physicians from adopting innovative procedures? This is probably more important than the question of whether tort law induces the practice of "defensive medicine." Whereas "defensive medicine" ordinarily increases the cost of health care via the provision of unnecessary medical treatments, the deterrence of medical innovations has a direct impact on health outcomes.

Gideon Parchomovsky and Alex Stein argued in 2008 that tort law deters medical innovations because the legal standard of required or reasonable care is defined by customary medical practices. A physician who innovates necessarily departs from custom. When her innovations cause harm, she faces the prospect of incurring malpractice liability for her apparently "unreasonable" behavior. That physicians might forego non-customary treatments in order to shield themselves from potential tort liability has been confirmed by a series of empirical studies conducted by Michael Frakes and others. Frakes and his colleagues have found that after a state has rejected local customs in favor of national standards for defining the required care, local surgery rates converge toward the national rate. When the standard of reasonable care was defined by local customs, physicians who followed these practices could avoid the threat of liability that they would face if they instead followed national norms. When jurisdictions shifted the legal measure of proper care from local to national customs, a significant number of physicians began to comply with the national practices. Apparently, this change in behavior was motivated by the change in tort law's test of reasonable care, not by any independent medical evaluation of whether compliance with the local or national custom was in the best interests of the patient.

This problem is the subject of Anna Laakmann's compelling article. Laakmann has a joint J.D./M.D., and this article showcases her interdisciplinary expertise. In addition to providing a helpful overview of the existing rules of malpractice liability across the country, Laakmann insightfully situates legal rules within the context of particular medical issues, thereby illustrating the acute problems that can occur when existing tort doctrines are not well suited for resolving hard problems faced by physicians. A customary practice ordinarily works well but is not necessarily best for an individual whose conditions or needs are not like the average patient. An innovative departure from custom could help such a patient, but this approach would increase the risk that the physician will be second-guessed in a lawsuit, and the patient's informed consent to the innovative treatment provides no immunity from that threat. The resultant disincentives for medical innovation are quite clear. The article does not break new ground by identifying a problem that has been missed by others, but Laakmann thoroughly develops that problem in a manner that is unmatched in the literature.

To solve this problem, Laakmann advocates a new regime based on an alteration of the existing fiduciary duty owed by a physician to her patient. Drawing on the "business judgment rule" governing the fiduciary duty owed by corporate directors to shareholders, Laakmann creatively argues that tort

law should similarly shield physicians from malpractice liability for treatment decisions that are the result of a process whereby the physician (1) considers generalized data and customary practices in order to assess their relative efficacy for the individual patient in light of her particular health needs and preferences; and (2) reaches a collaborative decision with the patient, based on the sharing of all material information, that an innovative departure from custom is warranted for the health condition in question. Like the "business judgment rule," the proposed "medical judgment rule" focuses on the process of decisionmaking rather than on outcomes, effectively shielding physicians from tort liability for their good-faith, informed decisions to improve patient outcomes by departing from a customary practice when agreed to by the patient. Laakmann is less clear about the extent to which this formulation of the fiduciary duty might provide new grounds for liability, and the proposal critically depends on the premise that the patient's consent will be sufficiently informed to justify a limitation of the physician's duty regarding treatment decisions. Perhaps for these reasons, Laakmann recognizes that implementation of the proposal might require some combination of "statutory revisions to standards of care, screening of malpractice claims by medical review panels, and self-regulation by health care systems" (p. 966).

Although Laakmann has expertly diagnosed the problem and recommended a highly plausible (and innovative!) cure, she has not fully considered the question of whether existing tort doctrine is capable of solving this problem. Laakmann recognizes that tort law could reject custom as the standard for determining the required or reasonable care (the approach taken in other contexts), but she summarily rejects that solution on the ground that courts do not ordinarily have sufficient data about the risks and benefits of health treatments to make good decisions about the matter. One could question this conclusion in light of other tort practices (consider products liability), but there is an alternative approach not considered by Laakmann. Outside of medical malpractice, tort law has long faced the issue of how customary practices should relate to the legal requirement of reasonable care. Whether compliance with custom necessarily constitutes reasonable care differs across the two contexts, but aside from this important difference, there is no evident reason why tort rules governing customary practices should be different in a medical case than in an ordinary tort case. Consider the question of whether a customary practice applies to the safety decision at issue in a tort suit. As Clarence Morris observed long ago, "[w]hen the defendant must practice his craft under conditions significantly different from others in the same business, there is no customary way of acting-under-the-circumstances."[1] The same argument applies to the cases considered by Laakmann, in which customary practices, though presumably well suited for most patients, are not sufficiently apt for a patient in light of her particular needs and circumstances. Departure from custom is warranted in these cases for the obvious reason that the custom is not reasonable when applied to the significantly different circumstances at hand. (Note that the same rule governs the question of whether a statutory violation can be "excused" for purposes of negligence per se.) A patient, therefore, could sue the physician for not departing from a customary practice when it is in her best interest to do so, and a physician should also be able to avoid liability by showing that the customary practice does not properly apply to the treatment in question. A more robust inquiry into the relevance of a medical custom as applied to an individual patient could perhaps ameliorate the disincentives that tort law otherwise creates for medical innovations. Regardless of how this solution compares to the fiduciary duty proposed by Laakmann, her depiction of the problem and analysis of its underlying causes provides a valuable contribution to the ongoing debate over the relation between tort law and the provision of health care.

1. Clarence Morris, *Custom and Negligence*, 42 **Colum. L. Rev.** 1147, 1155 (1942).

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