THE PROFESSIONAL PARADIGM
OF MEDICAL CARE:
OBSTACLE TO DECENTRALIZATION

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ABSTRACT

This article examines the tension between the medical profession’s control of medical decisionmaking and the decentralization strategy of placing control of costs and decisions in consumers’ hands. The author argues that society cannot fight the battle for efficiency in medical care because the professional paradigm limits the ability of consumers to influence physicians’ practices. He explains the paradigm as the medical profession’s belief that medical care is not a consumer good but is scientifically determined, and thus medical decisions are entrusted exclusively to physicians. The author analyzes the operation of the professional paradigm in the following areas: accreditation, hospital organization, payment for medical care, malpractice law, and practice guidelines. The author maintains that decentralization is achievable in each of these areas and would be beneficial to society.

I. INTRODUCTION

A. The Decentralization Strategy

Current health policy reflects the hope that decentralizing decision making about health care—putting more control in the hands of consumers and their agents—will favorably affect the performance of the health care sector.1 The

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assumption behind this strategy is that physicians have heretofore exercised too much control, collectively and individually, over the spending of society's resources on health services and were not motivated to economize even when it was responsible to do so. The new policy reflects a belief that empowering parties with an interest in keeping costs under control will put appropriate brakes on the spending proclivities of physicians.

Although this more market-oriented health policy has never been affirmatively embodied in a clear-cut legislative program, it emerged *de facto* in the late 1970s and was manifested in several actions taken during the Reagan administration, the effect of which was to place the responsibility for controlling health care costs more directly on those entities that were directly paying the bills. For example, in the early 1980s, the Medicare program assumed a more aggressive stance as a purchaser of hospital services by adopting the Prospective Payment System. At the same time, states were given new responsibilities for managing the costs of their Medicaid programs. Private health care costs were, for the first time, viewed as a predominantly private responsibility and not as a problem that government should undertake to solve through regulation or a program of national health insurance. Antitrust enforcement during this period began to stress the benefits of independent, rather than collective, action and checked attempts by the medical profession to dictate the ways in which physicians' services could be bought and sold.

The new policy had important and immediate consequences. During the 1980s, as cost problems intensified and as various legal and professional restraints on the actions of third parties were removed, health maintenance organizations (HMOs) increased their market share, and new kinds of managed-care and preferred-provider plans materialized. The Medicare program itself offered beneficiaries a chance to join HMOs and other competitive medical plans that provided their own cost-containment measures, distinct from those of Medicare. Following the federal government's various leads, employers began to offer workers a choice of health plans, and payers that had previously been passive collectors and disbursers of funds began to act as "prudent purchasers." These various middlemen asserted the consumer's interest in controlling costs and began to challenge two of the medical profession's major tenets—the necessity for "free choice of physician" and the sanctity of the "physician/patient relationship." Real competition and bargaining began to appear for the first time at the interface between providers and private health plans.

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2The watershed year was probably 1979, when Congress rejected the Carter administration's proposal to regulate revenue growth in the nation's hospitals and added language favorable to competition in health care to the federal health planning legislation. Although this latter legislation was finally repealed in 1986, the 1979 amendments signified Congress's new receptivity to a more market-oriented health policy. See C. Havighurst, *Deregulating the Health Care Industry* 129-56 (1982).
Because the new players active in the health care marketplace—employers, insurers, and organized health plans of various kinds—were accountable to consumers in various ways, they could reasonably be expected to balance the marginal benefits of health care against their marginal costs, as physicians treating insured patients had seldom done. The revolution in health care financing in the 1980s was thus expected to achieve a better allocation of societal resources than did the prerevolutionary situation, which left doctors and patients free to spend funds supplied by third parties without appreciable restraint, thus facilitating overinvestment in services of marginal and even negligible value. With decentralization, it was believed that new opportunities would arise for consumers to dictate how their money would be spent and for their agents to induce the changes in physician behavior that were needed to achieve more appropriate spending.

B. Dissatisfaction with the Strategy

Although the decentralization strategy was widely understood as a way to control costs, it never promised that health care would be cheap, only that prices would be closer to actual costs and that some wasteful spending would be controlled. Many observers have professed disappointment that, despite the many improvements in the market for health services that occurred in the 1980s, cost increases still continue year after year at rates difficult for government and private payers to absorb. Not all of the implied criticism of the more market-oriented health policy of the 1980s is justified, however. In fact, some public and private payers did enjoy a few years of moderate relief (particularly in hospitalization costs), only to be faced with rising costs again thereafter. One hypothesis is that efficiency did indeed improve but that these were one-time gains, which, once realized, could not prevent costs from taking off again.

Although the rapid increase of health care costs accounts for the perception that costs are still out of control, rising costs alone are not evidence of inefficient or inappropriate spending. Many reasons exist for why the nation might spend increasing amounts of its wealth on health services. For example, health care is “income-elastic”—meaning that individuals and nations spend greater percentages of their incomes on health care as those incomes increase. In addition, medical technology is yielding remarkable new modalities, many of which are clearly worth their high cost. Furthermore, the aging of the population and the AIDS and drug epidemics have added greatly to the demand for medical services. One cannot readily dismiss the argument that health care is

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See, e.g., Anderson & Erickson, National Medical Care Spending, Health Affs. Fall 1987, at 96.

simply a "growth industry"—like cellular telephones—in which there is good reason for society to invest more each passing year.

The conventional belief that the nation is spending too much on mainstream medical care is in fact extremely difficult to confirm with direct evidence. Although some inefficient spending undoubtedly results from foolish tax subsidies that encourage the purchase of excessive private health insurance, the private sector may well be spending its after-tax dollars optimally. Even the extensive anecdotal evidence of inefficient spending on unnecessary services is not conclusive, because some inefficiency of that kind—some wasteful spending—is an inevitable cost of having third-party financial protection (public or private), which all agree is desirable and necessary in some measure. Although some of that inefficiency could certainly be eliminated by tighter administrative controls, the various costs of those controls might add up to more than the savings they would achieve. When all is said and done, little solid empirical basis exists for our conviction that the various cost-containment tools that became available during the 1980s are not being used to control costs to the optimal extent.

It would be difficult, however, to persuade payers and the health policy establishment that the market now supplies adequate tools for cost containment and is working just as it is supposed to do. Not only do the government and employers face continual crises in coming up with the funds necessary to meet new needs, but there are more fundamental problems as well. For one thing, many signs of "adverse selection" exist, reflecting competition's tendency to divert private payers' attention to avoiding bad insurance risks and away from pursuing efficiency in the delivery of care. In addition, there is another aspect of the plight of government, employers, and other payers to which attention must be called—namely, the feeling that they have no real choice about whether or not to pay the increasing costs. Instead, they feel obliged to buy nearly everything that the health care industry produces—from specific services that a physician prescribes to whole new technologies that the medical profession embraces.

This involuntariness of most health care spending, more than anything else, distinguishes rising investments in health care from healthy economic growth. There is simply no basis for assuming—as we do for other commodities like cellular telephones—that those who are buying the new goods and services are deriving at least a commensurate benefit from their outlays that justify the increased social investment. In health care, we sense that a lot of spending

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5Like the tax subsidies for home ownership, the exclusion of health insurance premiums from taxable income induces more spending on the subsidized activity than would otherwise occur.
7The problem of "adverse selection," although viewed by some as the Achilles heel of a market-oriented approach to health care, is not necessarily unmanageable. See A. Enthoven, THEORY AND PRACTICE OF MANAGED COMPETITION IN HEALTH CARE FINANCE 75-118 (1988).
yields only minor or nonexistent benefits and that our institutions are inadequate for comparing those benefits to costs. This paper explores some reasons why this perception continues even after a decade of experience with the decentralization strategy.

II. THE PROFESSIONAL PARADIGM OF MEDICAL CARE AS A CONSTRAINT ON ECONOMIZING

The thesis of this article is that, despite all the organizational and financial changes that occurred in the health care sector in the 1980s, we still cannot fight the battle for efficiency effectively because we are saddled as a society with a particular paradigmatic conception of the medical care enterprise. The source of this paradigm is a deep-seated belief, long fostered by the medical profession, that medical care is not a commodity, that its characteristics are scientifically determined, and that decisions concerning it must be entrusted exclusively to professionals. That this paradigm is ideologically attractive and contains some significant kernels of truth simply complicates the problem of adapting it to accord with current economic realities.

The professional paradigm of the medical enterprise is a venerable one, stemming from the days early in this century when the medical profession rose to what sociologist Paul Starr has called a position of "cultural authority, economic power, and political influence." Although its tenets are nowhere officially set down, some of them can be deduced from the profession's performance during the era when it exercised rather complete hegemony over health care and its financing. Judging from that experience, the profession's ideology has included the following themes:

- medical care should be evaluated only on the basis of safety and efficacy;
- cost considerations should not enter into medical decision making because counting costs implies both a willingness to trade off a patient's welfare against other societal needs and a tolerance for differences based on ability to pay;
- decisions on the appropriate utilization of medical services should be based exclusively on scientific evidence and expert opinion;
- although patient preferences should be honored under the principle of informed consent, there is no similar urgency about giving people opportunities to express their preferences qua consumers, with cost differences in view; and
- professional norms alone should set the limits of a physician's judgment. Under these general principles, the role of payers was long limited to ensuring that professional norms were followed, so that only care that was virtually useless or positively harmful was excluded. Under the professional paradigm, any

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payer or other consumer agent who entered the noman’s land of trade-offs between quality and cost ran grave legal and business risks.

The professional paradigm derives much of its force from the egalitarian ideal in medicine—the belief that every citizen is entitled to medical care of the same quality and that “two-tier” medicine is unthinkable. Even though society has not seen fit to adopt an egalitarian policy by accepting either the heavy tax burden or the stringent rationing necessary to achieve it, the egalitarian ideal colors much thinking about medical care. Indeed, even in the absence of any actual legal or contractual entitlement, a powerful entitlement mentality must be confronted by anyone seeking to economize in the provision of health services. The professional paradigm generally supports this view of things, while the profession as a whole resists most of the measures that would be necessary to create an affordable, truly egalitarian system. There is here a marriage of convenience—between physicians’ desires to resist infringements on their clinical freedom and a particularly extreme view of the requirements of social justice.

The scientific character of medicine has also provided vital support for the professional paradigm. Indeed, the success of the medical profession in establishing its scientific character in the early part of the century—in the Flexner Report, for example—laid the groundwork for its claim of exemption from market forces and for its autonomy as a profession. Once medical care was viewed as the application of science to human problems rather than as a commercial service to be bought and sold in market transactions, the profession was able to resist most of the pressures that naturally arose and to head off, by effective lobbying or collective action, market developments that might have threatened its hegemony. Only after the government assumed much of the cost of medical care—in programs that were themselves designed in accordance with the tenets of the professional paradigm—did professional autonomy begin to come under public pressure.

As the rising costs of Medicare and Medicaid and rising doctors’ incomes coincided with anti-elitist trends in the society as a whole in the late 1960s and early 1970s, government began to threaten incursions on physicians’ economic and clinical freedom. Like the Medicare program itself, however, the mechanisms chosen in the 1970s for reviewing physicians’ treatment decisions were largely designed in accordance with the professional paradigm, conferring upon profession-dominated entities the power to define professional norms, criteria, and standards for the purpose of defining the specific limits of government’s obligation to pay for medical care.10 Ironically, the most serious challenge to the medical profession’s hegemony during this transitional period

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10See generally Havighurst & Blumstein, Coping with Quality/Cost Trade-offs in Medical Care: The Role of Professional Standards Review Organizations, 70 Nw. U.L. Rev. 6 (1975).
came not from liberals supporting government regulation but from the antitrust laws, which embodied free-market principles and barred collective action of the kind that the profession was accustomed to use against those who were tempted to depart from its precepts. These various developments led to the policy changes described earlier and thus to the awakening of the health care marketplace in the 1980s.

The revolution in the health care marketplace that was projected in the decentralization strategy is still not complete, however, because consumers and their agents are not yet truly free to purchase only those services that they regard as worthwhile, given other priorities. Much of the difficulty in fully realizing the benefits of the decentralization strategy is attributable to some still unchallenged aspects of the professional paradigm of medical care. Residues of the professional paradigm can be found in many places but are particularly significant in the legal system. Not only does the law tend to defer to the medical profession's presumed scientific authority on many points, but it is often administered with an egalitarian mentality that tends to define issues in terms of abstract rights. Indeed, the law frequently goes to great lengths to avoid appearing to concede that some persons might ever have a legal or even a contractual right to better medical care than someone else. This refusal to recognize the reality that some consumers might choose, or wish to choose, to purchase more or better health care than others—or have a lesser entitlement because of inability or unwillingness to pay—greatly complicates efforts to economize in the private sector. It also raises, perhaps inappropriately, the cost to government of providing for those who cannot support themselves. As long as the legal system does not acknowledge inequality or recognize efforts to escape the costly standards implicit in the professional/scientific/egalitarian paradigm, neither self-supporting consumers nor taxpayers are in a good position to economize on health care by refusing to buy too much of a good thing.

III. SOME MANIFESTATIONS OF THE PARADIGM

The remainder of this article reviews some of the areas in which the professional/scientific/egalitarian paradigm of medical care still operates, preventing realization of the full benefits of the decentralization strategy in health policy. Because the appropriateness of health care spending is always a technical question in part, a strong tendency exists throughout the industry to defer to the collective judgment of the medical profession on such matters. Reliance on professional norms and standards is also reinforced by the egalitarian belief in only one standard of care. Finally, professional organizations still control certain strategic points from which, entrenched behind the professional paradigm, they are fighting an effective rear-guard action against unwanted change.

The paradigm's influence renders it difficult for anyone to consider health care, in any context, as a consumer good that competing providers may design, produce, and package to appeal to consumers in different ways, some of which
may not fully coincide with the precepts of the medical profession.\textsuperscript{[1]} Anticipating that the legal system will embrace professional norms and standards and view skeptically any different standards established in private contracts, the private sector stops well short of employing all the tools that it might use to alter physician behavior in the interest of responsible cost containment. In addition, both the legal system and the general public still treat certain dominant professional organizations as having quasi-governmental regulatory power, instead of regarding them merely as private groups providing authoritative, but possibly biased, advice on important issues.

A. Accrediting and Credentialing

The professional paradigm still prevails strongly in educational and institutional accreditation in health care fields and in the private credentialing of health care personnel. Because accrediting and credentialing are typically monopolized by a single professional organization or carried out jointly by the dominant organizations interested in the particular field, the public is generally provided with only one authoritative opinion on each issue that arises. Medical specialists, for example, are certified by specialty boards that work closely with each other through the American Board of Medical Specialties to subdivide fields so that only one authoritative voice is heard on any subject. The public is thus dependent upon one professional organization for standards and their application in each submarket of the health care industry. Alternative views about what constitutes quality, how it should be measured, or what should be deemed adequate are either not heard at all or are effectively placed beyond the pale.\textsuperscript{[2]}

This monopoly of information and opinion about various quality-of-care and other issues in the health care industry is a clear reflection of the professional paradigm, which holds that fundamental decisions about health care should be made by the organized medical profession. Because the health care industry is highly complex and features many conflicting interests and perspectives, it has been no small challenge for the profession to preserve its control of the standard-setting function, and many outbreaks of independent initiative have occurred. But, on the whole, the profession continues to set standards for a great deal of the industry, enabling it to discourage developments that depart from the paradigm. Although medicine and health care are certainly more pluralistic than they once were, the control of information exercised by organized medicine is a holdover of the old paradigm and should be a source of continuing concern.

\textsuperscript{[1]}In addition to being a consumer good that may vary in accordance with purchasers' tastes and pocketbooks, health care is also a so-called 'merit good' that the public wishes not to see rationed solely on the basis of ability to pay.

My own antitrust analysis of these activities would treat competition in the production of information and opinion on commercial subjects as something to be protected under the antitrust laws. Thus, agreements to suppress public disagreements and resolve them behind closed doors rather than in the economic marketplace—which, after all, should also be a marketplace of ideas—would be subject to antitrust scrutiny. An entity such as the Joint Commission on Accreditation of Healthcare Organizations ("Joint Commission") could thus be challenged as a conspiracy by several powerful industry groups to speak with one voice on the question of hospital organization and quality—matters on which the groups represented on the Joint Commission do not have identical ideas. Because consumers are denied the opportunity to hear and choose among these differing views—that is, are denied the benefits of competition—I think the antitrust law should be invoked. Although antitrust law has successfully challenged many other bulwarks of the professional paradigm, it has yet to challenge the profession’s monopoly over information and thus over the setting of standards that govern many crucial aspects of the health care industry. Let me underscore, however, that I would strongly defend the right of professional organizations to advocate their views in a decentralized marketplace of ideas. All I object to is combinations that unduly suppress competition in that marketplace.

B. Hospital Organization

Another place where the professional paradigm is alive and well is in hospitals. This circumstance is directly attributable to the Joint Commission’s maintenance of unchallenged accreditation standards that prescribe the nature of the medical staff and its position in the institutional hierarchy and that require hospitals to confer substantial job security on all physicians. The requirement that the medical staff be self-governing and charged with certain of the hospital’s responsibilities is not written in the stars, nor is it generally statutory. It appears instead only in the Joint Commission’s Accreditation Manual. Although the law does sometimes prohibit hospitals from engaging in “the corporate practice of medicine”—thus embodying the professional paradigm—hospitals could usually assume much more direct responsibility for quality and cost than has been customary. Under the professional paradigm, however,

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13 Id. at 295–328. Although theoretically persuasive, this analysis has not yet been adopted (or refuted) by anyone that matters.

14 Indeed, Part One of Havighurst & King, supra note 12, at 150–201, includes just such a defense of private accrediting and credentialing.


physicians collectively control or strongly influence most aspects of the hospital in which they have a substantial economic or professional interest.\textsuperscript{17}

Courts faced with antitrust challenges to a hospital’s attempt to deny admitting privileges to a physician or other practitioner have revealed themselves to be in the grip of the professional paradigm. First, they have been highly deferential to the medical staff’s determinations, thus conceding that competing professionals have broad collective responsibilities for the quality of care and the operation of hospitals. Second, they seem to assume that every hospital decision on whether to retain a physician is necessarily a decision by the hospital’s physicians—the plaintiff’s competitors.\textsuperscript{18} Rarely does it cross the mind of any judge—or, for that matter, of any lawyer arguing the case on either side—that a hospital might decide such issues itself, consulting its medical staff but acting independently on the basis of its own interests. In my view, if the documents in a staff privileges case truly show that the hospital board acted independently, and not as a rubber stamp for its doctors, summary judgment should be granted. Under those facts, there would be no antitrust issue at all, because the discretion of buyers and sellers (here, hospitals and doctors) to decide whether or not to deal with each other is the essential force that drives competition and should not be subject to any review whatsoever in an antitrust court.\textsuperscript{19}

Unfortunately, the courts’ general assumption that hospitals are really operated by and for physicians is a self-fulfilling prophesy, perpetuating the professional paradigm. Recent federal legislation designed to provide a safe harbor for peer review in hospitals and elsewhere is even more confirmatory of the physicians’ view that they alone should be collectively in charge of setting and applying standards to practitioners.\textsuperscript{20}

C. Paying for Medical Care

The professional/scientific/egalitarian paradigm of medical care has long conferred a great strategic advantage on physicians in any dispute in which they are on the side of providing more and better services. Indeed, the paradigm is the ultimate reason why each payer is generally expected to pay for every service that a physician prescribes unless it can show affirmatively that the service could not contribute to better health. This presumptive obligation is embodied

\textsuperscript{18}For example, in Weiss v. York Hosp., 745 F.2d 786, 791 (3d Cir. 1984), the court stated at the outset that the defendant hospital was “controlled by” allopathic physicians even though the evidence it recited made it seem that the hospital was in fact governed by its governing board.
\textsuperscript{19}See generally Havighurst, Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships, 1984 Duke L.J. 1071.
in nearly all public and private plans for financing health care, in terms that commit the plan to pay for all care that is "medically necessary" or the equivalent. Such a formulation of the payer's obligation necessarily incorporates professional norms, so that the payer can resist underwriting a procedure or other service only by showing that the physician was irresponsible, by professional standards, in ordering it. The professional paradigm dictates this burden of proof on the theory that, unlike the payer, both the physician and the profession itself, whose norms impliedly define the patient's entitlement, are motivated solely by concern for the patient's total welfare. Moreover, under the paradigm, the medical profession is deemed to be the best judge of medical necessity, so that payers may be under pressure to have disputes resolved by the physician's true-believing peers.

The reasons insurers and other financing programs have traditionally defined their obligations by reference to professional norms are complex. One explanation, however, is the general acceptance of the professional tenets (1) that the appropriateness of medical care is ultimately a scientific, professional question and (2) that everyone is entitled to enjoy the same, professionally defined standard of care. These same tenets are commonly reflected in law and judicial thinking. Thus, payers are essentially locked into underwriting all care meeting professional standards. Any contract that promises less is suspected of being an unfair bargain, and courts that are asked to enforce private health insurance contracts tend to construe them narrowly against the drafter, to honor physician discretion within profession-defined limits, and to award punitive damages against any insurer that insists too hard on its own reading. Although courts are right to scrutinize contracts to provide substandard care, they should recognize that it is not necessarily irrational to purchase a less expensive product. The force of the professional/scientific/egalitarian paradigm is such, however, that most lawyers would counsel that contracts that depart from professional standards would be very difficult to enforce. Courts or legislatures rarely acknowledge that quality/cost tradeoffs exist in medical care and are proper matters for private as opposed to public or professional choice.

A great deal of tension exists these days between the old paradigm of medicine and new cost-containment measures being undertaken by employers and insurers. Indeed, many physicians believe that payers now have the upper hand.

\[^{21}\text{See generally Annotation, What Services, Equipment, or Supplies Are "Medically Necessary" for Purposes of Coverage Under Medical Insurance, 75 A.L.R. 4th 763 (1989).}\]

\[^{22}\text{See Havighurst, supra note 20, at 1148-50, 1158-60.}\]

\[^{23}\text{For the argument that incorporating professional standards by reference may sometimes be efficient, see Havighurst, Altering the Applicable Standard of Care, Law & Contemp. Probs., Spring 1986, at 265, 266-69 (citing Epstein, Medical Malpractice, Imperfect Information, and the Contractual Foundation for Medical Services, Law & Contemp. Probs., Spring 1986, at 201). But efficiency does not explain universal reliance on professional norms.}\]

\[^{24}\text{See Kalb, Controlling Health Care Costs by Controlling Technology: A Private Contractual Approach, 99 Yale L.J. 1109, 1117 (1990); Annotation, supra note 21.}\]
and are often arbitrary in denying claims. These perceptions are colored, of course, by the paradigm, according to which physicians believe they should hardly be accountable to payers at all. Nevertheless, some payers and managed-care programs are apparently able to harass physicians in the knowledge that few of their challenges over minor expenditures can be contested in fact. To the extent that this is occurring in the actual administration of health plans, the paradigm, with its reverence for physician judgment, is breaking down. Nevertheless, because the legal system still adheres to the paradigm’s basic tenets, explicit, open departures from professional norms remain difficult or impossible—even as those same norms are being increasingly ignored in day-to-day practice.

Thus, with all the changes that have occurred in the health care marketplace, payers are still in a position to challenge openly only apparent abuses by physicians. As long as payers remain practically precluded from setting their own standards, consumers will find it difficult to purchase anything different from what the profession would collectively prescribe. The survival of the professional paradigm thus explains why—with only the notable exception of closed-panel HMOs—there is still essentially only one brand of medicine available in the market for medical care.26

D. Practice Guidelines

The current movement to develop practice guidelines for medical care provides an interesting and important test for the survivability of the professional paradigm.27 The dominant view of practice guidelines is that they should be produced by professional societies, using scientific findings and expert opinion where science falls short. Most observers contemplate that normally only one set of guidelines will cover a particular area of medical practice. Thus, the assumption continues to be that society should turn to organized medicine for determinations of how, and how much of, its money should be spent on medical

25Although payers would contend that they are simply applying professional standards, not departing from them, the payers may be using their power to withhold payment arbitrarily in order to intimidate physicians, hoping that the physicians will modify their prescriptions accordingly. In fact, the payers are relying on their bargaining power and on the high costs that physicians face in challenging their judgments to assert an interest in cost containment that the paradigm was long able to suppress.

26And closed-panel HMOs are exceptional only because their departures from professional norms are implicit rather than explicit. To the extent that HMOs must fear lawsuits concerning the care given, they are bound by professional norms, to which the courts refer in establishing the legal standard of care. See Havighurst, supra note 23. But see Bovbjerg, The Medical Malpractice Standard of Care: HMOs and Customary Practice, 1975 Duke L.J. 1375 (arguing that the legal standard may shift to accommodate the differing professional norms in different practice environments).

services. The AMA currently stresses that guidelines should be only “parameters” or upper and lower limits within which clinical freedom should prevail.28

The guidelines movement is a direct response to recent findings that the actual practices of physicians vary widely without reason29 and often lack solid scientific support.30 While these findings might have been viewed as a telling indictment of the professional paradigm itself, the paradigm’s strength is such that most observers interpret them only as a reason for sending professional bodies in search of better professional norms and standards. Others have pursued an agenda of getting additional interests into the room with physicians in the hope that their participation will generate more cost-conscious guidelines.31 These latter observers include the drafters of the federal guidelines-development legislation now being implemented. But their object appears to be only to influence the definition of the “one right way”—not to put an end to the dominant idea that centrally developed norms and standards should govern all medical care.

The practice guidelines concept should be implemented in such a way as to depart fundamentally from the professional paradigm.32 This could be done by encouraging guideline development by researchers and groups not accountable to organized medicine and by encouraging the development of competing guidelines, so that would-be users could pick the ones most suitable for their circumstances. Ideally, guidelines would be amenable to incorporation into contracts for the provision of health services. Because such guidelines would be developed under processes ensuring their objectivity, they would have a legitimacy that other departures from professional standards generally lack. Therefore, the guidelines movement offers an opportunity finally to realize the promise of the decentralization strategy. But, in order for the movement to accomplish that objective, it will have to overcome a deep-seated tradition that the medical profession sets the standards for the industry’s products and that people cannot be expected, or allowed, to choose for themselves.

E. Medical Malpractice

It is a striking irony that the law of medical malpractice, which physicians understandably have come to hate, is founded on the professional paradigm of

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28 See Meyer, Medicine Debates Parameters (or Are They Guidelines?), AM. MED. NEWS, Dec. 15, 1989, at 36.
29 Chassin, Variations in the Use of Medical and Surgical Services by the Medicare Population, 314 NEW ENG. J. MED. 285 (1986); Wennberg, Dealing with Medical Practice Variations: A Proposal for Action, HEALTH AFFS., Summer 1984, at 6.
30 E.g., Eddy, Clinical Policies and the Quality of Clinical Practice, 307 NEW ENG. J. MED. 343 (1982).
31 Under the recent legislation, guidelines are to be developed under the auspices of panels including representatives of consumers as well as physicians. 42 U.S.C. §§ 299b-2(a)(2),(c).
medical care. Thus, the standards that malpractice courts employ in regulating medical practice (the term regulating is used advisedly) are drawn, ostensibly at least, from "customary medical practice," a professional standard. Even though the methods of proving professional negligence have changed somewhat over the years and national standards have replaced local ones, the law’s standards are still supposed to be professional ones, derived from actual medical practice and the testimony of peers. In this respect, the tort system continues to embrace the medical profession's essentially self-regulatory view of medicine—the view that (1) there is a single socially appropriate standard of medical care (whether local or national) and (2) that the profession itself should supply that standard.

But the law’s reliance on medical custom, local or national, as its source of standards is difficult to justify. For one thing, custom is often subject to serious scientific challenge, the very circumstance that prompted the recent interest in practice guidelines. In addition, customary medical practice has evolved under economic incentives that, for familiar reasons, ensure systematic overutilization of and excessive spending on medical services. Although cost considerations have intruded more and more in recent years, it is doubtful that the system has yet learned how to balance benefits against costs in any coherent way. There are thus good reasons to doubt that the tort system, designed to enforce adherence to professional norms and standards, is contributing to an efficient allocation of resources to health care.

Although the operation of the tort system could certainly be improved by practice guidelines specifying clearly in advance the standard of care to which physicians will be held, improved regulation of medical practice through the tort system may not be exactly what the public needs. It should also be considered whether there are opportunities for "deregulation" of a sort. And indeed there are—but only if the various fictions underlying the professional/scientific/egalitarian paradigm are finally dropped in the formulation of law and public policy. The answer again lies in rehabilitating notions of private contract—so that providers and consumers could come to their own arrangements with respect to how the risks of medical treatment should be borne. Not only might parties to such contracts redefine their respective rights and responsibilities in the event of an injury, but they might also redefine the standard of care by specifying particular services that a patient would or would not be entitled to receive. If practice guidelines suitable for incorporation in private contracts were available, the task of agreeing on a standard of care different from the costly professional one would be greatly simplified. Such guidelines would also be available for economizing in public programs.

35 See Havighurst, supra note 23; Kalb, supra note 24.
Whether courts would respect contractual alterations of consumers’ tort and other rights is, of course, far from clear. Indeed, medicine is not the only profession that thinks it knows, or has processes that can discover, what is best for people and that would therefore deny people the right to choose for themselves. The legal system is inclined to believe that the tort system specifies the optimal set of patient rights and that contracts (or even legislation) derogating from those rights are probably the result of provider overreaching. The fact that the greater portion of the premiums paid for malpractice insurance (at consumers’ ultimate expense) ends up in lawyers’ pockets rather than in the hands of injured persons may have something to do with the legal system’s position on these matters.

In any event, a certain irony lies in the fact that physicians are being victimized by a tort system that survives not because it serves consumers well but because a powerful professional paradigm—the legal system’s conviction that it knows best what rights people should have (and be forced to pay for)—stands in the way of desirable change.

IV. CONCLUSION

An interesting parallel can be drawn between the larger subjects discussed herein and the recent historic events in Eastern Europe. With no intention to push the analogy too far, it can be observed that communism, too, was based on a paradigm under which a single elite group set itself up as the ultimate authority on what was good for the people. In the name of the people whose interests it purported to serve, that elite group monopolized the flow of information and opinion. Transactions between willing buyers and sellers were not allowed, and freedom of choice was sacrificed to an ideology of equality.

The decentralization strategy in American health care is also an attempt to empower people by giving them choices that have previously been denied. The suggestions I have offered for carrying the decentralization strategy forward to its logical conclusion would foster glasnost, would invite market-driven perestroika, and would further weaken the medical profession’s one-party rule. Fortunately, however, there is no reason to think that the medical profession would suffer the same fate as old communist parties. Instead, precisely because the medical profession has a legitimate claim to the people’s continued respect, it would continue in its vital role as an advocate for important patient interests—even in a fully decentralized, fully democratic health care system.