> releasing party does not really acquiesce voluntarily in the contractual shifting of the risk, nor can we be reasonably certain that he receives an adequate consideration for the transfer. Since the service is one which each member of the public, presently or potentially, may find essential to him, he faces, despite his economic inability to do so, the prospect of a compulsory assumption of the risk of another's negligence. The public policy of this state has been, in substance, to posit the risk of negligence upon the actor; in instances in which this policy has been abandoned, it has generally been to allow or require that the risk shift to another party better or equally able to bear it, not to shift the risk to the weak bargainer.

Tunkl has been followed just about everywhere. Otherwise, one imagines that every hospital would follow UCLA's lead.

Theoretically, if a grocery store or hotel tried to make patrons agree to such a release, such releases would be invalidated as well. Grocery stores and hotels are essential services in modern life.

By contrast, skydiving is about as nonessential as a service could be. Courts in many states have thus refused to find a public policy exception to waivers for parachuting services.

A good example of a case that would seem to be on the bubble is a fitness center. Fitness advocates and physicians like to talk about regular exercise as being "essential." But Maryland's high court held that going to the gym was nonessential, and so no there was no public-policy exception for an express waiver signed by customer. *See Seigneur v. National Fitness Institute, Inc.,* 752 A.2d 631 (Md. 2000). Another case that would seem be in the gray zone is a ski resort. In Vermont, a general exculpatory agreement used by a ski resort was found to be invalid. *See Dalury v. S-K-I, Ltd.,* 164 Vt. 329 (Vt. 1995).

Another category of defendants traditionally barred from using agreements to avoid negligence liability are manufacturers of products. Products liability – a complicated area – is a subject for Volume Two of this casebook. But for now it is enough to know that

manufacturers and retailers cannot escape liability from property damage and personal injury caused by defective products.

Part III:
Liability Relating to Healthcare

11. Common Law Liability in the Healthcare Context

"Like a surgeon – hey! – cuttin' for the very first time.
Like a surgeon! Here's a waiver, for you to sign."
– "Weird Al" Yankovic, 1985

In General

The healthcare setting is a fertile one for torts. So many things can go wrong in the course of diagnoses, drug treatments, and surgeries. Of course, automobiles and roadways provide many opportunities for accidents as well, but hospitals and physicians tend to have one thing that the average driver does not – deep pockets. The confluence of injuries to fuel complaints and money to pay judgments makes healthcare a uniquely important setting for tort law.

At this point, you have learned the basics of negligence law, and thus you know most of what is relevant to lawsuits against physicians and hospitals. But there are a few important things to add. This chapter covers some additional common-law doctrine that applies to healthcare torts. The next chapter concerns the effect of a federal statute, ERISA, which often blocks plaintiffs from suing health-insurers and HMOs in tort.

There are three aspects of the common-law torts in the healthcare context that are covered in this chapter.

First, in a medical malpractice action for negligence, the standard of care is different. As we saw – in particular with *The T.J. Hooper* – the custom or standard practice of an industry is not dispositive when it comes to determining the standard of care. That is to say, the standard practice of an entire industry can be found unreasonable and thus held to fall below the standard of care to which defendants are held in negligence actions. That is not the case, however, with medical malpractice. Medical custom – what physicians generally call the "standard practice" or "standard of care" – is the benchmark for determining breach of duty in the context of medical malpractice

negligence claims. This means that what is called "standard of care" in medical jargon ends up dictating what we refer to as the "standard of care" in legal jargon.

Second, the intentional tort of battery – to be dealt with in a more general way in the second volume of this casebook – has a unique role in the medical setting. The healthcare version of battery, called **medical battery**, provides a way for patients to sue physicians who treat them beyond the scope of the patient's consent. Consistent with battery doctrine, and in distinction to negligence, a medical battery action has no requirement of showing damages or an injury.

Third, there is a kind of claim that is unique to healthcare: the action for **informed consent**. The informed consent action is generally available where a patient was not apprised of an important risk necessary to make an informed decision about treatment, and the patient then suffers the negative consequence associated with the undisclosed risk.

The Standard of Care for Healthcare Professionals in Negligence Actions

Basics

Most cases falling under the label "medical malpractice" are negligence cases. Examples of medical malpractice negligence actions would include suits arising from an internist who prescribes a drug contraindicated by something in the patient's history or a radiologist who fails to see a tumor that other radiologists would have seen.

There is a key difference between negligence law generally and negligence law as applied to physicians: the standard of care. Physicians are considered *professionals*, and for professionals, the standard of care is not that of a reasonable person, but is instead **the knowledge and skill of the minimally competent member of that professional community**. Another way of putting this is that custom becomes dispositive in cases of professional negligence. Is it the prevailing custom for neurosurgeons to order an MRI scan before undertaking a scheduled brain surgery? If so, then failing to do is a breach of the duty of care. If not, then there is no breach – even

if the plaintiff can demonstrate that a practice of doing so would be prudent.

This way of setting the standard of care works both for and against physicians. On the one hand, hewing to custom keeps a physician insulated from malpractice judgments – even where the hypothetical reasonable physician might be more cautious. On the other hand, deviating from custom – even when doing so would seem reasonable – exposes the physician to liability.

This standard for professional negligence is objective, and it is calibrated in accordance with the community of professionals in the defendant's practice. If the defendant is a general dentist, then the standard is the minimally qualified member of the relevant community of general dentists. If the defendant is a cardiologist, then the standard is the minimally qualified member of the relevant community of cardiologists. By saying the standard is objective, we mean that it is the same standard for all members of the professional community. That is, the standard of care is not adjusted in favor of professionals who have lower levels of experience, skill, or knowledge. Thus, it does not matter whether a physician is just out of medical school or has been in practice for 30 years. Also, the standard of practice will evolve over time. What starts as an obscure technique may gain enough acceptance to become standard practice. Thus, negligence law puts the onus on physicians and other healthcare professionals to stay up to date.

One thing to bear in mind: The objective standard of care for professionals applies only when they are accused of negligence in the course of their professional practice. If an orthopedist drives her car into your mailbox, the standard applied will be that of the hypothetical reasonable person and not that of the knowledge and skill of the minimally competent orthopedist.

The Role of Expert Testimony

The fact that the professional standard of care is defined with objective reference to the professional community means that it is almost always the case that expert testimony will be needed to establish the standard of care. In practice, this makes medical

negligence actions expensive to litigate. It also changes the role of the jury. Instead of jurors asking themselves what is reasonable, jurors are generally left to choose between the competing views of the plaintiff's expert and the defendant's expert. Thus, a medical negligence case can often come down to whether the plaintiff's expert or the defendant's seems more knowledgeable and credible.

Expert testimony is not always necessary. Some cases can be prosecuted based on common knowledge. If a surgeon mistakenly cuts off the wrong limb or removes the wrong kidney, no expert testimony is necessary to show that the standard of care has been breached. Another example is leaving foreign objects inside a patient, such as surgical sponges. In fact, a sponge left inside the body cavity is a leading example of the doctrine of *res ipsa loquitor* in action. One way to think about cases such as these is that they really are not medical malpractice cases at all, since medical knowledge and skill are not at issue. Most medical malpractice cases, however, involve a question of professional judgment. In such cases, the question of whether the physician used appropriate professional judgment is that case will require the testimony of a medical expert.

How the Professional Community is Defined

Since the standard of care is defined by the professional community, a key question concerns how to define the "community." The analysis of what constitutes the relevant community involves issues of both specialty and geography.

Exactly what skills and knowledge a physician is expected to have depends on whether or not the physician has a specialty, and, if so, what that specialty is. Physicians who are general practitioners are held to a different and lower standard than specialists. If a general practitioner prescribes an aerosol inhaler for asthma, the standard is different and lower than a pulmonologist who writes the prescription. For the general practitioner, the standard of care is set by the knowledge and skill level of a minimally competent general practitioner. For the pulmonologist, it is what is the knowledge and skill level of a pulmonologist. By the way, holding one's self out to

the public as a specialist is generally what counts for being held to the higher standard of knowledge and skill of a specialist.

Geography may be relevant as well. Historically, professional communities were conceived of as being local. If the question of negligence concerns a physician practicing in Ridgefield, population 20,000, then the standard of care is set by the customs, skills, and level of knowledge of Ridgefield physicians. So the question of whether a physician in a particular town was negligent required getting experts from that city to testify as to the standard practice in that town. Such a requirement, as you might imagine, works greatly to the benefit of defendant physicians in small cities and towns. First, it allows small-town medical care to be held to a lower standard than in the big cities. And the lower the standard, the easier it is for physicians to escape liability. But there is another, sharper advantage for physicians in smaller locales when the standard of care is defined locally. Professionals in small locals are often unwilling to testify against one another. Without an expert to testify as to the standard of care in the community, the lawsuit may be stopped in its tracks. Because of the recurrent problem of a lack of willing experts, the trend is away from defining professional communities in this way. The more favored alternatives are to use a national standard, or to use a nonparticularized local standard – that is, define the standard with reference to a *similar* city or town. The similar-communities standard means that experts for small towns and cities can be found across the country if necessary.

A typical way for courts to define professional communities is to use a similar-geographical-place standard for general practitioners and to use a national standard for members of a medical specialty. Thus, a cardiothoracic surgeon practicing in a city of a few thousand people will be held to the same standard as cardiothoracic surgeons in a megalopolis of millions.

Problems for Professional Medical Negligence

A. Delinda, a medical doctor practicing as a general practitioner, was trying her best when she prescribed sploramoxacin to her patient, Perry. Based on lab results, Delinda figured that Perry had a bacterial

infection that was causing him pain in his lower left side – around the site of a deep cut he had gotten while hiking. Delinda also knew that sploramoxacin was a good broad-spectrum antibiotic. Most physicians would have done exactly what Delinda did. Unknown to Delinda, the Nashlanta Journal of Medicine had published an article in the previous week showing that sploramoxacin was contraindicated in cases of lower-left-side pain because of a newly identified condition named Lower Left Syndrome. (The Nashlanta Journal of Medicine is a relatively obscure journal which few people read.) While Lower Left Syndrome presents with all the symptoms of a bacterial infection, it is in fact caused by a eukaryotic plasmodium. Generally, the body's natural defenses will destroy the plasmodia in two to three weeks without treatment. If, however, sploramoxacin is administered in patients with Lower Left Syndrome, the body's natural defenses against the plasmodium are lowered, and the plasmodium will attack the liver, causing liver failure. This is what happened to Perry. Will Perry prevail in a lawsuit against Delinda?

B. Same as A., but suppose Delinda had happened to have read the article on Lower Left Syndrome before she saw Perry. Different result?

C. Same as A., but suppose the standard of practice in a case such as Perry's was to use an expensive test that not only indicates infection, but also discerns the difference between a bacterial infection and a plasmodial infection. (And note that antibiotics do not work against plasmodia.) Different result?

Professional Negligence Outside the Healthcare Setting

The professional standard of negligence that applies to medical doctors and dentists applies to non-healthcare professionals as well, such as accountants, architects, engineers, veterinarians, and attorneys. That is to say that these professionals, when sued for negligence in the course of their professional practice, are held to a standard of care that is dictated by the custom or standard of practice that prevails in the relevant community of professionals – what the reasonable person would do is irrelevant. (Attorney malpractice is, of course, an important area of the law for budding lawyers to be

familiar with. But we will leave an in-depth treatment of the topic for your professional responsibility course.)

Whether or not something counts as a "profession" can be a tricky question. In general, a profession for the purpose of assigning a standard of care in negligence is one that consists primarily of intellectual labor and that requires higher education.

Plumbers, electricians, and carpenters, for instance, are not considered professionals in the negligence context – even though their work requires a great deal of knowledge. Meanwhile, surgeons are considered professionals, even though their work might be considered primarily manual as opposed to intellectual.

Medical Battery

Medical battery is an intentional tort cause of action that can be alleged against a physician or other healthcare provider who performs a course of treatment without the patient's consent.

What we are calling "medical battery" is not really a separate tort; instead it is really just a particular factual context for the tort of battery. The intentional torts, including battery, are covered later in this casebook. So, assuming you are proceeding through this casebook in order, and you have not studied battery yet, you will need the basics of the doctrine to be able to understand actions for medical battery.

The intentional tort of battery requires that the defendant inflict a harmful or offensive touching on the plaintiff's body. Consent is an affirmative defense. To break it down into elements, battery – including medical battery – requires: (1) an act; (2) intent; (3) actual and proximate causation; (4) a physical touching of the plaintiff's body; and (5) harmfulness or offensiveness. The fifth element and the affirmative defense of consent are key to preventing the tort of battery from getting out of control. People touch each other's bodies all the time, rarely accruing claims for battery. The reason why most touches do not create liability is that nearly all touches are either not harmful or offensive, or else they are consented to.

Now that you understand the basics of battery, you can see some key differences between the negligence cause of action and the battery cause of action. Unlike a prima facie case for negligence, a claim for battery does not require an injury. That makes a battery claim, at least in that sense, easier to allege. But there is a tradeoff. Unlike negligence, which works for accidents, a claim for battery requires intent. That makes a battery claim harder to allege.

In a later chapter on that covers battery in general, we will explore more of what it means for a touching to be "harmful or offensive." In the medical context, however, this is not a difficult requirement for plaintiffs to meet. Cutting into someone or introducing a medical instrument into a bodily orifice certainly counts as harmful or offensive.

The key issue for medical battery is generally whether there was consent. Physicians touch patients all the time, and almost always, that touching is in accordance with the patient's consent. To be valid, consent does not have to be in writing. It does not even need to expressed orally. Consent can be implied. When a patient opens up his mouth to say "ahh," permission to insert a tongue depressor into the patients' mouth is implied.

There is one important and constantly recurring circumstance in which physicians touch patients without any consent whatsoever: the emergency room. When an unconscious patient is brought into an emergency room, the consent to touching the patient is said to be "implied by law." This means that even though there is no actual consent, the law will pretend that there is consent for public-policy reasons. After all, if every unconscious patient given emergency treatment was able to win a lawsuit for battery, there would be a steep decline in emergency services.

Now that you have a firmer grasp of when medical battery claims will not arise, you can more readily discern the relatively rare circumstances in which they will arise. In particular, a common scenario that creates liability for medical battery is when a physician goes further with a touching than the patient consented to.

Case: Mohr v. Williams

The following case is the classic example of how a medical battery results when a physician goes beyond the patient's scope of consent.

Mohr v. Williams

Supreme Court of Minnesota
June 23, 1905

ANNA MOHR v. CORNELIUS WILLIAMS. Nos. 14,312, 14,360 - (94, 95). Opinion by Brown, J., Jaggard, J. took no part.

Justice CALVIN L. BROWN:

Defendant is a physician and surgeon of standing and character, making disorders of the ear a specialty, and having an extensive practice in the city of St. Paul. He was consulted by plaintiff, who complained to him of trouble with her right ear, and, at her request, made an examination of that organ for the purpose of ascertaining its condition. He also at the same time examined her left ear, but, owing to foreign substances therein, was unable to make a full and complete diagnosis at that time. The examination of her right ear disclosed a large perforation in the lower portion of the drum membrane, and a large polyp in the middle ear, which indicated that some of the small bones of the middle ear (ossicles) were probably diseased. He informed plaintiff of the result of his examination, and advised an operation for the purpose of removing the polyp and diseased ossicles. After consultation with her family physician, and one or two further consultations with defendant, plaintiff decided to submit to the proposed operation. She was not informed that her left ear was in any way diseased, and understood that the necessity for an operation applied to her right ear only. She repaired to the hospital, and was placed under the influence of anesthetics; and, after being made unconscious, defendant made a thorough examination of her left ear, and found it in a more serious condition than her right one. A small perforation was discovered high up in the drum membrane, hooded, and with granulated edges, and the bone of the inner wall of the middle ear was diseased and dead. He called this discovery to the attention of Dr. Davis – plaintiff's family physician, who

attended the operation at her request – who also examined the ear and confirmed defendant in his diagnosis. Defendant also further examined the right ear, and found its condition less serious than expected, and finally concluded that the left, instead of the right, should be operated upon; devoting to the right ear other treatment. He then performed the operation of ossiculectomy on plaintiff's left ear; removing a portion of the drum membrane, and scraping away the diseased portion of the inner wall of the ear. The operation was in every way successful and skilfully performed. It is claimed by plaintiff that the operation greatly impaired her hearing, seriously injured her person, and, not having been consented to by her, was wrongful and unlawful, constituting an assault and battery; and she brought this action to recover damages therefor.~

The trial in the court below resulted in a verdict for plaintiff for $14,322.50. Defendant thereafter moved~ for a new trial on the ground, among others, that the verdict was excessive~. The trial court~ granted a new trial on the ground, as stated in the order, that the damages were excessive~ appearing to have been given under the influence of passion and prejudice~. [W]hether a new trial upon the ground of excessive or inadequate damages should be granted or refused, or whether the verdict should be reduced, rests in the sound judicial discretion of the trial court~. [W]e are clear the trial court did not abuse its discretion in granting defendant's motion for a new trial, and its order on plaintiff's appeal is affirmed.

We come then to a consideration of the questions presented by defendant's appeal from the order denying his motion for judgment notwithstanding the verdict. It is contended that final judgment should be ordered in his favor for the following reasons: (a) That it appears from the evidence received on the trial that plaintiff consented to the operation on her left ear. (b) If the court shall find that no such consent was given, that, under the circumstances disclosed by the record, no consent was necessary. (c) That, under the facts disclosed, an action for assault and battery will not lie; it appearing conclusively, as counsel urge, that there is a total lack of evidence showing or

tending to show malice or an evil intent on the part of defendant, or that the operation was negligently performed.

We shall consider first the question whether, under the circumstances shown in the record, the consent of plaintiff to the operation was necessary. If, under the particular facts of this case, such consent was unnecessary, no recovery can be had, for the evidence fairly shows that the operation complained of was skilfully performed and of a generally beneficial nature. But if the consent of plaintiff was necessary, then the further questions presented become important. This particular question is new in this state. At least, no case has been called to our attention wherein it has been discussed or decided, and very few cases are cited from other courts. We have given it very deliberate consideration, and are unable to concur with counsel for defendant in their contention that the consent of plaintiff was unnecessary.

The evidence tends to show that, upon the first examination of plaintiff, defendant pronounced the left ear in good condition, and that, at the time plaintiff repaired to the hospital to submit to the operation on her right ear, she was under the impression that no difficulty existed as to the left. In fact, she testified that she had not previously experienced any trouble with that organ. It cannot be doubted that ordinarily the patient must be consulted, and his consent given, before a physician may operate upon him.

It was said in the case of *Pratt v. Davis*: "Under a free government, at least, the free citizen's first and greatest right, which underlies all others – the right to the inviolability of his person; in other words the right to himself – is the subject of universal acquiescence, and this right necessarily forbids a physician or surgeon, however skilful or eminent, who has been asked to examine, diagnose, advise, and prescribe (which are at least necessary first steps in treatment and care), to violate, without permission, the bodily integrity of his patient by a major or capital operation, placing him under an anaesthetic for that purpose, and operating upon him without his consent or knowledge."

1 KINKEAD TORTS, § 375, states the general rule on this subject as follows: "The patient must be the final arbiter as to whether he shall take his chances with the operation, or take his chances of living without it. Such is the natural right of the individual, which the law recognizes as a legal right. Consent, therefore, of an individual, must be either expressly or impliedly given before a surgeon may have the right to operate." There is logic in the principle thus stated, for, in all other trades, professions, or occupations, contracts are entered into by the mutual agreement of the interested parties, and are required to be performed in accordance with their letter and spirit. No reason occurs to us why the same rule should not apply between physician and patient. If the physician advises his patient to submit to a particular operation, and the patient weighs the dangers and risks incident to its performance, and finally consents, he thereby, in effect, enters into a contract authorizing his physician to operate to the extent of the consent given, but no further.

It is not, however, contended by defendant that under ordinary circumstances consent is unnecessary, but that, under the particular circumstances of this case, consent was implied; that it was an emergency case, such as to authorize the operation without express consent or permission.~ The medical profession has made signal progress in solving the problems of health and disease, and they may justly point with pride to the advancements made in supplementing nature and correcting deformities, and relieving pain and suffering~, but we are aware of no rule or principle of law which would extend to [a physician] free license respecting surgical operations. Reasonable latitude must, however, be allowed the physician in a particular case; and we would not lay down any rule which would unreasonably interfere with the exercise of his discretion, or prevent him from taking such measures as his judgment dictated for the welfare of the patient in a case of emergency. If a person should be injured to the extent of rendering him unconscious, and his injuries were of such a nature as to require prompt surgical attention, a physician called to attend him would be justified in applying such medical or surgical treatment as might

reasonably be necessary for the preservation of his life or limb, and consent on the part of the injured person would be implied. And again, if, in the course of an operation to which the patient consented, the physician should discover conditions not anticipated before the operation was commenced, and which, if not removed, would endanger the life or health of the patient, he would, though no express consent was obtained or given, be justified in extending the operation to remove and overcome them.

But such is not the case at bar. The diseased condition of plaintiff's left ear was not discovered in the course of an operation on the right which was authorized, but upon an independent examination of that organ, made after the authorized operation was found unnecessary.~

The last contention of defendant is that the act complained of did not amount to an assault and battery. This is based upon the theory that~ the absence of a showing that defendant was actuated by a wrongful intent, or guilty of negligence, relieves the act of defendant from the charge of an unlawful assault and battery.

We are unable to reach that conclusion,~ [i]f the operation was performed without plaintiff's consent, and the circumstances were not such as to justify its performance without, it was wrongful; and, if it was wrongful, it was unlawful. As remarked in 1 JAGGARD, TORTS, 437, every person has a right to complete immunity of his person from physical interference of others, except in so far as contact may be necessary under the general doctrine of privilege; and any unlawful or unauthorized touching of the person of another, except it be in the spirit of pleasantry, constitutes an assault and battery. In the case at bar,~ whether defendant's act in performing the operation upon plaintiff was authorized was a question for the jury to determine. If it was unauthorized, then it was, within what we have said, unlawful. It was a violent assault, not a mere pleasantry; and, even though no negligence is shown, it was wrongful and unlawful.~

The amount of plaintiff's recovery, if she is entitled to recover at all, must depend upon the character and extent of the injury

> inflicted upon her, in determining which the nature of the malady intended to be healed and the beneficial nature of the operation should be taken into consideration, as well as the good faith of the defendant.
>
> Orders affirmed.

Check-Your-Understanding Questions About *Mohr*

A. Would Anna Mohr have been able to sue in negligence? Why or why not?

B. Would Mohr have had a cause of action if she had been brought to the hospital unconscious and the surgery had been necessary on an emergency basis?

Questions to Ponder About *Mohr*

A. Do you think plaintiffs such as Anna Mohr should have a cause of action even in circumstances such as these where no harm is actually done?

B. If there is an interest in making sure that physicians do not exceed the scope of a patient's consent, could that be better handled through professional rules that are enforced by licensing boards? Or is the tort system a proper tool to use? Why or why not?

Informed Consent

An informed-consent action alleges that a patient was harmed by a physician's failure to disclose risks associated with medical treatment.

Informed-consent actions are something of a battery-negligence hybrid. That is, they have some things in common with the intentional tort of battery, and some things in common with the tort of negligence. As a matter of pleading, informed-consent actions might be brought as either an intentional tort or as negligence. Indeed, whether an informed-consent action is pled as an intentional tort or negligence may have important ramifications for what deadline applies for purposes of the statute of limitations (which typically is longer for negligence). Whether an informed-consent action is brought as an intentional tort or a negligence claim may also be important for determining whether a judgment would be covered

by insurance (generally insurance covers negligence but not battery). But as a conceptual matter, it is probably best to think of informed-consent actions as a breed of their own.

In general, an informed-consent action requires the following to be proved:

1. A risk should have been disclosed.
2. The risk was not disclosed.
3. The patient would have made a different decision about treatment if the risk had been disclosed.
4. The patient was injured as a result.

Let's look at an example of an easy prima facie case.

> ***Example: Spinal Injection –*** Suppose a man went to his physician with a complaint of moderate back pain. The physician suggested injecting a new drug directly into the spinal canal. The trials of this drug, used in this way, indicated a one-in-10 chance that permanent partial paralysis would result. The physician did not, however, disclose this risk. If the physician had disclosed the risk, the patient never would have agreed to the procedure – especially since the back pain was not severe. But, being ignorant of the risk, the patient was consented to the procedure. Unfortunately, the patient suffered paralysis as a result. Is there a good claim for informed consent? Yes. The patient will prevail in an informed-consent action. Why? There was a risk that should have been disclosed, the risk was not disclosed, the patient would have made a different decision if the risk had been disclosed, and the patient was injured. All the elements are met.

Let's discuss the requirements of an informed-consent action in a bit more detail:

1. The risk should have been disclosed. – The risk must be of the type that should have been disclosed in order for the patient to make an informed decision about the course of treatment. There are two

schools of thought on how to decide if the risk was of the type that should have been disclosed. One is to judge it by the standard of the reasonable physician. If the reasonable physician would have disclosed the risk, then this element of the informed-consent action has been fulfilled. This approach is sometimes called the **physician rule**. The other school of thought that the risk should be disclosed if it would be "material" to the reasonable patient. The word "material" here is related to the word "matter." A material risk is one that would *matter* to the patient's decision. This approach is sometimes called the **patient rule**.

2. The risk was not disclosed. The physician must omit to disclose the risk at issue. This requirement is generally a question of factual evidence to be submitted to the jury. In order to have evidence of the disclosure of risks readily available, it is common for physicians to ask patients who are about to undergo surgery or other invasive procedures to sign documents acknowledging that the risks have been explained to them.

3. The patient would have made a different decision about treatment if the risk had been disclosed. If, despite the risk, the patient would have gone ahead with the course of treatment anyway, then there is no claim. This requirement is essentially an actual causation requirement. If the patient would have had the treatment anyway, then it is not possible to say that *but for* the failure of the physician to disclose the risk, the patient would not have suffered the injury. There are two different approaches to this causation requirement. Some courts use a "subjective" standard, asking whether the particular plaintiff who is bringing the suit would have made a different decision. Other courts use an "objective" standard, asking whether the hypothetical reasonable patient would have made a different decision in awareness of the risk. The objective standard represents a slight departure from straightforward but-for causation.

4. The patient was thereby injured. In general, the patient must have suffered a bad outcome that counts as an injury. It is clear that an injury is required when the informed-consent action is brought as a form of negligence. In the absence of an injury, it may be possible to allege a claim of informed-consent as a battery action.

Case: Largey v. Rothman

The following is a leading case discussing in depth the question of whether informed consent action should use the physician-perspective to determine what risks should be disclosed (the physician rule) or the patient-perspective to determine what risks are material (the patient rule). You will notice that this case generally refers to the physician rule as the "'professional standard' rule," and the patient rule as the "'prudent patient' rule."

Largey v. Rothman

Supreme Court of New Jersey
May 5, 1988

JANICE LARGEY AND JOSEPH LARGEY, PLAINTIFFS-APPELLANTS, v. DONALD ROTHMAN, M.D., DEFENDANT-RESPONDENT. No. A-52. Justices Clifford, Handler, Pollock, Garibaldi, and Stein. All for reversal with none opposed.

PER CURIAM

This medical malpractice case raises an issue of a patient's informed consent to treatment. The jury found that plaintiff Janice Largey had consented to an operative procedure performed by the defendant physician. The single question presented goes to the correctness of the standard by which the jury was instructed to determine whether the defendant, Dr. Rothman, had adequately informed his patient of the risks of that operation.

The trial court told the jury that when informing the plaintiff Janice Largey of the risks of undergoing a certain biopsy procedure, described below, defendant was required to tell her "what reasonable medical practitioners in the same or similar circumstances would have told their patients undertaking the same type of operation." By answer to a specific interrogatory on this point, the jurors responded that defendant had not "fail[ed] to provide Janice Largey with sufficient information so that she could give informed consent" for the operative procedure. On plaintiffs' appeal the Appellate Division affirmed

in an unreported opinion, noting that the trial court's charge on informed consent followed the holding in *Kaplan v. Haines,* 96 N.J. Super. 242, 257 (App.Div. 1967), which this Court affirmed on the basis of the Appellate Division's opinion, 51 N.J. 404 (1968).

Plaintiffs argued below, and repeat the contention here, that the proper standard is one that focuses not on what information a reasonable doctor should impart to the patient (the "professional" standard) but rather on what the physician should disclose to a reasonable patient in order that the patient might make an informed decision (the "prudent patient" or "materiality of risk" standard). The latter is the standard announced in *Canterbury v. Spence*, 464 F.2d 772 (D.C.Cir. 1972). The Appellate Division rejected the *Canterbury* standard, not because it disagreed with that standard but because the court felt itself bound, correctly, by the different standard of *Kaplan*, which represents "the latest word" from this Court.

On plaintiffs' petition we granted certification, to address the correct standard for informed consent. We now discard *Kaplan's* "reasonable physician" standard and adopt instead the *Canterbury* "reasonable patient" rule. Hence, we reverse and remand for a new trial.

I

The narrow issue before us can be placed in satisfactory context by our adopting in pertinent part the Appellate Division's recitation of the facts. In the quoted passage as well as henceforth in this opinion, the word "plaintiff" refers to plaintiff Janice Largey.

> In the course of a routine physical examination plaintiff's gynecologist, Dr. Glassman, detected a "vague mass" in her right breast. The doctor arranged for mammograms to be taken. The radiologist reported two anomalies to the doctor: an "ill-defined density" in the subareola region and an enlarged lymph node or nodes, measuring four-by-two centimeters, in the right axilla (armpit). The doctor referred plaintiff to

defendant, a surgeon. Defendant expressed concern that the anomalies on the mammograms might be cancer and recommended a biopsy. There was a sharp dispute at trial over whether he stated that the biopsy would include the lymph nodes as well as the breast tissue. Plaintiff claims that defendant never mentioned the nodes.

Plaintiff submitted to the biopsy procedure after receiving a confirmatory second opinion from a Dr. Slattery. During the procedure defendant removed a piece of the suspect mass from plaintiff's breast and excised the nodes. The biopsies showed that both specimens were benign. About six weeks after the operation, plaintiff developed a right arm and hand lymphedema, a swelling caused by inadequate drainage in the lymphatic system. The condition resulted from the excision of the lymph nodes. Defendant did not advise plaintiff of this risk. Plaintiff's experts testified that defendant should have informed plaintiff that lymphedema was a risk of the operation. Defendant's experts testified that it was too rare to be discussed with a patient.

Plaintiff and her husband, who sued *per quod*, advanced two theories of liability * * *. They claimed that they were never told that the operation would include removal of the nodes and therefore that procedure constituted an unauthorized battery. Alternatively, they claimed that even if they had authorized the node excision, defendant was negligent in failing to warn them of the risk of lymphedema and therefore their consent was uninformed. The jury specifically rejected both claims.

II

The origins of the requirement that a physician obtain the patient's consent before surgery may be traced back at least two centuries. See *Slater v. Baker & Stapleton*, 95 *Eng.Rep.* 860

(K.B.1767). The doctrine is now well-embedded in our law. In *Schloendorff v. The Soc'y of the N.Y. Hosp.*, 211 *N.Y.* 125 (1914), Justice Cardozo announced a patient's right to be free of uninvited, unknown surgery, which constitutes a trespass on the patient: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages." Earlier case law recognized that theories of fraud and misrepresentation would sustain a patient's action in battery for an unauthorized intervention. Although that cause of action continues to be recognized in New Jersey, there is no "battery" claim implicated in this appeal because the jury determined as a matter of fact that plaintiff had given consent to the node excision performed by Dr. Rothman.

Although the requirement that a patient give consent before the physician can operate is of long standing, the doctrine of *informed* consent is one of relatively recent development in our jurisprudence. It is essentially a negligence concept, predicated on the duty of a physician to disclose to a patient such information as will enable the patient to make an evaluation of the nature of the treatment and of any attendant substantial risks, as well as of available options in the form of alternative therapies.

An early statement of the "informed consent" rule is found in *Salgo v. Leland Stanford, Jr. Univ. Bd. of Trustees*, 154 *Cal.App.*2d 560 (Dist.Ct.App.1957), in which the court declared that "[a] physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment." *Salgo* recognized that because each patient presents a "special problem," the physician has a certain amount of discretion in dismissing the element of risk, "consistent, of course, with the full disclosure of facts necessary to an informed consent."

Further development of the doctrine came shortly thereafter, in *Natanson v. Kline*, 186 *Kan.* 393 (1960), which represented one of

the leading cases on informed consent at that time. In *Natanson* a patient sustained injuries from excessive doses of radioactive cobalt during radiation therapy. Even though the patient had consented to the radiation treatment, she alleged that the physician had not informed her of the nature and consequences of the risks posed by the therapy. Thus, the case sounded in negligence rather than battery. The court concluded that when a physician either affirmatively misrepresents the nature of an operation or fails to disclose the probable consequences of the treatment, he may be subjected to a claim of unauthorized treatment. The *Natanson* court established the standard of care to be exercised by a physician in an informed consent case as "limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances." At bottom the decision turned on the principle of a patient's right of self-determination:

> Anglo-American law starts with the premise of thorough self-determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery, or other medical treatment. A doctor might well believe that an operation or form of treatment is desirable or necessary but the law does not permit him to substitute his own judgment for that of the patient by any form of artifice or deception.

After *Salgo* and *Natanson* the doctrine of informed consent came to be adopted and developed in other jurisdictions, which, until 1972, followed the "traditional" or "professional" standard formulation of the rule. Under that standard, as applied by the majority of the jurisdictions that adopted it, a physician is required to make such disclosure as comports with the prevailing medical standard in the community – that is, the disclosure of those risks that a reasonable physician in the community, of like training, would customarily make in similar circumstances. A minority of the jurisdictions that adhere to the "professional" standard do not relate the test to any kind of

community standard but require only such disclosures as would be made by a reasonable medical practitioner under similar circumstances. In order to prevail in a case applying the "traditional" or "professional" standard a plaintiff would have to present expert testimony of the community's medical standard for disclosure in respect of the procedure in question and of the defendant physician's failure to have met that standard.

In both the majority and minority formulations the "professional" standard rests on the belief that a physician, and *only* a physician, can effectively estimate both the psychological and physical consequences that a risk inherent in a medical procedure might produce in a patient. The burden imposed on the physician under this standard is to "consider the state of the patient's health, and whether the risks involved are mere remote possibilities or real hazards which occur with appreciable regularity * * *." A second basic justification offered in support of the "professional" standard is that "a general standard of care, as required under the prudent patient rule, would require a physician to waste unnecessary time in reviewing with the patient *every* possible risk, thereby interfering with the flexibility a physician needs in deciding what form of treatment is best for the patient."

It was the "professional" standard that this Court accepted when, twenty years ago, it made the doctrine of informed consent a component part of our medical malpractice jurisprudence. *See Kaplan v. Haines*. In falling into step with those other jurisdictions that by then had adopted informed consent, the Court approved the following from the Appellate Division's opinion in *Kaplan*:

> The authorities * * * are in general agreement that the nature and extent of the disclosure, essential to an informed consent, depends upon the medical problem as well as the patient. Plaintiff has the burden to prove what a reasonable medical practitioner of the same school and same or similar community, under the same or similar circumstances, would have

> disclosed to his patient and the issue is one for the jury where, as in the case *sub judice*, a fact issue is raised upon conflicting testimony as to whether the physician made an adequate disclosure.

In 1972 a new standard of disclosure for "informed consent" was established in *Canterbury v. Spence*. The case raised a question of the defendant physician's duty to warn the patient beforehand of the risk involved in a laminectomy, a surgical procedure the purpose of which was to relieve pain in plaintiff's lower back, and particularly the risk attendant on a myelogram, the diagnostic procedure preceding the surgery. After several surgical interventions and hospitalizations, plaintiff was still, at the time of trial, using crutches to walk, suffering from urinary incontinence and paralysis of the bowels, and wearing a penile clamp.

The *Canterbury* court announced a duty on the part of a physician to "warn of the dangers lurking in the proposed treatment" and to "impart information [that] the patient has every right to expect," as well as a duty of "reasonable disclosure of the choices with respect to proposed therapy and the dangers inherently and potentially involved." The court held that the scope of the duty to disclose

> must be measured by the patient's need, and that need is the information material to the decision. Thus the test for determining whether a particular peril must be divulged is its materiality to the patient's decision: all risks potentially affecting the decision must be unmasked. And to safeguard the patient's interest in achieving his own determination on treatment, the law must itself set the standard for adequate disclosure.

The breadth of the disclosure of the risks legally to be required is measured, under *Canterbury*, by a standard whose scope is "not subjective as to either the physician or the patient,"; rather, "it remains *objective* with due regard for the patient's informational needs and with suitable leeway for the physician's situation." A

risk would be deemed "material" when a reasonable patient, in what the physician knows or should know to be the patient's position, would be "likely to attach significance to the risk or cluster of risks" in deciding whether to forego the proposed therapy or to submit to it.

The foregoing standard for adequate disclosure, known as the "prudent patient" or "materiality of risk" standard, has been adopted in a number of jurisdictions.

The jurisdictions that have rejected the "professional" standard in favor of the "prudent patient" rule have given a number of reasons in support of their preference. Those include:

> (1) The existence of a discernible custom reflecting a medical consensus is open to serious doubt. The desirable scope of disclosure depends on the given fact situation, which varies from patient to patient, and should not be subject to the whim of the medical community in setting the standard.
>
> (2) Since a physician in obtaining a patient's informed consent to proposed treatment is often obligated to consider non-medical factors, such as a patient's emotional condition, professional custom should not furnish the legal criterion for measuring the physician's obligation to disclose. Whether a physician has conformed to a professional standard should * * * be important [only] where a pure medical judgment is involved, e.g. in ordinary malpractice actions, where the issue generally concerns the quality of treatment provided to the patient.
>
> (3) Closely related to both (1) and (2) is the notion that a professional standard is *totally* subject to the whim of the physicians in the particular community. Under this view a physician is vested with virtually unlimited discretion in establishing the proper scope of disclosure; this is inconsistent with the patient's right of self-determination. As observed by the

> court in *Canterbury v. Spence*: "Respect for the patient's right of self-determination * * * demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves."
>
> (4) The requirement that the patient present expert testimony to establish the professional standard has created problems for patients trying to find physicians willing to breach the "community of silence" by testifying against fellow colleagues.

Taken together, the reasons supporting adoption of the "prudent patient" standard persuade us that the time has come for us to abandon so much of the decision by which this Court embraced the doctrine of informed consent as accepts the "professional" standard. To that extent *Kaplan v. Haines* is overruled.

As indicated by the foregoing passages~, the policy considerations are clear-cut. At the outset we are entirely unimpressed with the argument, made by those favoring the "professional" standard, that the "prudent patient" rule would compel disclosure of *every* risk (not just *material* risks) to *any* patient (rather than the *reasonable* patient). As *Canterbury* makes clear,

> [t]he topics importantly demanding a communication of information are the inherent and potential hazards of the proposed treatment, the alternatives to that treatment, if any, and the results likely if the patient remains untreated. The factors contributing significance to the dangerousness of a medical technique are, of course, the incidence of injury and the degree of harm threatened.

The court in *Canterbury* did not presume to draw a "bright line separating the significant [risks] from the insignificant"; rather, it resorted to a "rule of reason," concluding that "[w]henever non-disclosure of particular risk information is open to debate by reasonable-minded men, the issue is one for the finder of facts."

The point assumes significance in this case because defendant argues that the risk of lymphedema from an axillary node biopsy is remote, not material. Plaintiff's experts disagree, contending that she should have been informed of that risk. Thus there will be presented on the retrial a factual issue for the jury's resolution: would the risk of lymphedema influence a prudent patient in reaching a decision on whether to submit to the surgery?

Perhaps the strongest consideration that influences our decision in favor of the "prudent patient" standard lies in the notion that the physician's duty of disclosure "arises from phenomena apart from medical custom and practice": the patient's right of self-determination. The foundation for the physician's duty to disclose in the first place is found in the idea that "it is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie." In contrast the arguments for the "professional" standard smack of an anachronistic paternalism that is at odds with any strong conception of a patient's right of self-determination.

Although today's decision marks the first time we have confronted directly the choice between the "professional" and "prudent patient" standards, and hence to that extent our stated preference for the latter represents a clear break with the past, surely the considerations that we have identified as having played a significant role in that choice are familiar features of our case law. For example, just two terms ago we declared that "[t]he doctrine of informed consent presupposes that the patient has the information necessary to evaluate the risks and benefits of all the available options and is competent to do so."

III

Finally, we address the issue of proximate cause. As with other medical malpractice actions, informed-consent cases require that plaintiff prove not only that the physician failed to comply with the applicable standard for disclosure but also that such failure was the proximate cause of plaintiff's injuries.

Under the "prudent patient" standard "causation must also be shown: *i.e.*, that the prudent person in the patient's position would have decided differently if adequately informed." As *Canterbury* observes,

> [t]he patient obviously has no complaint if he would have submitted to the therapy notwithstanding awareness that the risk was one of its perils. On the other hand, the very purpose of the disclosure rule is to protect the patient against consequences which, if known, he would have avoided by foregoing the treatment. The more difficult question is whether the factual issue on causality calls for an objective or a subjective determination.

Canterbury decided its own question in favor of an objective determination. The subjective approach, which the court rejected, inquires whether, if the patient had been informed of the risks that in fact materialized, he or she would have consented to the treatment. The shortcoming of this approach, according to *Canterbury*, is that it

> places the physician in jeopardy of the patient's hindsight and bitterness. It places the factfinder in the position of deciding whether a speculative answer to a hypothetical question is to be credited. It calls for a subjective determination solely on testimony of a patient-witness shadowed by the occurrence of the undisclosed risk.

The court therefore elected to adopt an objective test, as do we. Because we would not presume to attempt an improvement in its articulation of the reasons, we quote once again the *Canterbury* court:

> Better it is, we believe, to resolve the causality issue on an objective basis: in terms of what a prudent person in the patient's position would have decided if suitably informed of all perils bearing significance. If adequate disclosure could reasonably be expected to have caused

> that person to decline the treatment because of the revelation of the kind of risk or danger that resulted in harm, causation is shown, but otherwise not. The patient's testimony is relevant on that score of course but it would not threaten to dominate the findings. And since that testimony would probably be appraised congruently with the factfinder's belief in its reasonableness, the case for a wholly objective standard for passing on causation is strengthened. Such a standard would in any event ease the fact-finding process and better assure the truth as its product.

IV

The judgment of the Appellate Division is reversed. The cause is remanded for a new trial consistent with this opinion.

Questions to Ponder About *Largey*

A. Which is better, the physician rule (a/k/a the "'professional standard' rule") or the patient rule (a/k/a the "'prudent patient' rule")? Why?

B. Assuming that a jurisdiction opts for the patient rule, do you agree with the *Largey* court that the causation standard should be objective? Or should it be subjective? Stated differently, should the plaintiff have a cause of action if the hypothetical prudent patient would have made a different decision had the risk been disclosed? (The objective causation standard.) Or should it only matter whether the particular plaintiff would have made a different decision had the risk been disclosed? (The subjective causation standard.)

12. ERISA Preemption

"A rule without a penalty is just a suggestion."
– Unknown

Basics

The Employee Retirement Income Security Act of 1974 – known as "ERISA" – is a federal statute regulating employee benefits. ERISA is important in the negligence context because of its preemptive effect.

Federal laws can trump state laws – an effect called "preemption" – because of the Supremacy Clause of the U.S. Constitution in Article VI, Clause 2. It provides:

> "This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding."

This power allows federal statutes to erase state causes of action. As you know, tort law is a matter of state law.

The ERISA preemption provision is found in the federal statutes at 29 U.S.C. § 1144, but it is better known by its native section number as ERISA § 514. The statute provides:

> "[T]he provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan[.]"

This provision has been interpreted to bar tort lawsuits stemming from wrongfully withheld benefits. So if an employee is entitled to medical care under the employer's health plan, and that medical care is wrongfully denied, a common-law contract or tort lawsuit will not

be allowed. This has the effect of providing a substantial level of immunity for healthcare decisions made in the context of employee-benefit program. The ERISA preemption effect is especially sharply felt in the context of decisions made by health maintenance organizations (HMOs).

Although state-law causes of action are not available to employees wrongfully denied benefits, ERISA itself provides a cause of action. ERISA § 502 creates a special private right of action such that employees wrongfully denied benefits can sue to recover the value of the benefits. The crucial difference between ERISA § 502 and common-law causes of action lies in the amount recoverable. ERISA § 502 does not permit recovery for consequential damages or punitive damages. So if a person dies because of being wrongfully denied coverage for needed treatment under an employee-benefit plan, the recovery is limited to the monetary amount that should have been disbursed for the treatment. The family may not recover an amount that would compensate them for the loss of their loved one.

Critics charge that this gives insurers and HMOs little incentive to pay the benefits that insureds are legally due. If a health-care organization is confronted with an authorization request for a life-saving surgery that will cost $75,000, the organization can authorize the surgery, in which case it will be out $75,000, or the organization can withhold authorization, in which case it faces a potential liability – assuming a § 502 action is brought – of $75,000. This means that health-care organizations have little to lose by withholding treatment authorizations. Of course, if a health-care organization is chronically uncooperative, it can expect to lose customers. Since, however, the health-care organizations' true customer is the employer – not the covered employees – the organization may find that it wins more business by keeping costs low rather than through excellent service.

It is important to keep in mind what causes of action ERISA does not bar.

ERISA does not bar state tort law suits against health-insurers or HMOs that are not providing services as part of an employee benefit program. The vast majority of people with health insurance get that

insurance through an employee-benefit program. But where an individual contracts directly with a health-care insurer, ERISA does not apply. This point is particularly important, since the number of individuals getting insurance outside the employment context is increasing because of "Obamacare" – the Patient Protection and Affordable Care Act of 2010.

Moreover, ERISA does not bar suits against physicians who commit malpractice. Similarly, ERISA does not bar medical negligence lawsuits against hospitals. This is true even when the physicians' bills and hospital bills are being paid by an employee-benefit plan. Moreover, courts have often allowed suits against HMOs where the physician is directly employed by the HMO and where the basis of the claim is one of vicarious liability for employing the malpractice-committing physician.

Case: *Corcoran v. United Healthcare*

The following leading case shows the power of ERISA preemption in action and indicates the extent of its effect on common-law torts.

Corcoran v. United Healthcare

United States Court of Appeals for the Fifth Circuit
June 26, 1992

965 F.2d 1321. FLORENCE B. CORCORAN Wife of/and WAYNE D. CORCORAN, Plaintiffs-Appellants, v. UNITED HEALTHCARE, INC., and BLUE CROSS and BLUE SHIELD OF ALABAMA, INC., Defendants-Appellees. No. 91-3322. THORNBERRY, KING, and DeMOSS, Circuit Judges.

Judge CAROLYN DINEEN KING:

This appeal requires us to decide whether ERISA pre-empts a state-law malpractice action brought by the beneficiary of an ERISA plan against a company that provides "utilization review" services to the plan. We also address the availability under ERISA of extracontractual damages. The district court granted the defendants' motion for summary judgment, holding that ERISA both pre-empted the plaintiffs' medical malpractice

claim and precluded them from recovering emotional distress damages. We affirm.

I. BACKGROUND

The basic facts are undisputed. Florence Corcoran, a long-time employee of South Central Bell Telephone Company (Bell), became pregnant in early 1989. In July, her obstetrician, Dr. Jason Collins, recommended that she have complete bed rest during the final months of her pregnancy. Mrs. Corcoran applied to Bell for temporary disability benefits for the remainder of her pregnancy, but the benefits were denied. This prompted Dr. Collins to write to Dr. Theodore J. Borgman, medical consultant for Bell, and explain that Mrs. Corcoran had several medical problems which placed her "in a category of high risk pregnancy." Bell again denied disability benefits. Unbeknownst to Mrs. Corcoran or Dr. Collins, Dr. Borgman solicited a second opinion on Mrs. Corcoran's condition from another obstetrician, Dr. Simon Ward. In a letter to Dr. Borgman, Dr. Ward indicated that he had reviewed Mrs. Corcoran's medical records and suggested that "the company would be at considerable risk denying her doctor's recommendation." As Mrs. Corcoran neared her delivery date, Dr. Collins ordered her hospitalized so that he could monitor the fetus around the clock. ⤷This was the same course of action Dr. Collins had ordered during Mrs. Corcoran's 1988 pregnancy. In that pregnancy, Dr. Collins intervened and performed a successful Caesarean section in the 36th week when the fetus went into distress.⤶

Mrs. Corcoran was a member of Bell's Medical Assistance Plan (MAP or "the Plan"). MAP is a self-funded welfare benefit plan which provides medical benefits to eligible Bell employees. It is administered by defendant Blue Cross and Blue Shield of Alabama (Blue Cross) pursuant to an Administrative Services Agreement between Bell and Blue Cross. The parties agree that it is governed by ERISA ⤷Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829, 29 U.S.C. §§ 1001-1461.⤶

Under a portion of the Plan known as the "Quality Care Program" (QCP), participants must obtain advance approval for overnight hospital admissions and certain medical procedures ("pre-certification"), and must obtain approval on a continuing basis once they are admitted to a hospital ("concurrent review"), or plan benefits to which they otherwise would be entitled are reduced.

QCP is administered by defendant United HealthCare (United) pursuant to an agreement with Bell. United performs a form of cost-containment service that has commonly become known as "utilization review." *See* Blum, *An Analysis of Legal Liability in Health Care Utilization Review and Case Management,* 26 Hous. L. Rev. 191, 192-93 (1989) (Utilization review refers to "external evaluations that are based on established clinical criteria and are conducted by third-party payors, purchasers, or health care organizers to evaluate the appropriateness of an episode, or series of episodes, of medical care."). The Summary Plan Description (SPD) explains QCP as follows:

> The Quality Care Program (QCP), administered by United HealthCare, Inc., assists you and your covered dependents in securing quality medical care according to the provisions of the Plan while helping reduce risk and expense due to unnecessary hospitalization and surgery. They do this by providing you with information which will permit you (in consultation with your doctor) to evaluate alternatives to surgery and hospitalization when those alternatives are medically appropriate. In addition, QCP will monitor any certified hospital confinement to keep you informed as to whether or not the stay is covered by the Plan.

Two paragraphs below, the SPD contains this statement: **When reading this booklet, remember that all decisions regarding your medical care are up to you and your doctor.** It goes on to explain that when a beneficiary does not contact United or follow its pre-certification decision, a "QCP Penalty" is applied. The penalty involves reduction of benefits by 20 percent for the

remainder of the calendar year or until the annual out-of-pocket limit is reached. Moreover, the annual out-of-pocket limit is increased from $ 1,000 to $ 1,250 in covered expenses, not including any applicable deductible. According to the QCP Administrative Manual, the QCP penalty is automatically applied when a participant fails to contact United. However, if a participant complies with QCP by contacting United, but does not follow its decision, the penalty may be waived following an internal appeal if the medical facts show that the treatment chosen was appropriate.

A more complete description of QCP and the services provided by United is contained in a separate booklet. Under the heading "WHAT QCP DOES" the booklet explains:

> Whenever your doctor recommends surgery or hospitalization for you or a covered dependent, QCP will provide an independent review of your condition (or your covered dependent's). The purpose of the review is to assess the need for surgery or hospitalization and to determine the appropriate length of stay for a hospitalization, based on nationally accepted medical guidelines. As part of the review process, QCP will discuss with your doctor the appropriateness of the treatments recommended and the availability of alternative types of treatments – or locations for treatment – that are equally effective, involve less risk, and are more cost effective.

The next paragraph is headed "INDEPENDENT, PROFESSIONAL REVIEW" and states:

> United Health Care, an independent professional medical review organization, has been engaged to provide services under QCP. United's staff includes doctors, nurses, and other medical professionals knowledgeable about the health care delivery system. Together with your doctor, they work to assure that you and your covered family members receive the most appropriate medical care.

At several points in the booklet, the themes of "independent medical review" and "reduction of unnecessary risk and expense" are repeated. Under a section entitled "THE QUALITY CARE PROGRAM … AT A GLANCE" the booklet states that QCP "Provides independent, professional review when surgery or hospitalization is recommended – to assist you in making an enlightened decision regarding your treatment." QCP "[p]rovides improved quality of care by eliminating medically unnecessary treatment," but beneficiaries who fail to use it "may be exposed to unnecessary health risks. …" Elsewhere, in the course of pointing out that studies show one-third of all surgery may be unnecessary, the booklet explains that programs such as QCP "help reduce unnecessary and inappropriate care and eliminate their associated costs." Thus, "one important service of QCP will help you get a second opinion when your doctor recommends surgery."

The booklet goes on to describe the circumstances under which QCP must be utilized. When a Plan member's doctor recommends admission to the hospital, independent medical professionals will review, with the patient's doctor, the medical findings and the proposed course of treatment, including the medically necessary length of confinement. The Quality Care Program may require additional tests or information (including second opinions), when determined necessary during consultation between QCP professionals and the attending physician.

When United certifies a hospital stay, it monitors the continuing necessity of the stay. It also determines, for certain medical procedures and surgeries, whether a second opinion is necessary, and authorizes, where appropriate, certain alternative forms of care. Beneficiaries are strongly encouraged to use QCP to avoid loss of benefits: "'fully using' QCP means following the course of treatment that's recommended by QCP's medical professionals."

In accordance with the QCP portion of the plan, Dr. Collins sought pre-certification from United for Mrs. Corcoran's hospital stay. Despite Dr. Collins's recommendation, United

determined that hospitalization was not necessary, and instead authorized 10 hours per day of home nursing care.

Mrs. Corcoran entered the hospital on October 3, 1989, but, because United had not pre-certified her stay, she returned home on October 12. On October 25, during a period of time when no nurse was on duty, the fetus went into distress and died.

Mrs. Corcoran and her husband, Wayne, filed a wrongful death action in Louisiana state court alleging that their unborn child died as a result of various acts of negligence committed by Blue Cross and United. Both sought damages for the lost love, society and affection of their unborn child. In addition, Mrs. Corcoran sought damages for the aggravation of a pre-existing depressive condition and the loss of consortium caused by such aggravation, and Mr. Corcoran sought damages for loss of consortium. The defendants removed the action to federal court on grounds that it was pre-empted by ERISA and that there was complete diversity among the parties. ↳*See Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 66 (1987) (because ERISA pre-emption is so comprehensive, pre-emption defense provides sufficient basis for removal to federal court notwithstanding "well-pleaded complaint" rule).↵

Shortly thereafter, the defendants moved for summary judgment. They argued that the Corcorans' cause of action, properly characterized, sought damages for improper handling of a claim from two entities whose responsibilities were simply to administer benefits under an ERISA-governed plan. They contended that their relationship to Mrs. Corcoran came into existence solely as a result of an ERISA plan and was defined entirely by the plan. Thus, they urged the court to view the claims as "relating to" an ERISA plan, and therefore within the broad scope of state law claims pre-empted by the statute. In their opposition to the motion, the Corcorans argued that "this case essentially boils down to one for malpractice against United HealthCare. … " They contended that under this court's analysis in *Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enterprises, Inc.,* 793 F.2d 1456 (5th Cir. 1986), their cause of

action must be classified as a state law of general application which involves an exercise of traditional state authority and affects principal ERISA entities in their individual capacities. This classification, they argued, together with the fact that pre-emption would contravene the purposes of ERISA by leaving them without a remedy, leads to the conclusion that the action is permissible notwithstanding ERISA.

The district court, relying on the broad ERISA pre-emption principles developed by the Supreme Court and the Fifth Circuit, granted the motion. The court noted that ERISA pre-emption extends to state law claims "'of general application,' including tort claims where ERISA ordinarily plays no role in the state law at issue." The court found that the state law claim advanced by the Corcorans "related to" the employee benefit plan (citing the statutory pre-emption clause, ERISA § 514(a)), and therefore was pre-empted, because

> but for the ERISA plan, the defendants would have played no role in Mrs. Corcoran's pregnancy; the sole reason the defendants had anything to do with her pregnancy is because the terms of the ERISA plan directed Mrs. Corcoran to the defendants (or at least to United HealthCare) for approval of coverage of the medical care she initially sought.

The court held that, because the ERISA plan was the source of the relationship between the Corcorans and the defendants, the Corcorans' attempt to distinguish United's role in paying claims from its role as a source of professional medical advice was unconvincing.

The Corcorans filed a motion for reconsideration under Rule 59 of the Federal Rules of Civil Procedure. They did not ask the district court to reconsider its pre-emption ruling, but instead contended that language in the district court's opinion had implicitly recognized that they had a separate cause of action under ERISA's civil enforcement mechanism, § 502(a)(3). The district court had stated that "because the plaintiffs concede that the defendants have fully paid any and all medical expenses that

Mrs. Corcoran actually incurred that were covered by the plan, the plaintiffs have no remaining claims under ERISA." In a footnote, the court indicated that Mrs. Corcoran could have (1) sued under ERISA, before entering the hospital, for a declaratory judgment that she was entitled to hospitalization benefits; or (2) gone into the hospital, incurred out-of-pocket expenses, and sued under ERISA for these expenses.[↵] They argued that the Supreme Court's decision in *Massachusetts Mutual Life Ins. Co. v. Russell,* 473 U.S. 134 (1985), did not foreclose the possibility that compensatory damages such as they sought constituted "other appropriate equitable relief" available under § 502(a)(3) for violations of ERISA or the terms of an ERISA plan. The district court denied the motion. Although the court recognized that there was authority to the contrary, it pointed out that "the vast majority of federal appellate courts have … held that a beneficiary under an ERISA health plan may not recover under section 509(a)(3) [sic] of ERISA compensatory or consequential damages for emotional distress or other claims beyond medical expenses covered by the plan." (citations omitted). Moreover, the court pointed out, a prerequisite to recovery under § 502(a)(3) is a violation of the terms of ERISA itself. ERISA does not place upon the defendants a substantive responsibility in connection with the provision of medical advice which, if breached, would support a claim under § 502(a)(3). The court entered final judgment in favor of Blue Cross and United, and this appeal followed.

II. STANDARD OF REVIEW

Because this case is on appeal from the district court's grant of summary judgment, our review is plenary. We view the evidence in the light most favorable to the nonmoving party~.

III. PRE-EMPTION OF THE STATE LAW CAUSE OF ACTION

A. The Nature of the Corcorans' State Law Claims

The Corcorans' original petition in state court alleged that acts of negligence committed by Blue Cross and United caused the death of their unborn child. Specifically, they alleged that Blue

Cross wrongfully denied appropriate medical care, failed adequately to oversee the medical decisions of United, and failed to provide United with Mrs. Corcoran's complete medical background. They alleged that United wrongfully denied the medical care recommended by Dr. Collins and wrongfully determined that home nursing care was adequate for her condition. It is evident that the Corcorans no longer pursue any theory of recovery against Blue Cross~, they challenge only the district court's conclusion that ERISA pre-empts their state law cause of action against United.~

The claims against United arise from a relatively recent phenomenon in the health care delivery system – the prospective review by a third party of the necessity of medical care. Systems of prospective and concurrent review, rather than traditional retrospective review, were widely adopted throughout the 1980s as a method of containing the rapidly rising costs of health care. Blum, *supra,* at 192; Furrow, *Medical Malpractice and Cost Containment: Tightening the Screws,* 36 Case Western L. Rev. 985, 986-87 (1986). Under the traditional retrospective system (also commonly known as the fee-for-service system), the patient obtained medical treatment and the insurer reviewed the provider's claims for payment to determine whether they were covered under the plan. Denial of a claim meant that the cost of treatment was absorbed by an entity other than the one designed to spread the risk of medical costs – the insurer.

Congress's adoption in 1983 of a system under which hospitals are reimbursed for services provided to Medicare patients based upon average cost calculations for patients with particular diagnoses spurred private insurers to institute similar programs in which prospective decisions are made about the appropriate level of care. Although plans vary, the typical prospective review system requires some form of pre-admission certification by a third party (e.g., the HMO if an HMO-associated doctor provides care; an outside organization such as United if an independent physician provides care) before a hospital stay. Concurrent review involves the monitoring of a hospital stay to determine its continuing appropriateness. *See generally,* Blum, *supra,* at 192-93; Tiano, *The Legal Implications of HMO Cost*

Containment Measures, 14 Seton Hall Legis. J. 79, 80 (1990). As the SPD makes clear, United performs this sort of prospective and concurrent review (generically, "utilization review") in connection with, *inter alia,* the hospitalization of Bell employees.

The Corcorans based their action against United on Article 2315 of the Louisiana Civil Code, which provides that "every act whatever of man that causes damage to another obliges him by whose fault it happened to repair it." Article 2315 provides parents with a cause of action for the wrongful death of their unborn children, and also places liability on health care providers when they fail to live up to the applicable standard of care.~

B. Principles of ERISA Pre-emption

The central inquiry in determining whether a federal statute pre-empts state law is the intent of Congress. In performing this analysis we begin with any statutory language that expresses an intent to pre-empt, but we look also to the purpose and structure of the statute as a whole.

ERISA contains an explicit pre-emption clause, which provides, in relevant part:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a). …

ERISA § 514(a). It is by now well-established that the "deliberately expansive" language of this clause, *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 46 (1987), is a signal that it is be construed extremely broadly. *See FMC Corp.,* ("the pre-emption clause is conspicuous for its breadth"). The key words "relate to" are used in such a way as to expand pre-emption beyond state laws that relate to the specific subjects covered by ERISA, such as reporting, disclosure and fiduciary obligations. Thus, state laws "relate[] to" employee benefit plans in a much broader sense – whenever they have "a connection with or reference to

such a plan." *Shaw v. Delta Air Lines, Inc.,* 463 U.S. 85, 96-97 (1983). This sweeping pre-emption of state law is consistent with Congress's decision to create a comprehensive, uniform federal scheme for the regulation of employee benefit plans.

The most obvious class of pre-empted state laws are those that are specifically designed to affect ERISA-governed employee benefit plans. But a law is not saved from pre-emption merely because it does not target employee benefit plans. Indeed, much pre-emption litigation involves laws of general application which, when applied in particular settings, can be said to have a connection with or a reference to an ERISA plan. *See Pilot Life,* 481 U.S. at 47-48 (common law tort and contract causes of action seeking damages for improper processing of a claim for benefits under a disability plan are pre-empted); *Shaw,* 463 U.S. at 95-100 (statute interpreted by state court as prohibiting plans from discriminating on the basis of pregnancy is pre-empted); *Christopher v. Mobil Oil Corp.,* 950 F.2d 1209, 1218 (5th Cir. 1992) (common law fraud and negligent misrepresentation claims that allege reliance on agreements or representations about the coverage of a plan are pre-empted). On the other hand, the Court has recognized that not every conceivable cause of action that may be brought against an ERISA-covered plan is pre-empted. "Some state actions may affect employee benefit plans in too tenuous, remote or peripheral a manner to warrant a finding that the law 'relates to' the plan." Thus, "run-of-the-mill state-law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan" are not pre-empted.

C. Pre-emption of the Corcorans' Claims

Initially, we observe that the common law causes of action advanced by the Corcorans are not that species of law "specifically designed" to affect ERISA plans, for the liability rules they seek to invoke neither make explicit reference to nor are premised on the existence of an ERISA plan. Rather, applied in this case against a defendant that provides benefit-related services to an ERISA plan, the generally applicable negligence-based causes of action may have an effect on an ERISA-

governed plan. In our view, the pre-emption question devolves into an assessment of the significance of these effects.

1. United's position – it makes benefit determinations, not medical decisions

United's argument in favor of pre-emption is grounded in the notion that the decision it made concerning Mrs. Corcoran was not primarily a medical decision, but instead was a decision made in its capacity as a plan fiduciary about what benefits were authorized under the Plan. All it did, it argues, was determine whether Mrs. Corcoran qualified for the benefits provided by the plan by applying previously established eligibility criteria. The argument's coup de grace is that under well-established precedent, participants may not sue in tort to redress injuries flowing from decisions about what benefits are to be paid under a plan. One commentator has endorsed this view of lawsuits against providers of utilization review services, arguing that, because medical services are the "benefits" provided by a utilization review company, complaints about the quality of medical services (i.e., lawsuits for negligence) "can therefore be characterized as claims founded upon a constructive denial of plan benefits." Chittenden, *Malpractice Liability and Managed Health Care: History & Prognosis,* 26 Tort & Ins. Law J. 451, 489 (1991).

In support of its argument, United points to its explanatory booklet and its language stating that the company advises the patient's doctor "what the medical plan will pay for, based on a review of [the patient's] clinical information and nationally accepted medical guidelines for the treatment of [the patient's] condition." It also relies on statements to the effect that the ultimate medical decisions are up to the beneficiary's doctor. It acknowledges at various points that its decision about what benefits would be paid was based on a consideration of medical information, but the thrust of the argument is that it was simply performing commonplace administrative duties akin to claims handling.

Because it was merely performing claims handling functions when it rejected Dr. Collins's request to approve Mrs.

Corcoran's hospitalization, United contends, the principles of *Pilot Life* and its progeny squarely foreclose this lawsuit. In *Pilot Life,* a beneficiary sought damages under various state-law tort and contract theories from the insurance company that determined eligibility for the employer's long term disability benefit plan. The company had paid benefits for two years, but there followed a period during which the company terminated and reinstated the beneficiary several times. The Court made clear, however, that ERISA pre-empts state-law tort and contract actions in which a beneficiary seeks to recover damages for improper processing of a claim for benefits. United suggests that its actions here were analogous to those of the insurance company in *Pilot Life,* and therefore urges us to apply that decision.

2. The Corcorans' position – United makes medical decisions, not benefit determinations

The Corcorans assert that *Pilot Life* and its progeny are inapposite because they are not advancing a claim for improper processing of benefits. Rather, they say, they seek to recover solely for United's erroneous medical decision that Mrs. Corcoran did not require hospitalization during the last month of her pregnancy. This argument, of course, depends on viewing United's action in this case as a medical decision, and not merely an administrative determination about benefit entitlements. Accordingly, the Corcorans, pointing to the statements United makes in the QCP booklet concerning its medical expertise, contend that United exercised medical judgment which is outside the purview of ERISA pre-emption.

The Corcorans suggest that a medical negligence claim is permitted under the analytical framework we have developed for assessing pre-emption claims. Relying on *Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enterprises, Inc.,* 793 F.2d 1456 (5th Cir. 1986), they contend that we should not find the state law under which they proceed pre-empted because it (1) involves the exercise of traditional state authority and (2) is a law of general application which, although it affects relations

between principal ERISA entities in this case, is not designed to affect the ERISA relationship.

3. Our view – United makes medical decisions incident to benefit determinations

We cannot fully agree with either United or the Corcorans. Ultimately, we conclude that United makes medical decisions – indeed, United gives medical advice – but it does so in the context of making a determination about the availability of benefits under the plan. Accordingly, we hold that the Louisiana tort action asserted by the Corcorans for the wrongful death of their child allegedly resulting from United's erroneous medical decision is pre-empted by ERISA.

Turning first to the question of the characterization of United's actions, we note that the QCP booklet and the SPD lend substantial support to the Corcorans' argument that United makes medical decisions. United's own booklet tells beneficiaries that it "assesses the need for surgery or hospitalization and … determines the appropriate length of stay for a hospitalization, based on nationally accepted medical guidelines." United "will discuss with your doctor the appropriateness of the treatments recommended and the availability of alternative types of treatments." Further, "United's staff includes doctors, nurses, and other medical professionals knowledgeable about the health care delivery system. Together with your doctor, they work to assure that you and your covered family members receive the most appropriate medical care." According to the SPD, United will "provide you with information which will permit you (in consultation with your doctor) to evaluate alternatives to surgery and hospitalization when those alternatives are medically appropriate."

United makes much of the disclaimer that decisions about medical care are up to the beneficiary and his or her doctor. While that may be so, and while the disclaimer may support the conclusion that the relationship between United and the beneficiary is not that of doctor-patient, it does not mean that United does not make medical decisions or dispense medical

advice. *See Wickline,* 239 Cal. Rptr. at 819 (declining to hold Medi-Cal liable but recognizing that it made a medical judgment); Macaulay, *Health Care Cost Containment and Medical Malpractice: On a Collision Course,* 19 Suffolk U.L. Rev. 91, 106-07 (1986) ("As illustrated in *[Wickline],* an adverse prospective determination on the 'necessity' of medical treatment may involve complex medical judgment.") (footnote omitted). In response, United argues that any such medical determination or advice is made or given in the context of administering the benefits available under the Bell plan. Supporting United's position is the contract between United and Bell, which provides that "[United] shall contact the Participant's physician and based upon the medical evidence and normative data determine whether the Participant should be eligible to receive full plan benefits for the recommended hospitalization and the duration of benefits."

United argues that the decision it makes in this, the prospective context, is no different than the decision an insurer makes in the traditional retrospective context. The question in each case is "what the medical plan will pay for, based on a review of [the beneficiary's] clinical information and nationally accepted medical guidelines for the treatment of [the beneficiary's] condition." *See* QCP Booklet at 4. A prospective decision is, however, different in its impact on the beneficiary than a retrospective decision. In both systems, the beneficiary theoretically knows in advance what treatments the plan will pay for because coverage is spelled out in the plan documents. But in the retrospective system, a beneficiary who embarks on the course of treatment recommended by his or her physician has only a potential risk of disallowance of all or a part of the cost of that treatment, and then only after treatment has been rendered. In contrast, in a prospective system a beneficiary may be squarely presented in advance of treatment with a statement that the insurer will not pay for the proposed course of treatment recommended by his or her doctor and the beneficiary has the potential of recovering the cost of that treatment only if he or she can prevail in a challenge to the insurer's decision. A beneficiary in the latter system would likely be far less inclined

to undertake the course of treatment that the insurer has at least preliminarily rejected.

By its very nature, a system of prospective decisionmaking influences the beneficiary's choice among treatment options to a far greater degree than does the theoretical risk of disallowance of a claim facing a beneficiary in a retrospective system. Indeed, the perception among insurers that prospective determinations result in lower health care costs is premised on the likelihood that a beneficiary, faced with the knowledge of specifically what the plan will and will not pay for, will choose the treatment option recommended by the plan in order to avoid risking total or partial disallowance of benefits. When United makes a decision pursuant, QCP, it is making a medical recommendation which – because of the financial ramifications – is more likely to be followed.~

Although we disagree with United's position that no part of its actions involves medical decisions, we cannot agree with the Corcorans that no part of United's actions involves benefit determinations. In our view, United makes medical decisions as part and parcel of its mandate to decide what benefits are available under the Bell plan. As the QCP Booklet concisely puts it, United decides "what the medical plan will pay for." When United's actions are viewed from this perspective, it becomes apparent that the Corcorans are attempting to recover for a tort allegedly committed in the course of handling a benefit determination. The nature of the benefit determination is different than the type of decision that was at issue in *Pilot Life,* but it is a benefit determination nonetheless. The principle of *Pilot Life* that ERISA pre-empts state-law claims alleging improper handling of benefit claims is broad enough to cover the cause of action asserted here.

Moreover, allowing the Corcorans' suit to go forward would contravene Congress's goals of "ensuring that plans and plan sponsors would be subject to a uniform body of benefit law" and "minimizing the administrative and financial burdens of complying with conflicting directives among States or between States and the Federal Government." Thus, statutes that subject

plans to inconsistent regulatory schemes in different states, thereby increasing inefficiency and potentially causing the plan to respond by reducing benefit levels, are consistently held pre-empted.~

[A]lthough imposing liability on United might have the salutary effect of deterring poor quality medical decisions, there is a significant risk that state liability rules would be applied differently to the conduct of utilization review companies in different states. The cost of complying with varying substantive standards would increase the cost of providing utilization review services, thereby increasing the cost to health benefit plans of including cost containment features such as the Quality Care Program (or causing them to eliminate this sort of cost containment program altogether) and ultimately decreasing the pool of plan funds available to reimburse participants. *See* Macaulay, *supra,* at 105.

~The acknowledged absence of a remedy under ERISA's civil enforcement scheme for medical malpractice committed in connection with a plan benefit determination does not alter our conclusion. While we are not unmindful of the fact that our interpretation of the pre-emption clause leaves a gap in remedies within a statute intended to protect participants in employee benefit plans, the lack of an ERISA remedy does not affect a pre-emption analysis. Congress perhaps could not have predicted the interjection into the ERISA "system" of the medical utilization review process, but it enacted a pre-emption clause so broad and a statute so comprehensive that it would be incompatible with the language, structure and purpose of the statute to allow tort suits against entities so integrally connected with a plan.

* * *

The result ERISA compels us to reach means that the Corcorans have no remedy, state or federal, for what may have been a serious mistake. This is troubling for several reasons. First, it eliminates an important check on the thousands of medical decisions routinely made in the burgeoning utilization review system. With liability rules generally inapplicable, there is

theoretically less deterrence of substandard medical decisionmaking. Moreover, if the cost of compliance with a standard of care (reflected either in the cost of prevention or the cost of paying judgments) need not be factored into utilization review companies' cost of doing business, bad medical judgments will end up being cost-free to the plans that rely on these companies to contain medical costs. ERISA plans, in turn, will have one less incentive to seek out the companies that can deliver both high quality services and reasonable prices.

Second, in any plan benefit determination, there is always some tension between the interest of the beneficiary in obtaining quality medical care and the interest of the plan in preserving the pool of funds available to compensate all beneficiaries. In a prospective review context, with its greatly increased ability to deter the beneficiary (correctly or not) from embarking on a course of treatment recommended by the beneficiary's physician, the tension between interest of the beneficiary and that of the plan is exacerbated. A system which would, at least in some circumstances, compensate the beneficiary who changes course based upon a wrong call for the costs of that call might ease the tension between the conflicting interests of the beneficiary and the plan.

Finally, cost containment features such as the one at issue in this case did not exist when Congress passed ERISA. While we are confident that the result we have reached is faithful to Congress's intent neither to allow state-law causes of action that relate to employee benefit plans nor to provide beneficiaries in the Corcorans' position with a remedy under ERISA, the world of employee benefit plans has hardly remained static since 1974. Fundamental changes such as the widespread institution of utilization review would seem to warrant a reevaluation of ERISA so that it can continue to serve its noble purpose of safeguarding the interests of employees. Our system, of course, allocates this task to Congress, not the courts, and we acknowledge our role today by interpreting ERISA in a manner consistent with the expressed intentions of its creators.

Questions to Ponder About *Corcoran*

A. Do you agree that the language of the ERISA statute requires the preemption of medical malpractice suits of the kind brought in the *Corcoran* case?

B. Putting aside the language of the ERISA statute, do you think such pre-emption is a good idea? What are the arguments for and against it as a matter of policy?

Aftermatter

Unmarked Edits Generally

(For both volumes)

Various edits are not marked in the text. They have been left unmarked because to mark them would have made the text substantially less readable.

In general, whole citations and portions of citations have been liberally removed from the readings. Parallel citations have been removed generally. Spaces have been added or deleted in cases where the observed style was unconventional and jarring. In cases where case names were printed in roman type, case names have generally been italicized. Where quotation marks occurred around a blockquote, they have generally been removed. Lengthy portions of quoted material have sometimes been re-set as blockquotes. Dashes and ellipses have been set in a uniform typographical style regardless of how they appeared in the original document. Official headnote references have been eliminated. In addition, I have sought to remove all indicia of additions to any text made by unofficial publishers. Footnote references and footnotes have been removed without notation.

The author attributions at the beginning of case material, in general, are not attributable to the original source. In various places, the spelled-out word "section" has been replaced with the § symbol, including in *Rowland v. Christian, Beswick v. CareStat,* the text discussing California Civil Code § 847, and *Issacs v. Monkeytown, U.S.A.* Typesetting for citations may have been changed, such as from lower-case to small-caps for titles of journals, for example in *Tarasoff v. UC Regents* and *Weirum v. RKO.*

Case citations have generally been changed so that where the court uses a secondary-reference citation style, if it is the first reference in the case as it appears in edited form in this casebook, the secondary-reference cite has been replaced with the full citation as is appropriate

for use on first reference. In some cases, punctuation was changed to accommodate cites that were eliminated without notation.

Idiosyncratic Unmarked Edits in this Volume

Idiosyncratic unmarked edits were made as follows:

Material from footnotes was reworked into the body of the text without notation in the following cases: *Georgetown v. Wheeler, Rogers v. Retrum, Bruenig v. American Family Insurance, Sindell v. Abbott Labs,* and *Cocoran v. United Healthcare.* The reworked material does not necessarily appear at the precise point of the omitted footnote reference (often done because references were in the middle of sentences). Punctuation has in some cases been added or altered to accommodate this.

Georgetown v. Wheeler: An asterisk has been used to replace a numerical reference for a footnote reproduced in the case.

Weirum v. RKO: Quotation marks have been removed for material reformatted as a blockquote.

Boyd v. Racine Currency Exchange: Some text has been rearranged without notation. Recited facts are as alleged.

South v. Amtrak: Quotation marks have been removed for material reformatted as a blockquote. Underlining has been changed to italics. Some brackets have been changed to parentheses. "AMTRAK" has been changed to "Amtrak".

Vaughn v. Menlove: Two periods have been replaced by colons at the ends of paragraphs introducing the appellate lawyers' arguments.

Martin v. Herzog: A colon has been added without notation. Quoted matter re-set as blockquotes. Numbers spelled out in words have been replaced in appropriate instances with numerals.

In the text from *Calvillo-Silva v. Home Grocery* that follows California Civil Code § 847, spaces after dollar signs have been removed.

Campbell v. Weathers: Testimony excerpts have been reformatted and quotation marks dropped. Other quoted matter has been reformatted as blockquotes.

Rowland v. Christian: Long quotations have been re-set as block quotes.

In *the T.J. Hooper* and *United States v. Carroll Towing,* single quotes around vessel names were removed and vessel names were italicized. Inconsistent use of a period after "Anna C" was corrected to remove all such periods except where occurring at the end of sentences. In *Carroll Towing,* a typo "it it" was corrected to "it."

In *Fowler v. Seaton*: The errant comma in "September, 1958" was removed.

Beswick v. CareStat: A missing period was supplied. Some quoted matter was re-formatted in blockquote form.

Herskovits v. Group Health: Roman numeral section headers have been removed. Secondary-reference cites have been altered to be put into the form of first-reference cites, since the locations of the first-reference cites were removed through editing. The order of the opinions (concurring and dissenting) has been changed. Blockquotes have been reformatted to be inline quotes.

Hulsey v. Elsinore Parachute Center: Section headers have been removed, and case citations have been changed to a full citation on first reference.