Physicians and other healthcare professionals are human and will sometimes fail to meet up to standards of professional performance, either because of errors or of malfeasance. Some institutional infrastructure is essential to rein in such violations, but the question is how best to do so. Social and professional norms can be maintained by a variety of institutions. We can say that they come in two general types. As George Mason University economist Robin Hanson recently wrote[1]:

> "[O]ne can have either laws, or informal sanctions enforce[d] by 'mobs'. Both systems can discourage unwanted behaviors, and isolate unwanted people. So we usually face a choice: to discourage such things via law or via shunning (or both)."

With respect to the practice of medicine, for example, society can maintain standards in two general ways:

- Centralized, formal entities (e.g., legislative, executive, judicial bodies; regulatory agencies; officially sanctioned private organizations) can enforce formal laws, regulations, and professional codes. Enforcement involves state police powers.
- Decentralized social groupings (e.g., society-at-large, religious institutions, communications networks) can enforce norms via ostracism, acclaim, opinion, gossip, and private sanctions. Enforcement involves voluntary behavior of individuals, often mixed with elements of private coercion.

We can say that all of these methods and institutions constitute an expansive definition of occupational regulation. Importantly—crucially—the optimal design for these institutions depends highly upon the place and the time in which they operate. Below are some illustrative examples, drawn from my own personal experience. While the focus here is on the medical field, all of this is applicable to any professional field where practitioners have specialized knowledge that their customers lack.

Trust Communities and Distrust Communities

In 2008 or 2009, in the years leading up to the Affordable Care Act, I was at a roundtable meeting in Washington, DC. Public discussion had not yet degenerated into the hyperpartisanship that arose in late 2009, so the meeting included a large assortment of prominent policy wonks from sundry think tanks and trade associations from across the political spectrum.

At some point, one of the participants began waxing lyrical about some celebrated healthcare systems—Minnesota's Mayo Clinic[2], Utah's Intermountain Health[3], and Pennsylvania's Geisinger[4]. These institutions, he argued, are remarkable in their achievements and are characterized by a very close and quite unusual partnership between doctors and patients. He argued that whatever sort of healthcare reform Congress adopted, it needed to use Mayo, Intermountain, Geisinger and the like as the template for the whole nation. I raised my hand and said something like:

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[1] Robin Hanson, "To Sue Or to Shun," Overcoming Bias (Substack), August 27, 2023.
[2] Mayo Clinic website.
[3] Intermountain Healthcare website.
[4] Geisinger website.

> "I deeply admire all those institutions, too. But let me ask a politically incorrect, but serious question. Can you name any such institution that isn't located somewhere that isn't predominantly Lutheran, Calvinist, or Mormon?"

There was, as I anticipated and intended, a somewhat stunned silence. After a pregnant pause in the conversation, I continued:

> "Those models work wonderfully in communities where there is a high degree of social trust and a powerful aversion to filing lawsuits against one another. These models are terrific in places where there is an overwhelming sense of community and camaraderie. Having faith and a strong sense of community cohesion is highly valuable and, perhaps, essential to such a business model. **Try setting up a Mayo Clinic in Northern New Jersey," I said, "and see how far you get."**

Malpractice among the Nice

In 2012, I gave a talk in LaCrosse, Wisconsin, on the Wisconsin/Minnesota border. A number of physicians from Minnesota's Mayo Clinic were present, along with a similar number from the Gundersen Health System[5]—Wisconsin's equivalent to Mayo. Both institutions are renowned for their quality of care and for their degree of patient satisfaction.

During the discussion period, a questioner from out-of-state asked a Gundersen doctor to explain how his clinic handles malpractice actions. The doctor said that their arrangement was quite simple. Each doctor, he said, contributes some set dollar amount each year to a common fund, and whenever there was a malpractice settlement or judgment, the payout came from this fund. The doctor told the audience the size of each doctor's contribution and of the total fund. The questioner looked puzzled. "Those amounts sound awfully low," he said. he Gundersen doctor responded (and I paraphrase from memory):

> "Well, it is low, and there are a couple of reasons for that. First, people in Wisconsin are just generally nice people—they don't tend to sue each other a lot. But also, if one of us screws up and hurts someone—and it does happen—the patient hears the news straight from the doctor who made the mistake. We go to the bedside, tell the patient what happened, apologize, and promise that we'll do everything possible to minimize the effects of our error. They don't learn about the problem from some other doctor four years later."

A Death in the Family

Years before I was born, a member of my family, in her late 40s, became very ill. Her doctor had some sort of trip planned that week—possibly a honeymoon. (No one who remembers the story is still around to clarify the small facts.) As my relative grew sicker, the doctor went ahead with his plans, though townspeople who knew the case wanted him to delay his travels till more was known about the illness.

[5] Gundersen Health System website.

During his absence, a few days later, she died. She was well-known in town, and well-liked. People were livid. When the dust settled, the doctor packed up and left town—a drastic act in an age when people tended to stay put—particularly in small places like my hometown.

I don't think anyone contemplated suing the doctor. It just wasn't done in a place like that. In the eyes of many, the doctor had failed to meet the standard of care expected by the locals. And he self-punished by leaving forever—a far more devastating punishment than writing a check (or having your malpractice insurer write a check).

In his article mentioned above, Robin Hanson noted that with formal arrangements (e.g., malpractice lawsuits), communities must engage in arduous deliberations to agree on "how to specify what counts as a legal violation, and to fund the costs of enforcing related laws." Informal arrangements, he says, are more "nebulous" and "can often arise and change faster than with law." Importantly, with informal arrangements, punitive actions "can be triggered by information that would not be visible or verifiable to law."

In the case of my family's tragedy, did the doctor actually commit an act of incompetence or malfeasance? Had the case gone to litigation, would he have been found guilty in a court of law? From my memories of the story, I have my doubts that he would have. He wasn't the only doctor in town, and I suspect others were alerted to her case. I don't know whether she went without care after he left.

Nevertheless, as Robin Hanson argued, the community was free to devise its own standards of care and to revise them rapidly. And, for all I know, there was additional information, perhaps "not visible or verifiable to law." All I know is that this case was something of a family legend—something parallel to the cinematic notion of Frontier Justice. It was adjudicated only in the court of public opinion, but, so the family story went, justice was swift and stern.

I will venture a guess that in 2023, people in my hometown would be considerably more prone to file lawsuits than they were in the 1940s. Back then, doctors and patients were likely to have grown up together, to have been related to one another, to have lived near one another, and to have belonged to the same religious congregations and social organizations.. Today, those sorts of connections are far less common.

Mennonite Insurance

I mentioned some parts of the above three anecdotes during an online discussion. In response, I received an email whose contents dovetailed nicely with the stories. The author gave me permission to publish the following portion of the email, which I've edited slightly for punctuation and formatting:

> "I grew up conservative Mennonite and without insurance. But that didn't mean that we were without recourse in times of medical emergency. We had a 'brotherhood sharing plan' that members of the church contributed to monthly for large bills. Later, a member of the church was designated to negotiate with the hospital.
>
> In times of enormous bills, some groups did fundraisers. It provided a safety net, but you were responsible for smaller bills, and you knew how much your healthcare cost. You were also quite

motivated to keep costs low. Interestingly, when the hospital heard you were self-pay, they often dropped the bill considerably. They also usually had a deduction for immediate payments.

Many Amish and Mennonites still do this. It seems to me that there is a lot of motivation for innovation. For example, some plain people have developed a protocol to treat burns using a salve, developed by an Amish man, that includes honey and comfrey. It also uses burdock leaf as a wound dressing. It's much less painful and often results in much lower levels of pain and less scarring. They have even been able to use this protocol in at least one hospital.

Possibly one reason that some doctors are willing to work with them is because the Amish and Mennonites have a strict belief that suing at the law is wrong. Anyway, when I hear diatribes about medical health care and 'all the options' are laid on the table, I usually think, 'But wait, there are actually a few other options and people are actually using them.'"

Conclusion

Deciding whether to enforce social norms via formal or informal arrangements is an economic problem like any other. In a sense, formal oversight of occupations reflects a presumption, correct or incorrect, that informal arrangements have failed or are expected to do so. Equivalently, informal oversight can reflect a presumption, correct or incorrect, that formal arrangements have failed or are expected to do so. The challenge is in finding the sweet spot—the correct blend of formal and informal.

The point made here is that the choice of formal versus informal professional occupational governance is highly sensitive to geographic and temporal considerations. What is optimal for Wisconsin may be deeply suboptimal for Northern New Jersey, and what was appropriate for a small Virginia town in the late 1940s may be inappropriate for that same town in the early 2020s. All too often, policy analysts engage in a hunt for "the" optimal means of professional control. But, as in so many other areas of governance, one-size-fits-all can yield highly unsatisfactory results.

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