

ON DOCTORS AND JUDGES

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In convening the Conference on Measuring Judges and Justice and assembling this impressive Symposium, Dean David Levi and Professor Mitu Gulati urged the participating judges, political scientists, and law professors to “live in fragments no longer.”¹ Within that same spirit of cross-fertilization—aiming to forge dialogue across disciplines and seeking lessons from unfamiliar professions—I introduce in this Response some lessons from studying the medical profession. Relying on economics and sociology more than political science,² I suggest that there is much to learn about judges from thinking about doctors.

A superficial comparison between doctors and judges suggests that their social roles have much in common. Both wear austere frocks of uniform color. Both publicly commit to solemn oaths before beginning service. Both are addressed by their professional titles to convey respect, even outside their workplace. Both are atop a strict hierarchy, in which their words receive the highest deference and their relationships with others are characterized by authority and control.

For Nobel Prize-winning economist Kenneth Arrow, these social symbols were—for doctors—more than mere ornaments. In a seminal 1963 article that gave birth to the field of health economics, Professor Arrow suggests that the social roles enjoyed by doctors, and the institutions and norms that characterize the doctor’s position of authority and deference, arise to solve economic problems inherent in

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1. David F. Levi & Mitu Gulati, Introduction, “*Only Connect*”: *Toward a Unified Measurement Project*, 58 DUKE L.J. 1181, 1181 (2009) (quoting E.M. FORSTER, HOWARD’S END 214 (Alfred A. Knopf 1943) (1921)).

2. My own foray into the political science literature on judges includes Mario Bergara, Barak Richman & Pablo T. Spiller, *Modeling Supreme Court Strategic Decision Making: The Congressional Constraint*, 28 LEGIS. STUD. Q. 247, 247–48 (2003).

the delivery of healthcare.³ Healthcare services are “nonmarketable” because, among other reasons, they introduce uncertainty and unobservability, and thus a physician’s services cannot be evaluated and priced by a market of laypeople.⁴ Consequently, Arrow writes, nonmarket social institutions arise to improve upon the failure of the marketplace.⁵ Unlike most businesspeople, physicians are expected to prescribe advice and treatment that are divorced from their pecuniary interests, they are not expected to compete with other physicians on price or through advertising, and they are relied upon as experts. These nonmarket institutions convince patients they can seek care that they otherwise would distrust or, at the risk of harming others, underconsume. The financing and purchase of beneficial healthcare could not take place without mutually held and widely shared expectations that physicians are acting with utmost expertise and out of motivations purely designed to enhance the welfare of their patients. These expectations, Arrow writes, “are greatly assisted by having clear and prominent signals” and special relations that come from “various forms of ethical behavior.”⁶

At the postscript of Professor Arrow’s article, he notes that “[t]he medical profession is only one example” in which market mechanisms fail to insure against uncertainty and that “[a]ll professions share some of the same properties.”⁷ Perhaps he had judges, and the courtroom, in mind. Similar nonmarket institutions and norms characterize the social relationships judges have with laypeople, and these institutions arguably arise to overcome similar problems of uncertainty. The social institutions and symbols that surround the judicial role—such as the robe, gavel, honorific title, and even the power to hold parties in contempt—sustain the authority that judges require to dispense the law. Individuals follow the law not just because of the threat of sanctions but also because of a strongly-felt social norm, a deep reverence for the law, and a widespread belief in the prudence and integrity of the presiding judge. Indeed, without such social norms, it would be difficult to employ enough policemen to force compliance with the law or enough bailiffs to bring order in

3. See Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 947, 949–51 (1963).

4. See *id.* at 947, 951.

5. *Id.* at 947.

6. *Id.* at 965–66.

7. *Id.* at 967.

the courtroom. The severity of a judge's decrees might even be compared to the severity of a doctor's instructions. Failure to adhere to either is associated not just with risking personal welfare but also with exhibiting questionable judgment.

Another similarity between doctors and judges—one that is highlighted by Professor Jack Knight's excellent contribution to this Symposium—is that both are members of esteemed and insular communities.⁸ Knight refers to the importance of a judge's professional community when he writes that the legitimacy of a judicial decision depends on whether the decision's reasoning rests on “a reason that is included in that set of reasons about which there is a social consensus in the legal community.”⁹ Thus, judicial legitimacy is dependent on some notion of a professional community.

Professor Knight's selection of “community” is very deliberate—he invokes it eleven times in his article and never uses a substitute word. Relying on the word has certain costs: it is necessarily vague; as other commentators at this Symposium have suggested, it means something different to each judge (some judges seek legitimacy from fellow members of the bench, others from members of the academy, and many from ideological organizations such as the Federalist Society or the American Constitution Society); and it points to an ineffable motivation or sensibility that is hard to verify or quantify. As a careful social scientist himself, and particularly as one who (as he does in this paper) encourages more meaningful empirical research, Knight might be expected to rely on terms that more easily succumb to measurement.

Nonetheless, it is precisely the correct word to use. Professor Knight's invocation of “community” intersects with another intellectual tradition that examines the nature of the professions. Professor William Goode, a former president of the American Sociological Association (a position that is, for sociologists, the lawyer's equivalent of Chief Justice of the United States), wrote a foundational 1957 article, *Community within a Community: The Professions*.¹⁰ Goode observed that “a goal of each aspiring

8. Jack Knight, *Are Empiricists Asking the Right Questions About Judicial Decision-making?*, 58 DUKE L.J. 1531, 1550 (2009).

9. *Id.* at 1553.

10. William J. Goode, *Community Within a Community: The Professions*, 22 AM. SOC. REV. 194 (1957).

occupation is the ‘community of profession’¹¹ that exhibits the following features:

- (1) Its members are bound by a sense of identity. (2) Once in it, few leave, so that it is a terminal or continuing status for the most part. (3) Its members share values in common. (4) Its role definitions *vis-à-vis* both members and non-members are agreed upon and are the same for all members. (5) Within the areas of communal action there is a common language, which is understood only partially by outsiders. (6) The Community has power over its members. (7) Its limits are reasonably clear, though they are not physical and geographical, but social. (8) Though it does not produce the next generation biologically, it does so socially though its control over the selection of professional trainees, and though its training processes it sends these recruits through an adult socialization process.¹²

By exacting such demands from its members, and by imposing such demanding entry requirements on potential members, these professions are able to occupy a privileged status in society, enjoying more prestige and autonomy than other occupations. They also enjoy recognition by the “containing community” as having elite education and socially valuable expertise. This expertise enables a quid-pro-quo, where the larger society bestows upon the professional community a vaunted status, consults with them on matters of significant policy, defers to their judgment, and delegates to them significant regulatory authority. In turn, the professional community pledges to share the fruits of their expertise with the rest of society and administer its power responsibly.

Although Professor Goode writes generally about all professions and did not write with medical professionals exclusively in mind (he refers to physicians only in passing illustrations), his description of the community of professionals—its members’ motivations, its professional organization, its structural relationship with government and society, the content and meaning of professional duties and loyalties—have particular application to the medical profession. Professor Goode’s article is excerpted at length in the important Havighurst, Blumstein and Brennan casebook, *Health Care Law and Policy*,¹³ and other sociologists have similarly remarked on the

11. *Id.* at 194.

12. *Id.* (footnote omitted).

13. CLARK C. HAVIGHURST, JAMES F. BLUMSTEIN & TROYEN A. BRENNAN, *HEALTH CARE LAW AND POLICY* 288–93 (2d ed. 1998).

importance of professionalism in shaping the delivery of healthcare and health policy. Professor Paul Starr, for example, attributes the rise of medical authority to the social origins of professional sovereignty,¹⁴ and Jeffrey Berlant observes that the foothills of the first Code of Ethics for the American Medical Association (AMA) was motivated by writers who believed that “the Enlightenment and rationality were available only to elites paternalistically bound to assuming the burden of protecting the public [and thus] the only conceivable authority in medical matters was the practicing medical profession.”¹⁵ This vaunted position of responsibility and authority strikes a desirable chord for many current physicians, including Arnold Relman, a former editor of the *New England Journal of Medicine*, who includes in “The Role of the Medical Profession” the chore of making medical decisions and carefully allocating healthcare resources for all of society.¹⁶ The tradition of professionalism has also been an important force in shaping the field of health law, with “the professional paradigm” shaping the way lawyers, courts, and legal scholars look for coherence and integrity to the law’s many interactions with healthcare providers and institutions.¹⁷

Professionalism’s impact on the delivery of healthcare has been met with decidedly mixed reviews. To be sure, there is much to admire from doctors’ commitment to professionalism. We appreciate the connotation of professionalism with public duty, and the medical profession deserves admiration for both a general commitment to healing and a particular commitment to providing medical services to patients regardless of their ability to pay. In addition, the profession’s code of ethics directs a fidelity to a patient’s welfare, and this commitment guides unknowledgeable laypeople through the complicated health system to receive valuable and often life-saving care. And professionalism also drives a devotion to science and discovery. Despite the enormous monetary rewards that the healthcare financing system brings to innovations and services in short supply, it is hard to discount the innovators’ underlying motivation to heal the currently incurable and to advance the

14. See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 5–6 (1982).

15. JEFFREY LIONEL BERLANT, *PROFESSION AND MONOPOLY* 93 (1975).

16. See Arnold S. Relman, *The New Medical-Industrial Complex*, 303 *NEW ENG. J. MED.* 963, 967 (1980).

17. See Clark C. Havighurst, *The Professional Paradigm of Medical Care: Obstacle to Decentralization*, 30 *JURIMETRICS J.* 415, 419–29 (1990).

frontiers of medical knowhow. These benefits might explain the containing community's eagerness to support and advance professional norms and protect professional autonomy. It perhaps also is a reflection of what has been described as a collective nostalgia for "a simple world of doctors know best."¹⁸

However, as scholars of health law perhaps know as well as anyone else, medical professionalism also has imposed many significant social costs. The dominance of professionalism has motivated the AMA and other industry interests to preserve physician autonomy at all costs.¹⁹ Even as physicians claim to resolutely commit themselves to an ethical concern for patients' interests, they continue to undermine efforts to restrain healthcare costs or focus on consumer needs.²⁰ They are disdainful of efforts by third-party payors—whom physicians often decry as micromanagers of clinical decisions and intrusive, meddling bureaucrats—to enforce the limits of insurance contracts, including efforts to stem the costs of experimental, unproven, or unnecessary but shockingly expensive healthcare services.²¹ Physician groups and credentialing societies also mobilize to prevent less expensive healthcare providers from encroaching on their occupational territory, enabling them to continue extracting economic rents from premium payers.²²

18. Einer R. Elhauge, *Can Health Law Become a Coherent Field of Law?*, 41 WAKE FOREST L. REV. 365, 375 (2006).

19. See STARR, *supra* note 14, at 300 ("In short, the AMA insisted that all health insurance plans accept the private physicians' monopoly control of the medical market and complete authority over all aspects of medical institutions."); David Blumenthal, Commentary, *The Vital Role of Professionalism in Health Care Reform*, HEALTH AFF., Spring (I) 1994, at 252, 252 ("In most national health care debates, [professionalism] has been raised principally by opponents of reform—often organized medicine—and has been used for the explicit purpose of obstructing progress and protecting the self-interested prerogatives of the medical profession. Whatever the reform proposal, it is decryed as a threat to medical professionalism and implicitly, therefore, a threat to the quality of care and the satisfaction of patients.").

20. See Robert A. Berenson, Commentary, *Do Physicians Recognize Their Own Best Interests?*, HEALTH AFF., Spring (II) 1994, at 185, 187 ("The profession has proved incapable of disciplining itself to hold down costs or respond to consumer preferences.").

21. See *id.* at 185–86; see also HAVIGURST ET AL., *supra* note 13, at 1349–52 (documenting Blue Cross/Blue Shield's history of expanding insurance coverage and promoting the economic interests of providers and hospitals).

22. See, e.g., *Kreuzer v. Am. Acad. of Periodontology*, 735 F.2d 1479, 1484 (D.C. Cir. 1984) (questioning a medical society's exclusion of a physician, who managed a multi-service practice, from referral directory); *Greisman v. Newcomb Hosp.*, 192 A.2d 817, 824–25 (N.J. 1963) (rejecting a hospital medical staff's efforts to deny staff privileges to an osteopath); STARR, *supra* note 14, at 87 (quoting an early physician guide warning doctors to "be on guard against jealous midwives [and] ignorant doctor-women" (internal quotation marks omitted)).

Consequently, professionalism has directly contributed to the nation's escalating healthcare costs, which currently are at over 17 percent of our GDP and are as responsible as anything else for precipitating the current economic crisis.²³

Professionalism's dedication to autonomy also has impeded valuable healthcare innovation and reform. Innovative policy reforms that aim to redesign the delivery of care (many with proven track records), such as integrated healthcare or enterprise liability, are met with resistance from physicians because they require a reorientation of or departure from the doctor's traditional role.²⁴ The profession also flexes its opposition through explicit political activity, with the AMA's history of aggressively interfering with policy efforts to correct the nation's health disparities or mitigate its budget shortfalls. Sometimes the profession's interference was patently illegal; it has an unpleasant history of orchestrating illegal boycotts to punish early versions of HMOs and other innovative managed care plans.²⁵ This history is supplemented by a much longer list of antitrust battles, in which physicians organized under professional umbrellas to avoid price competition, prevent advertising and quality competition, punish innovators or nonconformists, and deny patients the opportunity to seek alternatives to traditional delivery mechanisms of

23. Healthcare spending in 2009 is projected at 17.6 percent of GDP, the largest in history and—at one full percentage point larger than 2008—the biggest increase in history. It is expected to increase annually by 6.2 percent, 2.1 percentage points faster than average annual growth in GDP. Andrea Sisko et al., *Health Spending Projections Through 2018: Recession Effects Add Uncertainty to the Outlook*, HEALTH AFF., Feb. 24, 2009, at w346, w346–47, w356. Rising healthcare costs (the average cost to insure a family of four is approaching \$13,000 a year) is squeezing working class incomes, precipitating bankruptcies, causing home foreclosures, triggering layoffs, and spreading the ranks of the uninsured. See HENRY J. KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2008 ANNUAL SURVEY 1 ex.A (2008), available at <http://ehbs.kff.org/pdf/7790.pdf> (reporting the average cost of family coverage as \$12,680 for 2008); ROBERT W. SEIFERT, ACCESS PROJECT, HOME SICK: HOW MEDICAL DEBT UNDERMINES HOUSING SECURITY 1 (2005), available at http://www.accessproject.org/adobe/home_sick.pdf (detailing the effect of medical debt on low- and middle-income families); Christopher Tarver Robertson et al., *Get Sick, Get Out: The Medical Causes of Home Mortgage Foreclosures*, 18 HEALTH MATRIX 65, 66 (2008); David U. Himmelstein et al., *Illness and Injury as Contributors to Bankruptcy*, HEALTH AFF., Feb. 2, 2005, at w5-63, w5-66 to -68 (presenting a study detailing the medical causes of bankruptcy). Many employers fear that health spending may eventually overtake profits. See *Will Health Benefit Costs Eclipse Profits?*, MCKINSEY Q. CHART FOCUS (McKinsey & Co., New York, N.Y.), Sept. 2004, http://www.mckinseyquarterly.com/newsletters/chartfocus/2004_09.htm.

24. Alain Enthoven, *Curing Fragmentation with Integrated Delivery Systems* 9–19 (Aug. 2, 2008) (unpublished manuscript, on file with the *Duke Law Journal*).

25. See, e.g., *Am. Med. Ass'n v. United States*, 130 F.2d 233, 244 (D.C. Cir. 1942), *aff'd*, 317 U.S. 519 (1943).

care.²⁶ Professionalism pits healthcare providers directly at odds with the aims of competition and stated antitrust policy.

And, most relevant to the focus of this Symposium, the tradition of professionalism has contributed to widespread antagonism to measures of quality. It is commonplace that medical errors are both pervasive and costly in our healthcare system, but errors are often depersonalized as either latent errors beyond human control or intrinsic or endemic error that cannot be avoided. Marianne Paget, a sociologist whose life was shortened by medical error, observed that:

Physicians do not talk freely about errors in their work. They are commonly reticent or silent about them. When they do talk, they frequently prefer technical terms, terms that mask their experience of error. . . . Too, the idea of endemic error radically undermines their claim to expertise. Rather, it throws the claim of expertise under new light. Physicians are “expert” in a work that proceeds by trial and error.²⁷

Perhaps this is a professionally-motivated fear of appearing unprofessional. Professor Arrow would offer a sympathetic, yet perhaps sardonic, explanation for such fears: since the perception of expertise—regardless of the underlying reality—supports the required trust for physician advice and instructions, the mere doubt of expertise could destabilize a foundation for the delivery of healthcare.

This would explain why outsiders—whether plaintiff attorneys or health economists—who aim to discover and understand the costs of medical errors are viewed by physicians with extreme skepticism and often hostility. It is safe to generalize that doctors have genuine contempt for the tort system, and they express regular anger that judges and juries cannot understand the difficulties, demands, and constraints of practicing medicine.²⁸ They also are resistant to research that examines the doctor-patient relationship with social scientific methods, whether seeking systemic causes for misdiagnosis or inconsistent treatments, because such measurements (they claim)

26. See, e.g., *United States v. Or. State Med. Soc’y*, 343 U.S. 326, 328–30 (1952).

27. MARIANNE A. PAGET, *A COMPLEX SORROW: REFLECTIONS ON CANCER AND AN ABBREVIATED LIFE* 15 (Marjorie L. DeVault ed., 1993) (emphasis omitted).

28. See, e.g., PETER D. JACOBSON, *STRANGERS IN THE NIGHT: LAW AND MEDICINE IN THE MANAGED CARE ERA* 25–26 (2002) (“Physicians resent being sued and having their clinical practices and motivations impugned by laypersons.”); see also, e.g., George J. Annas, *Doctors and Lawyers and Wolves*, 29 *JURIMETRICS J.* 437, 437 (1989) (lamenting the fact that “[r]elations between lawyers and physicians . . . are getting more and more destructive and counterproductive”).

cannot possibly capture the complexity and nuance of the physician's responsibilities.²⁹ And they oppose intelligent efforts to construct clinical guidelines that might codify standards of care. Such proposals are derided as advancing "cookbook medicine," threatening physician practice autonomy and professional discretion, even though they are sensible attempts to bring accountability for medical errors.³⁰

One consequence of such hostility is that these inquiries into the healthcare system are not met with the seriousness that they deserve. Reforms to the tort system are badly needed, but physician groups prefer to impose damage caps rather than to seek institutional improvements that can uncover and deter errors. And non-medical disciplines offer tools that can help remedy some of medicine's most critical shortcomings. The social sciences can, for example, measure cognitive biases and heuristics that might unconsciously influence physician decisionmaking, examine self-dealing and expose the costs of fee-for-service medicine, and develop organizational efficiencies that can help reorganize healthcare to contain expenses while carefully monitoring quality. The industry would benefit enormously from these inquiries by outsiders, and many of those benefits would accrue to the professionals themselves.

The question invited by this Symposium is whether any of these lessons can be fruitfully applied to judges and the judicial process. As a preliminary matter, there are strong currents of professionalism in the judiciary. This is vividly captured by Professor Jack Knight's focus on how consensus within a legal community bestows legitimacy to judicial acts. It is also highlighted by Dean Levi and Professor Gulati's observation that "there is probably no topic of greater importance and interest to judges in the United States than judicial independence,"³¹ just as physicians have expressed the same devotion to their own professional autonomy. Many of the motivations, identities, and values connected to Professor Goode's description of professional communities readily apply to the community of judges.

29. See, e.g., JACOBSON, *supra* note 28, at 154 ("Since [the rise of managed care], physicians have complained about . . . being second-guessed by non-physician managed care administrators" even though "[m]ost research has concluded that managed care's quality is roughly equivalent (i.e., there are no significant differences in most areas) to quality of care in the fee-for-service system.").

30. David A. Hyman & Charles Silver, *The Poor State of Health Care Quality in the U.S.*, 90 CORNELL L. REV. 893, 952–53 (2005) (internal quotation marks omitted).

31. Levi & Gulati, *supra* note 1, at 1187.

Additionally, like doctors, judges and legal academics often exhibit disregard for, and often hostility toward, outsiders who employ non-legal analytical methods to assess judicial quality, understand judicial reasoning, or predict judicial outcomes. Objections include charges that social scientists rely on imprecise measurements, excessively narrow (though I prefer the term “parsimonious”) theoretical constructs, and a general unfamiliarity with the judicial process. All of these are legitimate objections to the current literature, and symposia such as this one can lead to significant improvements in the empirical study of judges. But these objections also assume a tone of territorialism, that social scientific methods have nothing to add to—and have no place in—the discussion of judicial quality. There is something about this scholarship that seems to threaten judicial authority, something threatening about the invocation of insights from those outside the judicial and traditional legal community.³² These reactions very much resemble physician hostility to efforts by nonphysicians to reform medicine.

Does this inhospitality to social scientific critiques have consequences similar to the costly failure to critically examine and reform the American healthcare system? Professor Kenneth Arrow might offer a cynical justification—that we need to maintain perceptions of judicial authority, objectivity, and perhaps infallibility to maintain social order and sustain compliance with and reverence for the law. One might call this the Emperor-Has-No-Clothes defense. We must not look behind the curtain, for once we realize that judges are as ideological, cognitively biased, and expedient as other human beings, we will begin to question the social norms that serve as irreplaceable societal foundations.

A more modest normative conclusion—and the only one I offer here—is that conferences such as the one that spawned this

32. The Gulati, Choi, and Posner article that ranks judges is perhaps a paradigmatic example of a quality assessment by outsiders that has traditionally provoked hostility from the professional community. See Stephen J. Choi, Mitu Gulati & Eric A. Posner, *Judicial Evaluations and Information Forcing: Ranking State High Courts and Their Judges*, 58 DUKE L.J. 1313, 1317 (2009). Professor Goode writes,

Of course, professions are accustomed to ratings. . . . Professional life is so fundamentally based on achievement, that such judgments of rank are made constantly. . . . However, such data are not generally available to the public, and are not widely known, even when not secret. The professional community will not rank its members for the larger society; and the latter cannot do so.

Goode, *supra* note 10, at 198.

Symposium, in which social scientists and judges are encouraged to bring their respective and different toolkits to engage constructively with each other, offer unique opportunities to address these issues. One issue that I hope is addressed in these and future cross-occupational gatherings—and an issue that I think is ripe for interdisciplinary examination—is the powerful strain of professionalism in the judicial community. Does appreciating judicial professionalism bring clarity and transparency to the judicial process, or does it obfuscate the lucidity of the law? Does it humanize what judges do, or does it expose an underbelly of judicial decisionmaking? Does it justify judicial outcomes, or does it immunize judges from appropriate scrutiny and accountability? I submit that these are important questions, that interdisciplinary and interprofessional exchanges such as these are in unique and valuable positions to address those questions, and that—respectfully—the social scientist can, as an outsider, generate significant insights into the judicial process that academic and professional insiders cannot.