

CONTRACT, WARRANTY, AND THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

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INTRODUCTION

You can allay fears that your car transmission will fail by purchasing a 10-year/100,000-mile powertrain warranty, but you cannot purchase a warranty against your surgeon botching your appendectomy—or even leaving a sponge in your body. Why? Imagine a world in which health care providers offered warranties, which would necessarily vary with condition complexity and physician skill. Doctors could offer minimal warranties for complex, difficult-to-treat conditions, i.e., “I’ll offer a warranty that you will receive this experimental drug for your chronic disease—but there’ll be no warranty offered for a cure.” The standard arm fracture would receive a more complete guarantee: “You’ll be fine in three weeks or you won’t have to pay me.”

These warranties would ameliorate what economists call medicine’s information asymmetry—unlike purchasers of food in a supermarket, consumers cannot verify what health care treatment they need or if it was provided competently.¹ Because doctors make more money by doing more tests, procedures, and exams—and

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1. See Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 947, 965–66 (1963). Arrow’s argument is not quite an “information asymmetry” argument, as he correctly points out that *both* parties to the medical contract work under significant conditions of uncertainty. *Id.* at 951. Consumers have trouble picking effective doctors, and doctors have trouble picking effective treatments. The full significance of this point as it relates to the effectiveness of, and accountability within, medicine is discussed below. See *infra* Part I; see also Charles E. Phelps, *Information Diffusion and Best Practice Adoption*, in 1A HANDBOOK OF HEALTH ECONOMICS 223, 225 (Anthony J. Culyer & Joseph P. Newhouse eds., 2000) (“The ‘footprints’ of incomplete information can be found everywhere in health care markets . . .”).

because third-party-payer insurance renders price invisible to patients—physicians and consumers have incentives to *do more medicine* than they should, facing little to no economic pressure for cost effectiveness or even simply for safe, conservative medical practice. Indeed, the matter extends beyond mere economics. Unnecessary procedures performed without our full understanding invade our bodily integrity; this market failing threatens personal autonomy.

Health care economists attribute much of the excess cost of the U.S. system to this asymmetry. We spend roughly twice as much as do countries with state-controlled health care systems, which control this asymmetry from the top down.² This waste has been calculated at roughly \$700 billion a year, or one-third of all annual U.S. health care costs.³ The belief that health care provision is wracked with inefficiency motivated the recent health care act (“Health Care Act”)—The Patient Protection and Affordable Care Act (“PPACA”) and The Health Care and Education Reconciliation Act (“HCERA”)⁴—with the White House acknowledging the elimination

2. See ELIZABETH DOCTEUR & ROBERT A. BERENSON, HOW DOES THE QUALITY OF U.S. HEALTH CARE COMPARE INTERNATIONALLY? 10 (2009), available at <http://www.urban.org/publications/411947.html>. The United States spends 15.3% of its gross domestic product (“GDP”) on health care. See KAISER FAMILY FOUND., TRENDS IN HEALTH CARE COSTS AND SPENDING (2009), available at http://www.kff.org/insurance/upload/7692_02.pdf (“U.S. health spending as a share of GDP in 2006 (15.3% in [Organization for Economic Co-Operation and Development (“OECD”)] accounting) was considerably higher than all other OECD countries, including Canada (10.0%), France (11.0%), Germany (10.6%), Japan (8.1%), and the United Kingdom (8.4%). Switzerland was a distant second to the U.S., devoting an estimated 11.3% of GDP to health care.”). All these foreign countries have state-controlled health care delivery systems to varying degrees, yet these countries are generally considered to provide health care that is at least as good, if not better, than that of the United States. See DOCTEUR & BERENSON, *supra*, at 10 (surveying existing literature and concluding that “[t]he evidence suggests that other developed countries achieve comparable quality of care while devoting at most two-thirds the share of their national income”).

3. In 1996, one set of commentators estimated that health care spending waste approximated \$40 billion. See John E. Wennberg et al., *Geography and the Debate Over Medicare Reform*, HEALTH AFF., Feb. 13, 2002, at W96, W104, available at <http://content.healthaffairs.org/content/early/2002/02/13/hlthaff.w2.96> (“Our estimates are based on 1996 spending. In that year, spending under traditional Medicare was about \$138.3 billion, and per capita spending reached \$4,990. If, on an age-, sex-, and race-adjusted basis, spending levels in the lowest decile were realized in all higher regions, total spending would have been just \$98.2 billion, or a savings of \$40 billion (28.9 percent).”). Peter Orszag, White House budget director and architect of the health care reform, updated this number to \$700 billion per annum given medical care inflation over the last decade. See *The President’s Fiscal Year 2010 Budget: Hearing Before the H. Comm. on the Budget*, 111th Cong. 6 (2009) (statement of Peter Orszag, Dir., Office of Mgmt. & Budget).

4. The Health Care Act is contained in two pieces of legislation, the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119

of this \$700 billion waste as a chief goal.⁵

The Health Care Act adopts a top-down solution to the asymmetry problem and its attendant spiraling costs, by creating a bureaucratic mechanism through which government, by mandating best practices and using its tremendous purchasing power (Medicare, Medicaid, Veterans Administration, and now government-sponsored insurance exchanges), can demand more efficient health care provision.⁶ The Health Care Act, at least implicitly, assumes that consumers cannot effectively evaluate medical treatments but must simply accept them, and, therefore, that medical care is an appropriate area for government and professional regulation.⁷ Private health organizations, such as health maintenance organizations (“HMOs”), do (and have done) the same thing in the private sector. While HMOs are effective at reducing costs, their popularity has waned, it is claimed, because patients reject their limits on choice and patient autonomy.⁸

Warranties could achieve the same ends as either public or private top-down solutions. First, health care providers would not offer treatments likely to fail because they would not be paid for such treatments. This would solve the problem of what economists call “demand inducement,” i.e., the well-documented phenomenon that physicians often prescribe unnecessary treatment when it is financially advantageous to do so.⁹ Second, consumers could choose

(2010), and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

5. See *infra* notes 16–19 and accompanying text (discussing the role of cost savings in motivating the Health Care Act).

6. PPACA mandates this in numerous ways. For example, Title III (Improving the Quality and Efficiency of Health Care), Section 3001 links payment for hospitals to quality outcomes under Medicare. See Patient Protection and Affordable Care Act § 3001. Sections 3002–3015 create mechanisms for calibrating the quality of physicians and other health care providers and basing Medicare remuneration on these scores. *Id.* §§ 3002–3015. Section 3021 established the Center for Medicare and Medicaid Innovation to research optimal quality standards and payment regimes. *Id.* § 3021.

7. See Jennifer Arlen, *Contracting over Liability: Medical Malpractice and the Cost of Choice*, 158 U. PA. L. REV. 957, 981 (2010) (recognizing arguments that patients may not be able to effectively contract for medical services because they are not sufficiently informed); William M. Sage & Peter J. Hammer, *A Copernican View of Health Care Antitrust*, 65 LAW & CONTEMP. PROBS. 241, 270 n.104 (2002) (“Many health care services are what economists call credence goods, meaning that consumers cannot necessarily assess their quality even after consuming them.”).

8. See Larry B. Benko, *Loosening Their Grip: As HMOs’ Popularity Continues To Erode, More Plans Turn to Less-Restrictive Rules. But with Costs Rising, What’s Next?*, MODERN HEALTHCARE, Apr. 15, 2002, at 30 (identifying consumer frustration with lack of choice of providers as the cause for the decreasing popularity of HMOs in the 1990s).

9. The physician-induced-demand hypothesis posits that physicians take advantage of patients’ ignorance by recommending treatment that they may not need, thus “inducing” demand for medical services. See Rune J. Sørensen &

treatments based on their providers' credible assessments of risks and benefits, rather than "trusting" their doctors. This would allow for more efficient consumption of health care. Third, warranties would solve a nagging problem in medicine—how to tell if your doctor is any good. Better doctors would presumably offer more expansive warranties. Fourth, warranties properly align incentives by requiring doctors to have "some skin in the game," compensating them only when they achieve the outcomes they promise.¹⁰ Currently, physicians receive payment regardless of whether they kill a thriving child with some breathtaking negligence or raise Lazarus from the dead. Inappropriate incentives lead to substandard performance.¹¹ Fifth, medical warranties are not some law academic's folly. Warranties are already emerging in some areas of medicine, such as refractive surgery and fertility treatments.¹² This Article sets forth a program for expanding their use.

While both warranties and top-down mandates aim to correct inefficiencies in the current provision of health care, warranties have numerous advantages. First, warranties reward excellent doctors and allow them to easily distinguish themselves, while mandated treatment protocols create no incentives for innovation. Second, mandated standards, even if well supported and evidence

Jostein Grytten, *Competition and Supplier-Induced Demand in a Health Care System with Fixed Fees*, 8 HEALTH ECON. 497, 497 (1999) ("[Demand inducement] means overconsumption of medical services, generated by the economic self-interest of physicians. The information asymmetry between the financing body, the patient and the provider opens up the possibility for physicians to inflate health service demand. If physicians are financed on a fee-for-item basis, greater competition provides an incentive to exploit the information advantage.").

10. While admittedly a radical idea, results-based payment or specified-results treatment is not entirely new. See, e.g., David A. Hyman & Charles Silver, *You Get What You Pay For: Result-Based Compensation for Health Care*, 58 WASH. & LEE L. REV. 1427 (2001). Professors Hyman and Silver focus largely on the agency problem that traditional fee-for-service health care creates: the doctor lacks any incentive to be successful and, therefore, can act as an opportunistic agent. See *id.* at 1441–46, 1455–56. To fix the agency problem, Hyman and Silver focus primarily on physician compensation. *Id.* at 1430–31. This Article endorses their view and policy prescription but focuses on the issues of signaling and information asymmetry.

11. See David A. Hyman & Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 90 CORNELL L. REV. 893, 893–94 (2005) ("Health care error rates are higher than they should be not because providers fear malpractice liability, but because providers have defective incentives and norms. Since providers often lose money when quality improves, there is no 'business case for quality.' Moreover, providers' norms and attitudes, which are often highly punitive, impede efforts to improve quality by discouraging the creation of work environments in which error-reporting and other predicates for quality improvement can flourish.").

12. See *infra* Part II.B.

based, cannot truly drive most medical decisions. Medicine involves more than picking the right treatment from a standardized list; it involves diagnoses and procedures. The former involve the ability to detect subtle physical clues, which differ greatly among individual patients. The latter involve, to use surgeons as an example, good muscular control and sense of tissue. Protocols cannot tell consumers which doctors have these skills. Third, due to the difficulties of showing that any particular protocol should have been used, mandates are not clearly superior to medical malpractice standards for providing guidance to practitioners and protection to consumers.

While warranties can powerfully signal quality,¹³ any reform of the informational basis on which consumers purchase health care must also eliminate the legal barriers to obtaining credible information about physician performance. The better information parties have, the more effective contracting becomes.¹⁴ Many proponents of a pure contract regime in medicine envision information about physician quality emerging as it would for any other good. For instance, they point to word-of-mouth or reputation as working effectively to give patients adequate information about doctor quality.¹⁵ Law, regulation, and norms, however, discourage development of information.

Part I examines the problem of information asymmetry in medicine as well as the top-down approach that many academics advocate and that the Health Care Act adopts. Part II describes the benefits of medical warranties, how they might function, and their desirability in comparison to top-down approaches. In particular, it examines “reverse subrogation,” a proposed cause of action that would allow warranties to function in a third-party payment regime. Part III examines the legal and professional structures that stifle the flow of information about provider quality and sets forth suggestions for legal reform. Finally, Part IV examines the history of physician-patient contracts, arguing that current contracting conventions reflect the political economy, not the market.

13. See Michael Spence, *Consumer Misperceptions, Product Failure and Producer Liability*, 44 REV. ECON. STUD. 561, 561–62, 569–71 (1977) (discussing how guarantees function as indicators of reliability).

14. See George A. Akerlof, *The Market for “Lemons”: Qualitative Uncertainty and the Market Mechanism*, 84 Q.J. ECON. 488, 488–90, 495–96 (1970) (discussing the inefficiency of contracting in the car market that results from a lack of information); Michael R. Darby & Edi Karni, *Free Competition and the Optimal Amount of Fraud*, 16 J.L. & ECON. 67, 68–72 (1973) (analyzing consumer behavior in the absence of information about the exact qualities of a particular purchase).

15. See, e.g., RICHARD A. EPSTEIN, *MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE?* 415–16 (1999).

I. INEFFICIENCIES IN MEDICINE: TOP-DOWN AND BOTTOM-UP SOLUTIONS

Last year, at the beginning of the Obama administration's push to pass the Health Care Act, Peter Orszag, White House budget director and an architect of the reform, explained much of its impetus in *The Wall Street Journal*. Orszag warned of skyrocketing costs: "If costs per enrollee in Medicare and Medicaid grow at the same rate over the next four decades as they have over the past four, those two programs will increase from 5% of GDP today to 20% by 2050."¹⁶ He also stated that medicine is wracked with inefficiencies and that "even doctors and hospitals agree that substantial efficiency improvements are possible in how medicine is practiced."¹⁷ He concluded that "[w]e don't seem to be getting anything in exchange for the extra costs except more intensive tests and procedures, and additional days in the hospital—and who would want any of that if the additional tests and procedures do not actually help to promote health?"¹⁸ His solution: "changes in financial incentives for providers so that they are incentivized rather than penalized for delivering high-quality care."¹⁹

Orszag explained elsewhere what "high-quality care" means. Speaking before the Council on Foreign Relations, he stated,

[I]t seems that higher cost hospitals and regions provide lower quality, not higher quality, care.

And therein lies the opportunity. By replicating the best practices in the high-quality, low-cost regions and hospitals, we can boost quality and constrain costs in the long-term.

...

... [This can be done] by establishing an Independent Medicare Advisory Commission—or IMAC—of doctors and health experts to set Medicare reimbursement rates and institute other reforms.

IMAC would issue recommendations that would either improve the quality of medical care provided to Medicare beneficiaries or improve Medicare's efficiency.²⁰

The notion of a government board mandating "best practices" for medicine led to Sarah Palin's famous characterization that the

16. Peter R. Orszag, *Health Costs Are the Real Deficit Threat*, WALL ST. J., May 15, 2009, at A13.

17. *Id.*

18. *Id.*

19. *Id.*

20. Peter R. Orszag, Dir., Office of Mgmt. & Budget, Prepared Remarks: A Conversation with Peter R. Orszag (July 22, 2009), available at http://www.cfr.org/publication/19897/prepared_remarks.html.

administration supported “death panels.”²¹ The uproar that followed led to legislative language that scuttled any mention of end-of-life counseling.²² But these prohibitions are likely cosmetic, as other provisions of the Health Care Act empower Medicare to set reimbursement schemes based on quality metrics.²³ Indeed, only these reforms can achieve the huge deficit reductions that the administration promises.²⁴

Orszag’s (and the Health Care Act’s) analysis of medical care’s inefficiencies reflect widely accepted views among economists and health care specialists. Economists have pointed out that physicians “induce demand,” meaning that physicians perform many unnecessary procedures because patients cannot evaluate these procedures’ necessity or quality.²⁵ Patients lack reliable ways to measure physician performance, creating tremendous agency costs. The fee-for-service reimbursement scheme creates *no* incentives to perform competently, as doctors receive payment whether the treatments succeed or fail.²⁶

The Health Care Act, and conventional policy thinking, may underestimate the economic inefficiencies in health care. There is little to no data linking total health care expenditures with positive health care outcomes²⁷—which is particularly striking given that

21. Robert Coleman, *The Independent Medicare Advisory Committee: Death Panel or Smart Governing?*, 30 J. NAT’L ASS’N ADMIN. L. JUDICIARY 235, 239–40 (2010). *The St. Petersburg Times’* political truth-sayer called Palin’s characterization the “Lie of the Year.” Angie Drobnic Holan, *PolitiFact’s Lie of the Year: ‘Death Panels,’* POLITIFACT.COM (Dec. 18, 2009), <http://www.politifact.com/truth-o-meter/article/2009/dec/18/politifact-lie-year-death-panels/>.

22. Janet Adamy, *End-of-Life Provision Loses Favor*, WALL ST. J., Aug. 13, 2009, at A4; Foon Rhee, *Senators Eliminate End-of-Life Provision*, BOSTON.COM (Aug. 14, 2009), http://www.boston.com/news/politics/politicalintelligence/2009/08/senate_panel_dr.html.

23. See *supra* note 6 (pointing to sections in the Health Care Act that allow the federal government to impose quality mandates on providers).

24. See President Barack Obama, State of the Union Address (Jan. 27, 2010), available at <http://www.whitehouse.gov/the-press-office/remarks-president-state-union-address> (“[The administration’s approach] would bring down the deficit by as much as \$1 trillion over the next two decades.”).

25. See Jerry L. Mashaw & Theodore R. Marmor, Essay, *Conceptualizing, Estimating, and Reforming Fraud, Waste, and Abuse in Healthcare Spending*, 11 YALE J. ON REG. 455, 460 (1994) (explaining that asymmetric knowledge between health care suppliers and patients allows suppliers to dictate how much care patients need, thus allowing for abuse by physician-induced demand for expensive services).

26. See NAT’L HEALTH CARE PURCHASING INST., THE GROWING CASE FOR USING PHYSICIAN INCENTIVES TO IMPROVE HEALTH CARE QUALITY (2001), available at <http://www.academyhealth.org/files/nhcpi/incentives.pdf>; Hyman & Silver, *supra* note 10, at 1441–42.

27. See, e.g., Carolyn M. Clancy & Kelly Cronin, *Evidence-Based Decision Making: Global Evidence, Local Decisions*, 24 HEALTH AFF. 151, 151 (2005) (arguing that variations in health care expenditures do not uniformly translate

into better health care outcomes); Carolyn M. Clancy & John M. Eisenberg, *Outcomes Research: Measuring the End Results of Health Care*, 282 SCIENCE 245, 245–46 (1998) (explaining that incorporating patients' preferences in treatment can increase positive outcomes more than increased spending); Elliott S. Fisher, *2007 Robert and Alma Moreton Lecture: Pay for Performance: More Than Rearranging the Deck Chairs?*, 4 J. AM. C. RADIOLOGY 879, 879 (2007) (“The paradox, however, is that greater use of [supply-sensitive] services [as a result of higher spending] has been shown to be associated with lower quality, no gain in survival, and worse physician and patient-reported quality of care.”); Elliott S. Fisher & John E. Wennberg, *Health Care Quality, Geographic Variations, and the Challenge of Supply-Sensitive Care*, 46 PERSP. BIOLOGY & MED. 69, 69–70 (2003) (explaining that geographic variations in care are not the result of differences in spending on health care); Elliott S. Fisher, *Medical Care—Is More Always Better?*, 349 NEW ENG. J. MED. 1665, 1665–66 (2003) (explaining that recent research indicates that “high intensity” care did not generate better outcomes, but did increase spending); Elliott S. Fisher et al., *The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care*, 138 ANNALS INTERNAL MED. 288, 297–98 (2003) (finding no relationship between Medicare expenditures and medical outcomes); Paula M. Lantz et al., *Socioeconomic Factors, Health Behaviors, and Mortality: Results from a Nationally Representative Prospective Study of U.S. Adults*, 279 JAMA 1703, 1704–05 (1998) (demonstrating that the effect of income on mortality at lower incomes was very strong regardless of spending levels on health care); Robin Hanson, *Cut Medicine in Half*, CATO UNBOUND (Sept. 7, 2007), <http://www.cato-unbound.org/2007/09/10/robin-hanson/cut-medicine-in-half/>.

The RAND study of health care, which was designed to examine whether managed care offered worse health care than fee-for-service care, constitutes the most important evidence concerning the aggregate effectiveness of medical care. See RAND HEALTH, THE HEALTH INSURANCE EXPERIMENT: A CLASSIC RAND STUDY SPEAKS TO THE CURRENT HEALTH CARE REFORM DEBATE (2006), available at http://www.rand.org/pubs/research_briefs/2006/RAND_RB9174.pdf. The study was a rare “experiment” in which individuals were randomly assigned to various plans that differed in the degree to which they paid for health care. *Id.* at 2. The experiment lasted from 1971 to 1982 and cost significant amounts of money. *Id.* at 1–2. It randomly assigned over two-thousand nonelderly families in six U.S. cities to three to five years of a specific payment regime, including free, full price, and significant copay. *Id.* at 1–2. Not surprisingly, families that paid less for health care consumed about thirty percent (or \$300) more in per-person annual medical services, though they spent less for hospital spending and more for dental and “well care.” JOSEPH P. NEWHOUSE, FREE FOR ALL?: LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT 338 (1993) (“The more families had to pay out of pocket, the fewer medical services they used.”). The study’s primary conclusion was that “free care offers little benefit for the average person.” *Id.* at 356. Actually, that’s an oversimplification. Of the thirty-odd health care indicators examined, the free health care option did have better outcomes in one medical sphere—blood pressure. *Id.* at 339. Additionally, free health care resulted in better outcomes in vision and dental care. *Id.* The study went on to conclude that “[t]he reduced service use under the cost-sharing plans had little to no net adverse effect on health for the average person.” *Id.* Notably, however, the results of the RAND experiment have been criticized on data-mining grounds. See, e.g., Hanson, *supra*.

Other, less epidemiologically impregnable research has looked for a correlation between payment for health care and health care outcome. See, e.g., DAVID C. GOODMAN ET AL., DARTMOUTH ATLAS PROJECT, REGIONAL AND RACIAL VARIATION IN PRIMARY CARE AND THE QUALITY OF CARE AMONG MEDICARE

BENEFICIARIES (2010), available at http://www.dartmouthatlas.org/downloads/reports/Primary_care_report_090910.pdf; Elliott S. Fisher et al., *Associations Among Hospital Capacity, Utilization, and Mortality of US Medicare Beneficiaries, Controlling for Sociodemographic Factors*, 34 HEALTH SERVICES RES. 1351 (2000) [hereinafter Fisher et al., *Associations*]; Elliott S. Fisher et al., *The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality and Accessibility of Care*, 138 ANNALS INTERNAL MED. 273 (2003). Luckily, opportunities for this type of research abound, as there is tremendous national variation in health care expenditures and provision. Perhaps the most important line of research emerged from the Dartmouth Atlas of Health Care Project. See GOODMAN ET AL., *supra*. This research tallied for many years (and continues to do so as an inspection of its fascinating website indicates) the total number and kind of medical treatments performed nationwide in the Medicare program. See *id.*; see also Dartmouth Atlas of Health Care, *All Surgical Discharges per 1,000 Medicare Enrollees, by Gender*, DARTMOUTHATLAS.ORG, <http://www.dartmouthatlas.org/data/table.aspx?ind=59> (last visited Jan. 28, 2011). The amount of variation was quite surprising, suggesting that local influence and custom play a far greater role in treatment choices than does scientific evidence.

Researchers used this data to compare regional health care outcomes in order to see whether expenditure correlated with better outcomes. They found that areas with greater health care expenditures and greater numbers of doctors did *worse*. See Edward Guadagnoli et al., *Variation in the Use of Cardiac Procedures After Acute Myocardial Infarction*, 333 NEW ENG. J. MED. 573, 578 (1995) (demonstrating that treating heart attacks with a less expensive procedure was just as effective as with the more expensive procedure); Jonathan Skinner & John E. Wennberg, *How Much Is Enough? Efficiency and Medicare Spending in the Last Six Months of Life*, in THE CHANGING HOSPITAL INDUSTRY: COMPARING NOT-FOR-PROFIT AND FOR-PROFIT INSTITUTIONS 183 (David Cutler ed., 2000).

Finally, studies have shown little to no correlation between spending and outcomes using international comparisons. See, e.g., CHRIS L. PETERSON & RACHEL BURTON, CONG. RESEARCH SERV., RL 34175, U.S. HEALTH CARE SPENDING: COMPARISON WITH OTHER OECD COUNTRIES (2007), available at http://digitalcommons.ilr.cornell.edu/key_workplace/311/; Deon Filmer & Lant Pritchett, *The Impact of Public Spending on Health: Does Money Matter?*, 49 SOC. SCI. & MED. 1309 (1999). While specific intercountry comparisons are hardly dispositive because they by definition involve comparisons of societies often with vastly different diets and lifestyles, they are, at least from a layperson's point of view, quite striking. For instance, the life expectancy in the United States and Albania is, respectively, 78.14 and 77.78 years. See *The World Factbook: Country Comparison: Life Expectancy at Birth*, CIA.gov, <https://www.cia.gov/library/publications/the-world-factbook/rankorder/2102rank.html> (last visited Jan. 28, 2011). According to World Bank statistics from 2007, the United States spends \$7285 per year, per person on health care, while Albania spends only \$244. *Health Expenditure per Capita*, Worldbank.org, <http://data.worldbank.org/indicator/SH.XPD.PCAP> (last visited Jan. 28, 2011). While Albania has a lower rate of homicide than does the United States, the Albanians smoke more than Americans, with adult male smoking rates two to three times higher in Albania than in the United States. See Judith MacKay & Michael Eriksen, World Health Org., *The Tobacco Atlas 94–100* (2007), available at <http://www.who.int/tobacco/en/atlas40.pdf> (listing the smoking rates for various countries); *Intentional Homicide, Rate per 100,000 Population*, U.N. Office on Drugs & Crime, <http://data.un.org/Data.aspx?d=UNODC&f=tableCode:1&c=2,3,5,7,9,11,12&s=countryName:asc,yr:desc&v=1> (last visited Jan. 28, 2011) (listing the homicide rate for various countries).

other factors such as diet, wealth, smoking, and social status have been linked strongly with significant health gains (or losses).²⁸ While medicine undoubtedly does great things, it apparently also does much that is indifferent or harmful.²⁹ Consumers have trouble distinguishing between the two.

This strange ineffectiveness of medicine, while contradicted by the popular reverence for “modern medicine,” should nonetheless not be surprising. As health care experts realize, very little of medical practice stands on a firm evidentiary, scientific basis—rather, physicians simply do as they were trained, as in some medieval craft. Professor William Sage states, “Physicians must . . . grapple with the uncomfortable fact that, despite their belief in the scientific foundation of modern medicine, relatively little of medical practice is scientifically proven.”³⁰

The Health Care Act, and its academic supporters, not only share a similar diagnosis of health care’s problems, but also agree on a treatment. Many policy makers believe that adoption of evidence-based standards for health care provision—basing treatments on rigorous empirical analysis and experimentation—can remedy medicine’s inefficiencies.³¹ Echoing this chorus of scholars and policy analysts, the Health Care Act empowers government to use its tremendous purchasing and bargaining power to mandate best practices based on sound evidence.³² A board will be created to recommend best practices and craft reimbursement schemes to give providers incentives to follow them.³³

This top-down approach is flawed in its limited ability to empower patients. First, as doctors are fond of saying (particularly when their treatments fail) medicine is not a science, it is an art.³⁴

28. Hanson, *supra* note 27.

29. See Elliott S. Fisher & H. Gilbert Welch, *Avoiding the Unintended Consequences of Growth in Medical Care: How Might More Be Worse?*, 281 JAMA 446, 446 (1999) (“Although medical care has obvious benefits, many assume that more medical care must lead to improved health and well-being. There are theoretical reasons, however, to believe that additional growth will be associated with progressively smaller returns The law of diminishing returns also suggests that at some point additional growth will yield no benefit (the ‘flat of the curve’). And while the debate about where we sit on the curve is far from settled, the theory suggests that there is some point at which additional growth might actually produce harm.” (footnotes omitted)).

30. William M. Sage, *Reputation, Malpractice Liability, and Medical Error* 167 (Columbia Pub. Law & Legal Theory Working Papers, Paper No. 0587, 2005), available at http://lsr.nellco.org/cgi/viewcontent.cgi?article=1008&context=columbia_pllt.

31. See Peter Orzsag, *Malpractice Methodology*, N.Y. TIMES, Oct. 21, 2010, at A39 (arguing that limiting the liability of doctors who follow evidence-based guidelines will curb unnecessary tests and treatments).

32. Patient Protection and Affordable Care Act § 3014, Pub. L. No. 111-148, 124 Stat. 119, 384–87 (2010).

33. *Id.* § 3021.

34. H.E. Setterfield, *The Scientific and Humanistic Objectives of*

While that position may be self-serving, it is undeniable that medicine—at least significant parts of it—cannot be reduced into algorithmic guidelines. Medicine involves more than selecting treatments from a menu. Most obviously, medicine involves diagnosis: the reading of subtle, sometimes contradictory evidence. While this skill is not reducible to guidelines, some practitioners are clearly better at it than others. These practitioners likely possess unconscious abilities or heuristics to detect and interpret evidence. In addition, patients often have multiple conditions, with treatments helping one condition but exacerbating another. The physician must then optimize among inversely related treatment outcomes—again a matter that guidelines, which focus on one disease and one treatment, cannot resolve. Further, medicine also involves plain old manual dexterity in performing procedures, like surgery. Yet guidelines cannot mandate superior procedural skill.

Medical quality turns significantly on these skills. Consider prostate cancer, one of the cancers men are most likely to suffer.³⁵ Such a cancer can be slow growing, posing little risk, or invasive, posing life-threatening risk.³⁶ Doctors have difficulty knowing when treatment, such as surgery, is appropriate. Clear guidelines certainly cannot tell when treatment is required. Yet, undoubtedly, some doctors give better advice than others to patients who have to make treatment decisions with only murky scientific evidence upon which to rely. These doctors perhaps are able to weigh, in a manner not reducible to algorithm, risk factors and other evidence. Further, should prostate removal surgery (“prostatectomy”) be required, it is not costless; the patient risks, among other things, incontinence and impotence.³⁷ Avoidance of these highly undesirable complications depends mostly on skillful technique, which involves an ineffable skill at handling tissue and mastering the surgical environment. Yet no guideline can mandate that.

Second, mandated guidelines have numerous perverse impacts that result from the flawed attempt to reduce medicine into algorithm. Because diagnosis is sometimes not clear, involving the weighing of contradictory or subtle evidence, guidelines have the incentive to make doctors “see,” either consciously or unconsciously, diseases with clear treatment mandates. They will not explore other, more difficult possibilities. This will likely occur because even if the patient does not get better, the doctor will still get paid, provided he followed the guideline and had a reasonable justification

Premedical Education, 23 J. CHEMICAL EDUC. 330, 331 (1946).

35. AM. CANCER SOC'Y, CANCER FACTS & FIGURES 2010, at 23 (2010), available at <http://www.cancer.org/acs/groups/content/@epidemiologysurveillance/documents/document/acspc-026238.pdf>.

36. *See id.* at 26–35.

37. *Prostate Cancer: Treatment*, NAT'L CANCER INST., <http://www.cancer.gov/cancertopics/wyntk/prostate/page8> (last visited Jan. 28, 2011).

for applying it.

Third, guidelines do not reward excellence, at least to the degree that excellence involves matters that guidelines cannot capture, i.e., superior diagnostic ability or better surgical technique. Instead, guidelines, building on the cognitive biases they create, provide incentives for doctors to apply cookbook medical responses. This may be desirable. Perhaps it would improve care. But, to use the example discussed above, if anyone were facing prostate surgery, he would want to know something about his urologist's diagnostic and surgical skills, regardless of whether she followed guidelines—mandated standards fail to provide patients the information they most want.

Mandated guidelines do not provide incentives for innovation or better consumer service but only for an accepted mediocrity. A management nostrum, “wymiwyg” (what you measure is what you get)—associated with Jack Welch, former General Electric CEO and management guru³⁸—makes this point. If health care providers receive payment for following guidelines, they will follow guidelines and do little else.

Finally, guidelines do not account for an individual's risk assessment. Some consumers might fear a certain disease—and tolerate the possible bad effects of screening—and, therefore, want more screenings than Medicare mandates or approves.

Global guidelines underestimate the information asymmetry in medicine. Medicine is typically described as a “credence good.”³⁹ Patients cannot verify a treatment's effectiveness or quality.⁴⁰ Due to the difficulties in measuring physician performance, consumers must simply “trust and believe.” Evidence strongly suggests that trust in many doctors is misplaced;⁴¹ therefore, global guidelines would improve doctors' performance, by encouraging them to apply treatments that are well understood and clearly appropriate for the patient.

38. JACK WELCH & JOHN A. BYRNE, *JACK: STRAIGHT FROM THE GUT* 387 (2001).

39. See, e.g., Astrid Selder, *Medical Associations, Medical Education and Training on the Job*, 52 *CESIFO ECON. STUD.* 548, 551 (2006).

40. See James F. Blumstein, *Antitrust Enforcement in the Health Care Industry: A Battleground of Competing Paradigms*, 156 *U. PA. L. REV. PENNUMBRA* 421, 421–22 (2008), <http://www.pennumbra.com/responses/04-2008/Blumstein.pdf> (“[In the health care industry, there is a] ‘perceived market failure’—an asymmetry of information between professional provider-experts and uninformed (and uninformable) patient-consumers. The response to this perceived market failure is that ‘professional providers, such as physicians, serve as substitute decision makers, displacing consumers.’” (quoting James F. Blumstein, *Of Doctors and Hospitals: Setting the Analytical Framework for Managing and Regulating the Relationship*, 4 *IND. HEALTH L. REV.* 209, 219–21 (2007))).

41. See Huw T.O. Davies & Thomas G. Rundall, *Managing Patient Trust in Managed Care*, 78 *MILBANK Q.* 609, 614 (2000).

Medicine is such that the correct mode of treatment is not always known. Given that information deficits extend not only to picking the right doctor but to the nature of medicine itself, simply empowering a bureaucracy to make decisions about cost-effectiveness, whether run by the government, an insurance company, an HMO, or a panel of doctors, may not solve any problem. The problem is not merely information asymmetry but a lack of information per se.

In short, the distinction between risk and uncertainty—associated with Frank Knight and later John Maynard Keynes—is elucidating.⁴² People can measure risk. It is therefore suitable for cost/benefit analyses and, indeed, global guidelines. One can predict an event's likelihood and, therefore, estimate how much money should be expended to prevent it. Lawyers are quite familiar with this approach, as the famous Learned Hand formula reflects an application of risk to create guidelines for behavior.⁴³ This notion of risk forms the basis of the medical guidelines that the new Health Care Act envisions.

The problem with global guidelines based on risk is that medicine involves not simply risk, but as Knight or Keynes would say, uncertainty—risk that is *not* measurable.⁴⁴ Uncertain events may happen, but no one can really meaningfully predict their likelihood. For some treatments or procedures, doctors can state risk, e.g., you have less than a 0.01% likelihood of experiencing an adverse reaction to a vaccine. For others, they simply cannot, e.g., whether you will be better off receiving chemotherapy or surgery for certain types of cancer. Most importantly, global guidelines do not even give doctors incentives to improve and innovate in order to move from uncertainty to risk.

Variable warranties, on the other hand, force health care providers to distinguish between risk and uncertainty and encourage practitioners to learn to accurately gauge risk. Risk can be warranted (for a price); uncertainty cannot. Doctors whose better knowledge or superior skill and experience allow them to make risk estimates will offer broader warranties, making more money. Less knowledgeable or skilled physicians will wallow in uncertainty and will not offer warranties.

Finally, a new proposal for market-based standards forwarded by Professor Ronen Avraham offers a different solution.⁴⁵ Avraham

42. Knight and Keynes argued “that the business environment is riven by uncertainty in the sense of risk that cannot be calculated.” RICHARD POSNER, *THE CRISIS OF CAPITALIST DEMOCRACY* 280 (2010). I am indebted to Professor Dan McCartney for his insight to apply this distinction to the health care industry.

43. *See* United States v. Carroll Towing Co., 159 F.2d 169, 173 (2d Cir. 1947) (Hand, J.).

44. POSNER, *supra* note 42, at 280.

45. *See* Ronen Avraham, *Private Regulation—A New Approach to the US*

suggests encouraging a market for private medical standards, enforceable by patients in the event of a mishap.⁴⁶ Private medical research firms would compete to provide the “best” medical standards.⁴⁷ Medical providers would explicitly select a set of standards.⁴⁸ Patients could then sue the medical research firm that produced the standard in the event of mishap—or the provider, if the provider failed to follow the standard.⁴⁹ Rather than a pure top-down or bottom-up approach, Avraham offers a more middle-level or “competitive” top-down approach. This approach constitutes an intelligent, worthwhile reform, properly aligning incentives for the medical profession to develop and follow evidence-based protocols.⁵⁰ Indeed, as medicine becomes more algorithmic, Avraham’s position makes complete sense. But, to the degree medicine is not susceptible to reduction and to the degree individual physicians can distinguish themselves from the herd, warranties may make more sense.

II. WARRANTY-BASED MEDICINE: A NEW MEDICAL CONTRACT

The following Part examines how a medical-warranty regime would work with third-party payer insurance, including the legal mechanisms it would require, such as the “reverse subrogation” action, as well as other mechanisms aimed at similar ends, such as requiring the bundling of health insurance with life insurance.

Currently, “medical malpractice” is the liability regime that governs health care provisions. It is simply an implied warranty: the so-called standard of care governs every medical contract—and physicians cannot waive it. Under malpractice liability, a doctor must perform according to the “standard of care,” which is simply what the *average* doctor would do in a given situation.⁵¹ A doctor who fails to meet this standard is liable in tort.⁵²

Malpractice liability’s weaknesses are manifest and well-

Healthcare Crisis (Univ. of Tex. Sch. of Law, Pub. Law & Legal Theory Research Paper Series, Paper No. 162, 2009), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1480982 [hereinafter Avraham, *A New Approach*]; see also Ronen Avraham, *Private and Competitive Regulation of Medicine*, ECONOMISTS’ VOICE (Aug. 2009), <http://www.bepress.com/cgi/viewcontent.cgi?article=1629&context=ev>; Ronen Avraham, *Private Regulation of Medicine: A Win-Win-Win for Doctors, Patients and Public*, HUFFINGTON POST (July 22, 2009), http://www.huffingtonpost.com/ironen-avraham/private-regulation-of-med_b_242937.html.

46. See Avraham, *A New Approach*, *supra* note 45, at 40–41.

47. *Id.* at 7, 45.

48. *Id.* at 45.

49. *Id.* at 40–41.

50. *Id.* at 8.

51. Michael D. Greenberg, *Medical Malpractice and New Devices: Defining an Elusive Standard of Care*, 19 HEALTH MATRIX 423, 430 (2009).

52. See FRANK A. SLOAN & LINDSEY M. CHEPKE, MEDICAL MALPRACTICE 3–4 (2008).

documented, in terms of its expense (each dollar of compensation consumes much more in transaction costs); lack of predictability and effective compensation (it often compensates the wrong individuals and, due to its expense, often fails to compensate the deserving); and questionable deterrence value.⁵³ Perhaps most important, medical malpractice liability, like global standards, simply requires average performance. Malpractice liability does little to remedy the central problem in medicine—ineffectiveness—of which injurious malpractice is merely a part.

Under a warranty system, individuals paying out of pocket would have greater incentives to stay healthy because healthier people would likely receive more expansive warranties. Indeed, that incentive could create a true virtuous circle: warranties encourage better habits, which in turn permit more generous warranties and lower health care expenditures. Warranties could have the opposite effect of the moral hazard of health insurance, which allows individuals to avoid the consequences of their own unhealthy and injurious decisions.

A. *Medical Warranties in Practice*

Applying warranties to health care would involve giving the physician great flexibility in *what* to warrant and to what degree. In other words, in every patient interaction there would have to be a warranty of some sort, but physicians could decide what warranty to offer. For example, if you went to a dermatologist to treat your eczema, she would not have to guarantee a cure. Rather, she could simply guarantee the diagnosis. However, if she failed to do what she promised, you could get your money back.

Satisfaction or your money back could be just the beginning of the potential variations in the contractual negotiation. Providers and consumers could bargain over the extent of the warranty—all the way from “I will give you this pill” to “I will keep you healthy for one year.” They could even bargain over consequential damages or pain-and-suffering damages resulting from treatment. Or, possibly, given the high cost of determining such things, a damages schedule of some sort could be negotiated. The point is, as with all contracts, the preferences of the parties would control, resulting in greater efficiency. For instance, a health care provider might warrant “good health for a year” to a consumer who has low blood pressure, maintains a normal weight, and refrains from smoking. The provider and consumer could even contract over the monitoring mechanism, such as monthly blood tests to evidence continuing healthy habits. Indeed, this warranty regime could emerge into something like economist Robin Hansen’s notion of “buying health”

53. See *id.* at 3–4, 17–20 (reviewing the current evidence of malpractice liability’s deficiencies).

from providers, rather than having providers simply treat the sick.⁵⁴

There would be some situations in which no warranties would be offered. In particular, emergency medicine is not a good candidate for warranties. By definition, providers cannot make intelligent guesses about risk in this area of medicine. Further, emergency patients, especially those who are unconscious, facing life-threatening injuries, or writhing in pain, likely lack serious bargaining power.

The goal and hope of this system is that health care providers would compete based on the extent, nature, and price of their warranties. In this way, markets could be marshaled to create information about the relative effectiveness of providers. Warranties could serve as signals and markets as information aggregators—as opposed to what medical markets are today, information suppressors.

Warranties would work best in a high-deductible insurance environment. This type of insurance requires individuals to pay the first \$2000 or \$5000 either from a tax-favored medical savings account or out of pocket.⁵⁵ Patients, therefore, would have a direct incentive to get cost-effective treatment because they would benefit financially from such treatment.

B. *Warranty-Based Medicine Already Exists*

However, would it work in practice? It seems at least possible that doctors, if they were required to warrant, would not warrant much at all. The warranties would be no more extensive than “I’ll give you this pill” or “I’ll look at your eczema.” Such warranties would neither share risk nor signal quality.

To answer this objection, it is worthwhile to examine situations in which warranties have already developed. They exist between large health care third-party payers and providers. For instance, Medicare has announced numerous events, known as “never events,” for which a hospital cannot claim compensation.⁵⁶ These events, such as catheter infections and falls, involve medical failures that studies have shown can be avoided if health care providers observe accepted protocols.⁵⁷

Medicare’s list of “never events” constitutes a type of warranty imposed by the government. The government is able to impose

54. See Robin Hanson, *Buy Health, Not Health Care*, 14 CATO J. 135 (1994).

55. Robin Fisk, *Patient Financial Responsibility Under High Deductible Health Plans: What Providers Can & Can’t Do if the Patient Can’t Pay*, HEALTH LAW., Feb. 2006, at 16, 16.

56. See Kevin B. O’Reilly, *No Pay for “Never Event” Errors Becoming Standard*, AM. MED. NEWS (Jan. 7, 2008), <http://www.ama-assn.org/amednews/2008/01/07/prsc0107.htm>.

57. See COLO. BUS. GRP. ON HEALTH, POLICY AND PROSPECTIVE ON ‘NEVER EVENTS’ (2009), available at <http://www.coloradohealthonline.org/cbgh/?LinkServID=E05E6349-CFC5-ED82-30F881343DAF4459&showMeta=0>.

these warranties due to the massive purchasing power created by its Medicare and Medicaid programs. In addition to “never events,” Medicare is experimenting with “P4P,” or pay-for-performance, in which physicians would be rewarded for achieving certain successful health care results on a practice-wide scale.⁵⁸ Other government-run health care systems are also experimenting with requiring that guarantees be provided by drug producers. For instance, it has been proposed that the United Kingdom’s National Health Service require that pharmaceutical companies guarantee a drug’s effectiveness in reducing a health problem, as evidenced by nationwide population metrics, as part of the Service’s agreement to purchase a drug.⁵⁹ Finally, insurance regimes are beginning to experiment with warranty-type payment schemes, under which doctors are only paid for success. The “Prometheus” project is a leading effort.⁶⁰

Perhaps most significant of all, provider-to-consumer warranties have emerged. Ophthalmologists offer warranties for refractive surgery, the procedure in which lasers “shape” the cornea in order to “cure” near sightedness (myopia). Indeed, as predicted in this Article, these warranties are limited and differ according to the patient.⁶¹ Warranties are also quite common in fertility treatments.

58. Press Release, Ctrs. for Medicare & Medicaid Servs., U.S. Dep’t of Health & Human Servs., Medicare “Pay For Performance (P4P)” Initiatives (Jan. 31, 2005), available at <http://www.cms.gov/apps/media/press/release.asp?Counter=1343>.

59. See Stephen Chapman et al., *Setting Up an Outcomes Guarantee for Pharmaceuticals: New Approach to Risk Sharing in Primary Care*, 326 BRIT. MED. J. 707, 707 (2002).

60. See *What Is Prometheus Payment?*, HEALTH CARE INCENTIVES IMPROVEMENT INST., <http://www.prometheuspayout.org/?q=node/4/#/1> (last visited Jan. 28, 2011). A team of health care economists, lawyers, and other experts created the nonprofit Prometheus Payment system as a payment regime that attempts to improve quality and distribute risk evenly between the clinical and insurance sides of the system. See *The Framework of Prometheus Payment*, HEALTH CARE INCENTIVES IMPROVEMENT INST., <http://www.prometheuspayout.org/?q=node/61/#/2> (last visited Jan. 28, 2011); *History of Prometheus Payment*, HEALTH CARE INCENTIVES IMPROVEMENT INST., <http://www.prometheuspayout.org/?q=node/60/#/1/1> (last visited Jan. 28, 2011). Prometheus uses “Evidence-Based Case Rates” to determine the total resources required to deliver clinically appropriate care. See *The Framework of Prometheus Payment*, *supra*.

61. See, e.g., *20/20 Guaranteed LASIK*, BUCKLEY CHANG EYE INST., <http://www.buckleyvision.com/colorado-springs/lasik/20-20-guaranteed-lasik.htm> (last visited Jan. 28, 2011) (“There Are No Guarantees In Medicine—How Can Dr. Britt Buckley Offer a 20/20 Money Back Guarantee? It’s true—Medical and surgical outcomes cannot be guaranteed because there are just too many variables—BUT, when a surgeon has enough experience and historical evidence to observe consistent 20/20 or better results, and truly happy patients, he can express his confidence in your result by guaranteeing that you will achieve your desired result or he will refund the full fee. Of course Dr. Buckley can’t offer a money back guarantee to you personally until he knows your vision

Depending on the candidates' specific fertility evaluations, fertility clinics will guarantee pregnancy or your money back after a certain specified number of fertility treatments.⁶² An informal Internet search uncovered over a hundred fertility clinics offering warranties.⁶³ Regular hospitals, doing normal procedures, have also started to use them.⁶⁴

It is worth examining the situations under which warranties have emerged. On one hand, they have emerged when an entity with great purchasing power—e.g., Medicare—bargains with providers. Such large purchasers of health care are “price givers” who have the ability to largely dictate terms. On the other hand, they have emerged for procedures that are paid for out of pocket and are not typically covered by insurance, like fertility treatment or refractive surgery. It is worth pointing out, as well, that fertility treatment and refractive surgery have clear measures of success—the birth of a child, or improved vision.

The areas in which warranties are already being offered

objectives and confirms that your eye health and present vision characteristics are likely to allow you to achieve 20/20 or better vision which is why his involvement in personally reviewing your exam results is critical to the entire process. Dr. Buckley is the only LASIK surgeon in Colorado Springs who offers a 20/20 Money Back Guarantee . . .”).

62. See Chen May Yee & Josephine Marcotty, *Infertility Treatment: Selling Hope*, STARTRIBUNE.COM (Oct. 22, 2007), <http://www.startribune.com/lifestyle/health/11346671.html> (“With rising competition, some [in vitro fertilization (“IVF”)] clinics are offering money-back guarantees and going farther afield to look for patients.”). Indeed, the New York State Attorney General’s office has issued an opinion about fertility guarantees. Press Release, Office of the Gen. Counsel, State of N.Y. Ins. Dep’t, Proposed Fertility Warranty Agreement (Mar. 27, 2002), available at <http://www.ins.state.ny.us/ogco2002/rg203272.htm>.

63. See, e.g., *Cost of IVF at the Advanced Fertility Center of Chicago: High Quality, Low Cost IVF*, ADVANCED FERTILITY CTR. CHI., <http://www.advancedfertility.com/ivfprice.htm> (last visited Jan. 28, 2011) (“[W]e offer several different affordable IVF—in vitro fertilization cost plans, including pricing options with money back if it doesn’t work.”); *IVF Guarantee*, DOMINIONFERTILITY.COM, http://www.dominionfertility.com/fertility/ivf_guarantee.aspx (last visited Jan. 28, 2011) (“Should a qualifying couple not achieve a live birth, after receiving all of the indicated services (four IVF cycles and the transfer of all frozen embryos obtained from each of four fresh cycles), 100% of the program fee will be returned.”); *The ARC Refund Guarantee*, ARCFERTILITY.COM, http://www.arcfertility.com/family_building/refund_guarranty.html (last visited Jan. 28, 2010) (“This program provides that after receiving all of the required services you will be refunded most of the money you have paid if a live birth (baby) has not been achieved through the IVF treatments. . . . The pricing of the ARC Refund is determined after we have received The ARC Program Application™. The cost of the program depends upon many different factors like age, fertility status, [and] the type of treatment package chosen . . .”).

64. See, e.g., Keith Gary, *St. Luke’s Hospital Guarantees Robotic Surgery Results*, LEHIGHVALLEYLIVE.COM (Sept. 23, 2008), http://www.lehighvalleylive.com/bethlehem/index.ssf/2008/09/st_lukes_hospital_guarantees_r.html.

illuminate the boundaries and potentials of medical warranties. They certainly could not work in all situations. Emergency room physicians are unlikely to offer warranties. (Although, interestingly, some emergency rooms are beginning to guarantee a maximum waiting period!)⁶⁵ Clearly, warranties would work best in situations with easily verified outcomes and in areas of medicine like refractive surgery, in which there is considerable competition. They also would work best in situations in which patients “have skin in the game.” In others words, when patients are paying for treatments out of their own pocket, they will have the incentive to get the “better deal.” In response to the explosion of high-deductible insurance policies warranties seem an appropriate pro-consumer policy.

C. Warranty-Based Medicine, “Reverse Subrogation,” the Bundling of Life Insurance, and MCOs

Warranty-based medicine may work best in an out-of-pocket system, such as medical savings accounts. But it could also work with third-party payer insurance, which dominates most health care provision today, i.e., when we go to the doctor, insurance generally picks up most of the tab. Warranties in a third-party payer system would require enrollees in insurance plans to assign the proceeds from any recovery to insurance companies—much like subrogation clauses currently found in insurance contracts, which assign to insurance companies any money recovered from medical malpractice lawsuits that their enrollees bring.⁶⁶ In “reverse subrogation,” insurance companies could recover from providers for failed health care and could even negotiate the terms of the variable warranty. The third-party insurer would no doubt be in a better position to prosecute individual claims against health care providers. Insurance companies could also collect data on physicians’ performance globally and make that information available to consumers. Such a “reverse subrogation” cause of action would align insurance companies’ incentives with those of consumers—or at least improve the current alignment by giving providers an incentive to provide effective treatment or else face a large corporate plaintiff.⁶⁷

65. To take one example, Mercy Hospital in southern Florida offers a guaranteed waiting period in its emergency rooms. See *ER Quick Care Guarantee*, MERCY HOSP., <http://www.quickcareguarantee.com/> (last visited Jan. 28, 2011).

66. See 16 LEE R. RUSS & THOMAS F. SEGALLA, *COUCH ON INSURANCE* 3D §§ 222:25–:15 (2005).

67. For a similar concept, see generally Kenneth S. Reinker & David Rosenberg, *Unlimited Subrogation: Improving Medical Malpractice Liability by Allowing Insurers To Take Charge*, 36 J. LEGAL STUD. S261 (2007) (advocating complete subrogation and assignment of tort claims to insurance companies on the grounds that they can more effectively prosecute malpractice claims).

In addition to variable warranties, one could imagine other mechanisms, such as requiring bundling of life insurance with medical insurance, to give insurance companies an incentive to encourage providers to offer quality health care. Just as variable warranties would give physicians incentives to provide health care that at least fulfills their warranty, this type of insurance bundling would give insurance companies the incentive to ensure proper outcomes. Indeed, as discussed later in this Part, government and private insurers are already moving tentatively in this direction.

Many scholars have proposed enterprise-based liability, in which enrollees contract with their managed care organizations (“MCOs”) not only for health care but also for medical liability.⁶⁸ Under such a system, an MCO could provide different levels of medical liability insurance to enrollees; MCOs would then negotiate with health care providers for prices reflecting these different levels of liability insurance. This proposal shifts all liability for medical provider error to the MCOs, and then the MCOs would negotiate levels of liability with their providers and enrollees.⁶⁹ MCOs would solve many of the bargaining problems inherent in contracting liability. First, it would ameliorate the collective-goods and time-inconsistency problems that Professor Jennifer Arlen points out.⁷⁰ MCOs could offer their insurance subscribers provider networks whose members all offer a standard of liability.⁷¹ MCOs could then use their vast bargaining power and informational advantages to receive the best prices for the level of liability chosen. Unlike individuals, they would have the incentive to invest in collective safety measures for the long run.⁷² Insurance companies would have an incentive to bargain for effective health care, whereas under the current system, they only have an incentive to provide cheap health care. In addition, MCO-based liability would allow individuals to bargain, indirectly at least, for the level of insurance they want.⁷³

In short, MCO-based liability offers many of the same advantages as this Article’s proposed warranty-based medicine. The following discussion compares these two proposals, and concludes that warranty-based medicine could be incorporated into an MCO-based liability regime and still offer unique benefits.

68. See, e.g., Patricia M. Danzon, *Tort Liability: A Minefield for Managed Care?*, 26 J. LEGAL STUD. 491 (1997) (arguing for limited contractual liability for MCOs); Clark C. Havighurst, *Vicarious Liability: Relocating Responsibility for the Quality of Medical Care*, 26 AM. J.L. & MED. 7 (2000) (advocating for contractual enterprise liability for MCOs).

69. See Jennifer Arlen, *Contracting over Malpractice Liability* 53 (Am. Law & Econ. Assoc. Annual Meetings, Paper No. 42, 2008), available at <http://law.bepress.com/cgi/viewcontent.cgi?article=2627&context=alea>.

70. See *id.* at 53–57.

71. *Id.* at 53.

72. See *id.* at 53–57.

73. See *id.*

Perhaps the biggest difference between MCO-based and warranty-based liability is that the latter shifts emphasis onto providers, not insurers. As the Coase theorem would hold, the least cost avoider should bear the risk.⁷⁴ In the health care context, the identity of the least cost avoider turns significantly on the type of investment needed to improve medical safety and effectiveness. It seems that if safety and effectiveness measures constitute large, long-term, fixed investments, then the MCO rather than the local doctor should bear the risk. The MCO, due to its enormous enrollee pool, would have the bargaining power to make the large, systemic investments in health safety and effectiveness that would recoup its investments. This argument admittedly has less force when the provider is a large hospital or clinic. On the other hand, if safety and effectiveness require incremental costs particularized to patients, then it would seem that providers, who have superior information, could more cheaply make these decisions.

Whether providers or MCOs are the least cost avoiders is an empirical question. As discussed above, there is evidence that incremental investments (using magic markers to color the right or left side of the body before surgery, prescribing antibiotics on a standardized basis, etc.) may improve health outcomes.⁷⁵ However, this may not be the case and is a matter for further study.

One advantage that warranties have over MCO-negotiated liability standards is informational. Under the MCO-negotiated approach, each MCO would create a “uniform insurance plan[] in which every provider in the plan network [is] subject to a uniform liability rule (and uniform standard of care) and any patient seeking care from that provider [has] to accept those liability terms, without any ability to alter liability thereafter.”⁷⁶

Warranties, on the other hand, could be precise, specific, and tailored to the doctor and the patient. This would create a market in warranties, allowing a more precise alignment of the patient's preference for safety and willingness to pay, the effectiveness of treatments, and the provider's performance. Indeed, it is precisely this alignment that supporters of a contract approach make when arguing against the medical malpractice standard of liability.⁷⁷ This same argument, therefore, seems appropriate in preferring warranty-based medicine over enterprise-based medicine.

It has been proposed that medical liability be completely

74. See generally R.H. Coase, *The Problem of Social Cost*, 3 J.L. & ECON. 1 (1960).

75. Deborah F. Mulloy & Ronda G. Hughes, *Wrong-Site Surgery: A Preventable Medical Error*, in PATIENT SAFETY AND QUALITY: AN EVIDENCE-BASED HANDBOOK FOR NURSES 2-381, 2-387 to 2-388 (Ronda G. Hughes ed., 2008).

76. See Arlen, *supra* note 69, at 55.

77. See EPSTEIN, *supra* note 15, at 413–14 (identifying the problems with a one-size-fits-all medical liability system).

subrogated so that individuals could assign their medical malpractice recovery to insurers in exchange for lower premiums.⁷⁸ The benefits are obvious. If MCOs provided liability, they could use their bargaining power to obtain better safety and effectiveness measures. Warranty liability, if assignable, could work in the same way. Third-party payers could contract for warranty liability, and third-party payers could efficiently prosecute these contractual claims.

III. MEDICAL WARRANTIES FURTHER ECONOMIC EFFICIENCY

This Part examines several ways in which mandated warranties can improve economic efficiency. First, mandated warranties can function as a means of disclosure, for they indicate those parts of treatment in which a physician has almost complete confidence. Second, when warranties place risk on the party who can bear it most cheaply, warranties themselves can enhance efficiency, particularly when two separate prices (one for the service, the other for the warranty) are quoted.

A. *Warranties Provide Disclosure*

As a general rule, disclosure enhances efficiency. When a producer can provide, convey, or obtain the pertinent information about a service at a lower cost than can a consumer, mandatory disclosure may be appropriate. Such disclosure provides the market, in a cheap way, with the information that will allow consumers to buy things that best match their ideal preferences, resulting in economic efficiency.⁷⁹

Required warranties are a form of disclosure because they demonstrate the confidence, or lack thereof, that a physician has in treatments or parts of treatments. Obviously, a physician can provide this information more cheaply than can the health care consumer. With this information, a consumer could presumably “shop” for the physicians with the most expansive warranties.

Warranties may also signal quality. It has long been claimed that a warranty’s price and the extent of its coverage “signals” to consumers the quality of a firm’s product. This claim provides the basis for signaling theories of warranty practices.⁸⁰

78. See Reinker & Rosenberg, *supra* note 67, at S261.

79. See RICHARD A. POSNER, *ECONOMIC ANALYSIS OF LAW* § 4.6, at 112–13 (6th ed. 2003).

80. See Alan Schwartz & Louis L. Wilde, *Imperfect Information in Markets for Contract Terms: The Examples of Warranties and Security Interests*, 69 VA. L. REV. 1387, 1396–97 (1983) (“Proponents of signaling theory assert that a warranty ‘signals’ to consumers the quality of a firm’s product. Such explanations rest on four assumptions: (1) Consumers cannot distinguish among competing products based on their likelihood of failure; (2) Consumers believe that product quality correlates positively with the extent and duration of warranty coverage; (3) The cost to firms of making warranties varies

As discussed more fully below, some might argue that variable warranties are ineffective signals of liability because of time-inconsistency problems. Specifically, if a provider were to offer a more expansive warranty at a higher price to signal his competence, the rational consumer would choose the physician, but *not* take the warranty because the consumer would know that the doctor was good and that the warranty was unnecessary.⁸¹ Therefore, physicians would never offer such warranties.

There are a few responses to this argument. First, even if patients, in the end, did not pay more for the warranty, it is not clear that providers would not make one, particularly if some sort of warranty were mandatory. This is because consumers would still *choose* the provider making the more expansive warranty and, therefore, it would be a way of attracting more patients, even if it were not a way of providing additional revenue. Further, empirical reality undercuts the model's claims. Contrary to the model's expectations, doctors are in fact offering warranties, particularly in refractive surgery and fertility treatment.⁸²

Most important, this argument largely assumes that there are two kinds of doctors, good and bad, and that doctors cannot choose to perform better or worse. This is not terribly realistic. Some, if not most, doctors can be variable in their efforts. A warranty could ensure that every doctor did his or her best. The sort of "lemon" situation envisioned would not necessarily occur because patients would *not* forgo the warranty in order to ensure the physician performed at his highest level.

B. Warranties Generally Enhance Efficiency

Warranties are efficient, many have argued, because they permit the party that can most cheaply bear the cost of failure to

inversely with product quality—the more likely a product will fail, the more expensive it will be to comply with warranties for that product; (4) If firms do not signal their level of product quality to consumers, the consumers will assume that average quality in a market is relatively low. Were consumers to suppose average quality to be high, firms would exploit them by selling low quality products at high quality prices. Based on these four assumptions, warranty coverage should correlate positively with product quality." (footnote omitted)).

81. See Arlen, *supra* note 69, at 7 ("Negotiable contractual liability cannot be used to signal quality because any patient negotiated with a provider who has offered to bear liability has a strong incentive, if he believes the signal, to request that the provider accept a liability waiver in return for charging a lower price. This undermines signaling, however, because low quality providers can mimic the contracts of high quality providers, knowing that patients will waive liability. As a result, patients will not value liability as a signal of pre-contractual quality and thus will waive optimal liability when the primary benefit of liability is to induce pre-contractual investments in care." (footnotes omitted)).

82. See *supra* notes 61–64 and accompanying text.

bear the risk of that failure.⁸³ It has been recognized that certain types of warranties do this better than others. Standard warranties combine the insurance costs of individual product risks with the costs of production and distribution.⁸⁴ This grouping can mislead consumers in their efforts to estimate risk when the insurance portion of an item's cost is obscured. A simple solution is to use "modified warranty pricing," a pricing mechanism that separates production and distribution costs from the costs of insuring specific product risks. In effect, the manufacturer quotes a price for the product, plus a price for each warranty provision offered.⁸⁵

Thus, warranty-based medicine provides two-part pricing. This two-part price could be set forth by the doctor's own offer: a physician can charge more for more extensive warranties. Similarly, the insurance amount could be revealed by comparison shopping: a physician may offer a more extensive warranty for a higher price than the price charge by a competitor with no warranty.

C. *Would Patients Bargain for Warranties?*

Finally, the nagging question in this Article's entire proposal is whether patients would actually bargain. More specifically, would it be efficient for physicians and patients to bargain over the extent of the warranty? Several arguments suggest that it would not. First, one might ask why warranties have not developed without legal intervention. If they are so efficient, one would expect to see them emerge. Physicians are free to contract *above* the medical malpractice standard, yet they rarely do. If warranties do not emerge on their own, that might support the view that they do not offer any efficiency advantage.

Professor Jennifer Arlen has made a powerful argument, based

83. See, e.g., Schwartz & Wilde, *supra* note 80, at 1398–99 (discussing the theory of comparative advantage in the context of defects in refrigerator motors and asserting that "[t]he theory in this context rests on six assumptions: (1) Firms can reduce the costs of defects in refrigerator motors more cheaply than consumers because firms have more expertise regarding motors and benefit from economies of scale in buying repair tools; (2) Consumers can better ensure the durability of refrigerator doors and shelves because these items are best preserved through careful use; (3) Consumers are perfectly informed as to the risk of product defects and know what steps are necessary to reduce this risk; (4) Search costs are zero—consumers can costlessly observe every price and contract term that all firms in the market do or could offer; (5) Consumers minimize net purchase costs; (6) Firms maximize profits").

84. See Mark Geistfeld, Note, *Imperfect Information, the Pricing Mechanism, and Products Liability*, 88 COLUM. L. REV. 1057, 1062–63 (1988).

85. See *id.* at 1063–64 ("In general, the manufacturer is the party best able to make accurate estimates of product risks Were consumers charged separate prices for discrete product risks, they could infer the manufacturer's estimated valuation of each risk. Such an isolated price provides the consumer the best available information regarding a particular aspect of the product's quality and allows for an informed decision whether it is cheaper to self-insure.").

on this intuition, that contracting over medical liability would not be efficient. She points out that risk-reducing investments tend to have three features:

- (1) [T]hey are “collective” in that they benefit many patients,
- (2) they are “durable,” in that they reduce the risk of error for both existing and future patients, and
- (3) they are discontinuous (or “lumpy”) [i.e., these costs are large and fixed in comparison to the money that individual patients spend].⁸⁶

These features give the patient “strong incentives to waive contractual liability, even when state-imposed liability would be optimal, because his individual waiver will have little effect on the provider’s incentives to make substantial systemic investments.”⁸⁷

These features diminish the incentives for patients to bargain for liability. First, as Arlen points out, most of these long-term investments already have been made (or not made) when a patient enters into a contract with a provider.⁸⁸ Second, because these safety investments benefit *all* patients, and there is a small probability that they would directly benefit any given patient, each individual patient has the incentive to free ride on others’ bargaining.⁸⁹ Applying these insights to warranty-based medicine, it would seem that individuals would have little incentive to bargain for better warranties because they could only be offered if the provider had made long-term, fixed investments.

There are several responses to these points. First, it is an exaggeration to claim that *all*, or even most, costs associated with safety are large and fixed. To the contrary, some of the most important safety innovations simply involve small per-patient incremental costs. For instance, many hospitals require magic marker colors to designate on which side (right or left) a patient is to have surgery, or require a “time out” when surgery begins in order to ensure that basic safety checks are made.⁹⁰ And the simple act of

86. Arlen, *supra* note 69, at 5.

87. *Id.* at 6.

88. *See id.*

89. *See id.* (“This incentive to waive [liability bargaining] is exacerbated by the fact that a patient who waives can ‘free-ride’ on investments induce[d] by the liability imposed by others since providers who invest in safety tend to apply these investments to all their patients, regardless of their liability provisions.”).

90. *See* Mulloy & Hughes, *supra* note 75, at 2-387 to 2-388 (discussing marking and time-out procedures). Many commentators argue that these small innovations vastly improve medical safety. *See, e.g.,* Mary R. Kwaan et al., *Incidence, Patterns, and Prevention of Wrong-Site Surgery*, 141 ARCHIVES SURGERY 353, 357 (2006) (showing that two-thirds of wrong-site surgery could be eliminated through adoption of standardized safety protocols); Stephen Schenkel, *Promoting Patient Safety and Preventing Medical Error in Emergency Departments*, 7 ACAD. EMERGENCY MED. 1204, 1205, 1209–10 (2000) (showing how basic procedures, like checklists, can reduce iatrogenic injury); Samuel C.

hand washing has proved the most effective way to prevent the spread of infections in hospitals.⁹¹

Second, as Arlen admits, the existence of MCOs—large third-party payers—could alleviate the bargaining asymmetry.⁹² Unlike individuals, MCOs *do* have the incentive to bargain for long-term investments benefitting all of their enrollees.⁹³ As many have argued, MCOs could contract with enrollees for medical liability.⁹⁴ MCOs could then bargain with health care providers for safety measures.⁹⁵ But, as Arlen points out, requiring MCOs to contract for liability could very well create an adverse-selection problem⁹⁶—a problem that this Article’s warranty-based medicine proposal arguably avoids.

Moving away from an economic analysis, there are significant norms that discourage bargaining over any aspect of medical care. While not susceptible to a clear definition, a norm is generally a rule, the violation of which is punished with some social sanction or loss of standing or prestige.⁹⁷ Medicine has always operated within the context of norms, both for physician and patient. The former is supposed to give the patient the highest standard of care and should always act in the patient’s best interest. Doctors who appear mercenary, opportunistic, cruel, or compassionless violate the professional norms, and generally receive a social sanction of diminished respect. As mentioned above, physicians, perhaps as a

Seiden & Paul Barach, *Wrong-Side/Wrong-Site, Wrong-Procedure, and Wrong-Patient Adverse Events*, 141 ARCHIVES SURGERY 931, 934–936 (2006) (observing that wrong-site surgery is quite common and arguing that patient safety can be improved through the adoption of basic protocols from other industries).

91. See *Hand Washing: Do’s and Don’ts*, MAYO CLINIC, <http://www.mayoclinic.com/health/hand-washing/hq00407> (last visited Jan. 28, 2011).

92. See Arlen, *supra* note 69, at 4, 24 & n.75.

93. See *id.* at 55–57.

94. See, e.g., *supra* notes 45–50 and accompanying text; see also Danzon, *supra* note 68, at 492 (noting the growth of MCO liability through contracts); Havighurst, *supra* note 68, at 8 (arguing that “health plans, and not individual doctors, should be legally accountable in the first instance for the quality of care delivered to patients just as they are currently accountable to employers and consumers for the cost of care”).

95. See Arlen, *supra* note 69, at 2, 32.

96. See *id.* at 7, 57–62.

97. See ROBERT C. ELLICKSON, ORDER WITHOUT LAW: HOW NEIGHBORS SETTLE DISPUTES 127 (1991). The literature of norms and social behavior is, of course, enormous. See Eric A. Posner, *The Signaling Model of Social Norms: Further Thoughts*, 36 U. RICH. L. REV. 465, 465 (2002) (“One of the most notable trends in legal scholarship is the explosion of writing on social norms.”). Not all writers view norms as rules with “social punishments,” as opposed to torts or criminal laws that punish with fines or imprisonment; some explicitly adopt broader definitions. See, e.g., Eric A. Posner, *Law, Economics, and Inefficient Norms*, 144 U. PA. L. REV. 1697, 1699 (1996) (“In these ways, a norm is like a law, except that a private person sanctions the violator of a norm, whereas a state actor sanctions the violator of a law.”).

result of these norms, do not like discussing fees—let alone bargaining for levels of care.⁹⁸ Such bargaining would violate their professed ethical duty to do their best for each patient.⁹⁹

In addition to the medical-professional norms, there are norms for patients. Physicians expect patients to be “good patients,” a phenomenon that has been extensively studied and documented.¹⁰⁰ One group of physicians writes, “As clinicians and medical researchers, we have been taught and socialised to think, write, and act as physicians, but we, and our friends and families, have also been patients. We all try to be good patients.”¹⁰¹ Good patients are supposed to be trusting, cooperative, noncomplaining, and nondemanding.¹⁰² In general, “good patients” receive more attentive care.¹⁰³ Again, tenacious bargaining does not fit into the role of the “good patient” and might possibly diminish the quality and certainly the experience of health care received.

These norms undoubtedly exist and arguably impede patients from becoming effective consumers; indeed, they create a cost for such patient behavior. A law mandating the disclosure of warranties, if any, could help end this confining norm and make warranties both accepted and expected.

D. Warranties Offer Lower Transaction Costs Than Medical Malpractice

Warranties reduce transaction costs, at least compared to medical malpractice.¹⁰⁴ First, the current malpractice standard in

98. See Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643, 653–54 (2008); Howard Stein, *The Money Taboo in American Medicine*, MED. ANTHROPOLOGY, Fall 1983, at 1.

99. CODE OF MEDICAL ETHICS (Am. Med. Ass’n 2010).

100. See, e.g., Steven R. Hans et al., *The Difficult Doctor-Patient Relationship: Somatization, Personality and Psychopathology*, 47 J. CLINICAL EPIDEMIOLOGY 647 (1994); Michael P. Kelly & David May, *Good and Bad Patients: A Review of the Literature and a Theoretical Critique*, 7 J. ADVANCED NURSING 147 (1982); Bauke Koekkoek et al., “*Difficult Patients*” in *Mental Health Care: A Review*, 57 PSYCHIATRIC SERVICES 795 (2006); Marilyn Macdonald, *Seeing the Cage: Stigma and Its Potential To Inform the Concept of the Difficult Patient*, 17 CLINICAL NURSE SPECIALIST 305, 307 (2003) (explaining that a patient who is not “good” is one “who does not assume the patient role expected by the health care professional, who may have beliefs and values or other personal characteristics that differ from those of the caregiver, and who causes the caregiver to experience self-doubt”). See generally FELICITY STOCKWELL, *THE UNPOPULAR PATIENT* (1984).

101. Alejandro R. Jadad et al., *I Am a Good Patient, Believe It or Not*, 326 BRIT. MED. J. 1293, 1293 (2003).

102. Judith Lorber, *Good Patients and Problem Patients: Conformity and Deviance in a General Hospital*, 16 J. HEALTH & SOC. BEHAV. 213, 213 (1975).

103. See *id.* at 222–23.

104. David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 NEW ENG. J. MED. 2024, 2024 (2006)

tort uses an implicit warranty that is vague. If one wishes to recover, one must show that the doctor performed below his or her community's standard of care, that this failure caused the injury, and that damages resulted.¹⁰⁵ Generally, enforcing a standard, rather than a rule, is costly,¹⁰⁶ and so it is with the medical contract. A physician's reasonable duty of care is a remarkably vague standard. Assessing it requires a trial with a battle of experts that jurors—probably not the best qualified to do so—must decide. Evidence shows that medical malpractice litigation is wasteful, time consuming, and, to some degree, inaccurate.¹⁰⁷

Second, the medical malpractice standard does little to elucidate provider competence in any fine-grained manner. Given that the standard reflects what an average physician would do—indeed, often in practice, an average physician within the community—a doctor who has a clean malpractice record is within a standard deviation or two from average, either better or worse. Being born in Lake Wobegon provides a better signal.

Third, high rates of false positives and negatives render malpractice an imprecise signal. Some studies, particularly the famous but hotly disputed Harvard Study, show that medical malpractice fails to compensate the true victims of malpractice while those who experience a poor result, without being victims of negligence, often do well by the system.¹⁰⁸ Other studies dispute this result.¹⁰⁹

Fourth, the process is costly, consuming over one dollar in costs for every dollar in compensation.¹¹⁰ There is some evidence the standard leads to “defensive medicine”; doctors perform more tests than would be optimal in order to protect themselves from liability.¹¹¹ In addition, there is evidence that medical malpractice

(“The overhead costs of malpractice litigation are exorbitant.”).

105. TOM BAKER, *THE MEDICAL MALPRACTICE MYTH* 14–16 (2005).

106. See Isaac Ehrlich & Richard A. Posner, *An Economic Analysis of Legal Rulemaking*, 3 J. LEGAL STUD. 257, 267 (1974); Louis Kaplow, *Rules Versus Standards: An Economic Analysis*, 42 DUKE L.J. 557, 577 (1992).

107. Florence Yee, Note, *Mandatory Mediation: The Extra Dose Needed To Cure the Medical Malpractice Crisis*, 7 CARDOZO J. CONFLICT RESOL. 393, 407–09 (2006).

108. See A. Russell Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence*, 325 NEW ENG. J. MED. 245, 249 (1991).

109. For a recent study, see Studdert et al., *supra* note 104, at 2024 (“Most of the claims that were not associated with errors (370 of 515 [72 percent]) or injuries (31 of 37 [84 percent]) did not result in compensation; most that involved injuries due to error did (653 of 889 [73 percent]).”) Professor Tom Baker reviews a number of studies, finding mixed results. See BAKER, *supra* note 105, at 77–82.

110. Studdert et al., *supra* note 104, at 2028–29.

111. The notion of “defensive medicine” is quite hard to define. Doctors certainly believe that they perform more tests and other procedures than necessary due to the fear of litigation. See David M. Studdert et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice*

deters entry into the profession, as those states with high permissible medical malpractice damages have fewer entering physicians.¹¹²

IV. BEYOND WARRANTIES: HOW LAW AND REGULATION SQUELCH PHYSICIAN-QUALITY INFORMATION

In a world without warranties, how do individuals make health care decisions regarding quality? Many people rely on reputation and the advice of other doctors in choosing doctors. Others simply trust their insurance companies and look up the name of a doctor in the insurance company's doctor listings. But, do people trust (or behave indifferently) because trusting or indifference is good—or do they trust because other types of verification are not available? Consider how we learn about the skills of other service providers in areas in which consumers lack the expertise and experience to evaluate the service provider. When evaluating an investment advisor, one can look at past performance. When picking a litigator, one can examine trial win/loss records. When picking a contractor, one can ask past customers, inquire about the contractor's intended methods and procedure, and compare estimates. In short, we make decisions about quality and consumption based on past performance, word of mouth, price (higher price tends to signal quality), brand, current practice, certification, and advertising.

With medicine, however, these sources of information and signals are absent. Many claim that medicine's inherent complexity creates the information dearth.¹¹³ This Part shows, however, the degree to which law and regulation prevent the availability of this information.

A. *Past Performance*

Examination of past errors, or lack thereof, yields reliable quality information, provided that past is prologue, a reasonable assumption in most contexts. However, information relating to

Environment, 293 JAMA 2609, 2612 (2005). However, as Baker points out, “[N]one of the researchers who have studied defensive medicine have claimed that they are able to separate the wasteful effects of malpractice lawsuits from the good, injury-prevention effects.” BAKER, *supra* note 105, at 119.

112. For a very thorough and sophisticated investigation of these issues (with ambiguous results), see Jonathan Klick & Thomas Stratmann, *Medical Malpractice Reform and Physicians in High-Risk Specialties*, 36 J. LEGAL STUD. S121 (2007), and David A. Matsa, *Does Malpractice Liability Keep the Doctor Away? Evidence from Tort Reform Damage Caps*, 36 J. LEGAL STUD. S143 (2007).

113. See, e.g., Qing Zhang, *The Chinese Regulatory Licensing Regime for Pharmaceutical Products: A Law and Economics Analysis*, 15 MICH. TELECOMM. & TECH. L. REV. 417, 424 (2009) (“Given the considerable technological complexity of medicine, consumers often have insufficient information to choose the right medicine for themselves.”).

medical malpractice settlements is typically kept secret, as federal and most state law permits parties to agree to keep settlements confidential.¹¹⁴ Apparently, parties, particularly those in medical malpractice cases, take advantage of this option. A recent study of sealed settlements in federal courts reported that personal injury cases constitute the largest single category (thirty percent) of all sealed cases.¹¹⁵

This allows litigants to convert a public good—information about a physician—into private gain. In other words, the successful malpractice plaintiff agrees to keep quiet about the settlement in exchange for additional money, which the physician will pay to “protect” his or her reputation.¹¹⁶ This is particularly egregious in the medical malpractice context because a rule requiring secrecy would likely be quite effective at inhibiting the free flow of extremely scarce and socially valuable information.

Some argue that parties could engage in forum shopping to bring suit in jurisdictions with more protection than others.¹¹⁷ Generally, however, the medical malpractice plaintiff is limited to the venue in which he or she can bring suit, i.e., his or her place of residence or the place of treatment, and generally lacks a basis for federal-question or diversity jurisdiction.¹¹⁸ Some commentators also argue that because parties could settle the dispute before the claimant files suit, antisecrecy rules would in fact lead to less information being made available to the public.¹¹⁹ However, most states already strongly encourage medical malpractice claimants to settle out of court, and indeed most suits already do.¹²⁰ Finally, it

114. With few exceptions (such as New Jersey and Florida), most states allow parties to contract to keep medical malpractice settlements secret pursuant to court rule or discretion. See Ross E. Cheit, *Tort Litigation, Transparency, and the Public Interest*, 13 ROGER WILLIAMS U. L. REV. 232, 233–34 (2008); Andrew D. Goldstein, *Sealing and Revealing: Rethinking the Rules Governing Public Access to Information Generated Through Litigation*, 81 CHI-KENT L. REV. 375, 434 (2006).

115. ROBERT TIMOTHY REAGAN ET AL., FED. JUDICIAL CTR., SEALED SETTLEMENT AGREEMENTS IN FEDERAL DISTRICT COURT 3 (2004), available at [http://www.fjc.gov/public/pdf.nsf/lookup/sealset3.pdf/\\$file/sealset3.pdf](http://www.fjc.gov/public/pdf.nsf/lookup/sealset3.pdf/$file/sealset3.pdf) (“We studied all eleven districts whose local rules require good cause to seal a document. The rate of sealed settlement agreements in those districts was 0.37%. . . . More than half of the cases with sealed settlement agreements are either personal injury cases (30%) or employment cases (27%).”).

116. See Alan E. Garfield, *Promises of Silence: Contract Law and Freedom of Speech*, 83 CORNELL L. REV. 261, 263, 280 (1998) (analyzing secrecy agreements).

117. See Christopher R. Drahozal & Laura J. Hines, *Secret Settlement Restrictions and Unintended Consequences*, 54 U. KAN. L. REV. 1457, 1480–81 (2006) (discussing avenues for avoiding secret settlements).

118. See *id.*

119. *Id.*

120. See Douglas R. Eitel et al., *Medicine on Trial. Physicians’ Attitudes About Expert Medical Witnesses*, 18 J. LEGAL MED. 345, 351 (1997) (“[M]any

seems unlikely that in tort suits, as opposed to contractual disputes, parties would contract for the application of a particular jurisdiction's law as some commentators suggest.¹²¹

In addition, hospital error incident reports and disciplinary records are generally not made public.¹²² The Patient Safety and Quality Improvement Act of 2005 and its implementing regulations, though intended to improve treatment, require record keeping of safety violations and exchange of information to develop better safety protocols.¹²³ Despite these mandates, the regulations explicitly provide for the secrecy of reporting information concerning medical errors.¹²⁴

The federal government requires all physicians who receive Medicare or Medicaid payments to report all payments made on behalf of physicians in connection with medical malpractice settlements or judgments as well as all adverse peer-review actions against licenses, clinical privileges, and professional society memberships of physicians and other health care practitioners.¹²⁵ This data is collected and compiled into the National Practitioner Data Bank.¹²⁶ Unfortunately, federal regulations prevent consumers from looking at the data, a regulatory privilege supported by extensive American Medical Association ("AMA") lobbying.¹²⁷

One easy way to quickly evaluate performance is to get a second opinion. However, given that doctors legally own the physical copies of patient records,¹²⁸ it is costly to get easy, convenient "second

states developed medical malpractice review panels to encourage arbitration and settlement.").

121. See, e.g., Drahozal & Hines, *supra* note 117, at 1482; Bruce H. Kobayashi & Larry E. Ribstein, *Contract and Jurisdictional Freedom*, in *THE FALL AND RISE OF FREEDOM OF CONTRACT* 325, 327 (F.H. Buckley ed., 1999) ("Actors may be able to exit state regulation inexpensively by contracting ex ante for the application of a particular law rather than physically avoiding regulating states.").

122. See, e.g., N.Y. EDUC. LAW § 6527(3) (McKinney 2001); see also Troyen A. Brennan, *Hospital Peer Review and Clinical Privileges Actions: To Report or Not Report*, 282 JAMA 381, 381–82 (1999) (discussing the great discretion hospitals have to keep physician discipline actions and evaluations secret).

123. 42 U.S.C. §§ 299b-21, -22, 299c-2, -3 (2006); 42 C.F.R. §§ 3.204–.212 (2010).

124. Patient Safety and Quality Improvement, 73 Fed. Reg. 8112, 8113 (proposed Feb. 12, 2008). The regulations state that "[t]hese [secrecy] protections will enable all health care providers, including multi-facility health care systems, to share data within a protected legal environment, both within and across states, without the threat of information being used against the subject providers." *Id.*

125. 42 U.S.C. § 11101 (2006); 45 C.F.R. §§ 60.7–.9 (2010).

126. *About Us*, U.S. DEPT HEALTH & HUMAN SERVS., <http://www.npdhdb.hrsa.gov/topNavigation/aboutUs.jsp> (last visited Jan. 28, 2011).

127. See Thomas Reardon, *Consumer Access to the National Practitioner Data Bank: Against*, 41 HEALTHPLAN 18, 18–19 (2000).

128. Veling W. Tsai, *Cheaper and Better: The Congressional Administrative*

opinions.” Interestingly, this should be *easier* in the age of electronic records. At the very least, with electronic communications, it should be easy to pay another physician to review the records or, at least, in certain instances, x-rays or MRI scans. After all, hospitals send x-rays around the world for review by Indian radiologists¹²⁹—why couldn’t consumers do the same thing? Given that physicians own their records and patients only have access (not control) over them, such review is, in practice, difficult.¹³⁰

B. *Word of Mouth*

Of course, it is not clear that the consensus of laypeople on the virtues of a given doctor reflects anything but that doctor’s interpersonal skills. Since the time of the priests of Asclepius, physicians have excelled at giving the impression of concern and compassion, which may or may not be an accurate signal of quality. The failure, therefore, of word of mouth stems from doctors’ own reticence to speak frankly to laypeople about their fellow doctors’ skills. This reticence emerges from doctors’ own professional culture as well as the law and regulation that supports and protects it.

Doctor Atul Gawande, the surgeon and a sort of “medical public intellectual,” has written, “As is often the case, the people who were in the best position to see how dangerous [the surgeon] had become

Simplification Mandate Facilitates the Transition to Electronic Medical Records, 19 J. LEGAL MED. 549, 557 (1998) (“[C]ourts have continued to recognize that, although patients have rights to access their treatment records, the records belong to the physician or to the hospital.”); see also *McGarry v. J.A. Mercier Co.*, 262 N.W. 296, 297 (Mich. 1935) (holding that x-ray “negatives are the property of the physician or surgeon who has made them incident to treating a patient”).

129. See Nathaniel H. Hwang, *You’ve Got Mail: The Concerns of Electronically Outsourcing Radiological Services Overseas*, 25 J. LEGAL MED. 469, 469 (2004); Andrew Pollack, *Who’s Reading Your X-Ray?*, N.Y. TIMES, Nov. 16, 2003, at BU1.

130. As a general rule, under state law, the health care provider owns medical records and other related materials like x-rays. See, e.g., *Gotkin v. Miller*, 379 F. Supp. 859, 863, 866–67 (E.D.N.Y. 1974); *Pyramid Life Ins. Co. v. Masonic Hosp. Ass’n of Payne Cnty., Okla.*, 191 F. Supp. 51, 54 (W.D. Okla. 1961); *Cornelio v. Stamford Hosp.*, No. CV9601557795, 1997 WL 430619, at *4–5 (Conn. Super. Ct. July 21, 1997), *aff’d*, 717 A.2d 140 (Conn. 1998); *Cannell v. Med. & Surgical Clinic*, 315 N.E.2d 278, 280 (Ill. App. Ct. 1974); *Waldron v. Ball Corp.*, 619 N.Y.S.2d 841, 841 (App. Div. 1994); *Wallace v. Univ. Hosps. of Cleveland*, 170 N.E.2d 261, 261–62 (Ohio Ct. App. 1960). Many states provide for hospital ownership of medical records through statute or regulation. See, e.g., 28 PA. CODE § 115.28 (2011) (“Medical records are the property of the hospital, and they shall not be removed from the hospital premises, except for court purposes.”); TENN. CODE ANN. § 68-11-304 (2006) (establishing that hospital records are hospital property). For a more complete listing of cases and statutes, see Roger E. Harris, Note, *The Need To Know Versus the Right To Know: Privacy of Patient Medical Data in an Information-Based Society*, 30 SUFFOLK U. L. REV. 1183, 1190 & n.34 (1997).

were in the worst position to do anything about it: junior physicians, nurses, ancillary staff.”¹³¹ Given the nonpublic nature of medical information, it is essential that those who have access to it also have incentives to share it, but those in the medical hierarchy’s lower rungs rarely have such incentive. Further, established physicians also have little incentive to share information. Because doctors refer patients to one another, they often lack an incentive to offend each other by giving frank assessments of another doctor’s skills. Such indiscretion may “get back” to their target, drying up a source of references and revenue.

Perhaps most importantly, given the power of self-regulation that physicians possess, they can retaliate against each other by denying each other admission privileges at a hospital and blackballing each other from professional organizations. The hostility from other doctors toward physicians who testify for plaintiffs in medical malpractice cases strongly suggests the mafia-like retribution the medical profession metes out to those who do not conform to expected—and self-protecting—professional norms.¹³² Finally, because the law gives physicians the power to discipline and even de-license each other,¹³³ the average physician’s incentive to give frank advice about his or her fellow members of the profession must be discounted by the possibility that such fellow members may seek reprisals.

C. Price

Price is arguably the most important signal in a modern economy; it informs consumers about the cost of producing a given product or service.¹³⁴ It corresponds to quality, as generally suppliers could not make any money if they charged more for goods that failed to provide commensurate value. But, thanks to pervasive third-party payment regimes, consumers do not pay for health care directly.¹³⁵ Price is invisible and incentives are misaligned. Further, due to the complications of the third-party-payment regime, hospital prices are often meaningless artifacts of cross-subsidization and price discrimination, something that anyone who has ever received a master bill for a major medical procedure would know. Of course, as

131. ATUL GAWANDE, *COMPLICATIONS: A SURGEON’S NOTE ON AN IMPERFECT SCIENCE* 96 (2002).

132. See Alexis Wood, *Professional Oversight of Expert Testimony: Austin v. American Association of Neurological Surgeons*, VIRTUAL MENTOR (Apr. 2005), <http://virtualmentor.ama-assn.org/2005/04/pdf/hlaw1-0504.pdf>.

133. See Drew Carlson & James N. Thompson, *The Role of State Medical Boards*, VIRTUAL MENTOR (Apr. 2005), <http://virtualmentor.ama-assn.org/2005/04/pdf/pfor1-0504.pdf>.

134. See Friedrich A. Hayek, *The Use of Knowledge in Society*, 35 AM. ECON. REV. 519, 525–26 (1945).

135. See generally Milton Friedman, *How To Cure Health Care*, PUB. INT., Winter 2001, at 1 (discussing third-party-payment regimes).

is pointed out endlessly in public-policy circles, tax law supports and subsidizes health insurance; thus law and regulation help to deprive medical markets of information and to silence a potentially robust signal.¹³⁶

There are deeper reasons why price has failed to be a powerful signal. Doctors do not like talking about price—and they rarely do—because such discussion conflicts with their professionalism.¹³⁷ Since the time of Hippocrates, talking about prices has somehow sullied the quasi-religious role to which doctors often aspire.¹³⁸ Less melodramatically, doctors' failure to discuss price with patients may simply result from patients' lack of bargaining power. After all, when doctors deal with a customer that has significant market power, like the Medicare program, doctors are, in general, quite vocal about price.¹³⁹

D. Brand

Brands can serve as powerful signals. Milton Friedman famously argued that all medical licensure should be eliminated.¹⁴⁰ Rather than have laws that protect consumers from bad doctors, Friedman envisioned the emergence of prestigious medical firms, like prestigious banks, that would signal quality.¹⁴¹ In limited instances, prestigious firms have emerged, like the Mayo Clinic. Similarly, teaching hospitals associated with medical schools, signal quality to some degree. However, the Mayo Clinic is the exception

136. See *Bd. of Regents of Univ. of Minn. v. Shalala*, 837 F. Supp. 303, 306 (D. Minn. 1993) (recognizing that the part of the Medicare Act known as the "health insurance program" is funded out of social security taxes).

137. See *supra* note 98 and accompanying text.

138. See Hall & Schneider, *supra* note 98, at 654 ("Doctors dislike discussing fees. . . . [There is] a 'taboo in official American health culture: namely, a prohibition upon allowing the physician to appear concerned with financial matters.'" (quoting Howard F. Stein, *The Money Taboo in American Medicine*, MED. ANTHROPOLOGY, Fall 1983, at 1, 11)). Professors Hall and Schneider quote Hippocrates as follows:

Should you begin by discussing fees, you will suggest to the patient either that you will go away and leave him if no agreement be reached, or that you will neglect him and not prescribe any immediate treatment. . . . I consider such a worry to be harmful to a troubled patient, particularly if the disease be acute.

Id. at 654 (quoting John Fabre, *Medicine as a Profession: Hip, Hip, Hippocrates: Extracts from The Hippocratic Doctor*, 315 BRIT. MED. J. 1669, 1669–70 (1997) (internal quotation marks omitted)).

139. The AMA's lobbying and publicity campaigns concerning Medicare's reimbursement schedules, as well as the reimbursement schedules of private insurers, are notorious. See Sarah Rubenstein, *Medicare Patients Struggle To Find Primary Care Docs*, WALL. ST. J. HEALTH BLOG (Dec. 9, 2008, 9:13 AM), http://blogs.wsj.com/health/2008/12/09/medicare-patients-struggle-to-find-primary-care-docs/?mod=googlenews_wsj.

140. See MILTON FRIEDMAN & ROSE D. FRIEDMAN, *FREE TO CHOOSE: A PERSONAL STATEMENT* 228–47 (1980).

141. See *id.*

to the rule, and wide variations exist in the quality of research institutions.¹⁴² It is quite clear that no evidence establishes that care in teaching hospitals is per se better than in nonteaching hospitals.¹⁴³ Doctors have not branded themselves for reasons that are not clear to this author.

E. Advertising

Another important quality signal is advertising. As Professor Phillip Nelson first observed, expensive advertisement campaigns can be seen as indicating quality because consumers are more likely to be repeat buyers of quality goods and, therefore, it makes economic sense for purveyors of quality goods to make the “first sale” and do so by getting the attention of consumers through advertising.¹⁴⁴

Notions of professionalism—indeed, the AMA’s Code of Ethics—at one time prohibited doctors from advertising.¹⁴⁵ Even after the Supreme Court struck down the AMA’s ban as violating antitrust laws,¹⁴⁶ doctors did not start advertising.¹⁴⁷ It is still relatively rare,¹⁴⁸ and is perhaps found most commonly in connection with cosmetic surgery and other elective procedures such as refractive eye surgery.

Contractual incentive structures can also act as a signal.¹⁴⁹ If a car comes with a warranty, it signals the seller’s belief that the car is good; otherwise, the seller would lose money. Other contractual

142. See, e.g., Shukri F. Khuri et al., *Comparison of Surgical Outcomes Between Teaching and Nonteaching Hospitals in the Department of Veterans Affairs*, 234 ANNALS SURGERY 370, 374 (2001) (finding higher mortality rates in teaching hospitals than in nonteaching hospitals).

143. See Justin B. Dimick et al., *Hospital Teaching Status and Outcomes of Complex Surgical Procedures in the United States*, 139 ARCHIVES SURGERY 137, 140–41 (2004).

144. Phillip Nelson, *Advertising as Information*, 82 J. POL. ECON. 729, 732 (1974); see also Paul Milgrom & John Roberts, *Price and Advertising Signals of Product Quality*, 94 J. POL. ECON. 796 (1986) (positing a formal model of advertisements’ signaling function).

145. Robert L. Martensen, *Physician Advertising*, 272 JAMA 1623, 1623 (1994).

146. See *Am. Med. Ass’n v. FTC*, 638 F.2d 443 (2d Cir. 1980), *aff’d*, 455 U.S. 676 (1982).

147. See Hall & Schneider, *supra* note 98, at 653–54.

148. See John A. Rizzo & Richard J. Zeckhauser, *Advertising and the Price, Quantity, and Quality of Primary Care Physician Services*, 27 J. HUM. RESOURCES 381, 388 n.12 (1992) (finding that “physician price advertising continues to be quite rare,” because the FTC seldom receives complaints about price advertising by physicians, and polls show that “physicians are strongly opposed to price advertising”).

149. See Sanford Grossman, *The Informational Role of Warranties and Private Disclosure About Product Quality*, 24 J.L. & ECON. 461 (1981) (discussing the role warranties play in signaling product quality); Spence, *supra* note 13, at 561–62, 569–71 (same).

signals indicating quality include a “no questions asked” return policy or, as contractors often employ, a partial payment schedule in which the buyer only pays upon successful completion of certain, agreed-upon stages.

The medical contract—pay for services, not results—is not only a moral hazard in that it allows the provider to give less than excellent care and still get paid, but it signals nothing except, perhaps, mediocrity. As the previous Part discussed, this contract did not emerge from market forces but resulted from judicial regulation and professional self-interest.

F. Certification and Professionalism

Of course, the one signal of quality that the law does permit, and actually creates, is credentialing and the culture of professionalism that grows up around it. The law limits, as discussed in Part I, who can practice medicine. The public justification for these limits is to protect the public from mountebanks and quacks. Regulation is supposed to permit only qualified people to practice medicine and, thus, the credential should signal quality.¹⁵⁰ Medicine in the United States offers a bewildering mélange of credentialing and certifying organizations, from the hundreds of medical schools and programs for credentialing foreign-trained doctors, to programs for physician specialty board certification, to hospital accrediting organizations like the Joint Commission for Accreditation of Healthcare Organizations (“JCAHO”).¹⁵¹

By definition, credentialing only permits a bargain basement type of signaling—a person who has an M.D. and has passed his or her certifying exams satisfies a minimal level of competence. Credentialing and certification fails to provide more fine-grained distinctions. Moreover, it limits other types of signaling, i.e., designations of other types of health care professionals who could do some of the tasks currently performed by licensed medical doctors but who cannot demonstrate their competence.

More problematically, credentialing encourages, indeed,

150. See Timothy Stoltzfus Jost, *The Necessary and Proper Role of Regulation To Assure the Quality of Health Care*, 25 Hous. L. Rev. 525, 525 (1988) (“Assuring the quality of the care provided by medical professionals and institutions has been a concern of the law from ancient times.”).

151. About two-dozen medical specialties have certifying boards recognized by the American Board of Medical Specialties. *Specialties & Subspecialties: Recognized Physician Specialty and Subspecialty Certificates*, AM. Bd. Med. Specialties, http://www.abms.org/who_we_help/physicians/specialties.aspx (last visited Jan. 28, 2011). The JCAHO accredits hospitals, nursing homes, psychiatric hospitals, hospices, and other health care institutions. See Timothy Stoltzfus Jost, *The Joint Commission on Accreditation of Hospitals: Private Regulation of Health Care and the Public Interest*, 24 B.C. L. Rev. 835, 841 (1983).

arguably creates or reifies, what can only be described as primitive, cultic attitudes toward medicine.¹⁵² Some argue that a professional calling, as defined and created by credentialing, somehow transforms normal, self-interested service providers into professionals who will presumably ignore their self-interest, pecuniary gain, or other utility, in the name of their calling.¹⁵³ Indeed, some have argued that this special status is essential because it elicits trust and because

[a] patient's confidence and trust in a care provider obviously is central to this charismatic healing power. "The image of omnipotence is an essential component of the healer." Deep-seated trust appears to activate a patient's own, internal healing mechanisms—mechanisms that are still largely undiscovered and unexplained [undiscovered, indeed]. . . . [S]ociety recognizes the healing powers of a professional elite (physicians or shamans), who administer personally to the patient with physical touching and healing agents (drugs or herbs)

. . . Trust in the healer is elevated by the healer's status in society.¹⁵⁴

While undoubtedly placebo effects caused by confidence in providers' "healing powers," play an enormous role in getting people to feel better, the notion that law should work through credentialing and other mechanisms to create a class of "shamans" trained to elicit feelings of wellness seems medieval in its antirationalism.

It is true, as discussed below, that relatively little of medical practice boasts a rigorous scientific basis, and that medicine, as currently practiced, is certainly not a pure science. But, that does not mean that legal policy and contract law should reinforce, even reify, a faith-based approach to medicine. To the contrary, it should encourage evidence-based treatment to render medicine as scientifically predictable, indeed merely technical, as possible. More to the point, if the challenge for law and medicine truly is to provide "trust," other signals, like contractual warranties, probably can do a better job. Whom would one trust more—preening doctors displaying their "charismatic healing power" or doctors who will eat their fees if they fail to deliver promised outcomes?

On the other hand, to the degree that professionalism creates special reputational costs, it can be a signal. If physicians, due to

152. See, e.g., Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 480–81 (2002) (discussing the traits ascribed to doctors over the course of history).

153. See W. Glannon & L.F. Ross, *Are Doctors Altruistic?*, 28 J. MED. ETHICS 68, 68 (2002) (identifying commentators who make this argument).

154. Hall, *supra* note 152, at 480, 481 (footnotes omitted) (quoting ERIC J. CASSELL, *THE HEALER'S ART* 141 (1976)).

their status and position, which credentialing helps create, place a greater value on their reputation, then physicians can be expected to behave in ways consistent with promoting their reputation.¹⁵⁵ That would mean they would act in ways that would always make it appear as if they were acting in patients' best interests. If professionalism—and credentialing, which helps create the special mission of a profession—did make a physician's reputation more valuable, then professionalism would be a powerful and informative signal.

But it is far from clear that reputation functions effectively in large populations or in occupations like medicine in which information is scarce and unreliable and interactions between doctors and patients are often infrequent.¹⁵⁶ In other words, we might expect professionalism to function as an effective signal in a small town in which everyone knew about a doctor's reputation, and that public perception was relatively accurate. In those circumstances, doctors with bad reputations would be "punished" with smaller practices. However, medicine as practiced today is often anonymous, institutionalized, and bureaucratized. It is far from clear that professionalism would function as an effective signal of quality.

G. Comparative Performance

As the largest single payer of health care in the country through Medicare, Medicaid, and the Veterans Administration, the federal government has in its possession information about which doctors perform which procedures and in what quantities. This information could be used, among other ways, to see whether doctors were giving appropriate care, overusing certain treatments, or, in general, providing care consistent with that given by other physicians with similar patient loads. While the conclusions that could be drawn from the federal government's information would not be perfectly precise, as a Freedom of Information Act ("FOIA")¹⁵⁷ disclosure could not match diagnoses and services with specific patients, this information could clearly give some insight into particular doctors' prescription practices. This insight could be used to see how well physicians appear to be following the most current practices—as well as whether they perform services for which they are qualified, i.e., whether non-Board certified physicians are performing typically specialist-performed procedures. At the very least, it would show

155. See ERIC A. POSNER, *LAW AND SOCIAL NORMS* 13, 65, 187 (2000) (providing a classic account of the relationship between law and norms, and examining how reputation encourages prosocial behavior).

156. See Andrew Fichter, *The Law of Doctoring: A Study of the Codification of Medical Professionalism*, 19 *HEALTH MATRIX* 317, 381–82 (2009) (noting the contradictory nature of modern medical professionalism).

157. 5 U.S.C. § 552 (2006).

the experience that physicians have in performing certain procedures—a key indicator of quality.

This information would be clearly helpful to consumers. After all, if you were hiring a contractor to build a house, you would probably be interested in whether other contractors used the same concrete, used similar building materials, etc. Yet, ingrained assumptions about medical information have led courts to block the disclosure of comparative practice styles. An important administrative law case involving the FOIA powerfully provides a quite recent example of this resistance.¹⁵⁸ A consumer organization, Consumers' Checkbook, attempted to use the FOIA to obtain information concerning Medicare claims—specifically, diagnoses and type and place of service that certain physicians made or provided in 2004.¹⁵⁹

If this information regarding Medicare claims involved any other government contract or purchase, release of this information would likely be automatic. The Department of Health and Human Services (“HHS”), however, refused to release the data under Exemption 6 of the FOIA,¹⁶⁰ which states that its disclosure requirement “does not apply to matters that [involve] . . . personnel and medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.”¹⁶¹ Courts have read this exception to apply to information, such as Medicare reimbursements, which would “in some cases allow for an inference to be drawn about the financial situation of an individual.”¹⁶² Here, HHS feared that the data could be used to allow people to guess at individual physicians' salaries and it concluded that this privacy violation outweighed disclosure's public benefit.¹⁶³

Consumers' Checkbook won in the district court; HHS appealed.¹⁶⁴ Not surprisingly, the AMA, assuming the role of enemy of medical consumerism, intervened to support HHS's refusal to disclose.¹⁶⁵ The court of appeals, in a divided panel decision, reversed the district court and upheld HHS's original decision, concluding that there was a “substantial privacy interest in the total payments [doctors] receive from Medicare” but a “non-existent

158. Consumers' Checkbook, Ctr. for the Study of Servs. v. U.S. Dep't of Health & Human Servs., 554 F.3d 1046 (D.C. Cir. 2009).

159. *Id.* at 1048–49.

160. *See id.* at 1049.

161. § 552(b)(6).

162. Multi Ag Media LLC v. Dep't of Agric., 515 F.3d 1224, 1230 (D.C. Cir. 2008).

163. *See* Brief for Federal Appellant at 12–13, *Consumers' Checkbook*, 554 F.3d 1046 (No. 07-5343).

164. *See Consumers' Checkbook*, 554 F.3d at 1049–50.

165. *See id.* at 1049–50, 1060.

public interest” in revealing the data.¹⁶⁶

This bizarre conclusion reflects an indifference to medical consumerism and, indeed, an ignorance about the role of information in assuring functional markets. As Judge Judith Rogers wrote in dissent, “[T]here is a commanding and important public interest in disclosure of the data the Center seeks.”¹⁶⁷ Indeed, the court arrived at its conclusion through flawed logic—and a flatly erroneous understanding of FOIA precedent—that seemed designed to undercut the notion of patients as consumers.

The court’s analysis began with a narrow reading of the FOIA’s purpose as a mandate for disclosure that “contribut[es] significantly to public understanding of the operations or activities of the government.”¹⁶⁸ Under this reasoning, it examined certain, quite specifically defined HHS statutory missions, such as “promoting the effective, efficient, and economical delivery of health care services, and . . . promoting the quality of services of the type for which payment may be made,”¹⁶⁹ as well as the statutory purpose of the Centers for Medicare and Medicaid Services (“CMS”), the subdivision of HHS that collects the sought-after information.¹⁷⁰ CMS also has responsibilities to promote quality, enroll health care providers in the Medicare program, and ensure providers’ eligibility.¹⁷¹

As the dissent pointed out, the court’s entire approach—finding specific “statutory duties” and examining whether disclosure would further them—is rather beside the point.¹⁷² The FOIA’s purpose is to shed light on the operations or activities of government, and spending money is certainly one of those activities.¹⁷³ “Because Medicare ‘distributes extensive amounts of public funds,’ there is a ‘special need’ for public oversight of HHS’s activities in administering Medicare.”¹⁷⁴ What could be more basic to its core mission than how it reimburses doctors?¹⁷⁵

166. *Id.* at 1051, 1056.

167. *Id.* at 1059 (Rogers, J., concurring in part and dissenting in part).

168. *Id.* at 1051 (majority opinion) (emphasis omitted) (quoting U.S. Dep’t of Def. v. Fed. Labor Relations Auth., 510 U.S. 487, 495 (1994)).

169. *Id.* at 1051–52 (quoting 42 U.S.C. § 1395y(g) (2006)).

170. *See id.* at 1049, 1052.

171. *See id.* at 1052–53.

172. *See id.* at 1059, 1061 (Rogers, J., concurring in part and dissenting in part).

173. *See id.* at 1059.

174. *Id.* (quoting *Multi Ag Media LLC v. Dep’t of Agric.*, 515 F.3d 1224, 1232 (D.C. Cir. 2008)).

175. The majority’s narrow definition of statutory purposes, moreover, is incorrect under controlling precedent interpreting “public interest” under Exemption 6 of the FOIA. The court used the following test: “The only relevant public interest in disclosure is the extent to which disclosure would service the core purpose of the FOIA, which is contribut[ing] significantly to public understanding of the operations or activities of the government.” *Id.* at 1051

Even under its incorrectly narrowed definition of public interest, which required a connection between specific statutory purposes and disclosure, the court's reasoning was contradictory and flawed. First, Citizens' Checkbook argued that the release would further HHS's performance of its mission to promote quality health care for Medicare beneficiaries—specifically, that “the requested data [would] indicate the quality of care Medicare patients are receiving.”¹⁷⁶ The court stated, however, that the “medical community has not reached a consensus on whether the number of procedures performed by a physician correlates to the quality of those procedures.”¹⁷⁷

This court is simply wrong; there is a consensus. Indeed, the article on which the court relied for the assertion that the profession lacks consensus in fact builds on that consensus, which a cursory reading would have revealed.¹⁷⁸ The article, *Is Volume Related to Outcome in Health Care? A Systematic Review and Methodologic Critique of the Literature*, states (as the court quotes) that “[t]wenty years of research have established that, for some procedures and conditions, higher volume among hospitals and physicians is associated with better outcomes. However, the magnitude of the

(majority opinion) (emphasis omitted) (quoting U.S. Dep't of Def. v. Fed. Labor Relations Auth., 510 U.S. 487, 495 (1994)) (internal quotation marks omitted). This is uncontroversial.

However, the court continued, “The requested information must ‘shed[] light on an agency's performance of its statutory duties.’” *Id.* (quoting U.S. Dep't of Justice v. Reporters Comm. for Freedom of the Press, 489 U.S. 749, 773 (1989)). This further qualification has no support in precedent. The Supreme Court first applied this language to Exemption 6, which is less protective of privacy than is Exemption 7. *See* Hunt v. FBI, 972 F.2d 286, 288 (9th Cir. 1992) (“Where law-enforcement records are sought (Exemption 7(C)), the threatened invasion of privacy need not be as likely as where personnel, medical, or similar files are at issue (Exemption 6).”).

This language that the *Consumers' Checkbook* court used was part of a very different test. The test that the Supreme Court adopted requires disclosure if the information is related to the agency's statutory duties, but that requirement is only a subset of the greater disclosure requirement: the “citizens' right to be informed about what their government is up to.” *Fed. Labor Relations Auth.*, 510 U.S. at 495 (quoting *Reporters Comm. for Freedom of the Press*, 489 U.S. at 773) (internal quotation marks omitted); *see also* *Bibles v. Or. Natural Desert Ass'n*, 519 U.S. 355, 355–56 (1997) (“That is inconsistent with our opinion in *Department of Defense v. FLRA* . . . which said that the *only* relevant public interest in the FOIA balancing analysis is the extent to which disclosure of the information sought would she[d] light on an agency's performance of its statutory duties or otherwise let citizens know what their government is up to.” (citation omitted) (quoting *Fed. Labor Relations Auth.*, 510 U.S. at 497) (internal quotation marks omitted)). Through selective quotation, the D.C. Circuit changed this test and *only* looked at whether disclosure is related to an agency's statutory duties.

176. *Consumers' Checkbook*, 554 F.3d at 1052.

177. *Id.*

178. *Id.*

relationship varies greatly among individual procedures and conditions.¹⁷⁹ The article goes on to state, in a section the court did not quote, that “[w]e found that 71% of all studies of hospital volume and 69% of studies of physician volume reported a statistically significant association between higher volume and better health outcomes. No study documented a statistically significant association between higher volume and worse outcomes.”¹⁸⁰

As a throw-away point, the court stated that “[e]ven assuming a strong correlation between volume and quality, the data CSS requests will not indicate total volume because it does not include procedures performed by physicians for non-Medicare patients.”¹⁸¹ The court seemed to make the contradictory claim that Medicare volume is so informative that disclosure would allow patients to guess at doctors’ salaries—and therefore commit an impermissible privacy violation—yet is insufficiently informative as to allow consumers to draw conclusions about the appropriateness of a physician’s prescribing or treatment practices.

V. THE EMERGENCE OF THE MODERN MEDICAL CONTRACT

Some might argue that mandating warranties constitutes an unwarranted interference in the market. Medical services have developed without warranties and likely reflect certain efficiencies that regulatory meddling could upset, or so the argument goes. The problem with that argument is that casual examination of the history of the medical contract reveals the workings of the political economy, not the free-market economy.

Throughout history, contracts for medical services have differed from contracts for other services. In the Middle Ages, doctors, like lawyers, did not have a legal right to fees for their services.¹⁸² The law classified payments to professionals, such as doctors or lawyers, as gifts, and these professionals had no action at law to compel payment.¹⁸³ Presumably, only services that satisfied the consumer prompted a “gift,” and therefore, unhappy results did not require payment. Resultant damages were not part of the equation. Amusingly, the medieval notion of conditional payment is consistent with this Article’s position that physicians should only receive payment if they are successful. During the past three to four centuries, however, physicians and other professionals gained a

179. Ethan A. Halm et al., *Is Volume Related to Outcome in Health Care? A Systematic Review and Methodologic Critique of the Literature*, 137 ANNALS INTERNAL MED. 511, 517 (2002).

180. *Id.* at 514.

181. *Consumers’ Checkbook*, 554 F.3d at 1052–53.

182. See Catherine Crawford, *Patients’ Rights and the Law of Contract in Eighteenth-Century England*, 13 SOC. HIST. MED. 381, 392–95 (2000).

183. JOHN ORDRONAU, *THE JURISPRUDENCE OF MEDICINE IN ITS RELATIONS TO THE LAW OF CONTRACTS, TORTS, AND EVIDENCE* 34–35 (The Lawbook Exchange, Ltd. 2007) (1869).

legally enforceable right to their fees.¹⁸⁴ This shift raised the question of what should happen when a physician *fails* to bring about a cure. Malpractice's standard of care emerged as the judicial rule for determining whether the law would provide a remedy for such a medical failure.¹⁸⁵

Blackstone categorized *mala practice* not under contract or mercantile (business) law, but as a special class of personal wrongs, like trespass or assault.¹⁸⁶ Blackstone so classified malpractice because "it breaks the trust which the party placed in his physician."¹⁸⁷ Under this legal conception, the physician did not guarantee results. Instead, the medical relationship only required "ordinary diligence, care, and skill," *but that standard of care was read into every contract and could not be waived*. American courts arrived at this standard by the 1830s, at which time a proliferation of suits occurred along with the rise of the modern concept of negligence for all torts.¹⁸⁸ Indeed, the "standard of care," which looks to what the average practitioner within a given geographic area would have done, has largely remained unchanged over the last two centuries.

The current malpractice standard of care did not descend from Blackstone in a direct, unquestioning line. Rather, during the early and mid-1800s, some courts looked to contract law as the remedy for failed medical treatment.¹⁸⁹ These courts reasoned that the medical contract was like any other business contract.¹⁹⁰ Doctors only had to provide that standard of care for which they had bargained in the contract. An often-litigated aspect of this shift to contract was whether courts should accept contractual waivers of liability to bar malpractice litigation—or requirements that patients post bonds in

184. See Crawford, *supra* note 182, at 392–95.

185. See JAMES C. MOHR, DOCTORS AND THE LAW: MEDICAL JURISPRUDENCE IN NINETEENTH-CENTURY AMERICA 112–14 (1993); James C. Mohr, *American Medical Malpractice Litigation in Historical Perspective*, 283 JAMA 1731, 1732–33 (2000).

186. KENNETH ALLEN DE VILLE, MEDICAL MALPRACTICE IN NINETEENTH-CENTURY AMERICA: ORIGINS AND LEGACY 6 (1990).

187. *Id.* (quoting 3 WILLIAM BLACKSTONE, COMMENTARIES ON THE LAWS OF ENGLAND 122 (1768)) (internal quotation marks omitted).

188. See *id.* at 5–7; James C. Mohr, *The Emergence of Medical Malpractice in America*, 14 TRANSACTIONS & STUD. C. PHYSICIANS PHILA. 1, 10–14 (1992).

189. See, e.g., *Bowman v. Woods*, 1 Greene 441 (Iowa 1848); *Leighton v. Sargent*, 31 N.H. 119 (1853) (holding a surgeon liable but applying a contract-type analysis); see also Theodore Silver, *One Hundred Years of Harmful Error: The Historical Jurisprudence of Medical Malpractice*, 1992 WIS. L. REV. 1193, 1198 n.20 (noting that many courts referred to the physician's obligation as "aris[ing] from a contract 'implied by law'"). Commentators like Professor Silver call this contract language a "legal fiction." See, e.g., *id.* Yet as Professor Kenneth De Ville argues, it reasonably reflects the laissez-faire, democratic attitudes of the early nineteenth century. DE VILLE, *supra* note 186, at 171.

190. See *Bowman*, 1 Greene 441; *Leighton*, 31 N.H. 119.

the case of a malpractice suit.¹⁹¹

Whether to treat the medical contract as governed simply by the agreement between the parties or by a special duty of care emerged as a hotly contested issue in the 1850s, not only within the law but also in the public sphere.¹⁹² Given the explosion of medical malpractice suits in the prior decades, doctors debated, both in medical journals and the general press, the wisdom of malpractice and contractual waivers.¹⁹³ Consistently throughout this debate, physicians—especially prominent physicians and those involved in organized medicine—resisted the contract model of liability.¹⁹⁴ Leading physicians publicly criticized the contract model and called for the older standard of care. For instance, Worthington Hooker, the vice president of the AMA in 1864 and professor of medicine at Yale University, wrote, “The relation[ship] of a physician to his employers is not shut up within the narrow limits of mere pecuniary considerations [and it should not be] subjected to the changes incident to the common relations of trade and commerce among men.”¹⁹⁵ Valentine Mott, a leading surgeon, and John Ordranax, a physician, lawyer, and author of the leading treatise on law and medicine, expressed similar views, as did a Massachusetts medical society committee on malpractice.¹⁹⁶

Why did doctors defend higher standards of liability, despite the rapid increase of malpractice suits in the 1850s and 1860s and physicians’ harsh denunciation of this litigation? Doctors and their professional organizations complained loudly in their own publications and in the broader public discussion about the rising tide of litigation. In refrains remarkably similar to those of today, doctors decried the high costs that malpractice suits impose and ominously warned of the depletion of the physician supply that

191. See DE VILLE, *supra* note 186, at 177–79.

192. See Mohr, *supra* note 185, at 1733–36.

193. See *id.* at 1733, 1736 (“Mid-century medical journals were full of letters and articles from obviously stunned, sometimes bitter, and frequently irate physicians who regard the spread of malpractice litigation as a quasi-revolutionary assault. . . . American physicians, however, did not want to be classified with boilermakers and other nonprofessional occupations. . . they maintained that the patient-physician relationship could never be a contract between equals . . .”).

194. DE VILLE, *supra* note 186, at 166 (“Doctors generally resisted the notion of contractual relationships with patients because it conflicted with the image of the physician as a public servant with a distinct social status.”); see also *Case of Mal-practice*, BOS. MED. & SURGICAL J., Mar. 13, 1856, at 109, 112 (“[T]o make a written contract with the patient before proceeding to take charge of him. . . . [i]t may be objected that, in the first course, such refusals would be considered *inhuman*; and in the second, it is *undignified* for a well-qualified profession to resort to such expedients.”).

195. DE VILLE, *supra* note 186, at 181 (quoting WORTHINGTON HOOKER, PHYSICIAN AND PATIENT 410 (Arno Press & The N.Y. Times 1972) (1849)) (internal quotation marks omitted).

196. *Id.* at 181–82.

malpractice would induce.¹⁹⁷ Yet, despite their bitter antagonism toward malpractice, doctors resisted lower standards of legal liability.

Recognizing the parlous state of the medical profession can explain this seeming puzzle. By the mid-1800s, most state governments had adopted a true laissez-faire attitude toward licensing, a policy that emerged from fundamental shifts in American democracy. During earlier colonial times, physicians were generally highly educated individuals from the upper classes, and strict licensure laws adopted from England limited those who could practice.¹⁹⁸ The Jacksonian period, as part of a democratization of all the professions, marked the abolition of most licensure requirements adopted from Europe.¹⁹⁹ In the early and mid-nineteenth century, therefore, an enormous number of medical schools sprang up, often “diploma mill”-type operations.²⁰⁰

In addition, many individuals became practitioners of what we would likely term “alternative medicines,” like the Thomsonians, who advocated the therapeutic importance of steam infused with herbs; the reformed Thomsonians, who held slightly different beliefs; homeopaths; botanic healers; as well as “Broussaisian, Sangradorian, and Morrisonian” healers.²⁰¹ These practitioners opposed licensure requirements, creating tension between the “regular” physicians and the “nonregular” followers of these “alternative” practices.²⁰² Perhaps most importantly, additional competition from the nonregulars severely depressed fees, and doctors’ income and prestige fell during this period.²⁰³

As a reaction, “regular physicians” attempted to establish themselves as the science-based authority—those deserving of special legal protections and privileges as distinct from these various “alternative” approaches. They formed medical societies, published journals, worked for higher standards in practice and education—and toward elimination and isolation of alternative

197. See Mohr, *supra* note 185, at 1736. Contrary to conventional wisdom, medical malpractice crises are not only the children of present times. See Richard A. Epstein, *Market and Regulatory Approaches to Medical Malpractice: The Virginia Obstetrical No-Fault Statute*, 74 VA. L. REV. 1451 (1988).

198. See JAMES C. MOHR, *ABORTION IN AMERICA: THE ORIGINS AND EVOLUTION OF NATIONAL POLICY, 1800–1900*, at 32 (1978) (recounting the typical characteristics of physicians).

199. DE VILLE, *supra* note 186, at 171. Often the licensure laws were not repealed in their entirety. Instead, only the penalty clauses were eliminated. See Ronald Hamowy, *The Early Development of Medical Licensing Laws in the United States, 1875–1900*, 3 J. LIBERTARIAN STUD. 73, 104 n.2 (1979).

200. MOHR, *supra* note 198, at 33.

201. HENRY BURNELL SHAFER, *THE AMERICAN MEDICAL PROFESSION 1783 TO 1850*, at 201–02 (1936).

202. WILLIAM G. ROTHSTEIN, *AMERICAN PHYSICIANS IN THE NINETEENTH CENTURY: FROM SECTS TO SCIENCE* 145 (1972).

203. MOHR, *supra* note 198, at 34.

therapies.²⁰⁴ For instance, the Massachusetts Medical Society, in its official publication, *The Boston Medical and Surgical Journal* (which was eventually renamed *The New England Journal of Medicine*), regularly decried nonregulars as quacks and called for their isolation.²⁰⁵

Regular physicians founded the AMA in 1847.²⁰⁶ They used their group to push for regulation of economic competition and delegitimization of homeopaths and users of patent medicines, like the Thomsonians.²⁰⁷ The AMA efforts to stigmatize and isolate nonregular physicians seems remarkable. For instance, the AMA refused to admit African-American physicians because they belonged to the “National Medical Society of the District of Columbia,” a group that included nonregulars.²⁰⁸ The regular physicians eventually successfully lobbied state legislatures to renew and strengthen licensure requirements.²⁰⁹ While these boards had joint membership of regular physicians and the various other types of medical practitioners, regular physicians, through a strengthened AMA, began to set educational standards that largely eliminated nonregular medicine.²¹⁰

Throughout the late nineteenth and early twentieth centuries, the regular physicians had bigger fish to fry than establishing favorable liability standards. They had to establish themselves as the sole providers, the sole source of legitimate medical knowledge.²¹¹ If greater tort liability were part of the logic of their

204. *Id.* at 33–34.

205. *Connection of Druggists with Quack Medicines*, BOS. MED. & SURGICAL J., May 30, 1854, at 340, 342 (“If [quackery’s] continued presence from the dark ages had not rendered it familiar, if habit had not blunted our sense of its depravity, if it could now be presented in all its deformity before a civilized community for the first time, it would be regarded with wonder at its audacity, with execration at its reckless tampering with the best temporal interests of humanity.”); *Medical Education*, BOS. MED. & SURGICAL J., Apr. 29, 1858, at 264, 265 (“[O]nly by offering to the public a body of well-instructed physicians that we can successfully oppose the thousand forms of empiricism with which the community is deluged.”); *The Economy of Medical Association*, BOS. MED. & SURGICAL J., Feb. 12, 1851, at 2, 30–34 (critiquing allopathy).

206. See ROTHSTEIN, *supra* note 202, at 198; *Our History*, AM. MED. ASS’N, <http://www.ama-assn.org/ama/pub/about-ama/our-history.shtml> (last visited Jan. 28, 2011).

207. ROTHSTEIN, *supra* note 202, at 200.

208. Morris Fishbein, *History of the American Medical Association*, in A HISTORY OF THE AMERICAN MEDICAL ASSOCIATION 1847 TO 1947, at 19, 80–81 (Morris Fishbein ed., 1947).

209. MOHR, *supra* note 198, at 34; ROTHSTEIN, *supra* note 202, at 310.

210. RICHARD HARRISON SHRYOCK, *MEDICAL LICENSING IN AMERICA, 1650–1965*, at 60–76 (1967).

211. Indeed, this episode really does seem to illustrate Michel Foucault’s theory that medical authority is, in fact, created through a social process of legitimizing certain politically powerful interests’ claims to knowledge. See MICHEL FOUCAULT, *THE BIRTH OF THE CLINIC: AN ARCHAEOLOGY OF MEDICAL PERCEPTION* 245–46 (A.M. Sheridan trans., Routledge Classics 2003) (1963).

special professional calling, then they called for greater tort liability.

Supporting this theory, many of the fiercest physician opponents of the contract model played a significant role in early organized medicine, furthering regular medicine both politically and institutionally. For instance, Valentine Mott, quoted above, who was president of the New York University Medical College and was known as the “Father of Vascular Surgery,” urged the founding of the New York Academy of Medicine.²¹² This group’s “primary purpose was the separation of regular from irregular physicians.”²¹³ Another early force in the AMA, Worthington Hooker, who, as mentioned above served as its vice president, wrote *Physician and Patient*, which decries the Thomsonians as quacks.²¹⁴ The Massachusetts Medical Society (“Society”), the oldest “regular” physician society in the country, in an official report stated that “[i]t cannot be conducive to the interests of the patient that his relation with his physician should be reduced to a mere business transaction, to be judged as a contract, to which the employer strictly holds the employed.”²¹⁵ The Society took steps in the 1850s to expel nonregulars and, as discussed above, issued a report condemning the use of contracts to govern liability between patient and doctor.²¹⁶

This Article does not claim that these physicians used the standard of care as part of any conscious “secret agenda.” Rather, special standards of liability logically followed from their vision of medicine as an occupation with distinct ethical responsibilities and unique qualifications—standards that should receive special legal protections. As they would argue, the law could not allow anyone without training or certification to practice medicine, so those who practiced medicine could not be held to the mere contractual standards of performance that bound other businesses.

Medical malpractice liability can be viewed as a “deal” in the political economy: physicians received the benefits of licensure or a “guild monopoly” in exchange for adopting a higher standard of care.²¹⁷ The recent trends to limit medical malpractice liability

This is particularly true because the treatments of both the “regular doctors” and the quacks were equally ineffective, with the latter’s treatment option often preferable at least from a patient’s perspective. For instance, the “standard” treatment for gall stones was ingestion of mercury-based purgatives. The Thomsonians recommended breathing rosemary-infused steam. See ROTHSTEIN, *supra* note 202, at 132–35, for a discussion of Samuel Thomson’s herbal approach to medicine and rejection of the use of poisons such as mercury in the treatment of illness.

212. JOSEPH F. KETT, *THE FORMATION OF THE AMERICAN MEDICAL PROFESSION: THE ROLE OF INSTITUTIONS 1780–1860*, at 168–69 (1968).

213. *Id.* at 169.

214. HOOKER, *supra* note 195, at 103–19.

215. DE VILLE, *supra* note 186, at 181.

216. *See id.*

217. It has been argued, for instance, that the AMA, through such vehicles as the Flexner Report and control of medical school admissions, worked to limit

through caps on noneconomic damages or through other procedural barriers renege on that contract.²¹⁸ At the very least, consumers should receive in relaxed licensure laws what they have lost in less generous liability standards.

This historical analysis suggests that medicine's standard-of-care-liability rule emerged from intrusive judicial regulation and physicians' professional self-interest working in the political economy. It is far from clear that this liability standard best serves the economic and informational nature of the medical contract.

CONCLUSION: MARKETS, HEALTH CARE, AND CONSUMERS

The "health care crisis" and all its subsidiary crises—the "medical malpractice crisis," "the exploding health care cost crisis," and "the uninsured crisis"—exist within the greater problem of medical ineffectiveness, which, in turn, results from the failure of powerful quality signals to emerge in medical contracts. If law required mandated warranties, they might emerge as effective quality signals. This in turn would lead to patients making cost-effective decisions about their health care, which in turn would control costs—and possibly eliminate the need for medical malpractice.

Rather than strengthen consumers' power, the new health care legislation empowers bureaucracy to make decisions on consumers' behalf. The Health Care Act creates bureaucratic entities, such as the Patient-Centered Outcomes Research Institute and the Centers for Medicare & Medicaid Services Innovation, to determine what constitutes effective health care and to build incentives into reimbursement schemes. In a strange mirror, the procontract commentators want to give more power to providers, MCOs, and health-insurance companies.²¹⁹ Both solutions disregard the role of

physician supply. See Reuben A. Kessel, *The A.M.A. and the Supply of Physicians*, 35 *LAW & CONTEMP. PROBS.* 267, 267 (1970).

218. David Hyman, *Caps Table*, *THE VOLOKH CONSPIRACY* (Nov. 21, 2010), http://volokh.com/files/davidh-Caps_Table.jpg (displaying a chart listing state caps on medical malpractice); see also MICHELLE M. MELLO, *MEDICAL MALPRACTICE: IMPACT OF THE CRISIS AND EFFECT OF STATE TORT REFORMS* (2006) (discussing, in part, statutory caps).

219. See, e.g., Reinker & Rosenberg, *supra* note 67, at 275–76 ("[If insurers could recover all malpractice liability they] might change the type and burden of proof for establishing malpractice. Because the insurers would presumably seek to employ ever more reliable assessments of malpractice claims, they could come to rely more heavily on refined professional criteria and correspondingly rigorous scientific methodology and evidence—such as . . . sophisticated statistical and epidemiological studies—than is standard practice in the current system of lay adjudication. This reliance on professional criteria and scientific evidence and the desire for greater accuracy in malpractice determinations could also motivate further reforms, such as use of expert decision makers in place of lay jurors and judges to resolve claims. For example, insurers could convene panels of qualified physicians and other experts to arbitrate or

patients in making choices.

The question that this Article cannot completely answer is whether effective warranties would emerge if health care providers were only required to provide what this Article advocates as “flexible” or “variable” warranties. It is conceivable that, due to market power or other reasons, providers would only offer the bare minimum of warranties. This might counsel for making the right of recovery assignable under any warranty to a MCO or insurance company or, perhaps, to some third-party-claim aggregator. Or, it may suggest that warranties would not work, and that physicians would only offer the barest of guarantees even to large purchasers of health care.

Before one concludes that reading this Article was a waste of time, it is instructive to examine those areas in which warranties have emerged and are fairly widespread: refractive eye surgery and fertility treatments.²²⁰ These are procedures for which insurance and other third-party payers generally do not reimburse and for which there are clear metrics for success. While not all of areas of medicine enjoy such clarity, many do. Consider the warranty offered by an ophthalmologist in Colorado Springs: it involved a specific metric (“Dr. Buckley guarantees qualified candidates that they will be able to read the 20/20 line, or better, on the vision chart”) and varied according to the patient (“Of course Dr. Buckley can’t offer a money back guarantee to you personally until he knows your vision objectives and confirms that your eye health and present vision characteristics are likely to allow you to achieve 20/20”).²²¹ Fertility treatments have similar restrictions, only offering warranties to individuals with certain fertility characteristics (age, egg quality, etc.) and providing a clear success metric (a baby).²²² This evidence strongly suggests that a system of mandatory, but flexible, medical warranties will be most successful in those areas of medicine that have clear metrics and identifiable patient risks. It also points to the emergence of warranties in other areas of medicine as providers have the incentive to discover clear metrics and relevant patient risks, particularly in medical markets in which lawmakers permit access to information about provider quality and competence.

adjudicate questions of liability and sanctions for medical malpractice.”).

220. See *supra* notes 61–63 and accompanying text.

221. See *20/20 Guaranteed LASIK*, *supra* note 61.

222. See *supra* notes 62–63 and accompanying text.