

# MODERNIZING THE MEDICAL MALPRACTICE STANDARD OF CARE

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## I. INTRODUCTION

The standard of care for health care providers proposed by section 5 of the Restatement of the Law Third, Torts: Medical Malpractice marks a fundamental shift in the American Law Institute's position on professional tort liability. According to both conventional wisdom and prior Restatement provisions, the standard of care for physicians is determined by their customary practices. Professionals alone are given the unique privilege to set their own legal standard of care. However, the proposed section 5 departs from this position. Instead, reasonable care for health care providers is defined as conduct "regarded as competent" by medical peers. Customary practices are relevant but do not bind the jury.

In reality, the step taken by section 5 is much less radical than the hornbooks and legal encyclopedias would suggest. Many states have already abandoned the custom-based standard of care, and others ignore it in practice. As a result, the law in action already resembles the provisions of the new Restatement. I strongly endorse this new definition.

This paper is divided into three parts. Part II explains and defends the new definition of the medical malpractice standard of care. Part III describes the evidence that juries can responsibly handle their responsibility to apply this standard. Part IV discusses the recent debate in the American Law Institute (ALI) about the proposed language.

## II. THE NEW "COMPETENT" CARE STANDARD

In ordinary personal injury actions, the defendant's adherence to customary practices is relevant but not binding on the issue of negligence.<sup>1</sup>

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As Judge Learned Hand explained, “a whole calling may have unduly lagged in the adoption of new and available devices.”<sup>2</sup>

At the beginning of the twentieth century, physicians were governed by the same rule.<sup>3</sup> But as their social status grew,<sup>4</sup> their legal privileges grew with it. Those privileges ranged from immunity against liability under the antitrust price-fixing rules to rules excluding corporate competition.<sup>5</sup> One of these special rules gave physicians the power to set their own standard of care.<sup>6</sup>

#### *A. Conventional Wisdom: The Standard of Care is Defined by Customary Practice*

Throughout the twentieth century, legal scholars uniformly believed that customary medical practices set the standard of care in medical malpractice cases. This consensus extended from treatises like William Lloyd Prosser and W. Page Keeton, to legal encyclopedias, like American Jurisprudence. According to Prosser, tort law “gives the medical profession . . . the privilege, which is usually emphatically denied to other groups, of setting their own legal standards of conduct, merely by adopting their own practices.”<sup>7</sup>

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1. See RESTATEMENT (THIRD) OF TORTS: MISCELLANEOUS PROVISIONS § 4 cmt. e (AM. L. INST., Council Draft No. 4, 2022) [hereinafter, CD 4] (stating that “[i]n general tort law, customary practices are probative but not determinative of reasonable care”). Subsequently, the medical malpractice provisions of the ALI Miscellaneous Provisions project were spun off into a distinct Medical Malpractice project. The standard of care definition is now in section 5 of RESTATEMENT (THIRD) OF TORTS: MEDICAL MALPRACTICE (AM. L. INST., Council Draft No.1, 2023) [hereinafter CD 1].

2. The T.J. Hooper, 60 F.2d 737, 740 (2d Cir. 1932).

3. See Theodore Silver, *One Hundred Years of Harmful Error: The Historical Jurisprudence of Medical Malpractice*, 1992 WIS. L. REV. 1193, 1205–11 (1992) (stating that physicians were held to the standard of ordinary care).

4. Famed sociologist Paul Starr attributed this to medicine’s “service rather than profit orientation.” PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 15 (1982). Talcott Parsons noted the importance of medicine’s “ideology” of putting the “welfare of the patient” above the professionals’ personal interests. TALCOTT PARSONS, *THE SOCIAL SYSTEM* 317 (Routledge 2d ed. 1991) (1951).

5. See Philip G. Peters, Jr., *The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium*, 57 WASH & LEE L. REV. 163, 194 (2000) [hereinafter Peters, *Quiet Demise*]. These special rules have been gradually disappearing. See Philip G. Peters, Jr., *The Role of the Jury in Modern Malpractice Law*, 87 IOWA L. REV. 909, 915 (2002) [hereinafter Peters, *Role of the Jury*].

6. See Peters, *Role of the Jury*, *supra* note 5, at 915 & n.4 (collecting authorities).

7. W. PAGE KEETON ET AL., PROSSER AND KEETON ON TORTS § 32, at 189 (5th ed. 1984) (footnote omitted).

The custom-based standard of care is supported by two primary rationales. First, lay juries should not be given the power to conclude that practices widely followed by practicing physicians are negligent.<sup>8</sup> Second, that physicians can be trusted to place patient interests above their own financial interests when establishing their standards of care.<sup>9</sup>

Many modern decisions confirm their continuing adherence to the custom-based standard of care. For example, in 2018, the Nebraska Supreme Court said that “the standard of care is found in the customary practices prevailing among reasonable and prudent physicians.”<sup>10</sup> In 2012, the Connecticut Court of Appeals said that “[p]hysicians are required to exercise the degree of skill, care, and diligence that is customarily demonstrated by physicians in the same line of practice.”<sup>11</sup> The Wisconsin

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8. See, e.g., *Pedigo v. Roseberry*, 102 S.W.2d 600, 607 (Mo. 1937) (“Juries should not be . . . turned loose and privileged to say, perchance, the method of treating an injury . . . was negligent notwithstanding . . . [testimony establishing] that the uniformly adopted practice of the most skillful surgeons had been followed.”). This opinion is stated repeatedly throughout the Restatement Third of Torts. See, e.g., RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL AND EMOTIONAL HARM § 7 cmt. a (stating that “the modified duty applicable to medical professionals . . . reflects concerns that a lay jury will not understand what constitutes reasonable care in the complex setting of providing medical care”); RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR ECONOMIC HARM, § 4 cmt. c (stating that a professionally determined standard “is an appropriate benchmark for judgment because a professional’s methods, nearly by definition, will be difficult for lay jurors to evaluate from scratch” and thus it is “more practicable for them to say whether the professional’s acts were consistent with standard practice in the profession than to say whether the acts were reasonable”).

9. For example, Professor Clarence Morris believed that doctors as a class were “more likely to exert their best efforts than drovers, railroad, and merchants.” Clarence Morris, *Custom and Negligence*, 42 COLUM. L. REV. 1147, 1164 (1942). Professor Allan McCoid’s classic 1959 article on malpractice argues that a physician “should be free to operate in the best interests of the patient.” Alan H. McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 608 (1959). In a later article defending custom-based norms, Professor Richard Pearson opined, “[t]here is no need for courts to act as a source of pressure to compel the medical profession to give adequate consideration to patient safety and well-being.” Richard N. Pearson, *The Role of Custom in Medical Malpractice Cases*, 51 IND. L.J. 528, 537 (1976). Similarly, Professor James Henderson concluded that “[a]n important reason for allowing the medical profession to set its own standards is that courts can assume that these standards are adequate to protect the interests of patients.” James Henderson, Jr., *Expanding the Negligence Concept: Retreat from the Rule of Law*, 51 IND. L.J. 467, 926 (1976). According to the Arizona Supreme Court, the law defers to physicians because it trusts them to set their standards “with primary regard to the protection of the public, rather than to considerations such as increased profitability.” *Rossel v. Volkswagen of Am.*, 709 P.2d 517, 523 (Ariz. 1985). That is why doctors can set their own standard of care and automotive engineers cannot. *Id.* Thus, the Reporters’ Notes to section 4 in Council Draft No. 4, comment *e* say: “One reason for medical law to defer to professional standards is that there is less concern than with actors in many other economic and social arenas that medical professionals, on the whole, will short-change patients’ interests in adequate safety and competent care.” See CD 4, *supra* note 1, § 4 cmt. e.

10. *Hemsley v. Langdon*, 472, 909 N.W.2d 59, 67 (Neb. 2018).

11. *Guerra v. Fiengo*, 49 A.3d 243, 247 (Conn. Ct. App. 2012).

Supreme Court affirmed a decision that went even further, stating that “[b]ecause the standard of care is determined by the care customarily provided by other physicians, it need not be scientifically tested or proven effective.”<sup>12</sup> In these states, customary care is competent care.

Consistent with these cases, the Third Restatement of Torts itself has consistently endorsed a custom-based standard of care for all professionals.<sup>13</sup> Comment *c* to section 4 of the Liability for Economic Harm states: “It is more practicable for [the jury] to say whether the professional’s acts were consistent with standard practice in the profession than to say whether the acts were reasonable.”<sup>14</sup> In addition, Comment *a* to section 7 of the Restatement Third of Torts on Liability for Physical and Emotional Harm states, “the modified duty applicable to medical professionals . . . reflects concerns that a lay jury will not understand what constitutes reasonable care in the complex setting of providing medical care and the special expertise possessed by professionals.”<sup>15</sup> In this view, jurors should not be empowered to resolve medical issues on which physicians themselves cannot agree.<sup>16</sup> As noted by the Restatement of the Law Third, The Law Governing Lawyers, section 52, comment *b*, this approach to determining the standard of care is “generally true for [all] professions,” in that “the legal duty refers to normal professional practice to define the ordinary standard of care . . . rather than referring to that standard as simply evidence of reasonableness.”<sup>17</sup>

Proposed section 5 departs from this tradition. Instead, reasonable care for health care providers is defined as conduct that is “*regarded as*

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12. Seifert v. Balink, 888 N.W.2d 816, 840 (Wis. 2017).

13. Surprisingly, section 299A of the Second Restatement Torts took a more modern and expansive view of physician duties than the provisions of the Third Restatement that I describe in the text. Although section 299A does use language associated with a custom-based standard, such as requiring the exercise of the skills “normally possessed or “commonly possessed,” it later adds crucial qualifiers. These practices must be common for those “qualified, and competent to engage in it” and must reflect the exercise of “minimum” skills and “reasonable” practices. Thus, section 299A anticipates the standard of competence and acceptability proposed in our current section 4. See RESTATEMENT (SECOND) OF TORTS § 299A (AM. L. INST. 1965) and accompanying comments.

14. RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR ECONOMIC HARM § 4 cmt. c (AM. L. INST. 2020).

15. RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL AND EMOTIONAL HARM § 7 cmt. a (AM. L. INST. 2010).

16. See, e.g., Graham v. Alcoa S.S. Co., 201 F.2d 423, 426 (3d Cir. 1953) (applying Pennsylvania law and holding that it was proper to dismiss a case where testifying experts disagreed on the best way to treat the patient because “allow[ing] the lay jury to resolve this disagreement would be to let it decide a medical question upon which the doctors are divided”).

17. RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 52 cmt. b. (AM. L. INST. 2000).

competent” by a providers’ peers.<sup>18</sup> Customary practices are relevant but do not bind the jury.

*B. The Caselaw is Evolving in the Same Direction as the Proposed Restatement*

The actual case law has always been more complex than conventional wisdom suggested.<sup>19</sup> Many states have explicitly moved to a reasonable physician standard of care.<sup>20</sup> The test in these states is what a reasonable physician would have done, not what is usually done. According to a review published in 2000, the fraction of states using reasonable care language had grown to roughly forty percent.<sup>21</sup> The rationale is quite simple. As the Supreme Court of Wyoming put it: “Negligence cannot be excused” solely “on the grounds that others practice the same kind of negligence.”<sup>22</sup>

In addition, many states have now adopted pattern jury instructions, that use a reasonably prudent physician standard or something similar, even though the language of the state’s appellate opinions has yet to catch up. According to a research memorandum submitted by an advisor to the Medical Malpractice project, these states now constitute a majority.<sup>23</sup>

Furthermore, even in courts that theoretically defer to custom, trial courts often fudge—allowing experts to opine whether the defendant’s conduct was acceptable or reasonable, not whether it was customary. One set of these cases arises because patients often vary in ways that resist standardization; in these cases, there is no readily ascertainable “prevailing practice” to serve as a benchmark.<sup>24</sup> In them, the conflicting experts must base their testimony on their sense of good medicine, rather than adherence to custom.

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18. See CD 1, *supra* note 1, § 5.

19. See generally Peters, *Quiet Demise*, *supra* note 5 (outlining the conventional understanding of medical malpractice law).

20. See Peters, *Role of the Jury*, *supra* note 5, at 912–17.

21. See Peters, *Quiet Demise*, *supra* note 5, at 172–85. By 2000, twelve jurisdictions had expressly rejected reliance on custom, and nine others endorsed a reasonable physician standard of care. While unpublished research has found that some of these states have subsequently used language consistent with a custom-based standard, a closer look at the law in those states confirms that they no longer make custom conclusive. See *id.*

22. *Vassos v. Roussalis*, 625 P.2d 768, 772 (Wyo. 1981).

23. See Memorandum from Larry S. Stewart, Advisor to ALI Medical Malpractice Project to ALI Council (Oct. 29, 2023) (on file with author) (collecting jury instructions from fifty states).

24. See generally Tim Cramm et al., *Ascertaining Customary Care in Malpractice Cases: Asking Those Who Know*, 37 WAKE FOREST L. REV. 699, 702–10 (2002). See Peters, *Quiet Demise*, *supra* note 5, at 186–87; CD 1, *supra* note 1, § 4.

Another challenge posed by the use of a custom-based standard is the difficulty of reliably proving which practices have become customary. One physician-lawyer has suggested that a national survey would be needed.<sup>25</sup> In real life, experts often do not know and could not hope to know the fraction of doctors who would have behaved like the defendant did.<sup>26</sup>

For whatever reason, the courts in many ostensibly custom-based states allow plaintiff's experts to testify that the defendant's care was not "acceptable," "appropriate," or up to the "standard of care" without reference to prevailing practices.<sup>27</sup>

Thus, nearly half the states have already abandoned the custom-based standard of care as a matter of law. Many others ignore it in practice. A precise count is virtually impossible because many states have confusing or conflicting language.<sup>28</sup>

### *C. The Proposed Standard of Acceptable or Competent Care is the Right One*

As noted above, the traditional custom-based standard is unworkable. It is also bad public policy. The new standard based on conduct that peers "regard as competent" and believe to be "acceptable" is far superior.

The custom-based standard under protects providers in some cases and overprotects them in others. For example, scientifically defensible innovative practices are safer under a reasonable physician or acceptable care standard than under a custom-based standard of care. In the past, courts have found a way to protect well-supervised clinical trials, but the custom-based standard of care always hovers as a threat to doctors who lead the pack in less formal contexts.

At the same time, the custom-based standard of care overprotects obsolete practices. University physicians have often complained to me that it was safer to "stay in the pack," using scientifically discredited practices, than to depart from them. In one tragic episode, oncologists were so confident in the benefits of radical mastectomies that they actually

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25. See Cramm et al., *supra* note 24, at 710, 752–53.

26. See Peters, *Role of the Jury*, *supra* note 5, at 947–48.

27. See Peters, *Quiet Demise*, *supra* note 5, at 185–87 (citing examples); see also W. Page Keeton, *Medical Negligence—The Standard of Care*, 10 TEX. TECH. L. REV. 351, 363 (1979) (noting that "many courts have in reality allowed expert witnesses to testify in terms of what the defendant doctors *should* have done under the circumstances rather than what would be *customary*").

28. See Peters, *Quiet Demise*, *supra* note 5, at 175–85.

prevented clinical trials for decades, mutilating thousands of women with a worthless procedure.<sup>29</sup>

Researchers have found remarkable delays—as much as a decade—in the adoption of new best practices, even when their superiority is not in dispute. Fifteen years after a major study established that rigorous glucose control significantly reduced long-term complications from diabetes, only one of four diabetic patients was receiving the recommended number of annual tests.<sup>30</sup> Furthermore, studies have documented that nearly half of physicians do not follow Clinical Practice Guidelines.<sup>31</sup>

This is especially troublesome because a surprising number of clinical practices have no reliable evidentiary basis.<sup>32</sup> E. Haavi Morreim observes that many clinical “routines are based not just on clear data and careful reasoning, but also on habit, hunch, current fashion, and the profession’s folk wisdom.”<sup>33</sup>

One in five prescriptions is provided for an off-label purpose, even though most of those uses have no supporting research.<sup>34</sup> Sometimes that practice is beneficial, but sometimes—as in the common off-label use of the diet drug Fen-Phen—patients suffer devastating injuries.<sup>35</sup> Small wonder that repeated studies have found that medical practices vary widely and inexplicably from one community to another.<sup>36</sup>

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29. SIDDHARTHA MUKHERJEE, *THE EMPEROR OF ALL MALADIES: A BIOGRAPHY OF CANCER* 152 (2011).

30. See Lee N. Newcomer, *Physician, Measure Thyself*, *HEALTH AFFS.*, July–Aug. 1998, at 32–33.

31. See Cramm et al., *supra* note 24, at 750 (noting that “physicians are largely either unaware or noncompliant with, CPGS [clinical practice guidelines]”).

32. See Peters, *Role of the Jury*, *supra* note 5, at 953 (collecting authorities).

33. E. HAAVI MORREIM, *BALANCING ACT: THE NEW MEDICAL ETHICS OF MEDICINE’S NEW ECONOMICS* 51 (1995).

34. *Off-Label Drug Use: What You Need to Know*, AGENCY FOR HEALTHCARE RSCH. AND QUALITY, <https://www.ahrq.gov/patients-consumers/patient-involvement/off-label-drug-usage.html> [<https://perma.cc/2NNY-DXYV>]. A website for medical device manufacturers, the Medical Device Network, concedes that “off-label use of medical devices has become a common practice” and that “the devices may have drawbacks, which include patient safety.” GlobalData Healthcare, Comment, *Off-label Use of Medical Devices*, MED. DEVICE NETWORK (May 21, 2017), <https://www.medicaldevice-network.com/comment/commentoff-label-use-of-medical-devices-5820363/> [<https://perma.cc/D6EL-GFJB>]; see also AM. ACAD. OF ORTHOPAEDIC SURGEONS, POSITION PAPER: PHYSICIAN DIRECTED USE OF MED. PRODS. 2 (2009) (noting that off-label use of medical devices sometimes becomes a generally accepted medical standard within the physician community, but that best practices change over time and that sellers may make “misleading claims regarding product safety”).

35. See Caren A. Crisanti, *Product Liability and Prescription Diet Drug Cocktail, Fen-Phen: A Hard Combination to Swallow*, 15 *J. CONTEMP. HEALTH L. & POL’Y* 207, 208 (1998).

36. See, e.g., John E. Wennberg, Commentary, *Improving the Medical Decision-Making Process*, 7 *HEALTH AFFS.* 99, 99–100 (1988). See generally JOHN E. WENNBURG, *TRACKING*

In addition, the unselfish country doctor model of medicine is largely obsolete. Medicine is big business. Many providers have financial interests that conflict daily with patient interests. In some organizational arrangements, providers face pressure to skip expensive referrals and diagnostic procedures and discharge hospitalized patients quickly. In others, they are pressed hard to see more patients every day.<sup>37</sup> Surgeons can maximize income by operating on every patient who complains of pain. The well-established overuse of hysterectomies, bypasses, and C-sections makes that clear.<sup>38</sup> Thus, studies have found that cardiologists who do invasive procedures recommend them far more than primary care doctors and cardiologists who do not perform those procedures.<sup>39</sup> Physicians who own a lab or x-ray facility order those procedures far more often than physicians who do not.<sup>40</sup> Dangerous mistakes are bound to happen. As a result, the current version of comment *c* to section 5 correctly states that “prevailing professional practice may fall short of what medical professionals themselves regard as competent; in these circumstances, it should be no defense that many other providers render similarly deficient care.”<sup>41</sup>

In short, the custom-based standard of care gives clinical practices a veneer of unerring scientific validity they do not deserve. In the words of noted physician and policy analyst David M. Eddy, “if we actually measured what practitioners were doing and used that to define the standard of care, we would run a high risk of installing an inappropriate practice as the standard of care.”<sup>42</sup>

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MEDICINE: A RESEARCHER’S QUEST TO UNDERSTAND HEALTH CARE (2010) (providing a framework for understanding the health care crisis and outlining a roadmap for real change in the future).

37. My wife, an emergency physician, and my friends who practice in central Missouri universally complain about this. Computer systems enable business managers to get detailed output data.

38. See David M. Eddy, Commentary, *The Use of Evidence and Cost Effectiveness by the Courts: How Can It Help Improve Health Care?* 26 J. HEALTH, POL., POL’Y & L. 387, 396 (2001).

39. See John Z. Ayanian et al., *Rating the Appropriateness of Coronary Angiography—Do Practicing Physicians Agree with an Expert Panel and with Each Other?*, 338 NEW ENG. J. MED. 1896, 1901 (1998) (finding that beliefs about the appropriateness of coronary angiography varied by groups).

40. See RICHARD P. KUSSEROW ET AL., FINANCIAL ARRANGEMENTS BETWEEN PHYSICIANS AND HEALTH CARE BUSINESSES: REPORT TO CONGRESS 18 (1989) (documenting the higher incidence of treatment for self-referred patients).

41. Comments *b* and *c* to section 5 were revised at a meeting of the ALI Council in January 2024. The Reporters have sent me the text of those comments that will go to the membership in RESTATEMENT (THIRD) OF TORTS: MEDICAL MALPRACTICE § 5 (AM. L. INST., Tentative Draft No. 2, 2024) (on file with author) [hereinafter TD 2].

42. Eddy, *supra* note 38, at 396.



In light of these considerations, I strongly endorse the ALI's adoption of a standard based on conduct "regarded as competent" by medical peers". However, the wisdom of this departure from the guardrails of the custom-based standard of care depends on the jury's ability and willingness to sensibly evaluate medical evidence and treat providers fairly. Fortunately, the evidence indicates that they can and do. This analysis is at the core of Part III of this essay.

### III. THE JURY'S ABILITY TO EVALUATE MEDICAL NEGLIGENCE

Decades of research on medical malpractice jury verdicts show with remarkable uniformity that juries use their power wisely.<sup>43</sup> Negligence matters. The odds of a plaintiff's verdict rise as the evidence of negligence improves.<sup>44</sup> When in doubt, jurors regularly give physicians the benefit of the doubt.

Compelling studies show that doctors win half of the jury trials that independent medical experts believe the patients should have won.<sup>45</sup> They win seventy to eighty percent of the cases rated as toss-ups and ten to twenty percent of the cases that reviewing physicians feel they should lose.<sup>46</sup> In the category of cases rated as weak by the medical reviewers, the ten to twenty percent rate of disagreement between juries and those reviewers is a much lower than the twenty-five to thirty percent disagreement rate typically present among physician reviewers.<sup>47</sup>

If there is a significant bias afoot, it is a pro-physician bias. Patients win only half of the cases that physician reviewers felt they should win and only one-third of the toss-up cases.<sup>48</sup> Thus, jurors are more skeptical of patients who sue their doctors than medical reviewers are.<sup>49</sup>

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43. See Philip G. Peters, Jr., *Doctors and Juries*, 105 MICH. L. REV. 1453, 1476 (2007) (describing the wide variety of study designs leading to the same conclusion).

44. *Id.* at 1464–73, 1475–76. Because malpractice settlements are negotiated in the shadow of the law, they predictably exhibit the same strong correlation between the strength of the patient's case and the settlement outcome. See Philip Peters, Jr., *What We Know About Malpractice Settlements*, 92 IOWA L. REV. 1783, 1804–12 (2007) (providing evidence that settlement rates align with strength of evidence). See *id.* at 1812–13 (discussing evidence that settlement size correlates with the strength of the evidence).

45. Peters, *supra* note 43, at 1473, 1475–76.

46. *Id.*

47. *Id.* at 1477–78 (collecting studies). And when the risk of reviewer bias in favor of another physician is taken into account, the set of potentially unfair plaintiff's verdicts drops lower still.

48. See *id.* at 1477–78 (collecting studies).

49. See *id.* at 1463–73.

Malpractice plaintiffs win jury verdicts about half as often as plaintiffs in other torts cases.<sup>50</sup> Furthermore, they win in front of juries about half as often as they win in front of judges, a pattern not found in most personal injury litigation.<sup>51</sup> After one researcher eliminated trials in which only damages were contested, he found that medical malpractice plaintiffs won only eleven percent of the cases in his data set.<sup>52</sup> While selection bias could conceivably explain some of these outcomes, their uniform consistency with the more rigorous research on jury verdicts certainly suggests that juries view claims of physician negligence with some skepticism.<sup>53</sup>

These outcomes strongly suggest that doctors enjoy one or more systemic advantages.<sup>54</sup> Two strong candidates are access to better lawyers, experts, and evidence<sup>55</sup> and widespread public skepticism about patients who sue their doctors.<sup>56</sup> Whatever the explanation, juries give physicians the benefit of the doubt. Contrary to common conception, juries seem to be aware of their limited expertise and unwilling to find against a physician if they have any doubt about the merits.

Put differently, they seem to take very seriously the burden of proof and the two schools of thought doctrine.<sup>57</sup> If they do not feel comfortable choosing between opposing experts, they find for the defendant. They are more likely to do so than judges and even other physicians. If the complexity of some malpractice cases helps anyone, it helps defendants. Based on this body of research, there is no basis for doubting that juries will continue to look closely at the evidence and give physicians the benefit of the doubt unless the evidence of negligence is especially compelling.

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50. Thomas H. Cohen, *Medical Malpractice Trials and Verdicts in Large Counties*, BUREAU OF JUST. STATISTICS CIV. JUST. DATA BRIEF, Apr. 2004, at 1, <https://bjs.ojp.gov/content/pub/pdf/mmtvle01.pdf> [<https://perma.cc/4PY8-Q7C7>].

51. See Kevin M. Clermont & Theodore Eisenberg, *Trial by Jury or Judge: Transcending Empiricism*, 77 CORNELL L. REV. 1124, 1137, 1174 (1992) (discussing findings).

52. See Thomas B. Metzloff, *Resolving Malpractice Disputes: Imaging the Jury's Shadow*, 54 L. & CONTEMP. PROBS. 43, 52 (1991); see also Peters, *supra* note 43, at 1459–60 (collecting studies showing that patients win under thirty percent of all cases).

53. See Peters, *supra* note 43, at 1473–75.

54. See *id.* at 1482–90 (discussing jury bias in favor of doctors, medicine's media barrage criticizing juries, social norms against claiming, bias against challenging privileged members of society, and unequal litigation resources).

55. See *id.* at 1488–90.

56. See *id.* at 1482–88.

57. See *id.* at 1490–91 (discussing the possible role of the burden of proof when liability is uncertain). In light of our limited capacity to reconstruct past events and the inevitably subjective nature of quality assessments of past performance, along with the challenge of evaluating the credibility of medical experts, it may not be possible to design a system with a higher agreement rate in the cases rated as weak by inside or outside reviewers. See *id.* at 1495.

In my conversations with experienced lawyers on both sides, I have found that they already know these facts. It is very hard for a patient to win a malpractice verdict. Because it is also very expensive to litigate them, plaintiffs' lawyers are filing fewer and fewer cases in California and across the nation.<sup>58</sup>

#### IV. THE FINAL FORMULATION

Section 5(a) defines the medical malpractice standard of care as “the care, skill, and knowledge *regarded as competent* among similar medical providers in the same or similar circumstances.”<sup>59</sup>

Rather than asking whether the defendant behaved as physicians customarily do, this definition asks whether the defendant provided care “regarded as competent” by medical peers. Illustration 7 makes it clear that obsolete customary practices can now be challenged. In addition, the comments state that “the ultimate question remains whether the provider complied with, or deviated from,” conduct regarded as competent.<sup>60</sup>

At the same time, the Reporters decided not to define the standard of care as the care that a reasonable health care provider would provide. I think they believe that a “reasonable physician” standard would delegate too much discretion to the jury to create its own medical norms. I disagree. Patients would still need an expert to testify that the defendant did not act as a reasonably prudent physician would have acted, i.e., did not follow the “standard of care.” This, in my view, is the functional equivalent of testifying that the care was not the kind “regarded as competent.”

But I understand the belief that juries should be reminded that the standard of care is what *other physicians* consider competent—not what the lay jurors consider competent. In this respect, the language the Reporters choose represents a sensible, measured step intended to combine the best of both the reasonability and customary care approaches.<sup>61</sup> It owes a tip of the hat to Professor Joseph King, who proposed an “accepted practice” standard nearly fifty years ago.<sup>62</sup>

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58. For national data, see Philip G. Peters, Jr., *On the Cusp of the Next Medical Malpractice Insurance Crisis*, 25 J. HEALTH CARE L. & POL'Y 133, 139–46 (2022). For California data, see *Data Analysis Tool*, NAT'L PRAC. DATA BANK, <https://www.npdb.hrsa.gov/analysistool/> [<https://perma.cc/ESG2-XHU8>].

59. CD 4, *supra* note 1.

60. TD 2, *supra* note 41, § 5 cmt. b.

61. However, many states that have already moved away from the customary care standard use a reasonable physician standard. See Peters, *Quiet Demise*, *supra* note 5, at 180–87.

62. See generally Joseph King, *In Search of a Standard of Care for the Medical Profession: The “Accepted Practice” Formula*, 28 VAND. L. REV. 1213 (1975) (redefining the professional standard using the “accepted practice” formula).

For similar prudential reasons, I suspect, the Reporters proposed a stronger *evidentiary* role for customary practices in medical malpractice cases than that given to industry customs in ordinary negligence cases, where custom is simply one factor to be considered. This met strong resistance from critics who felt that far too much weight was being given to medical customs.

To be sure, the initial draft did place a heavy thumb on the scale in favor of using prevailing practices as the standard of care. Too heavy. In its earliest iterations, Comment *e* of Council Draft No. 4 implied that customary practices should usually govern, stating that “this professionally determined approach is often (but not always) determined by prevailing professional practices.”<sup>63</sup> As originally drafted, it went on to say that “[m]edical liability law thus elevates the importance of custom by regarding it as at *least presumptively* establishing the standard of care.”<sup>64</sup> Making a similar point, Comment *f* said that “in many, perhaps most, cases, *prevailing* professional practice *remains the touchstone* for determining the professional standard of care.”<sup>65</sup> With this and other language, the Reporters implied that courts should look first to custom in all malpractice cases, effectively conferring a *de facto* rebuttable presumption in favor of deferring to custom.

The Reporters defended this decision by pointing out that most courts continue to describe the standard of care as adherence to customary medical practice. They noted that deference to custom is already found in other provisions of the Restatement Third of Torts.<sup>66</sup> They clearly believe that fairness supports reminding lay jurors that prevailing practices in medicine are usually defensible.

But the pushback to this strong support for customary practices has been fierce. I was quite surprised. I had expected defense counsel to push back against the Restatement’s abandonment of the custom-based standard of care, citing the inconsistency of the new standard of care with conventional wisdom and other provisions of the Restatement Third. Instead, the opposition has come from the plaintiff’s side, perhaps from attorneys in states that already employ a reasonable physician standard. They argue that custom is being given too much weight.

Fortunately, the disagreement may have been resolved. The Reporters have removed the language that seemed to endorse a rebuttable

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63. CD 4, *supra* note 1, § 4 cmt. e.

64. *Id.*

65. *Id.* (emphasis added).

66. *See supra* Part II.

presumption in favor of custom.<sup>67</sup> They also dropped the text stating that customs can only “sometimes” be regarded as incompetent.”<sup>68</sup> The current draft also preserves language, clarifying that the standard of care is “ultimately” and “essentially” what other health care providers regard as competent, not what they typically do.<sup>69</sup> At the same time, however, the latest draft of the comments continues to say that customs will “frequently” or “often” be a useful benchmark and that prevailing medical practices are “usually” competent.<sup>70</sup> This is the compromise reached at the January 2024 Council meeting. The difficulty they had in framing a suitable compromise is reflected in this awkward sentence from Comment *c*: “the governing standard is not only prevailing professional practice, but ultimately what other professional regard as competent.”<sup>71</sup> Nevertheless, the current draft gets it about right. Widespread medical practices warrant a close look, but obsolete or unproven practices will not be immunized, as shown in illustration 7.<sup>72</sup>

The ALI Council gave its blessing to the compromise in January 2024, and the language will go to the ALI membership this summer.

## V. CONCLUSION

Section 5 adopts a definition of reasonable care based on peer acceptability rather than adherence to custom. This is an accurate reflection of the evolving law on the books in many states and of the law in action in many others. Custom, when there is one, will be relevant and often persuasive. Juries will decide the outcome whenever each party has an expert who relies on credible scientific evidence about the accepted standard(s) of care. In some cases, more than one school of thought will be acceptable. Research on jury decisions strongly suggests that juries handle their considerable responsibility with care and show substantial deference to physicians. That is likely to continue as courts adopt the Third Restatement’s proposed standard of care.

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67. In my view, the strong opposition to this provision was correct but overstated. While this presumption would surely have confused both courts and parties, it should not have changed the substantive law in any meaningful way because plaintiffs already have the burden of introducing proof that the defendant’s care was unreasonable, thus rebutting the presumption. At any rate, the language has been removed.

68. See CD 1, *supra* note 1, § 5 cmt. e.

69. See TD 2, *supra* note 41, § 5 cmt. c.

70. *Id.* § 5 cmt. b, c.

71. See *id.* § 5 cmt. c.

72. *Id.* § 5 cmt. c, illus. 7; see *supra* note 60 and accompanying text.